Safer Leeds: Community Safety Partnership

LEEDS DOMESTIC HOMICIDE REVIEW 'C'

OVERVIEW REPORT INTO THE DEATH OF DAWN RICHARDS

Report produced by Kathryn Shaw

Independent Chair and Author

ACKNOWLEDGEMENTS

Safer Leeds: Community Safety Partnership and the Domestic Homicide Review (DHR) Overview Panel would like to acknowledge the enormous impact for family members; and the difficulties of professional involvement and formal proceedings at a time of personal grief and loss.

This Domestic Homicide Overview Report would not have been possible without the co-operation and information supplied to the DHR Overview Panel by those invited to contribute through Individual Management Reviews.

This report reflects the views of the DHR Overview Panel who have invested their time, commitment and expertise which was invaluable throughout this process. The Panel and Overview Author also benefitted from the input and professional support provided by Leeds City Council Domestic Violence Team Manager and team colleagues.

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EXECUTIVE/PUBLIC SUMMARY

1. INTRODUCTION

All names in this report have been anonymised for publication and dissemination.

This summary outlines the key findings from the Leeds Domestic Homicide Review (DHR) Overview Panel in reviewing the murder of *"Dawn Richards";* a resident of Leeds prior to her death on Wednesday [redacted] 2013. The scope of the review will consider agency responses, contact and involvement with Dawn and her ex-partner *"Kenneth Ellis"* from 1st January 2009 to [redacted] 2013; this includes action and responses after the death of Dawn on the [redacted].

1.1. Agencies participating in this review

- Addiction Dependency Solutions (ADS)
- Adult Social Care (ASC)
- Crown Prosecution Service (CPS)
- HM Courts – Leeds Magistrates
- Leeds Children's Safeguarding Board (LSCB)
- Leeds City Council Housing Options
- Leeds Community Healthcare NHS Trust (LCH)
- Leeds Domestic Violence Service (LDVS)
- Leeds Housing Concern (LHC)
- Leeds Teaching Hospitals NHS Trust (LTHT)
- Leeds MARAC - Safer Leeds
- Leeds and Yorkshire Partnership Foundation Trust (LYPFT)
- NHS England (GP)
- Victim Support
- West Yorkshire Police
- West Yorkshire Probation Service (changed to National Probation Service & Community Rehabilitation Company on 1st June 2014)
- Yorkshire Ambulance Service

1.2. Overview Panel

The Panel consisted of members who were senior managers nominated by their agency with no previous involvement in the case, and with enough authority to effect change in their own agency. Some agencies have been reconfigured or renamed during the completion of this report. This report reflects the organisation as it was known at the date of their involvement.

Name and role of agency representative	Agency represented
Kathy Shaw: Independent Chair and Overview Author	Self-employed Safeguarding Consultant and Trainer
Linda Stevenson: Training Co-ordinator: Leeds Domestic Violence Team	DHR lead for Safer Leeds Leeds City Council
Supt. Samantha Millar: Superintendent for Partnerships	West Yorkshire Police and Safer Leeds (including MARAC)
Michelle Tynan: Chief Officer	LCC Adult Social Care
Susan Lines: Head of Service: Children Looked After & Safeguarding	Leeds Community Healthcare NHS Trust
Luke Turnbull: Designated Nurse for Safeguarding Adults (representing GP's)	NHS England West Yorkshire Area Team / Leeds Clinical Commissioning Groups
Jeff Barlow: Head of Safeguarding Caroline Ablett	Leeds Teaching Hospitals NHS Trust (LTHT)
Nik Peasgood and Kate Farrar: Service Manager, Leeds Domestic Violence Service	Leeds Domestic Violence Service (LDVS)
Lisa Parker: Head of Probation	West Yorkshire Probation Service
Bill Paterson	Addiction Dependency Solutions (ADS)
Lesley McLean: Divisional Manager	Victim Support
Rob McCartney Firaz Uddin	Leeds City Council Housing Options
Sharon Brown: Senior Manager Lesley Sendall	Leeds Housing Concern
Graham Bishop: Deputy Clerk to the Justices' for Leeds representing Magistrates Court	Her Majesty's Courts & Tribunal Service (HMCTS)

The author of the Overview Report has been commissioned by Safer Leeds to produce an independent report and has had no involvement in the delivery of identified services or line management for any service or individual mentioned in the report. The author and the Overview Panel agreed terms of reference and their responsibility to look openly and critically at individual and agency practice; to see whether this DHR indicates that changes could and should be made and if so, to identify how those changes will be brought about.

2. KEY ISSUES ARISING FROM THIS REVIEW

Key themes identified in the chronology and Individual Management Reviews

The Overview Panel identified three key themes where there is scope to improve practice relating to service provision, service providers and access to services.

- Service provision

Dawn often appears to fall between the gaps in referral criteria; she had mental health needs in terms of low mood, anxiety and risk of self-harm but these were too complex for some agencies. Options of support were limited unless Dawn addressed her use of alcohol, and this prevented her access to some other services. Dawn was clearly identifying she was unable to address her use of alcohol, and on occasion she did not want to be referred to other identified support agencies.

There were limited disclosures of her personal experiences of domestic violence and abuse, but there was evidence of [redacted] ongoing violence and abuse from Kenneth Ellis. Referrals from involved agencies to specialist domestic abuse services were limited; there was limited professional understanding of the risk and the fears Dawn was experiencing.

The DHR identifies that are limited resources in terms of specialist services providing accommodation or outreach to meet the needs for BME women who are experiencing domestic violence and abuse.

- Service providers

There was a tendency for some professionals to view domestic violence as physical violence and specific incidents; there was a general lack of understanding of the personal impact of stalking and harassment; or the risk associated with these behaviours. There was evidence that some services missed the cumulative nature of Dawn's reports of stalking; and dealt with incidents as "one-off" or minor events.

Culturally sensitive services were not a particular strength or feature in this DHR; several IMRs describe a range of policies and protocols but there was little evidence of how this transferred into specific practice adaptation, or consideration of the individual needs of Dawn as a black woman experiencing violence. It may be that the service provision reflected these qualities, but the IMR failed to fully explore and reflect this including after the opportunity for revisions.

Agency responses were often fragmented and demonstrated limited knowledge of what other support was available; evidence of effective information sharing and pro-active joint working was limited.

In order to promote a wider inclusivity and potentially improve the involvement of family and friends in the DHR process there is a need to strengthen the links to community based local groups and service providers.

- o Access to services

The presentation of Dawn as a person at risk of harm was not an immediate "fit" in terms of criteria to access services; there was apparent difficulty in responding to the complexity of her needs.

Dawn demonstrates the reality of research which identifies the barriers faced by black women when seeking help and support from a multitude of agencies. There appears to be little specific consideration of her ethnicity, cultural needs or personal history and how this might impact on her help seeking behaviours, referral information was sometimes incomplete and there was limited information sharing or examples of working cohesively.

The decommissioning of services and reduced funding has resulted in a negative impact on the provision of specialist services for women experiencing domestic violence and abuse.

- Theme 1: Service provision

i. Accommodation

- refuge and supported housing options, responding to the specific needs of domestic abuse, are limited
- specialist black and ethnic minority services in Leeds are diminishing rather than increasing or developing
- there are implications for the development and sustainable funding of specialist domestic abuse services and services for BME women in Leeds

ii. Commissioning priorities

- the provision of a comprehensive multi-systemic service model for domestic abuse, which is specialist based and includes direct services, refuges and community outreach is under threat

iii. Support services

- There is little evidence that Dawn was able to access support services which could address the complexity of her needs; and work with her on the issues she felt able to address
- There was limited evidence of an appropriate response from services which acknowledged the level of fear Dawn was reporting, or the potential risks from the situations she described. There is scope to improve service responses to risk assessment and risk management
- Effective case management and referral information has a positive impact on identifying and responding to risk; there is scope for this to be improved
- There is scope to evaluate and improve service responses to working with depression and risk of self-harm

- Theme 2: Service providers

iv. Develop understanding

The reviews identify that some agencies failed to fully account for the enormous impact of the stalking and harassment behaviour, or the fact that Dawn was clearly identifying the support she did not want. In terms of engagement it may be that Dawn became unwilling to access some services as she was being offered an intervention she felt did not reflect her needs.

- Practitioners and police responses need to demonstrate a wider understanding of the personal impact of stalking and harassment, and the associated risk of threats and violence
- There is scope to improve the response to disengagement and practice responses to working with resistance

v. Improve “joined up” working

The individual management reviews highlight that agency responses were often fragmented and there were few examples of cooperative or joint working.

- The individual management reviews highlight a lack of “joined up” work; services are often compartmentalised, criteria for referrals and moving on can limit access to support

- Information sharing and knowledge of other providers has the scope to be improved; some agencies demonstrated a lack of awareness of other providers and options of support, informed referrals were limited
- There was an identified need to improve knowledge and confidence for practitioners in working with disclosure of depression and risk of self-harm

vi. Improve responses to disclosures of domestic abuse

- Despite Dawn making several disclosures of domestic abuse there were limited referrals to specialist domestic abuse services
- Intervention for Kenneth Ellis was limited, and the effectiveness of this intervention was limited
- There were missed opportunities in the MARAC meeting to reduce risk and promote effective information sharing

vii. Improve responses to BME individuals and communities.

Some agencies demonstrated an inclusive way of working, but failed to recognise the individual needs or considerations that should inform culturally sensitive practice.

- There was little specific stated intention to describe how agencies responded to the individual needs of Dawn Richards as a black woman, and the particular and specific issues this presents. It is likely that several services failed to fully account for her increased vulnerability.
- Some agencies did not ask or were not given the ethnicity of Dawn at the point of referral
- There was little evidence that any separate consideration had been given to what cultural and ethnicity needs Kenneth Ellis may have, how this might impact on him, or how services might need to adapt their responses
- There is a need to develop consistent, pro-active and appropriate strategies to engage and support family and friends to contribute to the DHR process. Links with local community based organisations have created opportunities to pass on information through community advocates, this has particular relevance where the family have had limited or less positive contact with wider services. There is the capacity to strengthen and formalise links with these services as an integral part of future DHRs.

- Theme 3: Access to services

viii. Responding to harassment

Because the harassment was ongoing, Dawn sought help repeatedly. Analysis of her help seeking shows that:

- The barriers she encountered were substantial and effective support and specialist resources were limited
- Gaining access to help was often long delayed due to a lack of understanding of her needs, the risks she was experiencing or what support was currently available
- Options of support were limited through her use of alcohol and her choice not to address her use of alcohol; this resulted in a gap in agency support
- Several IMRs highlighted the need for agencies to consider risk management as part of case closure; to ensure that if a referral fails to meet the threshold for their particular service where possible an alternative referral should be made. Where a service will not be provided, cases should not be closed without ensuring information or support to access other agencies has been offered.

ix. Improving referral process

Services need effective referral information in order to successfully plan and adapt their provision to ensure this is accessible.

- Some agencies do not routinely ask a referral question relating to misuse of alcohol or whether domestic violence and abuse is an issue that requires support.
- Ethnicity was missed from some referral information

Summary:

The underpinning principle to improving service responses is that any agency intervention or offer of support to Dawn should have acknowledged the disclosure of 30 years of domestic abuse and the impact on her mental health; and provided referral and appropriate support to access alternative services if they were unable to meet her identified needs.

3. <u>Conclusions from the Review</u>

This review began on 18th September 2013 and was concluded on 29th May 2015. The guidance indicates that reviews including the Overview Report should be completed where possible within six months of the commencement of the review. Although individual

agencies have progressed their action plans this delay is unacceptable, and at times it has been difficult to drive the process forward. This is discussed further in the report and addressed in recommendations.

The Panel identified that there were missed opportunities to respond to the potential for Dawn Richards to be seriously harmed; but there was no indication that this homicide would have been prevented by the action of an individual or specific agency. The Panel reflected that there has been an overall failure to provide Dawn with the help she needed at the time she asked for it, and there was significant learning where some service providers could learn lessons and improve practice. Dawn declined the intervention of some services, and would not consent for some information to be shared which impacted on the evaluation of risk and provision of support. This was also a contributing factor to why there wasn't any significant external relationship or sustained agency engagement to support Dawn. However this review highlights the responsibility of agencies to be more proactive, and to understand and respond to the reasons why some people disengage.

There is scope to improve responses to BME individuals and communities. Some agencies demonstrated an inclusive way of working, but failed to recognise the individual needs or considerations that should inform culturally sensitive practice. The DHR identifies that Leeds has limited options of specialist services to meet the needs for BME women who are experiencing domestic violence and abuse.

There is a significant gap in information in the twelve months prior to Dawn's death and from the information available to this review there was no contact with any agencies during this time. We have no records or information from family and friends to confirm the reasons why Dawn was not in contact with any services.

The Panel identified that the opportunity of the DHR provided a collective overview which was not available to single agencies involved with Dawn at the time. The reflective process of the DHR has identified areas of improvement and if all agencies had been working to their optimum there is scope to have done more, but there is the risk that this assessment is partially based on hindsight. The Panel agree that the agency contact with Dawn highlights significant areas where service providers should and will learn lessons and improve practice. These are detailed in the Panel Recommendations and Agency Recommendations, in section 7 of this report.

LEEDS DOMESTIC HOMICIDE REVIEW (DHR)
OVERVIEW PANEL

CONCLUDING REPORT: DHR ‘C’

1.0. INTRODUCTION

All names in this report have been anonymised for publication and dissemination.

1.1. Summary of the incident that led to a DHR

At 3.07 am on Sunday [redacted] 2013 a call was passed to the Police from the ambulance service, they had responded to a call from the public who reported finding a seriously injured female in a car parked in Chapeltown, Leeds. This woman was later identified as "Dawn Richards", and she was reported to have life threatening injuries.

Dawn was transferred to an ambulance and she was admitted to the Intensive Care Unit at Hospital 1. "Kenneth Ellis" her ex-partner was arrested on suspicion of the attempted murder of Dawn Richards at 5.15am that morning. He had significant injuries caused by a separate incident and was admitted to Hospital 1.

Dawn's condition did not improve and she never regained consciousness, ten days later at 8.45pm on Wednesday [redacted], Dawn Richards died as a result of her injuries.

On [redacted] Kenneth Ellis was discharged from Hospital 1 and was taken to the police station where he was charged with her murder. On the [redacted] 2013, Kenneth Ellis was convicted of the murder of Dawn Richards at Leeds Crown Court, and sentenced to life imprisonment.

1.2. Statutory Requirement for a Domestic Homicide Review (DHR)

The requirement for Safer Leeds: Community Safety Partnership to conduct a Domestic Homicide Review is detailed in statutory guidance from the Home Office (2013) *Multi Agency Statutory Guidance for the conduct of Domestic Homicide Reviews.*[1]

The key purpose for undertaking a Domestic Homicide Review (DHR), as identified in the statutory guidance, is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence. DHRs are a vital source of information to inform national and local policy and practice. In Leeds, all involved agencies have a responsibility to identify and disseminate common themes and trends, and act on any identified lessons to improve professional practice and our safeguarding responses. In order for these lessons to

[1] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

A decision was made to recommend a DHR should be undertaken and the Home Office was notified on 18th September 2013. The grounds for doing so were based on the information available at the time, and that the following criteria for undertaking a Domestic Homicide Review (DHR) were met:

"A review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by –
(a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death". (Domestic Violence Crime and Victims Act 2004, s9:3)

The scoping enquiry was sent to 17 agencies for initial information relating to contact with the deceased and her partner.

- Addiction Dependency Solutions (ADS)
- Adult Social Care (ASC)
- Crown Prosecution Service (CPS)
- HM Courts – Leeds Magistrates
- Leeds Children's Safeguarding Board (LSCB)
- Leeds City Council Housing Options
- Leeds Community Healthcare NHS Trust (LCH)
- Leeds Domestic Violence Service (LDVS)
- Leeds Housing Concern (LHC)
- Leeds Teaching Hospitals NHS Trust (LTHT)
- Leeds MARAC - Safer Leeds
- Leeds and Yorkshire Partnership Foundation Trust (LYPFT)
- NHS England (GP)
- Victim Support
- West Yorkshire Police
- West Yorkshire Probation Service (changed to National Probation Service & Community Rehabilitation Company on 1st June 2014)
- Yorkshire Ambulance Service

2 agencies responded as having no contact with either Dawn Richards or Kenneth Ellis.

- Nil return from Leeds and York Partnership Foundation Trust
- Nil return from Leeds Safeguarding Children Board

- Yorkshire Ambulance Service had no contact with the subject of the review prior to the emergency call on Sunday [redacted] 2013.
- CPS were contacted to provide specific information relating to questions identified by the Panel
- Leeds Teaching Hospital Trust: some medical records were missing and not reviewed in scoping, but a full IMR was submitted by LTHT

The remaining agencies responded with information indicating some level of involvement with Dawn Richards and Kenneth Ellis. Thirteen agencies were asked to provide an individual management review (IMR) and a detailed chronological account of their contact during the time period under review.

An independent author was appointed to write the Overview Report and chair the Panel meetings. Terms of reference were agreed collectively and a chronology of each agency involvement was completed covering the timeframe agreed in the terms of reference, and merged using systems approved in serious case reviews.

All agencies were asked to confirm the date their records were secured and IMR authors were asked to identify how the findings from each IMR would feedback to staff.

1.3. Timescales

This review began on 18th September 2013 and was concluded on 29th May 2015. Reviews including the Overview Report should be completed where possible within six months of the commencement of the review. Although individual agencies have progressed their action plans this delay is unacceptable, and at times it has been difficult to drive the process forward.

There have been various contributing factors to delays; initially there was a delay in some agencies returning scoping which impacted on the ability to identify who should be asked to provide an IMR. Some agencies struggled with the process of identifying an IMR author, or failed to meet deadlines set for the return of completed reports or revisions which delayed the Panel members meetings to review completed documents. Panel recommendations include profiling and promoting the DHR process to engage and include partner agencies.

At the latter end of completing the report there were several months of working sensitively through a community advocate to explore the principles of family members contributing to the review, and this had some influence on timescales.

The impact of the DHR process on local capacity, resources and availability cannot be underestimated, and at the time of this report Leeds are currently managing 10 Domestic Homicide Reviews. Often the same Panel members are reviewing reports and attending Panel meetings and this has a bearing on the ability to deliver "learning lessons", there are issues to anticipate in the management of a realistic action plan which merges all the relevant recommendations from so many reports.

Safer Leeds represented by members of the Domestic Violence Team have been proactive in improving systems, and although there is scope for further changes this has continued to be a focus for discussion at strategic and operational level. This is discussed further in "learning lessons".

1.4. Confidentiality

In all cases the Overview Report and Executive Summary should be suitably anonymised and made publicly available. IMRs should not be made publically available.
(DHR guidance 2013: 74)

Safer Leeds: Community Safety Partnership is following the Home Office DHR guidance in publishing a Public Summary and Overview Report which are anonymised in order to protect the identity of the deceased and family members. All members of the family have been given fictitious names, rather than initials. The report has identified professionals and other individuals through job titles in order to comply with these principles of confidentiality and Data Protection Act (1998).

Panel members agree and sign a confidentiality statement at the first panel meeting which details information sharing; and identifies that all material generated or obtained in the DHR whilst the criminal case is ongoing can be made available to the police to assess whether it is relevant to the criminal case (Appendix 1).

The detailed findings of each individual management review (IMR) are confidential and will not be published, but relevant points are summarised in this report. Each IMR has been fully discussed with the DHR Overview Panel; and identified issues have been shared within their own agency to form recommendations and action plans where appropriate.

The DHR Overview Report will not be published or disseminated until directed to do so by the Home Office Quality Assurance Group and may be subject to Home Office approved redaction[2] before publication. Once agreed the Overview Report and Executive Summary will be published on the Community Safety web page; this is currently in development.

The findings of the review are regarded as 'Restricted' until the agreed date of publication. Prior to this, information has been made available only to participating professionals and their line managers who have a pre-declared interest in the review. Any other appropriate sharing of information such as with family members would be agreed by the DHR Overview Panel.

1.5. Methodology to the Overview Report

The Overview Report is informed by systems methodology and the principles of forensic social work. This means looking at how the actions of professionals are influenced by the organisations and systems in which they are working; and the application of social work to questions and issues relating to the law and legal systems. In a DHR context this also relates to understanding and responding to the implications of domestic abuse. Data triangulation has been used to increase the validity of the recommendations. This means through using different sources of information it has been possible to ensure that learning and findings are supported by the evidence from individual management reviews, research and Overview Panel and Author analysis.

- Independent author

The DHR author is an Independent Safeguarding Consultant and trainer; an experienced Children Services Manager and registered social worker qualified to Advanced level and MSc Advanced Professional Practice in Social Work. The author has extensive experience in operational and strategic development and delivery of family centred services, including refuge provision. The author of the Overview Report has been commissioned by Safer Leeds to produce an independent report and has had no involvement in the delivery of identified services, or line management for any service or individual mentioned in the report. The author and the Overview Panel will look openly and critically at individual and agency practice to see whether this DHR indicates that changes could and should be made and if so, to identify how those changes will be brought about.

