Bournemouth Community Safety Partnership

Domestic Homicide Review

DHR Anita
Date of death May 2016

Report Author

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1 INTRODUCTION

1.1. This Domestic Homicide Review was commissioned following the death of Anita[1] a 44-year-old woman. Her death occurred as a direct result of the actions of her male partner. Anita was a victim of domestic abuse.

1.2. Anita had been heroin and alcohol dependent since 1996 and had been prescribed methadone as an (OST)[2] since 2008. She was described as erratic with her methadone usage and her attendance at treatment appointments. She continued to use heroin and alcohol on top of her opioid substitute treatment prescription, which placed her at great risk of a fatal overdose. Her previous partner had died some two years earlier. She had a son.

1.3. Anita moved to the Bournemouth area in 2011. Anita was an individual with complex needs. This review will examine how agencies supported her.

The Reason for the Domestic Homicide Review

1.4. In May 2016, witnesses contacted the police and described how Anita was being assaulted by her partner, a 36-year-old male (John). Anita was punched in the face and was seen to strike her head on the ground as she fell. John then walked her away from the area. A few hours later John called 999 for an ambulance. Anita was taken to the hospital where she died a few days later from the injuries that she had sustained during the attack. John was arrested, charged and subsequently convicted of manslaughter.

1.5. It was established that Anita and John had been in a turbulent relationship since 2013, during which time police had attended numerous incidents of domestic abuse. They both were being supported by several agencies including Health, Criminal Justice and Adult Social Care.

1.6. Domestic Homicide Reviews were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). This provision came into force on 13th April 2011.

The purpose of a Domestic Homicide Review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and

[1] To ensure anonymity of person subject to this review the names have been changed.
[2] OST: Opioid substitution therapy supplies illicit drug users with a replacement drug, a prescribed medicine such as methadone or buprenorphine, which is usually administered orally in a supervised clinical setting. *www.who.int/bulletin/volumes/89/4/11-086850/en/*

procedures as appropriate.

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

Domestic Homicide Reviews are not inquiries into how the victim died or into who is culpable; that is a matter for coroners and criminal courts respectively, to determine as appropriate.

1.7. Having considered the circumstances surrounding Anita's death, Bournemouth Community Safety Partnership Chair commissioned a Domestic Homicide Review, having identified that it met the requirements as set out in the Guidance for Conduct of Domestic Homicide Reviews (Home Office 2013).

2 DOMESTIC HOMICIDE REVIEW METHODOLOGY

2.1. The author of this report was commissioned to undertake the review in line with principals set out in the Home Office Guidance. [3]

2.2. The independent overview author is Brian Boxall, a retired Detective Superintendent who served with Surrey Police for 30 years. Since his retirement in 2007, he has as an independent consultant, undertaken several Domestic Homicide Reviews and children and adult serious case reviews. He is an Independent Chair of both a Safeguarding Children and Adult Board.

2.3. The Review was Chaired by Mr Barrie Crook. He is the independent Chair of the Safeguarding Adults Board. He is not an employee of any of the organisations involved in the DHR and has not worked in Dorset for 9 years prior to becoming the Independent Chair in 2015. He has 40 years' experience of working with offenders in the Probation Service, including as a Chief Officer and Chief Executive.

2.4. A Domestic Homicide Review panel was appointed to support the lead reviewer. The panel members were:

- DCI Joan Carmichael (up to July 2017) DCI Gavin Dudfeild (from July 2017) - Dorset Police, Adult Public Protection Lead
- Stewart Balmer – Dorset Police, Force Review Officer
- Pamela O'Shea – Dorset CCG, Head of Quality Improvement, Quality Directorate
- Anne Humphries - Business Manager (Bournemouth and Poole Adult Safeguarding Board)
- Sian Jenkins - Community Safety Partnership Officer, Bournemouth Borough Council
- Barbara O'Brien - Interim Service Manager, Safeguarding Adults and Statutory Mental Health, Adult Social Care, Borough of Poole
- Hayley Verrico (Mtg 1) Sarah Webb (Mtg 2) - Joint Service Manager – Statutory Services (Principal Social Worker – Bournemouth) Adult Social Care, Bournemouth & Poole Borough Councils