[2] There may be editing or revisions made

The DHR Overview Panel met 5 times to agree terms of reference, receive and analyse the evidence from IMRs and draft Overview Report. The Panel considered equality and diversity issues throughout the process which informed how the review was conducted. It was identified that the membership had the skills and knowledge to address the particular complexities of this DHR, and relevant understanding of the impact of domestic abuse and the particular considerations for Dawn Richards required in this review. Specialist agencies were identified as potential consultants to the Panel for any specific issues the membership felt unable to resolve.

- Case briefing meetings with West Yorkshire Police

Case briefing meetings were arranged with the Chair, Safer Leeds and the Senior Investigating Officer at the time of these meetings this was part of West Yorkshire Police Homicide and Major Enquiry Team. Ongoing communication through email and phone contact ensured this process and information sharing was current and appropriate to the case. Information sharing with the police was based on the DHR Overview Panel confidentiality agreement (Appendix 1).

1.6. Family involvement

In any domestic homicide members of informal support networks such as family, friends and colleagues are often the best people to help professionals understand what happened. This also gives people their opportunity to ask questions and suggest other people they think should contribute. The Chair and Safer Leeds discussed family contact with the police Senior Investigating Officer and Family Liaison Officer and agreed that family members and friends, including the ex-partner of the deceased should be contacted in order to ensure that they were aware of the DHR process, have the opportunity to be involved and extend the learning of the review.

Family members were initially contacted through West Yorkshire Police Family Liaison Officer to obtain permission before contact was made by letter from the Chair. Several attempts were made to engage the family before the first Panel meeting without success, including the offering the opportunity to discuss the process informally before making any decisions. There was no response to letters and information about the DHR process sent to family and friends. Further letters were sent at the midpoint of the review.

A community group was identified as being in touch with some individuals and acted as intermediary over a few months from January 2015. This offered family and friends another opportunity to explore the possibility of being involved with the DHR process. A number of contacts were made through a known worker and issues that were relevant to the family were explored through this third party. It was vitally important to the family that assurances of confidentiality were given, and that they felt in control of any information shared. A direct contact was agreed in April 2015 but at the last moment family members felt too distressed to attend. In May 2015 we agreed that although the absence of any input from family or friends made an incomplete report, the decision not to contribute was understood and respected. The involvement of local community groups has been identified as essential in contacting and engaging people who are seldom heard and often ignored by formal consultations and reviews. The learning points from this process, and an input from the community group is explored further in "learning lessons". The method of contacting families is being evaluated; exploring approaches used in other areas to try to find a proactive and respectful way forward for future reviews.

The perpetrator, Kenneth Ellis was initially sent a letter informing him a DHR would be taking place, giving him the opportunity to ask any questions, but no response was received. Further contact with Kenneth Ellis was proposed by a panel member to establish if any relevant information could be established about the twelve months prior to Dawn's death when she had no contact with agencies. This left it unclear whether the harassment and stalking continued and Dawn simply felt unable or unwilling to engage and continue to report these events. It may be that there was reconciliation, or that Kenneth responded to the intervention of the Court and stopped making any unwanted contact.

Contact with the Offender Manager at Probation and prison Offender Supervisor was made to discuss whether this would be an appropriate consideration in this case. There were no immediate contra-indications and information was sent to the prison officer to discuss this further with Kenneth Ellis who agreed to a meeting. This was arranged for 17th April 2015; the Offender Manager had intended coming but was unable to attend.

It was felt that any input could also add value to the overall review in terms of context and history of this relationship, dependent on what information Kenneth felt he would share. During the structured programme with Probation Kenneth had continued to deny all offences, and failed to understand the reason for the court orders. It was unclear what motivated Kenneth to agreeing to this meeting as he had made no comment during the police investigation, and his last Offender Assessment was over a year ago, where he

continued to deny the offence and the history of a violent relationship. At this stage Kenneth is eighteen months into a life sentence and had no contact with the Offender Manager and had not met his Offender Supervisor prior to our meeting.

At the meeting there were elements of victim blaming and an absence of demonstrable guilt or remorse, and Kenneth continued to deny some aspects of the facts that had previously been proved. The visit did provide learning and the opportunity to add value to the Overview report, which is detailed in section 6.

We acknowledge the difficulties of any formal proceedings and professional involvement at a time of personal grief and loss; and although we feel the review would be incomplete without the input from family and friends, it is essential their decision not to participate is completely respected.

2.0. TERMS OF REFERENCE

The DHR Overview Panel agreed the following terms of reference to direct and support the Domestic Homicide Review into the death of Dawn Richards.

2.1. DHR Overview Panel: purpose for this DHR

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence.
- Identify clearly what those lessons are both within and between agencies, how those lessons will be acted on, within what timescales and define what will be expected to change as a result
- Assist in the prevention of future domestic homicides and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working
- Ensure that any findings which relate to children or vulnerable adults at risk are referred to the appropriate boards.
- Identify good practice and ensure this is disseminated.
- Give appropriate consideration to any equality and diversity issues that appear pertinent in relation to the victim or perpetrator

2.2. DHR Overview Panel: focus and key questions to address in this DHR

All IMRs will consider the events that occurred, the decisions and actions of their agency and include the areas defined in the terms of reference; using the format for IMRs identified in the statutory guidance. The DHR Overview Panel identified that the following areas would be addressed in the Management Reviews and the Overview Report:

KEY LINES OF ENQUIRY

1. Agency response to Dawn Richards

- Had Dawn disclosed her experiences of domestic abuse to anyone and if so, was the response appropriate? Were the risks of further violence identified and responded to; please detail what intervention increased her safety.

- Was the use or misuse of alcohol an issue that contributed to decisions made about access or service delivery? If so, please describe what assessments informed these decisions.

- When, and in what way, were the wishes and feelings of Dawn ascertained and considered? Was she informed of options/choices to make informed decisions? Was she given the right information? Was she supported to make contact with other agencies?

- Were practitioners sensitive to the needs of Dawn, knowledgeable about potential indicators of domestic violence and aware of what to do if they had any concerns? Did practitioners have the appropriate level of training and knowledge to fulfil these expectations?

- How accessible were your services for Dawn? Explain how your procedures and service provision address the ethnic, cultural, linguistic and religious identity of Dawn Richards and her family; how do you promote access?

- Are there lessons to be learned from this case relating to the way in which your agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators?

- Did you identify the risks as meeting the criteria for a MARAC referral; following the assessment from your agency were there any opportunities to refer to MARAC which were overlooked?

2. Agency response to Kenneth Ellis

- What was your agency involvement with the perpetrator?

- Was Kenneth Ellis identified as a perpetrator of domestic abuse: if so, how was risk of further abuse assessed and responded to?

- Were practitioners sensitive to the needs of Kenneth, knowledgeable about potential indicators of domestic violence and aware of what to do if they had any concerns? Did practitioners have the appropriate level of training and knowledge to fulfil these expectations?

- How accessible were your services for Kenneth? Explain how your procedures and service provision address the ethnic, cultural, linguistic and religious identity of Kenneth Ellis; how do you promote access?

- Are there lessons to be learned from this case relating to the way in which your agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators?

- Did you identify the risks as meeting the criteria for a MARAC referral; following the assessment from your agency were there any opportunities to refer to MARAC which were overlooked?

3. Information sharing

- Did you have the necessary information available at the right time from referral through to case history and relevant family information? Were there any significant gaps in the information; did information sharing impact or affect your service responses?

- Was information consistently recorded to the required standards? Did your agency ensure that the necessary information was available to other organisations; have you identified any areas for improvement?

4. Policies, Procedures and risk assessment

- Did the agency have policies and procedures for risk assessment such as DASH; and risk management for domestic violence victims or perpetrators, please describe. Were these assessments correctly used in this case? Did the agency have policies and procedures in place for dealing with concerns about domestic violence and were domestic violence protocols complied with? Were these assessment tools, procedures and policies professionally accepted as being effective?

- Dawn Richards was subject to a MARAC – what is the response from your agency if you receive notice after a MARAC that agencies are requested to "Flag and Tag"? How do you do this, is your system effective? Does this alert the right people, and ensure the right information is available to increase safety?

- Do assessments and decisions appear to have been reached in an informed and professional way? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments? Were any opportunities missed? Have you identified any areas for improvements?

- Were senior managers or other agencies and professionals involved at the appropriate points?

- Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

5. Good practice

Have you identified ways of working effectively that could be passed on to other organisations?

3.0. FACTS

3.1. Family members (anonymised); all resident in Leeds in August 2013

Dawn Richards	Black British	Died [redacted] 2013 aged 51 years
Kenneth Ellis	Black British	Ex-Partner of deceased. Convicted of her murder on 18th December 2013.
Michael Richards *Dawn's son*	Black British	Adult at the time of Dawn's death
Mark Richards *Dawn and Kenneth's son*	Black British	Adult at the time of Dawn's death
Melanie Richards *Dawn and Kenneth's daughter*	Black British	Adult at the time of Dawn's death

3.2. Case summary and brief chronology

The subject of this review is Dawn Richards; she is described as Black British. Dawn was a single mother of three adult children aged Adult years in [redacted] 2013. In May 2012 Dawn moved to an independent tenancy in a local authority property, and at the time of her death she lived in a two bed roomed flat in Leeds, with the youngest of her three children.

The perpetrator Kenneth Ellis is described as Black British; he also lived in Leeds and was the father of the two younger children. Dawn and Kenneth had been in a violent and abusive relationship for 30 years which ended in February 2009. In a statement to CPS, Dawn detailed a history of physical abuse that started in 1985; she did not report this to the police or other agencies at the time because of her fear, and she stated they ended the relationship "due to the children" but did not offer any additional information.

After February 2009, Dawn reported several occurrences of theft and damage at her address to the police; and reported ongoing abuse which included stalking behaviours. Dawn identified that Kenneth was responsible; she also stated that she had been in fear of her ex-partner for many years. Dawn told several agencies how the incidents of stalking and harassment made her feel extremely vulnerable; she was scared to go out of the house and often felt suicidal. She was worried Kenneth would get into her house, and she was scared he would kill her.

Dawn had contact with Alcohol Dependency Solutions through her GP; she was discharged in June 2010 due to not attending appointments and had one further contact in December the same year but no ongoing work was undertaken.

Housing records noted that in January 2011 that Dawn wanted to be rehoused because of harassment from her partner; there is no indication of any action being taken.

On 20th September 2011, Kenneth received a harassment warning from the police.

Dawn threatened to kill herself on 3rd and 7th October 2011 in the presence of a PC from the Police Safeguarding Unit, who made a referral to Adult Social Care with concerns about the reported harassment and domestic violence, and Dawn's mental health. A social worker contacted Dawn the same day. Dawn believed Kenneth Ellis her ex-partner has stolen her passport, driving licence, birth certificate and car keys. Dawn stated she wished she could take her own life but would not do this because of her son, daughter and 2 grandchildren. Dawn reported she had support from her GP who had referred her for counselling and that she was in touch with housing. Concerns were noted about Dawn's mental health in view of her comments about wishing to kill herself; but a specific diagnosis is not known or recorded. Dawn did not want support from ASC and they ended their involvement.

Police referred Dawn to Behind Closed Doors on 4th October after Kenneth received a harassment warning. Dawn said she did not want to take up support as she did not want to get Kenneth into trouble.

In October 2011 contact centre staff at Leeds Housing Options received information that Dawn was fleeing domestic violence from her ex-partner; the housing officer contacted the police and reported that her ex-partner had stolen a key and was entering her property at will. Dawn stated she was scared for her safety in her current accommodation and had attempted to end her own life on several occasions. Dawn said this had been reported to the police on numerous occasions, she was frightened all the time including a fear that he would kill her; she was very upset that the police did not appear to be doing anything. She was very angry and distressed at the way she felt she had been passed about from service to service and felt no one cared about her. The locks were changed at the property as a security measure and although her cable TV wire had been cut she did not report any further violent incidents.

The GP made a referral to Primary Care Mental Health Services and Dawn attended an initial appointment on 10th November 2011 which identified Dawn had a complexity of issues that could not be met by the service.

. Dawn indicated she had thoughts about ending her life and sometimes felt life was not worth living, and had attempted suicide in the past when she was 18 and took an overdose. The case was closed on 6th December 2011.

There were 20 separate instances when Dawn contacted police in Leeds to report incidents of harassment and stalking or related offending by Kenneth Ellis. A harassment warning was issued following the third report in September 2011; he was arrested but released without charge in October 2011. On one occasion in December 2011 the police were contacted by an external agency with concerns over Dawn's welfare. Dawn's son also contacted the police in January 2012 to report he was concerned about his Mum. Following the reports from Dawn police attended and found there was no corroborating evidence to prove that Kenneth had been at the property, and no further action was taken. It was not until the 16th report from Dawn in January 2012, after the contact from Dawn's son that a proactive investigation was initiated. This resulted almost immediately in the obtaining of evidence which was sufficient to sustain a prosecution.

In January 2012 Dawn obtained a non-molestation order from the court against Kenneth, and a CCTV camera was installed at the address. The damage to her property and car continued and Kenneth was identified on camera as causing the damage. The charge sheet in relation to the breach of non-molestation allegations is marked by the police as Dawn being a vulnerable victim.

In March 2012 police received information that Dawn carried a knife with her for personal protection as she was in fear that Kenneth Ellis would kill her, and she also kept a knife in the drawer at the side of her bed for protection.

On 3rd March 2012 Kenneth Ellis was arrested for 2 breaches of a non molestation order by going to Dawn's address, on 30th March he was in court for breaching these conditions again. He was released on bail conditions.

Dawn rang the Police Safeguarding Unit (SGU) following another threatening incident on 2nd April, and she said she needed to move that day. SGU arranged for her to go to Leeds Women's Aid emergency accommodation. Leeds Women's Aid (LWA) received paperwork the next day on 3rd April 2012 relating to a MARAC referral which would be held on 12th April. This included information and history that was previously unknown to LWA and based on this Dawn was assessed as too high a risk for shared accommodation, as she was known to carry an offensive weapon and refuge provision could not provide 24 hour staff cover. Dawn

was moved from LWA to alternative shared accommodation provided through Leeds Housing Concern (LHC) on 5th April 2012.

Dawn informed the housing support worker on 9th April 2012 that Kenneth had not contacted her since she had been in the hostel, although it later became apparent that Dawn believed another resident had told Kenneth she was there and that he had been to the hostel throwing stones at her window.

Dawn had no contact from HALT who provide the IDVA (Independent Domestic Violence Advocate) service. The MARAC paperwork indicated Dawn was accommodated in Leeds Housing Concern (LHC) with support from Victim Support therefore no contact was required. It was later identified that Victim Support was not in contact.

Housing reported at the MARAC meeting in April 2012 that Dawn had a Band A (priority for rehousing) since December 2011 but that she was bidding in high demand areas. The action points from this MARAC meeting were for LHC to propose to Dawn that she should be bidding in alternative areas, and for all agencies to "flag and tag" for 12 months. The purpose of flag and tag is to identify any further incidents within a year of the last referral to MARAC. Each agency may have a different method of putting a marker on these files but CAADA[3] require that all MARAC agencies should have the capacity to 'flag and tag' their files following the latest referral, so that they are aware if a service user/client experiences a repeat incident. The case was closed the same day for agency management and ongoing support.

In May 2012 Dawn moved to an independent tenancy in a local authority property. In June 2012 Kenneth Ellis was sentenced to a Community Order for 2 years with a supervision requirement of 2 years, the non-molestation order was in force to December 2012.

Dawn moved to her new property on 14th May 2012.

Probation contact was undertaken by the Victim Services Unit in August 2012. Dawn was visited at home and she stated she did not want to know any information and wanted to be left alone. She had moved to another address and had no contact with Kenneth Ellis, but she was angry he had not made contact with his children.

Kenneth was assessed as suitable to attend the Probation Integrated Domestic Abuse Programme (IDAP) starting on 12th September 2012. The tutor noted Kenneth was able to challenge other people's abusive behaviour but did not apply it to himself and he denied using power and control in his own relationships. Although he attended the programme

[3] Coordinated Action Against Domestic Abuse - CAADA

Probation notes indicated limited participation, Kenneth continued to deny the impact of his violence, failing to take any responsibility and demonstrated attitudes supporting male dominance and victim blame. He accused Dawn of lying to the police and stated he was baffled as to why the restraining order was put in place.

There was no recorded contact with Dawn from any agency in the twelve months preceding her death. Dawn Richards died on [redacted] 2013.

3.3. Agency Involvement

The Overview Report is based on information from Chronologies and Individual Management Reviews. The DHR Overview Panel has received and considered the following Individual Management Reviews (IMRs):

- **ADDICTION DEPENDENCY SOLUTIONS (ADS)**
  The IMR Author is a Service Manager based in Preston.

At the time ADS had contact with Dawn in 2010 they were commissioned to deliver advice and information services (Tier 2) based in GP practices; designed to target non-dependent drinkers where alcohol is becoming problematic.

Panel and Overview Author Analysis

The Panel identified that the issue of alcohol use is critical in terms of understanding how this may have presented as a barrier to Dawn accessing other services which may have provided more support; this has been an issue that has come up in several agency reviews, and ADS was identified as providing the best assessment as a specialist provider.

The GP told police officers in November 2011 that Dawn "often attends the medical centre after consuming alcohol" but they had no major concerns, and Dawn had refused offers of counselling. ADS have an agreement to share information with the GP; it is unclear from this review whether the worker accessed further information although this could have provided relevant background. Although the appointment time was very limited, an appropriate referral was made to a more suitable service for a dependant drinker but Dawn failed to attend any appointments for assessment. It is clear from the benefit of wider information and the reviews from other agencies that Dawn did not want to stop drinking; this appears to be a protection from dealing with her circumstances and traumatic life experiences from 13 years of age. In terms of engagement it may be that Dawn became

unwilling to access services, as she was being offered an intervention she felt was not appropriate.

There appears to be no disclosure of domestic abuse, apart from the reference in her first appointment describing a “difficult history”; Dawn walked out of her next contact as she wanted anger management not alcohol treatment. It was agreed that the original referral was not an accurate reflection of her needs at the time and the service changes would now address this difficulty. The opportunity to refer to MARAC and improvements to case recording are in the recommendations.

- **ADULT SOCIAL CARE (ASC)**
  The IMR Author is a Safeguarding and Risk Manager.

In Leeds the majority of referrals made to Adult Social Care are through a central contact centre. They are sent to the area team depending on the geographical area where further screening takes place so that a decision can be made how best to deal with the referral.

Panel and Overview Author Analysis

It was not recorded whether or not Dawn Richards was aware that a referral to ASC was being made on her behalf by the Police and/or if she had given consent for this. Had consent for the referral been sought prior to it being made, it was viewed by the panel as unlikely that she would have given her consent, as Dawn was contacted on the day of the referral and refused adult social care support. The issue of referral and consent for adults with capacity was raised in the review of this IMR and the Panel have discussed this at length in other DHR Panel meetings and it has been a continued area for debate. It was agreed this will be included in the Overview report.

There were significant indications that Dawn was at risk of self-harm so this should have raised a safeguarding response relating to her children/grandchildren, and also to establish if they were at risk of harm through witnessing domestic abuse. Information should have been taken to clarify this, and the introduction of the Front Door Safeguarding Hub will improve future practice. The Panel noted in the IMR that following the partnership model between the police and children’s social work services; a joint initiative between police and ASC is also being developed for future practice improvements focussing on work with adults which will become operational in 2015. This would have provided a more effective and integrated support for Dawn if this had been available at the time.

The panel noted that the changes identified in the IMR would support ASC to evaluate the training provision on domestic violence and abuse, and to ensure access is promoted for

ASC operational staff. The review notes that ASC and operational staff across all agencies working with victims of domestic violence would benefit from joint training and that finding the resources to deliver this will be problematic; this informs the wider training recommendation in the Overview Report.

The Panel responded to discussions relating to practice responses to self-harm. It was agreed that staff need to be aware of correct pathways and NICE guidance; and Leeds should have a protocol and training to support this.

The Panel felt that although contact was minimal and not current, the IMR illustrated the need for the Overview report to reflect that if a referral fails to meet the threshold for a particular service how important it is for practitioners to be referring to appropriate support; rather than closing cases without ensuring access or information has been given.

- **HM COURTS – LEEDS MAGISTRATES** (brief management report)
  The BMR Author is a Legal Team Manager at Leeds Magistrates Court

Most criminal court cases start in a magistrates' court, and more than 90 per cent will be completed there; the more serious offences are passed on to the Crown Court.

Panel and Overview Author Analysis

In terms of learning lessons and preventing a similar event in the future, it was discussed if exclusion requirements and non-molestation order could be effective as a joint response, particularly as Kenneth Ellis was apparently blatant in his disregard of court orders, and appeared to be unwilling to change his behaviour.

The court had information missing from the pre-sentence report which included the call-out information from the Police and the social care report which may have impacted on the risk assessment. It was identified that for many incidents of domestic abuse Magistrates do not get the full information, they get a brief overview of the incident, and no-one had the complete view the Panel has now.

The Panel debated how the process could be improved; the DHR could provide an opportunity to examine exclusion requirements, non molestation orders and boundaries and the process of analysing risk. The Panel representative will take this back for discussion and training could be offered to Magistrates in the future from members attending the Panel, to support understanding and promote opportunities of learning from this DHR.

- **LEEDS CITY COUNCIL: HOUSING OPTIONS**
  The IMR author is Head of Housing Support

Leeds Housing Options is the local authority advice service for people who are homeless or at risk of becoming homeless.

Panel and Overview Author Analysis

It was noted that this IMR was the only report to reference comments from customers which should be noted as good practice. In October 2011 Dawn provides a very clear indication of her state of mind and her view of service involvement; “She was very angry and distressed at the way she felt she had been passed about from service to service and felt no one cares about her.”

The Panel felt it was significant to highlight the issues around Dawn being in possession of a knife, she was openly sharing with agencies that she carried this for her personal protection. There has been a general issue about improving information sharing at the point of referral, relevant Panel members were asked to identify areas for improvement.

The Panel noted in the IMR that Leeds Housing Options will look at any improvements that can be made in respect of communication between agencies regarding the suitability of move on accommodation.

- **LEEDS COMMUNITY HEALTHCARE: NHS TRUST (LCH) :** Primary Care Mental Health Service (PCMHS)
  The IMR Authors are a Named Nurse for Mental Capacity and dementia, and a Named Nurse for Safeguarding Adults.

Leeds Community Healthcare NHS Trust is responsible for providing community healthcare services in the Leeds area.

Panel and Overview Author Analysis

The issue of referral and consent for adults with capacity was raised in the review of this IMR and similarly to contact with some other agencies it was unclear if consent was gained from Dawn to refer her to other agencies; it has been a continued area for debate in other DHRs. It was agreed this will be included in the Overview Report.

The 45 minutes screening appointment indicates that support services were offered but declined and the practitioner achieved a successful engagement in a short space of time; this level of disclosure was not generally indicated in contact with other services. Dawn

seemed to connect and disclose information, which is a good example of her ability at this appointment to share difficult things. The disclosure of historic sexual assault may have contributed to Dawn's use of alcohol to cope with difficult feelings, and her reluctance to consider reducing her use of alcohol. Potentially Dawn had been drinking before this appointment, (the practitioner said the room smelt of alcohol) and if she had been intoxicated she may have revealed more information than she would do otherwise.

It appears that this was a time when Dawn was able to make significant disclosures, but overall services have not been able to fully respond to her needs, this has been highlighted across a number of agency IMRs. Dawn appears to fall between the gaps in criteria; she has mental health needs in terms of depression, anxiety and self-harm but these are too complex for some agencies, her use of alcohol prevents access to some services and she does not want support from some recommended agencies. Dawn did seek support from specialist domestic abuse services, but she was assessed as too high a risk for shared accommodation as she carried a knife.

It was good practice that the risk of violence to her and others was discussed at the screening appointment, and Dawn disclosed important and relevant information. The Panel agreed that any agency response to Dawn should acknowledge the disclosure of 30 years of domestic abuse and the impact on her mental health, and provide referral and appropriate support to access alternative services if unable to meet her identified needs. PCMH suggested several possible support services which were declined. It is not documented if referrals to alternative mental health services were considered, responding to the disclosure that Dawn felt suicidal and was severely depressed. The Panel noted that there had been problems contacting the police domestic violence co-ordinator and the police representative will reflect these back through appropriate channels and address any issues raised.

The Panel discussion reflected that domestic violence within LCH has traditionally focused on children's safeguarding, and LCH is currently evaluating how to improve knowledge of safeguarding adult processes, such as MARAC across all services. It was useful for MARAC systems to note that safety plans such as the action identified in Dawn's case for "flag and tag" is not picked up by LCH community services for adults who do not have children under the age of 18. This is addressed by the IMR author in recommendations for LCH.

The Panel noted in this and previous DHRs that a charge for using mental health crisis numbers can exclude vulnerable individuals in need who may not have credit on their

phones. The mental health crisis team phone is prefixed 03 which charges calls at a standard national rate; this service is hosted by Leeds & York Partnership NHS Trust. The NHS has recently introduced a new service to access health care services (111) which is free of charge from mobiles and landlines.

The Panel noted that the author includes a recommendation to access multi-agency training offered through Leeds City Council. This resource is no longer offered by LCC Domestic Violence team therefore this action point will need to be revised.

- **LEEDS DOMESTIC VIOLENCE SERVICE (LDVS)**
  The IMR Author is an LDVS Manager and Service Manager of Leeds Women's Aid

Prior to 1st December 2011 Leeds Women's Aid (LWA), Behind Closed Doors (BCD) and Help, Advice and Law Team (HALT) were contracted separately by Supporting People. The three agencies now deliver the local authority contracted services as a consortium; Leeds Domestic Violence Service (LDVS). Refuge provision commissioned by the local authority is provided by Stonham, the Care and Support Division of Home Group.

Panel and Overview Author Analysis

The issue of Dawn carrying a knife for her own protection was seen as critical as this affected her access to specialist housing and the only opportunity to have a service which had expertise in the issues of domestic abuse. It was noted that LWA have a responsibility to other vulnerable women and children and other residents could have been affected by Dawn carrying a knife. LWA are not a 24 hour secure refuge and this was deemed to be an unacceptable risk; it is unclear why the local authority contracted refuge was not asked to accommodate Dawn. This option would have provided 24 hour security and support staff along with self-contained accommodation; this would enable a housing provider to meet the needs of a referral such as Dawn who has been assessed as high risk.

Dawn was assessed as too high a risk for shared accommodation at LWA, but there are shared communal areas in the emergency hostel she was moved to. Discussion concluded that at the time Leeds Women's Aid may have been able to make more independent decisions about managing risk. It is not clear from the review if staff responded to the level of fear indicated by Dawn's disclosure that she kept a knife at the side of the bed, or the specific risk that she could be injured by the perpetrator if the knife was used against her. Although the Panel representative was able to state that this would have been likely in terms

of the usual way staff work with residents, the case notes do not record the specific details to confirm it happened on this occasion.

An issue was raised relating to the timeliness of the MARAC minutes, linked to effective information sharing and wider issues of addressing risk. A recommendation through MARAC Strategy Group that Minutes need to circulate soon after the meeting is included in the learning points of this IMR.

The Panel noted that despite several agencies being made aware of the background of domestic violence and abuse, there had only been one referral to a specialist service. The IMR author identifies that LWA do not have full information around the type of support offered through Leeds Housing Concern and the Overview review process identified this may be an area to improve effective information sharing; and also to evaluate how specialist domestic services can add value to a placement in generic support.

The Panel identified that if background information used to inform a risk assessment was standardised and tracked through organisations who added any additional information this may be a more effective process; such as the principles of single assessments such as CAF (Common Assessment Framework). This is a collective recommendation and not specific to LDVS; recognising the gaps in information highlighted in the overall Review where some agencies did not know about alcohol use, the impact of harassment, Dawn carrying a knife or her history of experiencing violence. A system that travels with people was thought to have the advantage for individuals not having to repeatedly answer referral questions; and the use of a DASH questionnaire completed by each newly involved agency would give a picture of current risk, and also provide a comparative picture over time to assess increased vulnerability. It was recognised that dynamic risk assessments and information needs to be current to reflect the changing circumstances. It may be a difficult task to implement in practice, but the panel representative for Gipsil has offered to host discussions to see if this was an achievable task.

- **LEEDS HOUSING CONCERN (LHC)**
  The IMR Author is a Senior Manager at LHC.

LHC provides time limited supported housing, floating and community support services with a view to moving clients into independent accommodation. Homeless women are placed at the hostel by Leeds City Council: Housing Options (HO) using a placement system rather than a referral procedure.

Panel and Overview Author Analysis

Minimal information was shared by Dawn in relation to her personal account and experience of domestic abuse; this affected the depth of understanding and limited the specific response that staff could offer. The IMR author notes that levels of enquiry need to be more sophisticated, particularly with clients not wishing or enabled to disclose, there is a recommendation to source training to work with individuals who are difficult to engage.

The IMR recommendations include a focus on the MARAC process as some staff missed opportunities to update the MARAC co-ordinator about the possibility that Kenneth Ellis may have found where Dawn was staying; identifying the need to increase management oversight and increase introduce training. LHC has also introduced a new risk management procedure which will facilitate more effective risk management and the client handbook will be updated to include a specific section in respect to carrying weapons.

The Panel noted that there appeared to be no record of staff discussing Leeds City Council contracted refuge provision delivered by Stonham, which could have offered 24 hour support and self-contained accommodation. As there was no other suitable accommodation within LHC, there should have been a discussion with Dawn about securing accommodation outside of the organisation as a matter of urgency. Service providers developing a wider knowledge of referral sources are addressed as a partnership recommendation in section 7.

- **LEEDS MARAC:SAFER LEEDS** Multi-Agency Risk Assessment Conferences
  The IMR Author is Head of Localities and Safeguarding

Multi-Agency Risk Assessment Conferences (MARACs) are regular local meetings where information about high risk domestic abuse victims (those at risk of murder or serious harm) is shared between local agencies. At the time of the homicide, Leeds had three domestic violence MARACs operating across the city which correlate to the areas of the three Policing Divisions operating across Leeds at the time.

Panel and Overview Author Analysis

The Panel noted that that flagging and tagging was reported to be effective; but wider analysis of agency responses highlighted areas where this system is not working. Examples include; A&E (LTHT) were not aware of ever having received a notification after a MARAC meeting; there was no evidence that the GP was aware that Dawn Richards was subject of a

MARAC; LCH identified that flag and tag for adults who do not have a child under 18 is not undertaken.

It was agreed that an audit across all key agencies would be informative to establish what occurs when an action from MARAC is circulated such as flag and tag, and to evaluate if this is a response which effectively decreases risk. Members of the MARAC Strategy group will also periodically audit flagging and tagging arrangements across agencies

The Panel observed that practice overall has not accounted for the individual and specific needs of Dawn Richards as a black woman living in Leeds; and this needs to be addressed in the wider recommendations and learning from this DHR. Leeds no longer has a specialist service for BME women experiencing domestic violence and abuse; previously Sahara provided emergency accommodation and outreach support and this was decommissioned in November 2011. There is generally a lack of specialist domestic abuse services across the city, which is a huge issue. Several IMR's, including this MARAC IMR; refer to referrals being missed to services which could have offered specific emotional support and intervention responding to the needs of Dawn as a black woman. This lack of resources is also little known if some agencies still feel these options are available.

There are a number of agency recommendations which focus on practice relating to MARAC; and a comprehensive internal review has been completed which has the role of identifying and improving these areas of practice. Improvements in processes include additional administration resources, improving routine links to Public Health commissioned services, reviewing the "flagging" process, review of risk management within commissioned services, and guidance for agencies working with high risk victims who withdraw from services.

Other agency IMRs highlighted difficulties caused by the delay in sending out Minutes and agency actions; these and other areas identified by the Panel have been included in the revised recommendations from the IMR author, and are addressed in the MARAC Review Action Plan.

- **LEEDS TEACHING HOSPITALS:NHS TRUST (LTHT***)*
  The IMR Author is lead professional for Safeguarding Adults at risk; the report was amended by LTHT Head of Safeguarding.

Leeds Teaching Hospitals NHS Trust is the largest NHS Trust in the UK and has 14,000 staff over 6 main sites.

Panel and Overview Author Analysis

There is no indication that Dawn disclosed any experience of domestic abuse or violence to any member of staff at LTHT, but the IMR does not have the information to establish if the question was asked, as a significant portion of notes are missing. The IMR author identifies that having incomplete patient notes led to inaccurate and incomplete information for both internal and external investigations. The Trust reviewed its information governance arrangements for the retention and release of records in January 2014, and a new process is in place to ensure to minimise the risk of re-occurrence

In October 2011 Dawn told staff at Behind Closed Doors that she had been hospitalised after an extreme incident of domestic abuse and that Kenneth Ellis had admitted to medical staff that he had done it but "nobody has ever reported him." The chronology identifies Dawn attended the emergency department twice in 2009 with a fractured nose and injury to her arm, but specific patient records for Dawn Richards are missing from 11th January 2009 to 10th January 2012.

It is likely these patient notes include relevant information. In May 2012 Dawn was fitted with a hearing aid as she has a perforated eardrum; the information is not available to confirm whether this was an injury sustained as a result of a domestic assault. The Panel identified that the issue of 3 years paper files being missing was a critical factor; notes were not scanned onto the system and hard copies were missing; and if Dawn had been presenting with injuries as a result of domestic abuse it is not possible to assess how this was addressed. This has been included as a learning point and recommendation in the IMR.

There was a view that LTHT could have made a referral into the MARAC process as they had an opportunity from the presentations made although other views qualified this, as there appear to be no direct disclosures. Therefore evidence for this referral would be limited and it is possible that Dawn would not have given her consent. The Panel agreed that training to engage staff in proactive questioning and increasing confidence in their response to indicators as well as disclosures of domestic abuse would be a positive safeguarding response as part of the triage. It was agreed there needs to be standard practice within A&E so that the question relating to domestic abuse is asked, as it is by midwives. These and other areas identified by the Panel have been included in the revised IMR and recommendations; and the response to NICE guidance will ensure that these issues are addressed.

- **NHS ENGLAND: GP PRACTITIONER**
  The IMR Author is an independent author commissioned by NHS England

GP practices look after the health of people in their local community; NHS England lead on strategies for primary care and the contractual framework for GP services, and commission services across the health system in England.

Panel and Overview Author Analysis

The Panel noted that because the terms of reference were not fully used in the initial or revised IMR some information is missing, such as how services meet the specific needs of Dawn Richards in terms of her cultural identity.

On at least three occasions Dawn disclosed to her GP's that she was the subject of domestic violence. The first recorded disclosure in September 2011 when it is recorded that 'she was under stress from ex- partner' and October 2011 which states that she has a history of violence from her ex -partner. There is no evidence that these disclosures are followed up or discussed with Dawn, nor is there any evidence that she was offered any further support or onward referral for support.

Given that her ex-partner was also registered at the same practice no link was made with him. The practice may not have been aware that Dawn and Kenneth had a relationship, but if the GP had been able to make this connection there could have been appropriate awareness of any indicators of risk in terms of his behaviours. When Dawn disclosed domestic abuse an opportunity was missed to further discuss this with her and to offer her support; and with her consent an appropriate referral could have been made. The IMR author notes that it appears that guidance on the referral process for domestic abuse was new and not completely familiar to practice staff; this will be strengthened to ensure that all staff is trained and competent in these procedures. The GP Practice safeguarding newsletter will have details of referrals, signposting and training on domestic violence and the GP practice in this case will include Domestic Violence in forthcoming training.

It is noted that whilst the word depression is used within the GP record, it is used to indicate Dawn's reported feelings and not as a diagnosis. There is no evidence that her GP's made any formal assessment of either depression or anxiety in Dawn's case; which might have helped with both onward referral and treatment options. Simple structured questions used to assess mood are readily available but had not been administered. The IMR does not provide any analysis of why structured questionnaires or formal assessments of depression

anxiety were not used such as PHQ9 (App.3). It remains unclear if this was an oversight or because the GP diagnosed the primary problem as one of alcohol rather than mental health.

In terms of learning the Panel identified it would be helpful for GP practices to include asking and recording who the perpetrator of the violence is when a disclosure has been made. The rationale for having this information is to consider the potential risk if both parties are registered with the same GP and could be both offered similar times for planned appointments, particularly when an injunction is in place and in this case to protect Dawn from the impact of his stalking behaviour. There are also a number of areas where a GP could be monitoring risk and maintaining awareness of potential changes in behaviour, mental health or disclosures which would be relevant if the practice were aware a patient was physically violent and a risk to his or her partner. This would have a positive impact of early safeguarding referrals, particularly where children and young people are in the family.

The IMR author refers to a gap in record keeping relating to the GP noting that Dawn was subject of a MARAC; but other information indicates that the GP had not been made aware of this referral or that the GP had been updated after the MARAC meeting.

The Primary Care Mental Health team could not help because of Dawn's ongoing alcohol use and the GP practice was seen as best place to offer support. The IMR details the attempts made to provide brief intervention and referrals to additional support, but Dawn declined most referral options. There is a gap in identifying and responding to the disclosures of domestic abuse and the IMR author has addressed this in the GP recommendations.

- **VICTIM SUPPORT**
  The IMR Author is a Senior Service Delivery Manager.

Victim Support is a charity with trained volunteers providing free and confidential support to help anyone affected by crime. Witness Service is based in every court and offer support and information before and during contact with court process.

<u>Panel and Overview Author Analysis</u>

The IMR identifies areas where referral information can be improved in terms of ensuring partner agencies have relevant information relating to ethnicity. This is needed to inform considerations for adapting or responding to the individual needs of people accessing services; this is addressed in recommendations from the Panel to West Yorkshire Police and wider information sharing recommendations.

Where incidents have a history or are linked to other named individuals this is also an area where appropriate information could be effectively shared in terms of understanding and responding to risk. Discussions identified a lack of clarity about which information sharing protocol would be the reference point, which could include the MARAC information sharing protocol but other providers also consider there is a wider Leeds Information sharing protocol which is part of Leeds safeguarding protocols. The pan Leeds Interagency Protocol for sharing information[4] has been adopted by Leeds Teaching Hospitals Trust, Leeds Partnerships NHS Foundation Trust, NHS Leeds (Leeds Primary Care Trust), Leeds City Council, Education Leeds, West Yorkshire Police.

The lack of clarity could indicate this needs to be more widely promoted and available to practitioners and managers, or discussions need to be undertaken to identify which will be the information sharing protocol which will form the basis for future work with domestic violence and abuse.

The Panel members identified that Witness Service had been involved with supporting Dawn with her attendance at Court and also in providing emotional support as a result of this appearance, this had not been included in reports to a MARAC; it would be useful to ensure that in future reviews such as a DHR these agency reports are linked.

- **WEST YORKSHIRE POLICE**

  The IMR Author is a Safeguarding Delivery Manager.

West Yorkshire Police is the fourth largest in the country; between April 2013 and March 2014 West Yorkshire Police recorded 38,668 reports of domestic abuse. The Leeds district Safeguarding Unit (SGU) has dedicated domestic abuse coordinators and investigators under the line management of Detective Sergeants and Inspectors.

<u>Panel and Overview Author Analysis</u>

The detail of service involvement from the police records has been included as an appendix (App. 4) as the police had the most sustained professional contact with Dawn, and this gives the most comprehensive picture of the nature of the harassment Dawn was experiencing.

[4] www.leeds.gov.uk/docs/panleedsinformationsharingprotocol

The IMR author highlights several examples where there were short-comings or policy not followed; “there were a number of occasions when information was not recorded to the required standards, primarily as a result of staff failing to comply with recording standards because of their lack of apparent understanding of these standards”; this is addressed as a recommendation. The revised IMR provided information of a range of improvements relating to practice and West Yorkshire Police are now implementing a Force action plan which addresses many of the areas identified in this report, such as training, risk assessment and the management of medium and standard risk cases. However it is noted that this action plan does not currently include work to improve the Force’s performance specifically in stalking and harassment.

The IMR from Probation identifies difficulties in gathering information from the police which at pre sentence and post sentence assessment stage. Police Safeguarding and Probation have now agreed that updates to information would be provided from the date of the last report as Probation had not retained reports when full histories had been provided in the past. In June 2013 Probation requested information relating to Kenneth Ellis and was informed on 15 h July 2013 that no incidents had been recorded in the last twelve months.

The IMR author details a comprehensive process of Equality Impact Assessment and audit for all proposed policies and procedures to ensure that they are compliant with the principles of equality and fairness. There is no evidence in this case that West Yorkshire Police’s policies and procedures acted in any way to prevent Dawn or her family receiving services as a result of their ethnic, cultural, linguistic and religious identity. However similarly to several other agency reviews there is no specific stated intention of how services responded to the individual needs of Dawn Richards as a black woman, and the particular and specific issues this presents.

The Panel discussed the issue of Dawn making 20 reports of stalking and harassment before the referral to MARAC was made (detailed in Appendix 4). Repeat victims of domestic abuse are now identified in WY Police monthly district reports however this information was not available during the period under review. Records show that a MARAC referral was discussed with Dawn in January 2012 but it is not recorded why this was not made; the IMR author indicates it is likely that the objective threshold was not met as the previous incidents were not assessed as high risk, and therefore did not meet the Leeds MARAC criteria. The Panel noted this could indicate a lack of training, as escalation and increase in repeat lower level incidents is one of the criteria for referring to MARAC.