[3] Home Office: *Multi- agency Statutory Guidance for the Conduct of Domestic Homicide Reviews.* Home Office (Dec 2016)

- Deborah Bilton - Named Professional + Safeguarding, South Western Ambulance Service NHS Foundation Trust
- Cara Southgate - Associate Director of Nursing & Quality, DHUFT
- Tonia Redvers - Head of Domestic Violence and Abuse Services, The YOU Trust (Independent Domestic Abuse Expert)
- Karen Wood, Senior Commissioner, Bournemouth Drug & Alcohol Commissioning Team

2.5. The Domestic Homicide Review panel met on five occasions.

2.6. **Scope of review**

- The panel identified that the review should focus on the period between May 2013 and May 2016.Term of Reference for the review were produced (Appendix A).

2.7. Individual Management Reviews were produced by the following agencies.

- *Avon & Wiltshire Partnership Mental Health NHS Trust (AWP) Specialist Drug and Alcohol Service*
- *Bournemouth Borough Council Community Safety and Adult Social Care*
- *NHS Dorset Clinical Commissioning Group (CCG)*
- *Dorset Health Care University NHS Foundation Trust*[4]
- *Prospects: Poole Hospital Foundation Trust*
- *Bournemouth Drug & Alcohol Commissioning Team representing the Bournemouth Assessment Team (BAT)*
- *Dorset Police*
- *South Western Ambulance Service NHS Trust*
- *Providence Community Addiction Service (PCAS)*
- *Bournemouth Church Housing Association (BCHA)*
- *Bournemouth Council Housing Options*

2.8. The overview author met with several the Individual Management Review authors at the start of the review to explain the process. The authors were then invited to several the subsequent panel meetings, to discuss their findings. The panel reviewed the Individual Management Reviews and challenged accordingly.

2.9. The author was provided with additional documents as requested.

Family Involvement

Anita's father was informed of the review and asked if he would like to be involved. This letter was followed up, but he has not responded to date.

Perpetrator Involvement

2.10. The perpetrator was asked via letter if he would participate in the review, but the review has received no response.

[4] Dorset Healthcare University Foundation Trust was formally known as Dorset Healthcare. The title changed during the review timeline.

3 CASE SUMMARY

Significant Agency Involvement

3.1. As part of the review process, agencies prepared chronologies of their individual organisation's contact with Anita and John. The following provides a summary of the significant contacts.

2013

3.2. In April 2013 Anita attended a local hospital. She stated that her ribs were hurting. She explained that John had hugged her, and she heard a crack.

3.3. Anita disclosed to the Bournemouth Assessment Team (BAT)[5] nurse (whilst in hospital) that she was scared and would ask John to move out if he continued to drink. This was the first recorded reference to John. Anita was discharged from hospital in May 2013.

3.4. A reported domestic incident in May 2013 (following her hospital discharge), led police to assess Anita as being at 'medium' risk of domestic abuse, a level that upon review was raised to 'high risk'. This resulted in a referral to Multi Agency Risk Assessment Conference (MARAC)[6]. An Independent Domestic Violence Advisor (IDVA)[7] was allocated. Anita disclosed that John had grabbed her around the throat and pushed her around. It was identified by the BAT social worker that Anita was now being 'supported' by another male who was a known perpetrator. Bournemouth Churches Housing Association (BCHA)[8] assessed that she was not at high risk as she had a floating support worker and specialist addiction worker.

3.5. A multi-agency meeting involving the IDVA, Floating Support Worker and Bournemouth Specialist Drug and Alcohol Service (SDAS)[9] was arranged. A male (Male 2) she had become involved with tried to contact the BAT social worker stating that he was looking after Anita. Male 2 wanted to be allowed to attend the meeting with her. A meeting did take place at Anita's flat. Male 2 was there and it is recorded that he was demonstrating controlling behaviour towards Anita.