Attending officers did not connect incidents into a pattern of behaviours which led them to minimise incidents and, in the absence of any corroboration of Dawn's belief that Kenneth was responsible, did not respond to them as domestic in nature. Consequently no pattern was identified which would have prompted an earlier assessment of high risk and appreciation of the number of incidents, which would have indicated a referral to MARAC. It was only during the period of closer engagement with Dawn in March 2012 that the risk was appropriately identified and a formal referral made on the 20th of March, the case being discussed at the MARAC held on the 12th of April 2012. There were no further domestic abuse incidents reported by Dawn after this date and therefore no occasion to re-refer the case.

The Police involvement and WYP IMR was seen as central to the agency contact with Dawn and the IMR author was asked to revise and add information to this report in order to maximise the opportunities for learning, and to enhance the recommendations. The Panel discussed how this IMR raises the question of training. There was a gap in knowledge relating to the use of relevant risk assessment tools (DASH). There is mention of dip-sampling and looking at cases; but the training of staff in taking the appropriate response was not included as a recommendation, this has now been added following recent revisions.

West Yorkshire Police were asked to consider the issues of supervisory oversight of officers attending incidents; and to support the understanding of supervisors and other staff in recognising linked incidents and patterns of behaviour, responding to the context and potential gravity of otherwise apparently minor incidents.

The Force accepts these points and has already acted to implement processes to achieve this. An automated ' question set' is being placed on the Force system which will assist call takers to correctly identify and code an incident as domestic abuse related, which did not happen in many of the incidents reported by Dawn Richards, and this will also ensure supervisory oversight. The Force is also introducing detailed guidance which will give greater clarity to staff about the required actions which must take place at different levels of risk, and in the context of repeat and escalating incidents. This will ensure that patterns of behaviour and repeat calls for service are identified and responded to. The Leeds District Senior Leadership Team will ensure that these lessons are embedded locally and in particular will undertake that the recommendations are achieved within the next 12 months.

- **WEST YORKSHIRE PROBATION TRUST**
  The IMR Author is a Partnerships Manager

At the time of the review Leeds was served by three probation offices providing probation supervision, community service, offending behaviour programmes and specialist support services, to both adult and young offenders.

The previous individual Probation Trusts have now been reorganised into a single public sector National Probation Service (NPS) and 21 new government-run Community Rehabilitation Companies, which began operating on 1st June 2014. West Yorkshire Probation Trust was split into two organisations; the National Probation Service and the West Yorkshire Community Rehabilitation Company.

Panel and Overview Author Analysis

Probation is the only organisation in the DHR process that had any ongoing contact with Kenneth Ellis, other than police and court intervention.

The IMR identifies this case was inappropriately allocated to an insufficiently trained and inexperienced first year offender manager who was not trained to work with cases of domestic abuse. This had significant implications for the assessment and management of risk. There was little evidence of line management support with this case, and no chain of accountability for case management. The critical issue of allocation was felt to be fully covered in the learning points of the IMR, and addressed in the agency recommendations and practice improvements.

There is no evidence that the ethnic cultural linguistic or religious identity of Dawn was specifically considered in the way Victim Services worked with her, although workers involved were inclusive and sought to take her views into account. Although identified training covers these issues, the IMR author does not explain the gap between provided training and observed practice. There was evidence that some work had been considered in terms of the ethnicity and cultural identity of Kenneth; but also potential missed opportunities in terms of relating his experiences to his sense of identity, and how this would impact on service provision.

- **YORKSHIRE AMBULANCE SERVICE**

The main role of Yorkshire Ambulance Service (YAS) is to provide an accident and emergency response to 999 calls. YAS does not hold historical information regarding the subjects of 999 calls, a search of the YAS 999 system was undertaken by date and address, not by patient name. This identified one attendance at the relevant location and Ambulance transport was given to the Emergency Department on 4th August 2013.

The DHR Panel agreed that Yorkshire Ambulance Service NHS Trust (YAS) was not required to submit an Individual Management Review, given that YAS's only involvement with Dawn Richards was emergency transport following the assault that resulted in her death, and there was no indication that there were any areas of learning from this involvement.

Panel and Overview Author Analysis

The panel agreed that as YAS nationally search on addresses it would be appropriate to establish if there was potential for YAS to investigate their data collection systems to see if searches could be undertaken by name. It was agreed that searching by name when information was requested after serious injury or death would improve information sharing and increase opportunities for learning in risk assessments for vulnerable adults, children, those at risk from domestic abuse and for those who regularly change address.

It was identified that at present the systems are not in place for this to be undertaken.

4.0. ANALYSIS

Analysis of information presented to the Overview Panel identified three key themes where there is scope to improve practice relating to service provision, service providers and access to services. This is expanded further in the report in analysis of the terms of reference (4.1) and in section 6: areas of learning.

4.1. Key themes identified in Chronology and Individual Management Reviews

1. Service provision

Dawn often appears to fall between the gaps in referral criteria; she had mental health needs in terms of low mood, anxiety and risk of self-harm but these were too complex for some agencies. Options of support were limited unless Dawn addressed her use of alcohol, and this prevented her access to some other services. Dawn was clearly identifying she was unable to address her use of alcohol, and on occasion she did not want to be referred to other identified support agencies.

There were limited disclosures of her personal experiences of domestic violence and abuse, but there was evidence of [redacted] ongoing violence and abuse from Kenneth Ellis. Referrals from involved agencies to specialist domestic abuse services were limited; there was limited professional understanding of the risk and the fears Dawn was experiencing.

The DHR identifies that Leeds has few options of specialist services in terms of accommodation or outreach to meet the needs for BME women who are experiencing domestic violence and abuse.

2. Service providers

There was a tendency for some professionals to view domestic violence as physical violence and specific incidents; there was a general lack of understanding of the personal impact of stalking and harassment; or the risk associated with these behaviours. There was evidence that some services missed the cumulative nature of her reports of stalking and dealt with incidents as “one-off” or minor events.

Culturally sensitive services were not a particular strength or feature in this DHR; several IMRs describe a range of policies and protocols but there was little evidence of how this transferred into specific practice adaptation, or consideration of the individual needs of Dawn

as a black woman experiencing violence. It may be that the service provision reflected these qualities, but the IMR failed to fully explore and reflect this.

Agency responses were often fragmented and demonstrated limited knowledge of what other support was available; evidence of effective information sharing and joint working was limited.

In order to promote the involvement of family and friends in the DHR process there is a need to strengthen the links to community based local groups and service providers.

3. Access to services

The presentation of Dawn as a person at risk of harm was not an immediate "fit" in terms of criteria to access services; there was apparent difficulty in responding to the complexity of her needs.

Dawn demonstrates the reality of research identifying the barriers faced by black women when seeking help and support from a multitude of agencies. There appears to be little specific consideration of her ethnicity, cultural needs or personal history and how this might impact on her help seeking behaviours, referral information was sometimes incomplete and there was limited information sharing or examples of working cohesively.

- Theme 1: Service provision

1.1 Accommodation

- refuge and supported housing options, responding to the specific needs of domestic abuse, are limited
- specialist black and ethnic minority services in Leeds are diminishing rather than increasing or developing
- there are implications for the development and sustainable funding of specialist domestic abuse services and services for BME women in Leeds

1.2 Commissioning priorities

- the provision of a comprehensive multi-systemic service model for domestic abuse, which is specialist based and includes direct services, refuges and community outreach is under threat

1.3 Support services

- There is little evidence that Dawn was able to access support services which could address the complexity of her needs; and work with her on the issues she felt able to address
- There was limited evidence of an appropriate response from services which acknowledged the level of fear Dawn was reporting, or the potential risks from the situations she described. There is scope to improve service responses to risk assessment and risk management
- Effective case management and referral information has a positive impact on identifying and responding to risk; there is scope for this to be improved
- There is scope to evaluate and improve service responses to working with depression and risk of self-harm

- Theme 2: Service providers

2.1. The reviews identify that some agencies failed to fully account for the enormous impact of the stalking and harassment behaviour, or the fact that Dawn was clearly identifying the support she did not want. In terms of engagement it may be that Dawn became unwilling to access some services as she was being offered an intervention she felt did not reflect her needs.

- Practitioners and police responses need to demonstrate a wider understanding of the personal impact of stalking and harassment, and the associated risk of threats and violence.
- There is scope to improve the response to disengagement and practice responses to working with resistance

2.2. The individual management reviews highlight that agency responses were often fragmented and there were few examples of cooperative or joint working.

- The individual management reviews highlight a lack of “joined up” work; services are often compartmentalised, criteria for referrals and moving on can limit access to support
- Information sharing and knowledge of other providers has the scope to be improved; some agencies demonstrated a lack of awareness of other providers and options of support, informed referrals were limited

- There was an identified need to improve knowledge and confidence for practitioners in working with disclosure of depression and risk of self-harm

2.3. Responses to disclosures of domestic abuse need to be improved

- Despite Dawn making several disclosures of domestic abuse there were limited referrals to specialist domestic abuse services
- Intervention for Kenneth Ellis was limited, and the effectiveness of this intervention was limited
- There were missed opportunities in the MARAC meeting to reduce risk and promote effective information sharing

2.4. Responses to BME individuals and communities need to be improved. Some agencies demonstrated an inclusive way of working, but failed to recognise the individual needs or considerations that should inform culturally sensitive practice.

- There was little specific stated intention to describe how agencies responded to the individual needs of Dawn Richards as a black woman, and the particular and specific issues this presents. It is likely that several services failed to fully account for her increased vulnerability.
- Some agencies did not ask or were not given the ethnicity of Dawn at the point of referral
- There was little evidence that any separate consideration had been given to what cultural and ethnicity needs Kenneth Ellis may have, how this might impact on him, or how services might need to adapt their responses
- There is a need to develop consistent, pro-active and appropriate strategies to engage and support family and friends to contribute to the DHR process. Links with local community based organisations have created opportunities to pass on information through community advocates, this has particular relevance where the family have had limited or less positive contact with wider services. There is the capacity to strengthen and formalise links with these services as an integral part of future DHRs.

- Theme 3: Access to services

3.1. Because the harassment was ongoing, Dawn sought help repeatedly. Analysis of her help seeking shows that:

- The barriers she encountered were substantial and effective support and specialist resources were limited
- Gaining access to help was often long delayed due to a lack of understanding of her needs, the risks she was experiencing or what support was currently available
- Options of support were limited through her use of alcohol and her choice not to address her use of alcohol; this resulted in a gap in agency support
- Several IMRs highlighted the need for agencies to consider risk management as part of case closure; to ensure that if a referral fails to meet the threshold for their particular service where possible an alternative referral should be made. Where a service will not be provided, cases should not be closed without ensuring information or support to access other agencies has been offered.

3.2. Services need effective referral information in order to successfully plan and adapt their provision to ensure this is accessible.

- Some agencies do not routinely ask a referral question relating to misuse of alcohol or whether domestic violence and abuse is an issue that requires support.
- Ethnicity was missed from some referral information.

Summary:

The underpinning principle to improving service responses is that any agency intervention or offer of support to Dawn should have acknowledged the disclosure of 30 years of domestic abuse and the impact on her mental health; and provided referral and appropriate support to access alternative services if they were unable to meet her identified needs.

4.2. Analysis of the Terms of Reference

This section focuses on analysis of the key lines of enquiry in the terms of reference, applying the findings from agency IMR's as evidence for learning and recommendations.

Key lines of Enquiry

What was known by agencies?

- The Addiction Dependency Service had limited contact and there appears to have been no referral information or disclosure of abuse other than a “difficult history” which was not clarified further on the records. Dawn’s misuse of alcohol was a cause for concern.
- Adult Social Care knew about the domestic abuse from Dawn’s ex-partner and her suicidal intent and risk of self-harm. Dawn reported that she was scared to go out and was adapting her behaviour due to fear of Kenneth Ellis. ASC had no information relating to the use of alcohol.
- The Magistrate Court responded to the harassment and stalking behaviour and was made aware of a history of domestic abuse. The Court had information missing from the pre-sentence report; this included the call-out information from the Police and the social care report which may have impacted on the risk assessment, and understanding of the impact of the harassment on Dawn Richards.
- Leeds City Council Housing Options had a detailed account of the domestic abuse from referral information; and were aware of her conviction of assault and that she carried a knife for personal protection. They asked about alcohol and drug use and Dawn did not disclose any issues. They were aware that Dawn feared Kenneth would kill her; she had attempted to end her own life on several occasions. Dawn reported she felt angry and distressed and felt passed about from service to service; and that no one cared about her.
- Leeds Community Healthcare NHS Trust (LCH): the Primary Care Mental Health Team had limited contact but knew the background of emotional abuse, harassment and threats from her ex-partner. [redacted] Dawn reported she had suicidal thoughts and had attempted suicide when she was 18, and had identified symptoms of depression. Dawn was clearly identifying she did not have any motivation to stop or reduce alcohol at this time.
- Leeds Domestic Violence Service (LDVS): Dawn disclosed domestic violence and abuse, sustained harassment and that her ex-partner was continually breaching injunctions. She reported a history of violence, [redacted]. Dawn disclosed she carried a knife to protect herself; there is no indication that alcohol use was identified as an area of concern.

- Leeds Housing Concern (LHC): Dawn was referred with an extensive background of information relating to her domestic abuse and harassment, and the service was aware she was at high risk of harm as there had been a referral to MARAC. Dawn was upset at leaving her tenancy and making her daughter homeless, she did not make any further disclosures of abuse and would not discuss family or mental health issues. She disclosed she was still using cannabis and alcohol but did not want to be referred to any support services.
- Leeds Teaching Hospitals NHS Trust (LTHT) was not aware of any current or historical domestic violence or abuse; or that Dawn was subject of a MARAC and identified as vulnerable and at risk. During her contact with the Emergency Department no significant risks were identified, and there was no evidence that Kenneth Ellis was identified as a perpetrator of domestic abuse.
- Leeds MARAC - Safer Leeds: MARAC were aware of the long history of abusive behaviour from Kenneth Ellis, the breaches of court orders and the "considerable harassment and distress" caused to Dawn due to the long running and continual pattern of his behaviour. There was limited information available relating to Dawn's use of alcohol and this was not identified as an issue.
- NHS England: The GP was aware of Dawn's stress, depression and risk of self-harm; and a rapidly increasing alcohol use that was seen as excessive and problematic. There were at least three disclosures of domestic violence related to her ex-partner. No link was made to Kenneth Ellis as a possible perpetrator although he was registered at the same practice.
- Victim Support were notified of incidents of criminal damage and harassment, on making contact with Dawn she identified the impact of the long running pattern of behaviour from her ex-partner, and a history of domestic abuse. Dawn was very anxious about appearing in Court, and reported she was still in fear of Kenneth. Victim Support was also notified of an incident of grievous bodily harm where Kenneth Ellis was a victim of assault.
- West Yorkshire Police had a detailed chronology of reports from Dawn describing the stalking and harassment from her ex-partner. They were aware of a history of domestic violence and criminal damage and that as a result Dawn was very frightened, depressed and had suicidal thoughts. There is one report relating to the use of alcohol where the officer notes Dawn suffered from depression and drank to cope with it; there are no other references in police reports relating to alcohol.
- West Yorkshire Probation Service had a background of offending history for Kenneth Ellis including the more recent breaches of the non-molestation orders and information from Dawn Richards that her ex-partner was physically violent, controlling

and demanding. He was unable to take responsibility for his behaviour and continued to deny and minimise the abuse. They were aware of Dawns misuse of alcohol and that Kenneth smoked cannabis daily.

- Yorkshire Ambulance Service provided an emergency service response based on the 999 call, and treated Dawn's medical needs as she was transported to A&E. They had no background information relating to Dawn or her ex-partner Kenneth.

Responding to the Terms of Reference:

The overall agency responses to Dawn Richards including her disclosure of domestic abuse; identified risk, agency responses and intervention to reduce safety; to include consideration of alcohol use or misuse; agency assessments and impact on access to services.

It appears at times Dawn was able to make significant disclosures and give detailed and personal accounts of her experiences but overall the agency reviews identify that services were not able to fully respond to her needs. Dawn appears to fall between the gaps in criteria; she had mental health needs in terms of low mood, anxiety and self-harm but these were too complex for some agencies, her use of alcohol prevented access to other services and on occasion she did not want to be referred to relevant support agencies. Dawn's contact with specialist domestic abuse services was limited. Dawn was referred to Behind Closed Doors by the police but she did not want any support at that time; she did later seek support from Leeds Women's Aid, but was assessed as too high a risk for shared accommodation as she carried a knife and had a conviction for violence.

Dawn felt that she was passed around agencies and a brief example highlights this experience. Dawn told the police that she suffered from depression and was drinking to cope with it; she stated she can't have anti-depressants due to the alcohol, and does not want counselling as she doesn't want to talk about what she's gone through. Dawn said the only way out was to kill herself. With Dawn's consent the officer made contact with the GP and made an appointment on her behalf, but she did not take up the offer through the GP of support from alcohol counselling. A referral was made to Behind Closed Doors for additional support, but she did not want contact at that time in case she got Kenneth into trouble, subsequently a referral was also made to Adult Social Care but she did not meet their criteria.

The tendency for some professionals to view domestic violence as physical violence and specific incidents can be specifically problematic; resources and risk management can evolve to prioritise a response as a result of this perception. This can impact on accessing services where the presentation of the person at risk of harm is not an immediate "fit" in terms of criteria, or where they have more than one identified need. The reviews identify that some agencies failed to fully account for the enormous impact of the stalking and harassment behaviour, or the fact that Dawn was clearly identifying the support she did not want.

Following the GP referral for mental health support Dawn continued to cite domestic violence as an underlying cause for her stress, on-going alcohol use and depression. It was agreed by the Panel that any agency response to Dawn should have acknowledged the disclosure of 30 years of domestic abuse and the impact on her mental health, and should have provided referral and appropriate support to access alternative services if they were unable to meet her identified needs. The reviews highlight that agency responses were fragmented and there were few examples of cooperative or joint working. A single point of contact is in line with the principles of person centred services providing better routes for information sharing, integrated responses and more opportunities to share resources and expertise. For Dawn this could have been a way to support her access to services.

Case management:

It was noted that some agencies do not routinely ask a referral question relating to misuse of alcohol or whether domestic violence and abuse is an issue that requires support. The Panel agree that referral information has scope to be improved through including these specific questions at the first point of contact.

Several IMRs highlighted the need for agencies to consider risk management as part of case closure; to ensure that if a referral fails to meet the threshold for a particular service, practitioners need to be referring to appropriate support; rather than closing cases without ensuring information or support to access has been given. Where reviews identified that responding to delays, staff sickness and case management oversight has been an issue the Panel have ensured this is addressed in agency recommendations.

Evaluating how agencies responded to the wishes and feelings of Dawn, ensuring she had information to make decisions and support to contact other agencies

The individual reviews identify several interventions which clearly responded to the wishes and feelings of Dawn, and supported access to relevant and appropriate agencies. The overall DHR identifies areas where this can be improved, and this is highlighted in the areas of learning; agency or Panel recommendations.

Dawn was an adult who was judged to be a person with the mental capacity to make informed choices about the services she would choose to access, even where these decisions reduced the options for support. Several agencies made suggestions of potential support agencies such as alcohol counselling [redacted] which was declined; it was entirely appropriate that practitioners respected the choices Dawn made at that time.

The issue of referral and consent for adults with capacity was raised for discussion and the Panel have discussed this at length in this and other DHR Panel meetings. The Overview Panel debated the interpretation of an adult at risk and the context of protection from harm in a situation of domestic abuse. One perspective felt that the potential risk of serious injury or death in domestic abuse took precedence over consent as it would in child protection. Alternative views support the view that adults at risk need to be able to make informed decisions about situations in their own lives; and where a person has mental capacity to make a decision they have the right to choose whether an alert is made. The principles of the Mental Capacity Act and "no decisions without me" meant that consent must be sought as a matter of routine prior to a safeguarding alert being made.

In terms of 'lessons learned' it is clear that conversations are needed around using and interpreting the current definition of an adult at risk and the context of serious harm. The Panel agreed that not meeting the individual agency criteria should not preclude someone from being referred to other support services. It was agreed the issues relating to consent will be included in the Overview report and this has also been passed through Safer Leeds to pick up in the MARAC Steering group as an area for further discussion, as the Panel reflects different approaches and understanding.

Addressing the ethnic, cultural, linguistic and religious identity of Kenneth Ellis, Dawn Richards and her family and accessibility of services

There is no evidence in this case that agency policies and procedures or practitioner responses prevented Dawn or her family receiving services as a result of their ethnic, cultural, linguistic and religious identity.

However this aspect of agency responses is not a particular strength or feature in this DHR. Practice reflects there was a broad consideration of overall needs in several agencies or a process that required Dawn to have both understanding of her own needs, and a pro-active response to identifying the appropriate service response in meeting these needs.

The Panel identified this is an area that could be improved; and further training on these issues would be of benefit.

There is no evidence that the ethnic cultural linguistic or religious identity of Dawn was consistently considered in the way agencies worked with her, although several responses were inclusive and sought to take her views into account. However, there was little specific stated intention to describe how organisations responded to the individual needs of Dawn Richards as a black woman, and the particular and specific issues this presents. As a result it is likely that services failed to fully account for the increased vulnerability that resulted.