3.6. Anita was spoken to away from this individual and was risk assessed by the IDVA using the DASH[10] Risk Identification Check list (RIC). (RIC score of 11). Anita stated that she would accept a refuge place but was informed by the IDVA that she would not be accepted as she would not pass the required risk assessment due to her heavy drinking. She asked about bed & breakfast but was informed it was too late in

[5] BAT: Bournemouth Assessment Team (the care –coordinators for drug and alcohol services for drug and alcohol users) who at that time hosted the alcohol liaises nurse based in the local hospital.
[6] MARAC: Multi Agency Risk Assessment Conference (MARAC) is a regular local meeting to discuss how to help victims at high risk of murder or serious harm.
[7] IDVA: The main purpose of independent domestic violence advisors (**IDVA**) is to address the safety of victims at high risk of harm from intimate partners, ex-partners or family members to secure their safety and the safety of their children.
[8] BCHA: Bournemouth Church Housing Trust: Managed the IDVA service until October 2015.
[9] SDAS: Specialist Drug and Alcohol Service run by Avon and Wiltshire Partnership Mental Health Trust (AWP)
[10] SafeLives (Formally CAADA) DASH risk Identification checklist (RIC) for use by IDVAs and other non-police agencies for identification of risks when domestic abuse, 'honour'-based violence and/or stalking are disclosed. Risk identification is conducted through a series of 'gateway questions' to help the user identify stalking, harassment, honour-based violence and high-risk indicators in the domestic abuse setting. Using the responses given by the victim, the outcome of the intelligence checks and any other information the officer is aware of the assessment of risk is made of the incident. The recognised risk categories are standard, medium and high.

the day, and she could not be helped with housing at that time as 'professionals were busy'. Anita agreed that she would stay with a friend. There is no evidence that Housing Option or the out of hours service were contacted to discuss housing options.

3.7. A MARAC meeting was held in July 2013 following an incident in June 2013 when Anita and John were found fighting in the street. John was still to be arrested for the June incident at the time of the MARAC.

3.8. The MARAC identified that Anita had separated from John but was still under threat from him and another male, the latter having threatened, by letter, to break her knee-caps. The MARAC identified several risks to Anita. Actions recorded were for the IDVA to update the victim regarding the MARAC, and for police to update the tasking/briefing slides for local staff.

3.9. An individual safety plan was created for Anita with the IDVA. It focussed on keeping her safe within her own flat. The flat was subject to target hardening, including the installation of a spy hole, chain and a fireproof letter-box.

3.10. Anita provided police with a statement. John was arrested in early August 2013 at Anita's address after 13 attempts had been made to locate him. In the interim period between the incident and the arrest, Anita had got back together with John and as a result declined to support a prosecution. Police still arrested John, and whilst a police prosecution without a victim was considered, it was not pursued due to lack of corroborative evidence. The case was reviewed by a detective sergeant who specialised in domestic abuse investigations. John was given an official caution, which was a positive response.

3.11. In August 2013, an adult safeguarding strategy meeting was convened. In attendance was the IDVA, representation from BAT (CRI, care co-ordinator and social worker)[11] and police. Anita did not attend. Adult social care closed the case in August 2013.

3.12. A few days later police attended a domestic incident where John had pinned Anita down. John was arrested. The [12]Crown Prosecution Service (CPS) would not pursue a prosecution due to Anita having previously received a fixed penalty notice for wasting police time. This was in respect of an allegation that she made (2007) against a previous partner, which she later withdrew stating that she had made it up. The Crown Prosecution Service referred to this affecting her credibility as a witness. At this time Anita was still being supported by the IDVA service however, she disengaged with several agencies following this incident and the IDVA closed her case in September 2013.

3.13. In October 2013 Anita was again subject to domestic abuse and police referred the incidents to the MARAC (RIC score 10). The same IDVA was allocated to Anita and undertook a risk assessment (RIC score 16). On the 7th November 2013 the IDVA

[11] C R I: Commission Provider of the Bournemouth Assessment Team Drug (Single contact point for the Bournemouth Treatment System) self-assess individuals for their treatment needs and co-ordinates their treatment journey.
[12] The Crown Prosecution Service (CPS) is the principal prosecuting authority for England and Wales, acting independently in criminal cases investigated by the police.

made an adult safeguarding alert to [13]Care Direct. This was good practice.

3.14. A MARAC took place on the 14th November 2013. Protective factors were identified as target hardening and engaging with IDVA. The agreed actions recorded included BAT undertaking preparation work with Anita towards attendance at [14]Flaghead, a request for secure letterbox and a flag on the police system for officers to check on her medical condition when dealing with her.

3.15. A safeguarding strategy meeting was held on the 29th November 2013. At that meeting it was disclosed that John could be taking financial advantage of Anita. An investigative action plan was produced. Actions recorded as:

- *Police have added Anita onto Operation Maple[15] list from December 9 to 6 January. DV car will go out and check on high risk clients.*
- *BAT to arrange outreach to link in with Anita at home to motivate her into 1:1 sessions at Regency House,*
- *SDAS to liaise with BAT when they have appointments for BAT to tag on after.*
- *Appropriateness of referral to CRI when case closed to IDVA, Floating support to continue to participate in motivating Anita. Long term DV needs.*
- *Social Worker /BAT's to meet with Anita and explore last allegation to Domestic Violence and see what Anita wants to do.*

Anita started to increase engagement, having meetings with the BAT care coordinator and social worker.

3.16. On the 21st December 2013 police attended a violent domestic incident. Anita had bitten John and he had in turn hit Anita on the head with a mug. Officers assessed the risk as high (RIC score 13). The BAT care co-ordinator contacted the BAT social worker and was advised to refer the case direct to Care Direct due to the severity of the incident. John, who had been arrested, was bailed to an address in Poole. Anita informed the BAT social worker that she wanted to support a prosecution. John was subsequently charged with an offence of actual bodily harm (ABH)[16].The police sought a remand in custody, but John was bailed by the court with conditions not to contact Anita and to report to Poole police station and not to enter the Bournemouth area.

3.17. The BAT social worker made a welfare telephone call to Anita. Anita was upset as John was making contact, trying to get her to drop the charges. The BAT social worker informed the IDVA that John had been texting Anita. Police were informed. The CRI floating worker helped Anita to complete a Home Choice application form as she wanted to move. Anita indicated that she had had no contact with John over the Christmas period.

2014

[13] Care Direct: Local authority care, safeguarding adult assessment team

[14] Flaghead Unit provided inpatient treatment for people with substance misuse problems.

[15] Op Maple: Dorset Police operation with officers conducting welfare visits to high risk victims of domestic abuse.

[16] Assault Occasioning **Actual Bodily Harm** (ABH) Section 47 of the Offences Against the Persons Act 1861 creates the offence of assault occasioning **actual bodily harm**. ABH is an either way offence which means it can be tried in either the Magistrates Court or the Crown Court.

3.18. On the 29th January 2014, Police made a safeguarding adult alert following Anita being threatened by drugs dealers. The BAT social worker decided not to refer for safeguarding investigation. The reasoning behind this decision is not recorded.

3.19. Anita informed her BAT social worker that she wanted to move away from her ex partners. Again, it was assessed that she could not go to a refuge because of her drinking. The BAT social worker and care co-ordinator undertook a joint visit with Anita. A lengthy case file note was made by the BAT social worker. It identified Anita's drug history and her rehousing and treatment needs.

3.20. On the 30th January 2014 Anita approached Housing Options and informed them that that she needed to move as she was experiencing violence. The housing officer contacted the BAT social worker. An appointment was made with housing, but Anita failed to attend the appointment.

3.21. For a month there was confusion as to where Anita was staying. Sometimes she was with a friend and at other times at home or visiting her son in Oxford (this is the first indication that her son was able to help his mother). Anita indicated to the BAT care co-ordinator that she was selling methadone to buy alcohol. (It is not clear if this was prescribed or illegal methadone).

3.22. It appears that there was an intention to hold a professionals meeting in early March 2014, to highlight concerns regarding drugs, drug gang, her health and ex partners. The aim was to formulate a protection plan to safeguard Anita without engagement. There is no record of a meeting having taken place.

3.23. The IDVA case was closed due to lack of engagement in March 2014. It was not open to the IDVA service again until July 2014. Adult social care closed the case on the 11th April 2014.

3.24. On the 28th April 2014, a drug support worker advised the police that Anita was with John. This was in breach of his bail conditions, but no action was taken.