There was little evidence that any separate consideration had been given to what cultural and ethnicity needs Kenneth Ellis may have, how this might impact on him, or how the service might need to adapt their responses to work with him.

The Panel noted that because the terms of reference were not used in the initial or revised IMR from several agencies some information is missing, such as how services meet the specific needs of Dawn in terms of her cultural identity. In addition several agencies had no details of ethnicity, nationality or religion as these were not recorded at the point of the referral. The process of completing IMRs and the DHR system overall is being reviewed and revised; and these are all matters to be included in a new protocol. This has also been addressed in wider recommendations.

Identifying lessons to be learned in safeguarding, managing risks and MARAC referrals; evaluating practitioner knowledge and training and responses to indicators of abuse

- Risk assessment

The Panel identified that if background information used to inform a risk assessment was standardised and tracked through organisations who added any additional information this may be a more effective process; following a similar principal to single assessments such as CAF. This is a collective recommendation recognising the gaps in information highlighted in the overall review where some agencies did not know about issues relating to Dawns misuse

of alcohol, the impact of harassment from her ex-partner, Dawn carrying a knife or her history of experiencing violence. A system that travels with people would have the advantage for individuals not having to repeatedly answer referral questions; and the use of a DASH questionnaire would give a picture of current risk, and also provide a comparative picture over time to assess increased vulnerability.

- Self-harm

The Panel responded to the findings in several reviews which identified that Dawn was at risk of self-harm and had suicidal thoughts on several occasions. It was agreed that these practice responses had the scope to be improved; and a more consistent and informed response would be gained if practitioners were aware of correct pathways and NICE guidance. It was agreed that Leeds should have a protocol and training to support this.

- MARAC

There has been a review of MARAC processes by the MARAC Strategy Group and this has resulted in a number of recommendations which have been included in a MARAC Review Action Plan. There are several individual agencies which have highlighted relevant issues relating to MARAC, and these will need to be reflected in the dissemination and response to learning lessons from this DHR.

Information sharing: significant gaps in information; impact on service responses.

The Panel identified gaps in information sharing and subsequent impact on service responses. Examples were analysed from several agency reviews;

- There appears to have been a general issue about improving information sharing at the point of referral, particularly relating to Dawn carrying a knife.
- Attending police officers did not connect incidents into a pattern of behaviours which led them to minimise incidents. In the absence of any corroboration of Dawn's belief that Kenneth was responsible, they did not respond to them as domestic in nature.
- There were gaps in the information received by Victim Support, for example not knowing that the first three referrals were linked or related to domestic abuse. It is possible that if the three cases had been linked and the perpetrator identified as the same in each case, that this could have been flagged as potential domestic abuse, but this information was not available. Victim Support does not usually have information relating to the ethnicity of the victim of crime referred through the police, and they did not have any information relating to the ethnicity of Dawn Richards.

- The individual management review identifies that Leeds Women's Aid do not have full information around the type of support offered through Leeds Housing Concern; and the Overview process identified this may be an area to improve in effective information sharing.
- LDVS identify if another agency had made a referral for specialist outreach support this could have been provided, but the Panel observed there is also a role for proactive intervention, particularly when a person is leaving specialist services and is still at risk of harm. There is scope to evaluate how specialist domestic services add value to a placement such as Dawn's in more generic support.
- Learning points in the review highlight a need for Leeds Housing Options to evaluate the decision making process in relation to offers of housing and the distance from the areas of potential risk. LHO will look at any improvements that can be made in respect of communication between agencies regarding the suitability of move on accommodation to address the issue relating to suitable housing provision.
- Leeds Teaching Hospitals NHS Trust (LTHT) were not aware of any current or historical domestic violence or abuse; or that Dawn was subject of a MARAC and identified as vulnerable and at risk of harm.
- There were three recorded disclosures to the GP of domestic violence related to her ex-partner, and no evidence of any follow up or offer of specialist support.
- Misinformation resulted in Dawn not receiving an offer of support from an IDVA; the Panel identified an issue to reflect back to the MARAC steering group that relates to the timeliness of the MARAC minutes to ensure effective information sharing and the wider issues of addressing risk.
- Several agencies assumed other agencies have made a referral to MARAC therefore they don't have to, or there is an assumption that other services will already have given information on relevant support services.

Learning points for all agencies should reflect the need for practitioners to provide referral and appropriate support to access alternative services if they are unable to meet identified needs. In terms of responding to risk it was identified as good practice to duplicate or repeat support information and not assume someone else has made a referral, recognising that situations and circumstances may change and the individual may later choose to access a service they have previously refused. The underpinning principle to improving service responses is that any agency intervention or offer of support to Dawn should have acknowledged the disclosure of 30 years of domestic abuse and the impact on her mental health; and provided referral and appropriate support to access alternative services if they were unable to meet her identified needs.

Policies and procedures: risk management, domestic violence protocols

The DHR identified a range of relevant risk assessment and risk management protocols across service provision; and opportunities for improving practice as a result of learning from this DHR have been acknowledged throughout the report.

Individual management reviews highlighted gaps in procedures or where protocols had not been successfully implemented and this has been addressed in agency recommendations.

It was identified that administration systems in MARAC should support timely distribution of Minutes and action plans to ensure agencies are updated with relevant changes in circumstances which indicate a potential increase in risk.

Training: implications for ways of working, training and resources

There are implications for training and improving the knowledge and confidence of practitioners; this includes increasing opportunities for a range of learning in terms of mentoring, resources and e-learning as well as subject specific input. This has been addressed in individual agency reports and action plans as well as wider recommendations.

A number of agency IMRs reflects staff training as a learning point;

Leeds Housing Concern notes that levels of enquiry need to be more sophisticated, particularly with clients not wishing or enabled to disclose, there is an agency recommendation to source training to work with individuals who are difficult to engage. The Panel noted this is reflected in other interventions and this informs a wider recommendation.

Leeds Community Health noted that training on domestic abuse is not mandatory in adult community services, if practitioners have a special interest they are able to access additional training and it is unclear if this knowledge and good practice would be replicated across the PCMH (mental health) service. This reflects a potential training need to ensure consistent practice.

The review from Adult Social Care notes that ASC and operational staff across all agencies working with victims of domestic violence would benefit from joint training with other agencies and that finding the resources to deliver this will be problematic; this informs the wider recommendation from the Overview report.

There is scope to improve and develop the knowledge base of professionals across some services regarding the nature of stalking and harassment, and potential indicators of domestic abuse.

5.0. EFFECTIVE PRACTICE

Identifying effective practice in Leeds and multi-agency collaboration

- The Leeds Safeguarding Partnership – Domestic Violence Hub

Leeds is currently developing a new service response, to actively deliver a more cohesive response across relevant sectors. Since this DHR the Front Door Safeguarding Hub has been established between the Police and Children's services which are based in the Contact Centre building. This project brings together the work currently undertaken by Leeds District Police Safeguarding Unit and the first point of contact for Children Social Work Services Duty and Advice team. All cases of domestic violence will be reviewed jointly by a police officer from the Police Safeguarding Unit and a duty social worker from children's' services. This will include adults with children under 18, adults without children and young people aged 16 and over. This will provide a faster and more co-ordinated response; ensure more collaborative working and better sharing of information.

- Criminal Justice process

Leeds has a Specialist Domestic Violence Court which sits weekly with Independent Domestic Violence Advocates (IDVAs) who provide practical and emotional support relating to the legal system for individuals who are at the highest levels of risk as a result of domestic abuse. Leeds has well established multi-agency initiatives such as Multi-Agency Risk Assessment Conferences (MARACs); and Multi Agency Public Protection Arrangements (MAPPAs). Both processes have at the core a focus on risk assessment and improving safety.

- Leeds Domestic Violence Quality Mark

This Quality Mark provides a framework for agencies to help promote consistency in the delivery of services. Leeds City Council DV Team support agencies to reach minimum standards through providing training, providing model policies and supporting the development of an agency action plan. Agencies are given regular "health check" to review the quality mark. The team are currently developing a Quality Mark for Children's Services Clusters and a Business Model.

6.0. AREAS OF LEARNING: Merging key themes and learning from the terms of reference

This section includes areas of learning from the analysis of agency IMRs and Panel analysis; responding to the key themes, terms of reference, the individual circumstances of Dawn Richards and making links to relevant research findings.

6.1. Stalking and harassment

The DHR process has highlighted that there are specific dimensions to Dawns experience that professionals needed to account for, and areas of learning to respond to in terms of risk and understanding the personal impact of stalking and harassment.

The contact with Dawn Richards often did not respond to domestic abuse and harassment as an ongoing series of incidents. Whatever the incident was that led to professional contact there needs to be consideration of the ongoing pattern of coercive control. There may not have been an incident every day, but the fear and ongoing impact were an everyday experience for Dawn. This raises critical implications in terms of understanding the prevalence and the professional responses required to fully address this behaviour.

- Relationship history and context

The prior relationship between Dawn and Kenneth was characterised by fear and physical assault. The result of being forced to leave her home to escape harassment and to live in a hostel resulted in the loss of a secure base, being isolated from her social networks and the support and access to her community. It also had the distressing effect of making her youngest daughter homeless.

The past history of violence provides cues that often only the two people with that history can fully understand, for example a certain look from her ex-partner may not be interpreted by an outsider as threatening, or if it was perceived as a threat it is likely that they would not appreciate the fear this could induce in someone like Dawn who knows his past. Kenneth's stalking and harassment did not happen at a distance, he wanted Dawn to know he was there, and that he could continue to control and affect her life.

Many violent ex-partners do not need to deliver explicit threats to scare or control their victims; and many deliberately operate under the legal threshold of a criminal offence which makes it harder to evidence the profound impact of their threatening behaviour. Professional understanding of how implicit threats are conveyed and interpreted is an important aspect of this dimension of partner stalking.

- Stalking tactics

Having a prior history of intimacy provided Kenneth with a wider array of stalking tactics; he knew Dawn's customary routines and areas where he could inflict most damage. This gave Kenneth more information to invade parts of her private life, to punish, torment and humiliate her. Through his behaviour Dawn had almost daily evidence that she lacked control over her own life, and she was constantly reminded that Kenneth was able to continue to dominate and have power over her. Research describes how up to two thirds of stalkers will destroy property (Blaauw, 2002); Kenneth was undermining Dawn's belief in a safe environment through the reported behaviour of damaging her car, entering her property, his continued surveillance and throwing stones at her window.

Stalking often includes behaviours when taken at face value appear to be non threatening such as walking past the house or standing across the road; with repetition however these can feel menacing and intimidating. Even when no direct threat is made and there is not a great deal of evidence it is important to respond to the level of fear and intimidation caused by this behaviour. For many victims it is the uncertainty of what they will do next which causes the most concern, Dawn knew Kenneth was violent, therefore she was dealing with an ongoing and underlying sense of danger.

- Timing

There are few crimes where the victim's safety is threatened over a long period of time or where resolution through the criminal justice system must predominately rely on the victim for evidence of the crime. It may be that Dawn had to cope with this continued behaviour for a period of time without professional support or advice; research shows people may experience more than 100 incidents before telling the police (Sheridan, 2005). As a result it is possible that she developed coping behaviours that on the surface appear to undermine the seriousness of the threat and the fear she was experiencing. By the time Dawn felt able to seek support it is likely there was an increased level of stress caused by the duration of time, and the unremitting nature of the harassment.

The ongoing intrusion and the violation of her privacy caused a personal impact; Dawn reported that Kenneth had entered her home and taken personal items, he shouted abuse at her in public in the area where she and her children lived; it was already impacting on choices she made as Dawn reported she was afraid to go out with her grandchildren. The lack of time between episodes and the ongoing nature of the stalking must also play a role in the level of distress she experienced.

Dawn did not disclose a lot of detail in relation to her past experiences of violence in her relationship with Kenneth; but it is probable this included elements or indicators of his future stalking through coercive control and jealous surveillance, particularly during periods of separation. Being separated from a violent ex-partner is associated with more severe and frequent stalking (Melton, 2007) and ongoing risks of increased violence (Logan et al 2008). Dawn began reporting the stalking behaviour to the police in August 2011. It is important that professionals understand and account for the trajectory of stalking within a violent relationship such as when the stalking started and how it escalates or de-escalates in relation to changes in the relationship. Understanding the timing and links between stalking and other kinds of abuse would provide valuable information in terms of assessing and predicating risk factors in violent relationships.

- Increased risk of threats and violence

One of the best predictors of future behaviour is past behaviour, and stalkers are no exception. Research suggests that it is critical for practitioners to consider the importance of coercive control and jealous surveillance (Regan et al, 2007) recommending that all work with perpetrators, and all understandings and definitions of domestic violence should reflect the significance of these core behaviours.

Kenneth demonstrated he felt he had a sense of ownership or entitlement to Dawn; generally where stalkers have been violent before, as Kenneth had during their relationship, this is an indicator he would be more likely to be violent again in the context of this continued harassment and stalking behaviour.

A number of studies suggest that stalkers targeting partners are more likely to threaten and commit violence (James and Farnham, 2003; Mohandie et al., 2006) and those who made threats were more likely to carry out the violence (Roberts, 2005). Stalking is also associated with intimate partner homicide and attempted homicide; approximately 90 percent of actual or attempted homicide victims who experienced a physical assault in the preceding year were also stalked by the violent partner (McFarlane et al 1999 and 2002)

In terms of assessing risk many boundaries had already been crossed in this relationship, this made Kenneth Ellis more likely to use approach tactics to intimidate, and his continued threats were more likely to be carried out.

Victims who were stalked after obtaining a protective order experienced more overall violations and more severe violence than victims who experienced ongoing violations but who were not stalked (Logan and Walker 2010). Dawn reports that Kenneth came to her

property immediately after leaving the police station on bail; his behaviour was not changed by the non molestation order and the stalking behaviour continued.

- Psychological distress

The impact on Dawn as a victim of stalking cannot be underestimated, and it is apparent she experienced significant psychological distress as well as the ongoing fear of further assaults. There was a continued loss of control and predictability in her home and surrounding environment, an ongoing and credible threat of harm, injury or death, and social isolation as a result of the stalking. She reported feeling depressed, and on more than one occasion had thoughts of suicide as a result of what Kenneth was doing; and disclosed her feeling of despair that services would not or could not stop the harassment.

There is a strong relationship between domestic abuse and anxiety, post-traumatic stress syndrome and depression; added to this is the terror of being stalked by a violent partner who has already evidenced he is more than willing to carry out his threats. Studies identify that victims of stalking from ex partners can experience over three times as many anxiety symptoms and much higher levels of distress (Nicastro et al 2000; Brewster 2002).

Psychological wellbeing is also threatened when life and routines are disrupted; Dawn made several reports of Kenneth throwing stones at her window in the early hours of the morning, and on consecutive nights. Her routines had to be modified to avoid Kenneth, and she must have spent time anticipating events prior to him committing any offence, or dealing with the aftermath of reporting his behaviour to the police.

This DHR demonstrates that some agencies had a more simplistic response which did not account for the risks indicated by the stalking behaviour as a pattern of coercive control; or respond to the duration, intensity and impact of the implicit and explicit threats. This indicates a gap in understanding about what this conduct really means.

Initially this led to a policing response to view the reports of stalking as an incident, rather than a pattern of behaviour and it was not until the sixteenth report in January 2012 that a proactive police investigation was initiated, which resulted almost immediately in evidence for a prosecution. An effective response to stalking would require the police to look at reports as a course of conduct rather than to focus on an event; but also to anticipate the persistence of the crime in the future. This is an elusive and difficult challenge within the constraints of an evidence based legal system; the identity of the stalker was known but until the installation of a camera there were few direct sightings to prove it was Kenneth.

Methods, locations and patterns changed and these attributes make it a difficult crime for criminal justice systems to address.

The demarcation between coping and defensive behaviour is blurred when the options for change or personal safety are limited, or appear to be non-existent. Some of Dawn's risk taking behaviours such as her reliance on alcohol may not have been a healthy response, and on occasion she was described as "incredibly rude" to attending police officers, or she walked out of appointments with the GP or counselling service. In order to understand Dawns reactions the context of her trying to survive within conditions of extreme and constant threat must be included; understanding that coping strategies and her responses to professionals were likely to fluctuate over time.

Because the harassment was ongoing Dawn sought help repeatedly but this presented as being linked to discrete episodes; and her fear which accumulated over time could be interpreted as exaggerated when the incident appeared to be relatively minor.

If the risk response is based on the incident rather than the offender there is the potential for the same offender to be "high risk" or "low risk" depending on the event. This reduces the likelihood that related offences are taken into account when planning safety measures or managing risk; and the absence of sanctions can send a message to abusive partners that domestic abuse is not taken seriously.

Informing recommendations

Describing these harms and losses gives this review the opportunity to focus on the specific impact on Dawn's life, health and the right for her to have an autonomous existence.

Dawn's abuse was chronic rather than acute; it was the pattern of harassment that should be the appropriate focus for agency intervention rather than seeing events as discrete episodes. Agency responses indicate they were missing the evidence that the harm and impact were cumulative, rather than incident specific. This approach fragmented her experience and made the multi-faceted nature of the harassment invisible, and there were occasions when this moved some agencies into a potentially victim blaming response.

A greater emphasis on the narrative Dawn gave about her stalking experience might have informed more assertive safety planning and earlier intervention, and a more supportive appreciation of the stressful conditions which Dawn was subjected to.

6.2. Working Together

The individual management reviews highlight that agency responses were often fragmented and there were few examples of cooperative or joint working; effective information sharing was limited.

Joint training is often a route to better informed referrals as well as developing additional skills, providing the opportunity to share professional knowledge and build co-operative relationships; several agency IMRs identify gaps in knowledge and a need for further training; these have been addressed in individual or wider recommendations. Appropriate training should increase awareness about domestic violence, as well as how to ask about it. It should enable exploration of practitioner concerns, and provide knowledge and resources including use of safety planning and referral to local advocacy and support services.

Mechanisms need to be in place for all staff to receive information, advice and support through various methods such as supervision, ongoing reviews and consultancy from advice or support posts in specialist agencies. This might include agencies establishing a named specialist or “champion” for domestic violence as an access point for practice staff.

<u>Informing recommendations</u>

Improving access to services and the need for a lead professional was a critical finding. A single point of contact is in line with the principles of person centred services providing better routes for information sharing, integrated responses and more opportunities to share resources and expertise. For Dawn this could have been a way to support her access to services.

Several agency IMRs identify gaps in knowledge and a need for further training. Multi agency training plans will promote joint working and effective information sharing and improve practice responses.

There should be an expectation from commissioners in Leeds to ensure that any service should include the Safer Leeds DV quality mark in contracts.

6.3. Working with resistance and supporting engagement

The theme of supporting engagement and working with resistance was a recurring theme across several agency reviews, and relates to the balance of working with risk and ensuring people have informed choices. It was identified that for those individuals who consistently disengage there is an opportunity once they are in a stable supported environment such as specialist or generic hostel accommodation, and housing support has a key role at this point.

Informing recommendations

The Overview Panel agreed that agencies should have a disengagement process or protocol and identified that information and training relating to working with resistance, assessment and supporting engagement would improve practice, particularly in high risk and complex referrals.

There is a need for further training and professional development linked to improving practitioner skills in critical questioning and professional enquiry; “asking the difficult questions”.

6.4. Working with diversity

The IMR reviews indicate there is scope for some agencies to improve their culturally or racially sensitive response; several reports stated there was little evidence that Dawn was signposted or referred to any specialist BME organisation. In addition several agencies had no details of ethnicity, nationality or religion as these were not recorded at the point of the referral. It is a core principle of good practice to ensure agencies know the background of those using their services; otherwise they have no information to consider in what way they might need to adapt and improve access.

The Panel discussed the role of a specialist care system and in a more resourced and ideal safeguarding landscape this would be in place. It was identified that there are now fewer BME services in Leeds, so referral sources are diminishing not increasing. In this case it seemed that MARAC would have been the ideal forum to ensure someone was tasked with a specific action.

Leeds has historically been effective in developing the discourse on violence against women and in promoting initiatives that focus on prevention, protection and recognising the needs of the individual. This has been harder to achieve within the constraints of reduced funding and economic realities. National strategies and therefore local funding have more recently

focussed on the criminal and civil legal system or other state mandated responses; services outside of these priorities are often secondary and commissioning priorities appear to have changed over time. The DHR indicates a missing link in early intervention and violence against women services, particularly for BME women.

The allocation of resources in sustaining risk management of low and medium risk cases before these escalate to high risk is proven to be cost effective in monetary terms, and in recognising and responding to the impact on women and their families. The direct and indirect cost of domestic violence and abuse is well documented; specialist domestic abuse services and BME specific services contribute to key aims of Social Return on Investment (SROI) and create value from a service impact perspective, minimise inequality and offer better outcomes. Key findings from current DHRs in Leeds and also from recent research (Hirst and Rinnie, 2012; Roy and Ravi, 2012; Chitembo and Tsikira, 2012) make a strong case for BME specialist women's services.