3.25. It is of note that there was minimal contact across the agencies for a period of three months, the reason for this is unclear. John was due to appear in court on the 3rd July 2014 in respect of the assault in December 2013. The Crown Prosecution Service (CPS) dropped the case when Anita failed to appear at court to give evidence. The defence team had disclosed that Anita had indicated that some aspects of her statements were untrue. The police were unable to refute this suggestion.

3.26. On the 16th July 2014 Anita informed police that John had assaulted her. He was arrested for assault and breach of the peace. Anita again was unwilling to support a prosecution, but to help safeguard Anita, police obtained a [17]Domestic Violence Prevention Notice (DVPN). The Court issued a Domestic Violence Prevention Order on the 18th July. This lasted for 28 days and prohibited John from having contact

[17] An initial temporary notice, the Domestic Violence Protection Notice (DVPN) can be issued when authorised by a senior police officer, and this is then followed by a **DVPO** which will be imposed at the magistrates' court. It does not require a victim's support.

with Anita. Police made a Domestic Violence referral and a separate adult safeguarding alert was made to Care Direct. The RIC score was 17 and so was subject to a MARAC.

3.27. The allocated IDVA attempted to contact Anita but the only place she seemed to be attending regularly was the pharmacy. The pharmacist had previously reported to the BAT care co-ordinator (in March 2014) that a male was picking up her prescription.

3.28. On the 27th July 2014 Anita reported that John had stolen her mobile phone and was being abusive towards her, she refused to make a complaint. John was arrested for these offences and for the breach of the Domestic Violence Prevention Notice (DVPN). He was released with police taking no further action, due to Anita refusing to support the evidence. She disclosed that she was three months pregnant but was intending to have an abortion. She requested contact with the police domestic abuse team.

3.29. Two days later John reported that Anita had attended his flat and had tried to strangle him. Anita was arrested but was released with no charges as John would not support a prosecution

3.30. A MARAC took place on the 31st July 2014.
Actions were noted as follows:

- *Health: provide info re alleged pregnancy.*
- *BAT: provide update.*
- *IDVA: update complainant re MARAC if possible.*

3.31. During August 2014 police received several reports that John was breaching his Domestic Violence Prevention Order (DVPO), including one from a chemist. John reported to police on several occasions, that Anita had attended his flat as an unwanted visitor making him in breach of his bail conditions. He was arrested on one occasion when Anita was found at his flat.

3.32. On the 7th August 2014, the BAT care co-ordinator was informed by the Children First Team Manager (children services) that they had received a referral from the IDVA, but as Anita was going to have a termination, children services would not be involved. The following day Anita confirmed to the BAT care co-ordinator that she had decided to have a termination.

3.33. On the 9th September 2014 Anita reported that the previous evening John had been abusive towards her. He pinned her down removed her bra, bit her on the breasts and stomach and tried to strangle her (RIC score 16). She started to make a victim statement but stopped prior to the statement being completed. John was arrested and bailed, and significant attempts were made by police and the BAT social worker to get Anita to support a prosecution. She refused and over the following days she visited John's address and had to be physically removed. The police case review officer concluded that the case against John could not continue.

3.34. The case was subject to an adult safeguarding strategy meeting on the 18th September 2014. Present were the Chair, BAT social worker and police. The risks

identified included increased risk of abuse due to pregnancy and risks associated with drug and alcohol use. The action plan focussed on her possible pregnancy and the risk to the unborn child.

3.35. The review has not identified any evidence confirming that Anita was ever pregnant. (There is no GP record of a termination. It is recorded by the BAT care co-ordinator in the Plan Issues Update, that Anita stated that she had the termination in Oxford).

3.36. The case was closed to the IDVA service. They had not seen Anita in person.

3.37. During October 2014 there were several incidents. In November 2014 John alleged that Anita had threatened him with a knife and as a result he sustained a cut arm and hand. Anita was arrested but John refused to cooperate with the completion of the SCARF/DASH. One was completed by officers showing him as a victim. Again, there were suggestions from John that Anita was pregnant. John refused to make a statement, so Anita's bail was cancelled.