Dawn sought help repeatedly, and felt that services were not responding to her needs and were "passing her around." This is particularly significant as it is likely that Dawn's help seeking behaviour was influenced by her life experiences as a black woman and shaped by the [redacted] physical violence she was subjected to as a child.

In Leeds we must demonstrate our understanding of how the issues of race and ethnicity in domestic violence and abuse can exacerbate the difficulties experienced by victims. Service providers need to respond to a wide diversity of communities, and recognise the barriers BME service users face in accessing statutory and voluntary organisations. It is critical that specialist services for domestic abuse, and services for BME women are strengthened and expanded.

The visit to Kenneth Ellis provided an opportunity for a context and background to the relationship with Dawn and at times Kenneth was able to recall significant events. The meeting provided some context for their relationship although this was informed by aspects of his denial and avoidance. Part of this denial was probably informed by his family history and experience of attachment and social norms created by his formative years in Manchester as part of a gang culture. This indicated an acceptance of violence and a lack of emotional reflection, which could impact on his ability to have empathy and understanding of why Dawn may have been in fear. This is relevant as Kenneth described how he and Dawn were involved in gangs as young adolescents, therefore Dawns expectations and tolerance of violence may also have been influenced by her own experiences.

There was a value in listening to this narrative from Kenneth and this perspective provided further understanding of Dawn's experiences. Contact with perpetrators could be a valid consideration in future DHRs as part of relevant and appropriate information seeking, but would not be necessary in all cases.

- Engaging and supporting so called "hard to reach" communities

The terminology *hard to reach* could be criticised for implying it is the person or group of people who are responsible for failing to access services, when in fact it should be agencies and professionals who look to respond to the barriers for people who are "seldom heard" or largely ignored, and remain under-represented. Professionals need to demonstrate how we have moved from this "hard to reach" perspective to "how to reach".

According to the Social Care Institute for Excellence (SCIE, 2006), mainstream service user participation in social care has increased over the last 20 years. However, participation of black and minority ethnic (BME) people has diminished over this period of time, even though there is no evidence to suggest these service users do not want to participate. BME service users have reported feeling that mainstream services were often inappropriate; that services made assumptions based on stereotypes and prejudice; religious and cultural identity was rarely responded to by mainstream service providers; and that common myths about informal family networks looking after each other should not be taken for granted (Chahal and Ullah, 2004). Stereotypical views of black people, racism, stigma and cultural ignorance were also seen to affect responses from mental health services to the needs of African Caribbean communities (Sainsbury Centre for Mental Health, 2004).

Many factors can contribute to people being *seldom heard,* several of these can be seen as potential considerations for Dawn Richards. At times when people are most in need of assistance they may not feel comfortable seeking help, and professionals can sometimes misunderstand the practical and emotional difficulties that impact on people's ability to engage. The family had experience of statutory agencies in the past which were punitive, and Dawn may have felt there was a history of not receiving help when requested by her as an individual, and intervention being led by what professionals identified she needed.

In recognising Dawn was often presenting as uncooperative and sometimes hostile it is important to recognise the negative influences from her life experiences as a young black woman who had experienced [redacted] abuse, and as an adult experiencing decades of intimate partner violence. Agencies in Leeds have a wide range of experiences which include working with resistant and aggressive service users; but it may be that some

professionals felt unable to address Dawn's presentation of defensiveness and underlying anxieties. This is explored by Littlechild (2000) and Brandon et al (2008) referring to where the fears and anxieties of workers can impact on the engagement process. It is unclear if Dawn had a good understanding of the support services could offer her, but overall there is evidence across the DHR that practitioners could improve their awareness of the cultural differences and social experiences of particular groups of people

Contact with relevant voluntary sector and third sector organisations as part of this and other Domestic Homicide Reviews have identified a need to increase the involvement of early intervention and preventative services. These providers, often including local volunteers, are ideally placed to develop early engagement at the pace and style often preferred by individuals who find it harder to sustain professional relationships. Even when families are not accessing statutory services, they can still be engaging with local centres, even if it's just a lunch club or child care. They are often a trusted organisation at the heart of a community, with a reputation of understanding their relevant culture or faith; and can sometimes know who is at risk of harm, or when a sudden or violent death has happened who is best placed to speak to family members, and how this should be approached. Appropriate information sharing can add value to the review, and provide context and depth to the understanding of family and community dynamics.

There is ample research which identifies the range of obstacles experienced by seldom-heard people who use services including attitudinal, organisational, cultural and practical barriers. Similarly there are practice guides and resources which look to identify strategies to improve opportunities of engagement and working with resistance. If Leeds is going to become more personalised to the needs of all people who use services, those in seldom - heard groups need to be further supported to overcome the barriers affecting access, and this theme is reflected in other areas of learning and in panel recommendations.

<u>Informing recommendations</u>

It was identified that training, resources, support and information are needed to improve the service response to individuals from some BME communities; and to support individuals in overcoming barriers to access culturally sensitive services. It was identified that specialist services need to be expanded to respond to gaps in service provision.

One director of a community based centre identified a need for better information sharing with the voluntary sector, highlighting a need to be proactive in seeking out which

organisations are potential sources of information, and statutory agencies having more trust in their understanding and management of confidential information.

Another project manager highlights the flexible and organic way families need to be contacted as part of a professional review; particularly where people have initially chosen not to be involved or there is a lack of trust with statutory services; or they may find it harder to relate to some of the more formal routes of contact. The value of a personal contact to community based services is highlighted, not through letters or emails but contact from a known and trusted colleague from which relationships can grow and lead others to be introduced to family and friends. Although a further investment of time is required, this commitment can also lead to contributions which would otherwise remain unheard.

Community based agencies can act as advocates, or routes for information to flow both ways as has happened in this review although not until the very end of the DHR process. In several domestic homicide reviews the contact and discussion about family and friends contributing has only begun as the reports were in the final stages. There are implications in considering the timing of approaching families to ensure that another offer is made to contribute after the initial shock of bereavement and the formal process of court proceedings have been addressed.

Recommendations have been developed to reflect strategies to identify appropriate relational networks in relevant communities; better understand how contact from professionals might impact on the family and develop interactive learning opportunities to support further input from “grassroots” organisations.

- Before contacting agencies in the scoping activity, Safer Leeds and the Chair of the review should map potential family connections and access to services such as identifying which is the local community centre, elder or child care provider based on the information known about the family locality, faith and local community provision.
- Following the process in some local authorities after the sudden or unexpected death of a child or infant, Safer Leeds should consider sending an email to a comprehensive list of providers, particularly focussing on community based services who work with adults and children. This has been shown to be a good safety net to pick up wider information in serious case reviews. No names are given, but the email could inform them that there has been a domestic homicide in the area and advise them to ring for further information.

- Promote contact with relevant organisations in the local area, with a particular focus on small service providers who are not part of the "mainstream" third sector; such as Getaway Girls, Hamara Healthy Living Centre, Shantona Women's centre, Together for Peace and other organisations with a similar agenda of community development, partnership working and direct service provision.

Dependent on the individual needs of the review consider how community organisations could;

  - Add value to the review process
  - Support contact with family and friends
  - Be involved as panel members
  - Be included in dissemination and learning opportunities
  - Accessed as consultants, training support, advisors to the panel

- In order to identify as many agencies as possible who might be able to contribute to the DHR process Safer Leeds should add an additional question to the initial scoping enquiry, to ask all agencies "are there any other local agencies involved with this family"; or "do you know of any voluntary sector, faith based or community services, groups or organisations where this individual or family might have accessed support"
- Consider how the principle of "community messengers" modelled by Shantona in their infant mortality project can be transferred to disseminating attitudinal change and empowerment in a domestic violence context. Trained volunteers are tasked with presenting specific information to ten members of the local community, family and friends and this could be utilised to promote support available for people in abusive relationships.
- If possible, gain permission to make contact through a third party or whatever the family finds acceptable to ensure family contact includes a further offer of involvement at different stages of the review process; including as the report is concluding.

The project manager of a local community group, involved with many families in the local area, provided helpful comments to be considered in the learning for this review.

Family centred involvement in DH reviews

Relationships are at the centre of this work. This is because for families and close friends the DHR is so personal; it's about their mother, best friend, aunty, or sister. When families and close friends are genuinely involved in a domestic homicide review, a different process can

unfold. This process allows their voice and grievances to be heard. The process of involving families is often organic; however, some principles could be applied:

1. ***No size fits all****: Explore various ways for the family to be involved and contribute.*
2. ***Context****: Take into account the historical factors that have undermined trust*
3. ***Patience & time****: This work is family-centred not task centred. Family-centred involvement has to be patient. It recognises that people have multiple motives for most things they do, and multiple things going on in their lives. The Home Office and local authority timeframes are not the grieving family's priority. Initial contact through a family worker could be followed up by interim contact mid-way through a review to allow non-pressured involvement. Family and friends often need time to think it through.*
4. ***Respect a 'no'****: Respect a no at any time or stage of the process. They may become involved and later change their minds.*
5. ***After the DHR:*** *Consider space for feedback to families following their input into the DHR. Some families may wish to say their piece and that be final. Others may wonder if their views had any significant impact or made changes to procedures, so this should be considered.*

6.5. Working with the risk of self-harm

The Panel responded to the findings in several reviews which identified that Dawn was at risk of self-harm and had suicidal thoughts on several occasions. The Panel are mindful that there is a distinct advantage in having an overview of all the agencies involved that was not open to the individual organisations and practitioners who often had limited contact with Dawn. Through the opportunity of this DHR it has been possible to assess a catalogue of incidents that collectively painted an alarming picture, and to appreciate more fully the significant impact this had.

<u>Informing recommendations</u>

It was agreed that practice responses had the scope to be improved; and a more consistent and informed response would be gained if practitioners were aware of correct pathways and NICE guidance. It was agreed that Leeds should have a protocol and increase opportunities of training to support this.

6.6. Responsive Services: understanding and responding to risk

Research demonstrates that the victim is frequently the best assessor of risk posed to them (Weisz, 2000). In October 2011 Dawn told one agency she is frightened all the time, including the fear that Kenneth will kill her; and refers to attempts to end her own life on several occasions.

Dawn states she is very angry and distressed at the way she felt she had been passed about from service to service and felt no one cares about her. This gives a very clear indication of her state of mind, and view of service involvement.

It is clear that Dawn did try asking for help but agencies failed to meet her needs on a number of occasions, and the Panel was clear that Dawn felt she was not being heard. Issues identified include staff not taking appropriate action when an individual did not meet the threshold for a particular service and the different assessments which produced conflicting information. One of the reviews said Dawn had complex needs but not specifically alcohol; others focussed on her use of alcohol and did not respond to the history of domestic abuse and violence. This was exacerbated by the information Dawn chose to share, and who she chose to disclose to. On occasion Dawn specifically stated there were no issues to address, or that she would prefer not to discuss her family or mental health.

<u>Informing recommendations</u>

The Panel agreed that any agency response to Dawn should have acknowledged the disclosure of 30 years of domestic abuse and the impact on her mental health, and should have provided referral and appropriate support to access alternative services if they were unable to meet her identified needs.

6.7. Risk management

Agency IMRs reflect areas for improved practice and improved information sharing; increased training and joint working will all contribute positively to improved management of risk.

Research suggests that it is critical for practitioners to consider the importance of coercive control and jealous surveillance (Regan et al, 2007) recommending that all work with perpetrators, and all understandings and definitions of domestic violence should reflect the significance of these core behaviours.

Kenneth Ellis had admitted to smoking cannabis daily which was assessed by probation to be linked to his offending; but an objective to address his substance misuse was not included in the sentence plan. Research identifies that substance misuse by the stalker has been found to be associated with physical assault on the victim in a significant number of cases (Rosenfeld, 2004) and this should inform risk management and safety plans.

- Integrated risk assessment and planning

Although Leeds can demonstrate areas of good practice in multi-agency working and collaboration the DHR identified areas where joint working, information sharing and communication has the scope to be improved. There are examples of agencies working in isolation or with partial information which led to incomplete assessments of risk.

Informing recommendations

The Panel identified the potential in investigating individual risk assessments and support plans that travel with the person, based on the same principles as a CAF where one assessment should provide a personal history and effective information needed for agencies; and would have the advantage for individuals not having to repeatedly answer referral questions. The multi-agency use of a DASH risk assessment questionnaire at presentation at subsequent agencies would give a picture of current risk, and also provide a comparative picture over time to assess any increased vulnerability.

This was seen as a creative proposal and the practicalities should be explored. Identifying a single point of contact to act as a “care coordinator” would also have been an effective resource for Dawn and would have overcome some of the gaps in information and planning, and may also have supported more sustained engagement.

6.8. Case management

Effective case management and referral information has a positive impact on managing and responding to risk. It was noted that some agencies do not routinely ask a referral question relating to misuse of alcohol or whether domestic violence and abuse is an issue that requires support. The Panel agree that referral information has scope to be improved through including these specific questions at the first point of contact; this is also known as “routine enquiry”.

There have been repeated references to grandchildren and varying detail in agency IMRs which directly contradicts each other in this regard, this has been followed up to establish if children were present when there was incidents of domestic abuse and if they have been at risk of harm as a result. It has been difficult to move forward and several agencies have not used the opportunity of contact with Dawn to include family names and details as part of referral information, which leaves contradictions and gaps.

Informing recommendations

The Panel identified areas in the review where the use of routine enquiry would have improved the potential for Dawn to access services and for more effective risk management and support plans. Overall referral information has the scope to be improved.

Good multi-agency relationships and referral systems are necessary for routine enquiry to enable safe disclosure and provide further support for the women concerned. Close working relationships with specialised domestic abuse agencies and the police should be evaluated prior to the development and increased use of routine enquiry.

Several IMRs highlighted the need for agencies to consider risk management as part of case closure; to ensure that if a referral fails to meet the threshold for particular service practitioners must include referring to appropriate support as a concrete action; rather than closing cases without ensuring information or support to access has been given.

6.9. Responding to adults at risk

Since this referral was made to Adult Social Care an initiative between police and children's services has been introduced. This is known as the Front Door Safeguarding Hub which is based in the Contact Centre building; new incidents of domestic violence where children may be affected are screened jointly by a police officer from the Police Safeguarding Unit and a duty social worker from children's' services. It is doubtful whether this new approach would be applied to the same information about Dawn if this was given now, as the police information was that there were no children in the household. It is more likely that Dawn would still be referred to ASC as a person at risk in her own right; the referral would still be taken by an unqualified worker at the contact centre, and passed to the area duty team for screening.

ASC duty teams are busy and prioritise their responses to adults at risk based upon current criteria, established protocols and team resources. The definition of an adult at risk did not

apply to Dawn at the time of her referral and she was not deemed to be vulnerable by ASC; although there were a number of concerns relating to her mental health as a result of harassment from her ex-partner and her fear of his continued violence.

The new definition in the Care Act 2014 has widened the definition and it may have applied to Dawn had this been in place in 2011.

"Adult Safeguarding duties defined in the Care Act 2014 require enquiries to be undertaken for an adult who has care and support needs, is at risk of abuse or neglect and cannot protect themselves due to their needs. This supersedes the language and definitions of "vulnerable adult" previously used in No Secrets (2000). . The purpose of such enquiries is to establish what if any action is required in response to the concerns raised".

(Think Family, Work Family Protocol April 2014; Leeds Safeguarding Children's Board and Leeds Safeguarding Adults Board).

The changes in definition and legal responsibilities within the Care Act 2014 are significant and programmes of training and communication briefings are being planned by ASC and the Leeds Safeguarding Adults Board.

<u>Informing recommendations</u>

In terms of 'lessons learned' the Panel identified the need for conversations around using and interpreting the current definition of an adult at risk, and the context of serious harm. The role of responsive services and the issue of consent in safeguarding referrals for adults with mental capacity has been a continued area of debate. This has been included in the Overview report and passed through Safer Leeds to pick up in the MARAC Steering group as an area for further discussion, as there are views that reflect different approaches and understanding.

6.10. Meeting DHR deadlines

The DHR process has not met agreed deadlines; and there has been a number of contributing factors.

The process was new and associated systems had to be developed and were added to the existing workload of existing staff in Safer Leeds and partner agencies. There was a lack of awareness about DHRs in general, and initially this impacted on identifying IMR authors and a timely response to the DHR process.

As the Leeds experience of undertaking DHRs has developed with further reviews, agencies and managers have become more familiar with these requirements and equate these more readily with a similar process to Serious Case Reviews.

The Domestic Violence team have developed a comprehensive manual which includes detailing the DHR process and timescales. This will form the basis for consistent and improved practice (Safer Leeds Executive, November 2014; Policies, Procedures and Toolkit for Domestic Homicide Reviews).

- The DHR process has been refined and streamlined
- All agencies are now asked for full IMR and chronology to standardise information
- The issues of accountability for failing to meet DHR deadlines are clarified and there is a process of escalation to address any outstanding reports
- There is additional administration and practice staff allocated to the DHR process; overall there is now a number of staff who are experienced and fully conversant with the DHR process

Safer Leeds will respond to the findings in Leeds DHR's where case specific dissemination could identify family members and cause a potential risk of harm, and merge lessons learned where appropriate. The learning opportunities will evaluate and promote partner agency knowledge and awareness of the DHR process and establish where there are gaps and where effective links can be made.

<u>Informing future developments</u>

In order to maximise engagement and support there is scope to profile the benefits of DHRs to the commissioners and heads of services as well as using this opportunity to engage with managers and individuals on their experiences, giving Safer Leeds qualitative data on their perceptions and recommendations to improve the DHR process.

This can be used to enhance and develop future systems, and also for agencies and individuals to feel this has a relationship to other forms of reviews, and one where they can construct as well as be beneficiaries of lessons learned. A profiling event to focus on DHR learning would also provide an opportunity to engage managers and practitioners in providing feedback and including their contribution in the revision and development of DHR systems and processes.

There is scope to improve the quality of IMRs in terms of analysis and the input from senior managers in ensuring that all reviews follow the Terms of Reference; this would contribute to reducing the delay to the DHR process in awaiting revised reports.

6.11. Domestic Homicide Reviews

Nationally there has been little exploration of the content, process, analysis or recommendations in adult Serious Case Reviews when compared with the similar processes in children's services. Similarly there has been limited analysis of Domestic Homicide

Reviews to offer a national overview of recommendations to improve practice and avoid repeating "lessons learned". The Home Office (2013) has identified some common themes, but there is scope for a regional sharing of learning to include a more comprehensive analysis. This would offer a more local investigation of themes and trends, risks factors and provide opportunities to disseminate good practice.

The number of DHR's now undertaken in West Yorkshire now offers an opportunity to evaluate where joint working and regional resources could effectively add value to the DHR process in Leeds, such as regional joint training, DHR profile events and conferences. There is also scope to assess the viability and identify resources to collect data as a region.

<u>Informing recommendations</u>

- Evaluate opportunities where joint working and regional resources could effectively add value to the DHR process in Leeds, such as regional joint training, DHR profile events and conferences.
- Assess viability and identify resources to collect data as a region
- To evaluate where there are already plans in services to collate findings from DHRs in Leeds and share resources and findings
- Evaluate training needs for IMR authors responding to identified gaps in analysis skills, aiming to improve overall quality of IMR reports.

<u>EXTERNAL REVIEWS</u>

1. Home Office: Common themes (2013)

In 2013 the Home Office completed a report "Domestic Homicide Reviews: common themes identified as lessons to be learned". 54 completed reports informed common themes, and also reported on what is being done nationally to respond to these issues. This review has

identified where the issues in Leeds correlate with these national findings, and has identified recommendations for a local response.

I. (HO) Awareness raising and communication

There are gaps in awareness and understanding of what constitutes domestic abuse; the power and control aspects have not been fully recognised; coercive control is considered to be an important risk factor in domestic abuse and there are improvements to be made to understanding the impact of stalking and harassment.

Leeds response: Recommendation includes a review of education and training to ensure these key messages are highlighted.

II. (HO) Awareness and training for health professionals

The Home Office identify a national need to improve training and awareness on domestic violence and abuse for GPs and health professionals to ensure disclosures are responded to, and referrals are made to appropriate services.

Leeds response: GPs to access identified guidance for general practices and implement any relevant service improvements

III. (HO) Risk Assessment

The importance of consistency is identified in risk identification, assessment and management for all professionals, this includes the use of DASH (Domestic Abuse, Stalking and Harassment) risk assessment tools, and ensuring there are reassessments which account for changes in circumstances, and a potential increase in violence.

Leeds response: Recommendation for service providers to review risk assessment and management to ensure process is robust, and accounts for learning in this DHR such as responding to risk indicators of coercive control, depression and self-harm.

IV. (HO) Information sharing and multi-agency working

There was some evidence nationally that information was not adequately shared across reviews and this failed to give a full picture of the potential risks, this included some cases where previous domestic abuse was known or other victim vulnerabilities. The Home Office report notes the importance of sharing information, preferably with the consent of the victim, and ensuring the victim is not placed at any greater risk.

Leeds response: Recommendations address agency specific issues raised in the review process; service providers will also be supported to evaluate and improve information sharing with a particular focus on effective referral information. Leeds information protocol to be reviewed and profiled to service providers

V. (HO) Complex needs

The Home Office note the difficulty of providing a multi-agency response to people like Dawn, who had a range of complex needs. This identified a need to develop understanding and awareness.

Leeds response: Recommendations include developing multi agency training and awareness responding to the issues of misuse of alcohol, depression and self-harm, and working with resistance and disengagement.

2. HMIC (2014)

The Overview author has included consideration of the recent HM Inspectorate of Constabulary (HMIC)[5] inspection of police handling of domestic violence and abuse.

As a result of this inspection, HMIC has developed 7 force-specific recommendations for West Yorkshire Police, designed to tackle any risks identified in the service to victims of domestic abuse; additional recommendations are set out in HMIC's national report on domestic abuse. There are a number of areas which are relevant to the DHR process:

- In West Yorkshire HMIC found that there has been a lack of training for staff in dealing with domestic abuse. Most frontline staff identified they could not recall much, if any, training about domestic abuse beyond an initial input delivered when they first joined the force.
- There is no systematic consistent process in place to ensure that the lessons learned from domestic homicides are fed back to all staff, and processes and practices improved as a consequence.
- ACPO should consider collating findings from domestic homicide reviews to encourage learning across forces.
- Following HMIC's inspection, there should be a further multi-agency inspection; this should consider how local services provide advice, assistance and support to victims

[5] www.hmic.gov.uk

of domestic abuse. The inspection should not only consider how individual services contribute to keeping victims safe, but also the quality of the partnerships and the ways in which joint working is scrutinised.

Since August 2013 a number of developments have occurred in the Force's management of domestic abuse issues:

- September 2013: Leeds Safeguarding Unit wrote a staff guidance document detailing best practice in the management of domestic abuse incidents, all staff have been circulated and briefed on this document.
- November 2013: HMIC recommended improvements were to be made to the completion of DASH forms (risk assessment for domestic abuse). This is now being progressed under a dedicated project manager and with a Force action plan.[6]
- September 2014: hand held electronic devices are now used to allow completion of reports at the scene and from April 2015 this will include DASH forms. This will allow officers to record assessments with the victim at the time, directly onto Force systems.
- Training has been undertaken in DASH risk assessment and continued through 2014.
- There is a current trial of body worn video equipment; the value of this evidence is widely recognised in domestic abuse incidents and it is hoped this will be routinely used.
- The custody process has been amended to ensure that a victim has been notified and necessary safety measures are in place before a person is released from police custody.

Management of domestic abuse reports is directed by the Force Domestic Abuse Policy which was in place at the time of Dawn Richards's death in August 2013. This policy defined all operational practice including responding to complaints of harassment and risk assessment. Police officers have been required to use the DASH[7] risk assessment tool since May 2011 (Domestic Abuse, Stalking, Harassment and Honour based violence) the policy requires officers to complete a DASH risk assessment at all domestic abuse incidents and have the risk level they identify authorised by a supervisory officer.

[6] HMIC Force action plan
http://www.westyorkshire.police.uk/sites/default/files/files/reports/domesticabuseactionplan_010914.pdf
[7] DASH 2009 Appendix 2

Positive changes include national legislation which enacted the use of Domestic Violence Protection Notices and Orders. This provides a temporary non-molestation/restraining order for victims to receive support and consider their situation without the presence of the perpetrator in the household. This went "live" in June 2014 and by February 2015, 66 orders have been obtained by West Yorkshire Police.

In March 2014 the Force launched the Domestic Violence Disclosure Scheme, known as Clare's Law. This allows members of the public to request information from the police about the previous domestic abuse and violent offending history of individuals they are in a relationship with. Formal multi agency arrangements now exist within Leeds to respond to these requests and share information between partners and with potential victims.

Informing recommendations:

The DHR Steering group and appropriate representatives from WYP should evaluate the Leeds response to "Improving the police response to domestic abuse" (HMIC: 2014); to explore the recommendation to overhaul face to face Force training on domestic abuse, supporting and adding value to the Force action plan.

<u>Relevant Leeds reviews:</u>

- MARAC Review

During 2014 there has been a review of MARAC processes in by the MARAC Strategy Group which resulted in a number of recommendations which have been included in a MARAC Review Action Plan to be overseen by the MARAC Strategy Group. These are detailed in the MARAC IMR but include a revision and focus on systems in order to improve the management and delivery of the MARAC response. A new operational model has been agreed which will be operational in Spring 2015; the multi-disciplinary team will operate a daily meeting responding to high risk cases of domestic violence and abuse which will promote a more timely and proportionate response.

7.0. RECOMMENDATIONS Further detail in Overview Report Action plan (Appendix 3)

7.1 Review Panel Recommendations from analysis of IMRs and Research Findings:

<u>Recommendation 1:</u> Safer Leeds, Leeds Adult Safeguarding Board and Leeds Safeguarding Children Board should respond collectively to gaps in practitioner knowledge and training needs by delivering multi-agency training, e-learning, shadowing and mentoring to:

- Increase understanding of the impact of stalking and harassment to improve risk assessments. This should include exploration of the factors that increase risk in stalking such as substance misuse, history of violence and coercive control (including perpetrator tactic changes)
- Explore the ways in which victim blaming and the concept of "deserving victims" can affect professional judgement and risk assessment
- Develop skills around working with resistance and disengagement
- Improve skills in engagement, critical questioning and professional enquiry
- Support routine and triggered enquiry in appropriate settings to encourage early identification and timely intervention
- Increase understanding of the help seeking process and opportunities for engagement and intervention
- Increase understanding of the links between to the misuse of alcohol, domestic abuse and access to support services
- Increase understanding of depression, self-harm and domestic abuse

<u>Recommendation 2:</u> All agencies involved in this review should implement good practice to ensure a proactive approach to disclosures and risk including:

- Identifying key individuals in agencies to provide a lead on domestic abuse advice and consultancy
- Developing a disengagement protocol
- Promoting NICE guidance on responding to self-harm
- Evaluating training needs for IMR authors to address gaps in analysis skills to improve the quality of IMRs

- Evaluating the Leeds response to “Improving the police response to domestic abuse” (HMIC: 2014) and WYP training on domestic abuse (WYP) and offer opportunities to increase understanding of stalking and harassment
- Providing guidance to promote a proactive approach to disclosures of partner abuse, stalking and/or harassment to increase involvement with MARACs, improve risk assessments and increase knowledge of available support
- Continue the requirement of commissioners to include a standard in all LCC commissioned services and LCC direct services to attain the Leeds Domestic Violence Quality Mark or other required minimum standards in responding to domestic abuse

<u>Recommendation 3:</u> All agencies involved in this review should improve their responses to working with BME communities. This should include:

3. Utilising the Leeds Domestic Violence Quality Mark to quality assure support and information to individuals from some BME communities.
4. Promoting anti-racist, culturally sensitive responses that address the complex and additional issues facing BME victims within their communities as well as the barriers they face in accessing services.
5. Ensure that providers are more aware of the limited resources and lack of specialist services as referral sources, and identify and promote alternatives where available.
6. Strategy and Commissioning in Public Health to evaluate the Leeds response to working with BME communities as part of the domestic violence commissioning review. This should include the voice of service users and BME community based service providers to identify gaps and recommend how culturally sensitive services can be improved and developed.
7. Delivering culturally sensitive services and helping marginalised individuals to overcome issues and barriers to access generic services
8. Identifying how referral information can be improved to ensure that the ethnicity of each referral is recorded and considered in service delivery and that relevant referrals are linked such as family members and ex-partners

<u>Recommendation 4:</u> Improving Inter-Agency Working

- Safer Leeds to co-ordinate a response to identified gaps in inter-agency working and information sharing
- All agencies involved in this review should make themselves aware of relevant Information Sharing Protocols and Agreements including any recent amendments

- Safer Leeds and CPS to respond to the findings that CPS has been identified as a critical partner in more than one DHR and CPS needs to be included and actively contributing to the process.
- Leeds Domestic Violence Strategy group to investigate the potential for a model where service users have one support plan created with input from all agencies involved rather than a separate plan from each agency which is rarely shared. This would offer the opportunity for a more comprehensive background to inform risk assessments and interventions. The principle of an individual support plan that travels with the person addresses the missed referral information identified through this and other DHRs.
- Investigate the principle of agencies identifying a single point of contact to act as a "care co-ordinator" to help overcome gaps in information and sustain engagement. Identify how a lead professional would enhance service responses for individuals reporting domestic abuse; and if the practice implications can be overcome.
- Safer Leeds and Adult Social Care to address threshold issues raised in recent DHR panel meetings and facilitate agreement for a consistent response and understanding of safeguarding referrals without consent and choices for adults with capacity not to access services
- Strategy and commissioning to evaluate the contract specification and domestic violence and abuse policies for housing support providers relating to housing discretion in providing alternative accommodation:
  - To explore how this would apply to Registered Social Landlords
  - To ensure that safety is a key priority where a person is identified as requiring re-housing as a result of domestic abuse and this will not be denied as a result of rent arrears
  - To promote the wider use of DASH risk assessments across agencies
  - to include risk management as part of case closure

- All agencies in this review should include the following in their assessment procedures:
  - Ethnicity is asked and recorded
  - Links are made between referrals to identify where abusive relationships exist between clients using the same service
  - A standard of "asking the question" identifying if domestic abuse is a current or a historic issue
  - Where possible and safe, ask if the name of the perpetrator can be recorded to ensure joint access to services does not increase risk

- Appropriate information sharing of perpetrator information with agencies providing services to the victim to assess potential risk of harm
- Ensuring that if a referral fails to meet the threshold for particular service practitioners are referring to appropriate support as a recorded action; rather than closing cases without ensuring information or support to access alternative services has been given

7.2 Review Panel Recommendations for specific agencies informed by analysis of agency IMRs (Individual agency recommendations from IMR authors are included in next section.)

HM Court

- Leeds Magistrates Court Legal Training Manager to promote opportunities for learning from this DHR such as exclusion requirements, non molestation orders and the process of analysing risk.

MARAC

- MARAC Strategy Group to evaluate administration systems to support timely distribution of Minutes and action plans; and to ensure agencies are updated with relevant changes in circumstances which indicate a potential increase in risk
- MARAC Strategy Group to identify potential gaps in MARAC information sharing and include contact with A&E and other relevant providers

Housing

- Housing support agencies to evaluate information sharing and knowledge of partner resources, services and support including how specialist domestic violence services can provide added value without duplicating resources.
- Housing support agencies to evaluate their domestic violence and abuse policy relating to housing discretion in providing alternative accommodation to ensure that where a person is identified as requiring re-housing as a result of domestic abuse this will not be denied as a result of rent arrears.

NHS England: GPs

- GP practices to include recording who the perpetrator of the violence is when a disclosure is made.
- GPs to access identified guidance and implement any relevant service improvements

West Yorkshire Police

- West Yorkshire Police to identify how referral information can be improved; particularly to ensure that the ethnicity of each person is recorded in referrals to partner agencies, and that linked referrals are identified.
- To consider appropriate information sharing and risk assessments of perpetrator information to partner agencies that may also be providing services to the victim to assess whether there is a potential risk of harm if they are unknowingly accommodated by the same provider or receiving support in the same building.

7.3 IMR Authors: Agency Recommendations from Individual Management Reviews; this includes the submission of a full agency action plan which is approved and signed off by senior managers. Agency action plans will also be monitored by Safer Leeds.

Addiction Dependency Solutions (ADS)

- Develop strong effective links with MARAC team; ADS staff to fully engage with the process
- Include MARAC training for current and new staff team
- Transform GP based Tier 2 services into a Tier 3 service
- Review current case notes system

Adult Social Care (ASC)

- Recording is of a high standard, ensuring defensible decision-making and effective accountability
- Risks are assessed when an adult with care and support needs experiencing domestic abuse is referred to ASC for support
- ASC staff understand the interface between safeguarding and domestic abuse
- ASC staff to understand and exercise their role and responsibilities within the City Council 'Think Family' approach
- ASC staff to be clear about their statutory duties in relation to children and young people

Noted in IMR: A joint initiative between police and ASC is being developed and will be operational in 2015.

HM Courts – Leeds Magistrates

No recommendations in the brief management report (see recommendation in 7.2).

Leeds City Council: Housing Options

- Leeds Housing Options should ensure that all frontline staff and the relevant support staff complete training in the DASH risk assessment, its use with victims and the evidence base behind the risk factors. DASH risk assessment training should be provided annually
- Leeds Housing Options should have internal Quality Assurance functions in place to enable increased management oversight of assessment through regular audit
- Case management framework should allow identification of safeguarding cases and case prioritisation during staff absences
- Leeds Housing Options should continue to work with the LCC Domestic Violence team to attain the Safer Leeds Domestic Violence Quality Mark, Level 1

Noted in the IMR: Leeds Housing Options will identify any improvements to be made in respect of communication between agencies regarding the suitability of move on accommodation.

Leeds Community Healthcare NHS Trust (LCH): Primary Care Mental Health team

- Reflect learning from DHR back to PCMH team managers- to include clarity in documentation & decision-making processes; referral criteria; information-sharing & good practice
- Domestic Abuse- identification of risk factors, triggers, referral for support and referral to MARAC
    - review NICE guidance for Domestic Violence; joint project with children's safeguarding
    - include in safeguarding team work plans for 2014/15
    - develop One Minute Guide (OMG) for Domestic Violence or adapt children's OMG for Adult services and profile to every clinical practitioner
    - make recommendations for training – options to be identified
- Review LCH representation on MARAC

- named nurse to attend MARAC steering groups & ascertain any gaps in service representation, effectiveness of information/risk sharing & make recommended changes
- scope effectiveness of 'flag & tag' for adults at risk without children under 18 years.

Leeds Domestic Violence Service (LDVS)

- Consider that when clients are moved on from refuge or other locations and may still be at risk from a perpetrator, that appropriate referrals could/should be made for specialist support e.g. LDVS, outreach/IDVA or resettlement regardless of whether there is generic support in place. LDVS senior managers consider publicity of LDVS services for generic services providing support for DV Victims
- That MARAC paperwork sent out after meetings gives clear information on agencies already involved, actions to be taken and by whom.
- The criteria for closing cases at MARAC are raised for discussion.

Leeds Housing Concern (LHC)

- MARAC processes need to be fully embedded into LHC risk management process, MARAC cases need to be viewed as High Risk and incorporated into the LHC Risk Register for Senior Management oversight.
- Front line staff have regular refresher training for the recording of information
- All new information gathered is utilised in subsequent risk assessments and management plans to improve the level of enquiry
- MARAC and DV to be addressed within Adult Safeguarding and to be incorporated into the bi-monthly safeguarding reviews currently undertaken.
- Incorporating MARAC updates into LHC's quarterly safeguarding newsletter
- Staff to attend refresher training in MARAC processes and receive in house training update regarding Risk Management Processes
- Client handbooks to be updated to include DV in the Safeguarding/Keeping Yourself Safe Section.
- Update the Risk Matrix guidelines for completion to include the risks of carrying knives/weapons to ensure personal safety.
- Provide feedback regarding DHR9 recommendations and the reasons for these to the organisation via the LHC safeguarding newsletter, team meetings, and individual supervisions.

- Source and provide appropriate training for individual staff regarding working with people who are difficult to engage

Leeds MARAC - Safer Leeds

- The MARAC Strategy Group should review how information is documented at MARAC meetings and shared among MARAC partners and the action planning and recording process should be reviewed. Additionally, MARAC minutes to more accurately reflect attendance at MARAC, by highlighting which attendees are present for specific cases, and which attendees leave early.
- Investigate and implement a process for GP's, and alcohol/ substance misuse services to input into, and receive feedback from MARAC.
- Flagging and tagging processes across agencies should be reviewed and strengthened, including periodic auditing of this arrangement across MARAC partners.
- Consideration to how agencies respond to high risk victims' disengagement from support service should be given generally and specifically as to whether it becomes an automatic trigger for a repeat MARAC.
- The MARAC develops a full range of tactical options (both civil and criminal) available to manage the behaviour of the perpetrator and ensure that a perpetrator focussed action plan is developed within the MARAC.
- Options for increasing the administrative resource to be explored.
- Risk management plans are developed for victims, who may pose a risk to staff or other service users.
- All BME victims to be invited to express their wishes about how best services can respond to their support needs, acknowledging that not all BME victims want to be supported by someone from the same/ similar background.
- MARAC to agree a single point of contact for each case discussed at MARAC to be identified as the support point for informing the subject of the MARAC and checking their welfare and views on the safety plan and intervention. This person is likely to be the representative who is having most contact with the individual or the IDVA.
- MARAC to agree which agency is best placed to provide on-going support to victim as part of each case discussion.
- MARAC to ensure a process for the Chair (or identified person) to identify significant gaps in information and follow up after the meeting if the representative does not attend.

- MARAC Strategy group to look at how reporting back on actions agreed at MARAC can be strengthened, to ensure all updates are effectively captured in a timely manner.

Leeds Teaching Hospitals NHS Trust (LTHT)

- LTHT to undertake training needs analysis to identify staff requiring training on domestic abuse issues. This analysis should identify high priority specialties and pathways including Emergency Department and maternity Services. This will include types of abuse that are non-physical. It is to be ensured that this training links in with the National Institute for Clinical Excellence (NICE) guidelines.
- Review the current PAS and Symphony Systems (electronic recording systems in LTHT) to determine whether it is possible and appropriate to include a Domestic Abuse alert flag.
- There has been work done on mapping the process flow for case note recording and storage for the different departments within the Trust. There should be an educational focus on the mapping process with staff to raise awareness of the process review.
- Review the compliance and monitoring arrangements of the Trust policy on the releasing medical records to a coroner if a post-mortem is to be conducted at a site external to LTHT.
- LTHT to review its involvement with and receiving information from the MARAC process. This needs to include reviewing the process of 'completed' MARAC cases, when the victim of domestic violence is no longer deemed to be at risk.
- Recommend that the Emergency Department develops a Standard Operating Procedure to inform staff of the procedures when patients attend with cases of suspected and known domestic violence.
- Review the Trust safeguarding policies to ensure there is a specific reference to domestic violence and link to any domestic violence standard operating procedures.

NHS England (GP)

- Interventions and referrals to reduce alcohol intake should be made as soon as a problem is identified.
- Support practitioners to encourage disclosure of domestic abuse, offer advice and guidance on local support and signposting to local services.
- For Leeds CCGs to work with MARAC to establish mechanism for effective communication between MARAC and GP practices in Leeds

Victim Support

- Victim Support should receive agenda's for all MARAC meetings in advance
- A member of Victim Support staff should attend all MARAC meetings when any support, no matter how brief, has been given to any victim on the agenda or submit a written report to outline the same, including any referral to, or contact with Witness Service
- There should be a robust Information Sharing Agreement between Victim Support, Leeds MARAC and all other MARACs across West Yorkshire
- All victims of domestic violence and abuse not wishing to engage with Victim Support Service, either after contact or when contact has been denied, should be flagged up with a supervisor who should decide on what further action to take, if any.
- In high risk cases, support should be proactive and the victim should not be left to find out, or follow up information themselves, unless they request to. This should be done at all and any point of contact with Victim Support.
- Refresher training for Witness Service staff and volunteers to remind that witnesses should be offered a referral back to community service for further support should they be anxious or concerned when a trial is finished
- Refresher training for Victim Care Officers (VCO) in the completion of CAADA RIC (risk assessment) forms to ensure that all VCOs are completing them completely and correctly
- Feedback should be given at regular intervals to any police officer or any other agency who refer cases of domestic violence and abuse to Victim Support, concerning progress on the case, whether the victim has been contacted or not.

West Yorkshire Police

- That the Force conducts an audit of the current standards of management of stalking and harassment reports to ensure that recording and investigation is in accordance with Force Policy and national best practice and in compliance with National crime Recording Standards identifying any remedial action required.
- The Force consider how repeat calls for service which are not initially tagged or recognised as domestic abuse can be flagged to the District Control Room supervisors for review and consideration of referral to appropriate staff, such as Neighbourhood Policing Teams or the Police Safeguarding Unit

West Yorkshire Probation Trust

At the time of the original IMR these actions were to be undertaken by West Yorkshire Probation Trust. As this was split into two organisations from 1st June 2014 these recommendations are now separately ascribed to the National Probation Service, and the West Yorkshire Community Rehabilitation Company.

National Probation Service

- Victim Services
- Further development of signposting practices when specific vulnerabilities are identified of a victim.
- Develop disclosure guidance where risk issues are identified from the victim.
- To follow up appointment when the victim is unable to engage with disclosures.

- Information Sharing
- To refine process for obtaining details of police domestic violence call outs pre and post-sentence.
- To ensure that the process for communicating call outs whilst a service user is on a domestic violence programme.