3.38. On the 2nd December 2014 Anita reported a domestic incident. She spoke with a police domestic abuse officer stating that she had had enough. She was desperate to move away but Anita explained that she could not go into refuge as she was an alcoholic. She would not let John in, stating that "*he is so jealous, isolates me, bullies me and takes my money.*"

3.39. John was arrested because of this incident. The case was referred to the Crown Prosecution Service, but they decline to authorise any criminal charges. Consideration was given to the service of a further DVPN, but as Anita continued to engage with John the request had to be withdrawn. The matter was referred to MARAC.

3.40. Police attended several incidents between Anita and John over the next two months which resulted in a referral to the IDVA service. The IDVA spoke with Anita on the 8th December 2014. She indicated she wanted support as John had dragged her down so much. Anita also indicated that her son was coming to stay with her. The IDVA had a meeting with Anita a few days later when her son was present. Anita stated that:

1. She had to show John her phone, so he could see who rang and texted her.
2. He had threatened to strangle her and kill her.
3. He had previously sexually assaulted her.
4. He told her he had overdosed and cut his hands.

Her son indicated that a non-molestation order would be a good option but believed that she would just go back to John as she normally did. She stated that she had to leave the alcohol group as John also attended. The IDVA undertook a risk assessment (RIC score 18).

3.41. In December 2014 police received intelligence indicating that Anita's address might be being 'cuckooed' (used) by drugs dealers.

3.42. The IDVA identified several risk factors:

- *Potential risk of further physical harm.*

- *Risk of benefits being stopped.*

The IDVA recorded several actions:

- *IDVA to share at MARAC risk of John self-harming.*
- *Target hardening completed on flat.*
- *Anita to continue to engage with benefit agencies.*

3.43. It appears that Anita's son was staying with her as he prevented John entering the flat. Anita stated that she would have let him in otherwise. Anita stated that her methadone had been reduced but she would not use it because her son was there. (The reduction in methadone was due to her drinking too much). A further risk assessment was undertaken (RIC score 13).

3.44. In early December 2014 police were called to John's parent's home where his father reported that he was self-harming. He was taken to hospital. He was found to be self-harming again a few days later. Police took him to hospital following advice from the Street Triage Services provided by Dorset Healthcare (DHUFT).

2015

3.45. A MARAC was held on the 8th January 2015. It was disclosed that Anita's son was staying with her and that she had allegedly recently had an abortion. The MARAC recorded the RIC score as 19. This was an increase on previous scores, the recorded action plan was:

- *IDVA to update complainant re MARAC.*
- *BAT provide update re proposed appointment 19/1/15.*

3.46. In mid-January 2015 Anita stopped engaging and police started again to attend domestic incidents. To protect Anita and John from a perceived threat from a drugs gang, police agreed to pay for them to stay in a hotel separately, however they wanted to stay in the same room. Whilst together at the hotel John and Anita were involved in a domestic dispute resulting in John being moved to a different hotel.

3.47. The threats received were from known drug dealers and believed to be credible. Target hardening was conducted at both Anita's and John's home addresses. An investigation into the threats to kill (from drugs dealers) continued for several months. Both Anita and John failed to attend identification procedures, so the Crown Prosecution Service was unable to proceed with the case against the drugs gang individuals.

3.48. An adult safeguarding strategy meeting was held on the 28th January 2015. Present were the Chair, BAT social worker and the IDVA. The case was closed with Anita being informed that she could still seek help when needed.

3.49. The following day John assaulted Anita and was arrested. He was subsequently charged and bailed. A couple of weeks later John was arrested for breach of his court bail conditions, having attended and caused damage to Anita's flat. (RIC score was 18). Her son appeared to have left Anita at this time.

3.50. The IDVA closed the case in February 2015.

3.51. In March 2015 Police executed a drugs warrant at Anita's address. Drugs were

found, and Anita was arrested. Police believed that her flat was still being used by London drugs dealers. A safety plan was devised with police. A panic alarm and a response plan were put in place to try and minimise the risk to Anita from the drugs gang.

3.52. The 1st April 2015 saw the commencement of the Care Act 2014.

3.53. On 17th April 2015 Anita was arrested for supplying drugs after substances were found at her flat by police. Another male was also arrested. It was believed that a drugs gang were using her flat. No further action was taken against Anita.