- Offender Management
- Pre-Sentence Report guidance in the Domestic Violence Practice Guidelines to be reviewed.
- Guidance on the completion of SARA for domestic violence perpetrators should be reviewed.
- The learning agreement for PQF students should be reviewed to include clear accountability for risk.
- Reporting and recording MARAC processes need a full review.
- Develop guidance on frequency of contact with specific reference to dropping frequency before the identified risk has reduced.

West Yorkshire Community Rehabilitation Company

- Information Sharing
  - To refine process for obtaining details of police domestic violence call outs post-sentence.
  - To ensure that the process for communicating call outs whilst a service user is on a domestic violence programme.

- Offender Management
  - Guidance on the completion of SARA for domestic violence perpetrators should be reviewed.
  - Reporting and recording MARAC processes need a full review.
  - Develop guidance on frequency of contact with specific reference to dropping frequency before the identified risk has reduced.

- Activities Team
  - Review communication guidelines when a risk to the victim is identified.
  - Develop recording practice to ensure information is recorded on the system that the Offender Manager can access.

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APPENDICES

Appendix 1: Confidentiality agreement – DHR Overview Panel

Appendix 2: Brief chronology of victim contact with West Yorkshire Police

Appendix 3: Overview Report Action Plan

- NB: Copies of individual agency action plans can be requested through Safer Leeds

Appendix 1: Confidentiality Agreement – DHR Overview Panel

CONFIDENTIALITY AGREEMENT

DHR 9: Review Panel: Initial meeting 18th March 2014

Any DHR can be subject to high levels of public interest and legal processes in the criminal and civil courts. IMR authors, panel members and any others involved with the review process are aware that the information they learn about the case and any agency involvement is confidential. This means it should not be discussed with anyone apart from officers within the agency who are responsible for either the current case management or where senior managers need to be kept informed.

Documents related to the Domestic Homicide Review must be stored in a locked cupboard with restricted access. Electronic documents must be password protected and access restricted. Once a DHR is completed the agency should securely archive all relevant documents but draft copies of overview reports and executive summaries should be shredded.

In order to inform a comprehensive response and to address the purpose of a domestic homicide review all relevant data should be shared and reviewed by the DHR Panel in accordance with current statutes and guidance. This includes historical information concerning the deceased, her or his family, the perpetrator/suspect and the circumstances surrounding the death.

All material generated or obtained in the DHR whilst the criminal case is ongoing can be made available to the SIO and disclosure officer to assess whether it is relevant to the criminal case.

The content of the Executive summary and Overview report will take proper account of privacy and confidentiality and be subject to advice from Leeds City Council lawyers and the Home Office.

Public statements about the general purpose of the Domestic Homicide Review process may be made, as long as they are not identified with any specific case.

Any breach in confidentiality will be discussed with relevant agencies.

The undersigned agrees to abide by the terms of this confidentiality agreement:

NAME	AGENCY

Appendix 2: Brief chronology of victim contact with West Yorkshire Police

Case background: police record of contact

In August 2011 Dawn feels she is being stalked by her ex-partner, Kenneth Ellis. She describes how he has made threats to kill her for 2 ½ years and she is now afraid to leave the house, over the past three weeks her ex-partner has been outside her address on an almost daily basis. Dawn reports he last assaulted her five days ago and made threats via their daughter 2 days ago and he states he isn't scared to go to jail for her. Dawn says she hasn't told anyone about this previously. Police report this as a non crime domestic incident, and speak to both parties. Dawn feels she is being stalked but it is not submitted as a harassment occurrence. Dawn does not consent for her information to be passed to other agencies, and Force policy states that information is only shared with consent, except in High Risk cases.

In September Dawn contacts the police on two occasions to report that Kenneth Ellis has made verbal threats, making "gun" signs at her through her windows and he has told other people he is going to kill her. Dawn wants the police to warn him, and he was spoken to. In a further report she states he is stalking her, "walking past her house most of the day and night" and sitting on the steps opposite her house watching her. He has sent threatening texts and he has hit her, she has only just started reporting this to the police so previous assaults will not be recorded. On the 18th September a decision is made that a harassment warning is to be issued which was served on 20th September 2011.

During October there are five occasions where the police are informed of concerns.

Dawn told the police that she suffered from depression and drinks to cope with it. She states she can't have anti-depressants due to the alcohol, and does not want counselling as she doesn't want to talk about what she's gone through. Dawn said the only way out is to kill herself. With Dawn's consent the officer made contact with the GP and made an appointment on her behalf, and a referral was made to Behind Closed Doors for additional support, subsequently a referral was also made to Adult Social Care but it did not meet their criteria.

- A housing worker reports domestic violence to the police and informs them that Dawn has mentioned suicidal intent due the harassment from her ex-partner, and he appears to have obtained keys to her home. The report is not accepted as true as it is without corroboration; no enquiry is made with Kenneth Ellis despite the history of harassment.

- Dawn makes further allegations of burglary by Kenneth apparently not accepted by the responding officers and makes reference to killing herself; and states her GP is referring her for a mental health assessment. Dawn stated if nothing was done about this matter she would commit suicide by going round to Kenneth Ellis and asking for her property back.
- Dawn reports that stones have been thrown at her window, the incident is not linked to her previous history and the case is closed.
- Dawn reports continued text messages from Kenneth, her TV aerial and Sky TV cable have been cut.
- A statement made by Dawn at the end of October indicates a history of domestic violence and assault, broken bones and a previous hospital admission for a punctured lung. Kenneth has a harassment warning but continues to send texts and Dawn feels in fear to leave her house, he continually walks past her house

Dawn continues to contact the police during November 2011:
Kenneth admitted sending texts to Dawn but says she him texted first; he is arrested and his mobile phone seized and released without charge or conditions on police bail. On contacting Dawn the police report she is abusive and rude. Dawn tells the police that Kenneth appears to have gone to her house immediately on release from bail and was peering through her letter box. Later that night he appears to be in the garden and has done something to the electric box, she daren't go out to check. The report is not identified as a domestic incident, there is no indication that officers are aware of recent incidents; there is no enquiry to locate or arrest Kenneth and there are no new risk assessment or safety measures. On the 9th November there is insufficient evidence to charge, therefore no crime has occurred.

The following day Kenneth answers his bail and states Dawn makes things up as she did during their "brief relationship". Officers state it is "word on word", as there is no corroborating evidence and that this is the first allegation of harassment. The Inspector reviewed the case the following day and states no crime occurred and there is nothing to suggest harassment in this case.

On 15th November Dawn makes further reports of damage; there is no evidence provided to confirm Kenneth Ellis is responsible, this was not crimed as no permanent damage was caused. Dawn is described as very abrupt in her attitude, she states she is being harassed, "caller was advised re her attitude but she didn't seem to care". She attended the police station the following day and was unable to provide evidence or link the offences to her ex-

partner. Referred to safeguarding as no crime, no report submitted, no evidence of further action.

On 30th November Dawn believes Kenneth has been to her address and damaged the lock and states over and over "its domestic violence" and they have a long history. As neither Dawn nor her son can confirm they saw him at the address there is no crime.

December 2011:
There are two further occasions when Dawn reports harassment in December, and in addition the police are contacted by a professional who is concerned about the impact of this on Dawn's wellbeing.

The police received an email on 2nd December from a senior mental health practitioner as she has been unable to make contact with the domestic violence coordinator at Killingbeck and she is concerned about the possible seriousness of the threats. She reports that Dawn has detailed 30 years of abuse by her ex-partner Kenneth Ellis and his continued intimidation and harassment; he walks past her house and has made a shooting gesture to her. Dawn states he has burgled her, taking her passport, driving licence, car keys and put water in the diesel tank of her car. There is a restraining order in place, but Dawn states any previous help has been ineffective.

- Dawn rang the police on the 14th December to say Kenneth Ellis is outside and staring at the house, no action was taken. Two days later Dawn reports he walked past the house shouting "you think it's all over?" Dawn tells the police he has been harassing her for nearly five months. An officer attended the following day; no further action is taken as Kenneth has to pass her house to go to the shops. The event is treated as a one off and not linked to previous incidents.

On 20th December 2011 a non molestation order is issued. Two days later the police are informed that Dawn is believed to carry a knife to protect herself from her ex-partner. This is described as "community intelligence from an untested source which cannot be judged re accuracy." There is no indication if the police safeguarding unit (SGU) addressed this with Dawn.

2012

There are a series of escalating events in January 2012;

- On 10th January there is a report that Kenneth throwing stones at Dawn's window at 2am, a note is passed to the attending officer that this may be vulnerable repeat caller. As there is no damage and no evidence to prove it is Kenneth Ellis no report

is submitted, and there is no notification to SGU or any link made to previous incidents.

- The following night Dawn contacts the police at 5.30am reporting he is throwing stones at the window, she says he comes to her house and does this every night. There is no damage or evidence it is Kenneth Ellis, there is a negative search of area, and advice is given.
- On the 13th January at 3.52am Dawn states he is outside her property; Dawn refuses to look out to confirm he is still there, and says it is pointless sending officers as she can't say she has seen him, although there is a court order that he is not to go within 50 metres of her property. Crime prevention advice is given and she is advised to ring with any further problems.
- The following night at 3.14am her rear bedroom window is smashed, Dawn wants police to attend as soon as possible. The log later describes Dawn as "incredibly rude" and she would not give the police any information. Dawn stated Kenneth had done this and asked if they would arrest him, but when told there was no evidence it was him she said "that's it then, go." On reviewing this log the supervisor was concerned and contacted Dawn. She was very upset and put her son on the phone who said it was his and his mother's belief that Kenneth Ellis was involved but each time officers told them nothing could be done. A request was made for SGU to contact Dawn.

On 19th January the non-molestation order is continued. The police liaise with Housing to discuss rehousing and repair of damage, discuss a possible MARAC referral with SGU and arrange the installation of a covert camera. Dawn's son is updated with action taken.

- On 21st January Dawn reports that Kenneth is outside her house and has tried to smash her windows, he was not seen by police officers who searched the area

February 2012:
Assessments are completed to fit a covert camera and this is fitted on 1st February 2012.

In February there are two reports of criminal damage to Dawn's vehicle; Kenneth is identified as approaching her car and stabbing the rear tyre with a sharp instrument. Dawn also reports Kenneth has thrown a brick and tried to smash her front window. This incident is recorded on CCTV and Kenneth is identified.

On 29th February a seven page statement is taken from Dawn, this details a history of harassment, theft from her property and damage. Dawn says she fears Kenneth will kill her, and she has suicidal feelings.

March 2012:

On 1st March an intelligence report is noted by the police that Dawn carries a knife for personal protection and she fears Kenneth will kill her, she also keeps a knife in her drawer next to her bed. No action appears to have been taken.

An additional statement is taken after reviewing the CCTV footage and identification of Kenneth Ellis as the perpetrator. The DASH risk assessment is medium risk; indicators include Dawn is very frightened, depressed and has suicidal thoughts. There is also recent separation, breach of injunctions and the abuser has a previous criminal history. Stalking and harassment is indicated as negative on the DASH form; although the same officer creates an offence of harassment on the system and states the victim "has suffered considerable harassment and distress "due to the continual and long running pattern of behaviour". Kenneth is charged with 2 breaches on the non-molestation order on 3rd March and not charged with criminal damage. He is detained to appear on 5th March at the Magistrates Court and is given conditional bail not to approach her property or contact Dawn directly or indirectly.

A police officer from SGU contacted Dawn who was very upset and feels she has had no support; she agrees a referral to MARAC and rehousing support. A referral to MARAC is made on 20th March for the next meeting on 12th April 2012.

On 29th March there is a further incident; Dawn flagged down a passing officer and stated she was been followed by her ex-partner Kenneth Ellis, she was with her children and very scared. A witness statement was taken relating to his breach of bail. Dawn went into the local community centre to avoid him but on leaving he shouts from the street "it will wait, it will wait": The risk assessment (DASH) does not indicate stalking or harassment although other risk indicators are included. The following day Kenneth was arrested for breach of bail and released with conditions as before.

April 2012:
Dawn contacted the domestic violence co-ordinator stating she urgently needed to move, she was staying at her friends but needed to leave; Leeds Women's Aid were contacted and they provided emergency accommodation. On 10th April SGU contacted Dawn for an update and were told she was shortly moving to supported housing and was in touch with Victim Support who would help with a victim personal statement. No further action was identified for SGU.

12th April: MARAC meeting identified no action for police other than to flag as a MARAC case and to notify MARAC coordinator of any repeat incidents. Leeds Housing Concern would feedback to Dawn and discuss her bidding options for rehousing.

Police attended at the Leeds Housing Concern hostel and asked Dawn to hand over a knife which was a small craft blade wrapped in toilet roll, she was advised the knife would be destroyed and advice was given regarding the dangers of carrying a knife.

May 2012:
Kenneth was found guilty of 2 breaches of non-molestation order and was remanded on conditional bail then sentenced in June to 50 days community order. There was a supervision requirement to 10th June 2014. There was no restraining order as the non-molestation order was still effective for six months, and there had been no recent contact.

There are no further reports of police contact from Dawn, or any recorded incidents of harassment from Kenneth.

Subsequent enquiries by the murder enquiry team suggested that there had been telephone and text contact between Dawn and Kenneth in the weeks before the homicide. This was not known to the police who had no opportunity to intervene, having had no contact with Dawn for over a year prior to her murder. West Yorkshire Police believe that during that period significant progress had been made by them in their management of incidents of stalking and harassment and that management is currently subject to ongoing internal scrutiny. It cannot be known however if, had the police been involved with Dawn after the conviction of Kenneth Ellis in June 2012, they could have averted her death in [redacted] 2013.

2013

The next police involvement responds to the report that Dawn was taken to Hospital 1 after a serious assault on [redacted] 2013; Kenneth Ellis was subsequently charged with her murder and detained

Appendix 3: Overview Report Action Plan

DHR 9: ACTION PLAN: PANEL RECOMMENDATIONS

Recommendation	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
1. Safer Leeds, Leeds Safeguarding Children Board and Leeds Safeguarding Adults Board should respond collectively to address gaps in workforce knowledge, understanding and skills by delivering multi agency training, e-learning, shadowing and mentoring opportunities.	Three boards to jointly assess current training provision to ensure identified areas outlined under this recommendation are addressed (see Recommendations Summary)	Safer Leeds, LSAB, LSCB	Agreement from Chairs to identify common workforce development related themes from reviews and address training needs collectively.	Feb 16	Apr 16. Work in progress to identify and address gaps in workforce skills, experience and knowledge addressed and service responses improved
2. Implement good practice to ensure a proactive approach to disclosures and risk.	Promote DV Champion / Lead roles within agencies	DV Team	Increase in DV Champions	Nov 15	Nov 15 Established LCC DV Champions Network, LCC HR Champions trained and external DV Leads. Evaluation indicates improved responses to disclosure and earlier identification of risk.

	Develop disengagement protocols	Specialist DV Services	Protocols devised and implemented	Dec 16	Protocols developed and implemented and disengagement integrated into DV training.
	Promote NICE Guidance on self-harm	Public Health	Nice Guidance has inform local guidelines for staff supporting young people who self-harm	Dec 16	Completed.
	Address training needs of IMR Authors	Safer Leeds, LSCB, LSAB	Review of progress undertaken	Jan 16	Training delivered to IMR Authors at beginning of each review leading to improvements in quality of IMRs.
	Evaluate WYP Leeds District response to the 2014 HMIC on DV responses	WYP	Training delivered to front line officers	Nov 15	In progress. Improved responses to police call outs including a more empathetic response.
	Include DV Quality Mark requirement in all relevant LCC commissioned services	DV Team	Requirements going into specifications as part of commissioning cycle	Mar 16	Completed. Increased identification of DV and improved responses to DV.
3. Improve responses to working with BME communities	Utilise DV Quality Mark to promote support to BME communities	DV Team	Inclusion of standard around BME service users in QM	Feb 16	Completed. Improved access to services to BME communities.
	Promote and deliver anti-racist, culturally sensitive responses to BME victims	All agencies in this review	Integrated into QM and training	Mar 16	Completed. Improved access to services to BME communities.

	Promote knowledge of services available to BME victims	All agencies in this review	Inclusion on Leeds DV website and in training	Nov 16	Improved access to services to BME communities.
	Evaluate effectiveness of current LCC commissioned specialist DV services through commissioning review	Commissioning Panel	Re-tendering exercise in progress and evaluation undertaken as part of this	Mar 16	Informed decisions made in relation to new contract.
	Improve referral information to ensure ethnicity is recorded and considered and linked to associated service users	All agencies in this review	Initial assessments include ethnicity details	Dec 15	Improved information sharing and better understanding of BME client needs
4. Improve Inter-Agency Working	Co-ordinate a response to identified gaps in inter-agency working and information sharing	DV Team	DV Services Review and DV Strategy amalgamation of MARAC and Front Door Safeguarding Hub (FDSH) management of high risk cases	Mar 16	DV Strategy and action plan as well as on-going service improvement intervention are addressing gaps
	Improve awareness of information sharing protocols and Agreements	All agencies in this review	Discussions at Safeguarding Boards and Safer Leeds	Mar 16	Plans to review existing protocols and devise a single protocol in development
	Key areas identified under this recommendation (see Recommendations Summary) to be included in assessment procedures	All agencies in this review	Inclusion of these points as standard in QM	Mar 16	Review of QM in May 2016 will involve inclusion of these points in service standards
	Public awareness campaigns should include information about	Communications Sub	Inclusion of coercive control in public	Dec 15	Campaign delivered over 16 Days of Action. Included range

	family support and coercive control	Group	information and public awareness campaigns		of abuse in information provided
	Explore potential for a support plan which travels with the person and / or a 'Care Co-ordinator' model	DV Project Board	Discussion at DV Services Review Panel	Mar 16	Spec for new service to offer opportunity for innovation and piloting of different care models including Care Co-ordinator model.
	Promote a consistent understanding of informed consent for adults with capacity	Safer Leeds and Adult Social Care	Discussion at Leeds Safeguarding Adults Board Meetings and DV Board Meetings	Nov 16	Mandatory training devised and delivered to Adult Social Care including issues around DV and capacity. Also integrated into DV training to other services.
	Evaluate current commissioning arrangements for housing support providers in relation to housing discretion in providing alternative accommodation	Strategy & Commissioning	New contract is informed by learning from DHRs	Mar 16	Spec for new contract includes key DV points

Recommendations for specific agencies; from Overview Panel analysis of agency IMRs

Safer Leeds to confirm with relevant agencies that the recommendation is included in their DHR agency action plan and the proposed date of implementation is recorded

Agency	Recommendation	Date of completion
• HM Court	Leeds Magistrates Court Legal Training Manager to promote opportunities of learning from this DHR such as exclusion requirements, non molestation orders and the process of analysing risk.	
• MARAC	MARAC Strategy Group to evaluate administration systems to support timely distribution of Minutes and action plans; and to ensure agencies are updated with relevant changes in circumstances which indicate a potential increase in risk To identify potential gaps in MARAC information sharing and include contact with A&E and other relevant providers -or to confirm that these matters have been addressed and included in the MARAC Review and Action plan	
• West Yorkshire Police Noted in IMR: A joint initiative between police and Adult Social Care is being developed and will be operational in 2015.	The Panel identified the wider issues such as training in DASH should be included in relevant action plans, and this is addressed in the Force response to the recent HMIC inspection and detailed in section 6 -Areas of Learning. In addition the following areas were identified for further evaluation:	

	- DHR Steering group and appropriate representatives from WYP to evaluate the Leeds response to "Improving the police response to domestic abuse" (HMIC: 2014); and to explore the recommendation to overhaul face to face Force training on domestic abuse; linked to supporting and adding value to the Force action plan. - Leeds District Police to identify how referral information can be improved; particularly to ensure that the ethnicity of each person is recorded in referrals to partner agencies, and that linked referrals are identified. - Leeds District Police to consider appropriate sharing of risk assessments and relevant perpetrator information to partner agencies that may also be providing services to the victim of their abuse; to assess whether there is a potential risk of harm if they are unknowingly accommodated by the same provider, or receiving support in the same building.	
• Housing providers Noted in the IMR: Leeds Housing Options will identify any improvements to be made in respect of communication between agencies regarding the suitability of move on accommodation.	Housing support agencies to evaluate information sharing and knowledge of partner resources, services and support - Include how specialist domestic violence services can provide added value without duplicating resources. Housing support agencies to evaluate their domestic violence and abuse policy relating to housing discretion in providing alternative accommodation: - To ensure that where a person is identified as requiring re-housing as a result of domestic abuse, this will not be denied as a result of	

	rent arrears.	
• NHS England: GPs	- To promote the principle and support GP practices to include asking and (with consent) recording who the perpetrator of the violence is when a disclosure of domestic violence and abuse has been made. - GP practices in Leeds to be supported to access identified guidance for general practices and implement any relevant service improvements	
• Victim Support	Victim Support to establish systems to ensure Witness Service are included in scoping and responses to DHR, serious case reviews and reports to MARAC. - Since the completion of this report this area of work has now been contracted to another agency; Witness Service and Safer Leeds will ensure that the relevant learning and action points from this DHR are made available, and the agency is included in dissemination.	