3.54. John appeared before court on charges related to the January 2015 incident. Anita failed to turn up at court and give evidence despite the police requesting a witness summons. The Crown Prosecution Service could did not proceed with the case.

3.55. Police submitted a safeguarding alert to Care Direct on the 12th May 2015. Further incidents were recorded over the next couple of weeks, including arguments in the street and at Anita's flat.

3.56. On the 21st May 2015 the BAT social worker visited Anita. Anita stated that she had no choice but to stay with John due to her health and John scoring drugs for her. An adult safeguarding planning meeting was held on the 2nd June 2015. Anita and John were both present, but the meeting was split into two sections, one for each individual.

3.57. The meeting was focussed on the risk posed to both Anita and John by members of a drug gang. Police did not attend the meeting. They had been notified by the 27th May 2015, and because they had not responded, a follow up call was made on the morning of the 2nd June 2015.

3.58. On the 8th June 2015 Anita attended the BAT premises for an assessment. John was also seen at the venue.

3.59. On the 11th June 2015 police were contacted by Anita and John, both making allegations of domestic abuse against each other. As a result, John was arrested but no further action was taken. Anita refused to engage with the investigation.

3.60. On the 19thJune 2015 the BAT care co-ordinator made telephone contact with Anita. Anita stated that her legs were all swollen and she could not walk, and she could not carry on like that. During the call John was heard shouting down the phone that Anita was cutting herself. The BAT care co-ordinator contacted Anita's Doctor to inform them that Anita was feeling low. They advised that she should contact the surgery to get her leg looked at. No referral was made to other agencies. There is no reference to self-harm in the BAT risk plan Issues update (RF 3) completed on the 24th June 2015.

3.61. A SCARF[18] was produced following police attendance at an alleged assault by John on Anita. John was arrested but released with no charge following Crown

[18] **SCARF**: All police officers and police staff will use the SCARF this has been developed to incorporate all the forms that identify vulnerable victims, children or adults and is being used in conjunction with the change to Niche. This form is generated

Prosecution's Service advice. An IDVA was allocated, and on the 25th June 2015 a MARAC meeting was held. There had been 10 recorded incidents since the January 2015 MARAC.

3.62. At the MARAC, the BAT social worker disclosed that a drugs gang was threatening both Anita and John and that a planning meeting had taken place. Both were working with BAT care co-ordinators. Residential detox was being sought for both parties (subject to an application being made to the Multi-Disciplinary Panel (MDP)).

3.63. On the same day (believed prior to the MARAC) the BAT social worker and the BAT care co-ordinator met Anita. They spoke to her away from her residence. Anita stated that she wanted to separate from John and that she was willing to relocate to Oxford. She was informed that she was to be discussed at a MARAC.

3.64. In early July 2015, the Multi-Disciplinary Panel authorised the application for an inpatient detox, and the BAT care co-ordinator arranged for a 21-day in-patient detoxification out of the area for Anita. The intention was for Anita after the detox, to relocate out of Bournemouth and as part of her aftercare package to engage in treatment services in Oxford. It was identified that she may not yet be ready for detox, but it was approved based on the risk to her, due to her relationship with John and her health difficulties i.e. heart problems, injecting in her groin, swollen legs. John was also subject to a plan for a detox and structured treatment with accommodation in a dry house but was unaware that it involved separating them. For the detox to be commenced, the requirement was for Anita to attend 3 weeks of preparation work (6 sessions) with the BAT care co-ordinator to prepare her for detoxification, motivate her for treatment and prepare her for aftercare.

3.65. The IDVA case was closed on the 8th July 2015 due to 'non-engagement'.

3.66. On the 14th July 2015 John threatened to jump off a car park. He was taken to St Anne's[19] for a Mental Health Act assessment. John indicated that Anita may be pregnant. He stated he was on witness protection scheme and was consuming cider sherry, heroin and crack cocaine most days. He had fleeting thoughts to harm others and felt low and scared.

3.67. John moved into a Dry House to commence detox on the 20th July 2015. Three days later he was moved out of the Dry House as he was struggling to complete the seven-day detox programme and was not following advice on how to keep safe and away from his partner.

3.68. By the 22nd July 2015 Anita had attended four detox preparation meetings. She ideally needed to attend two more. It was felt her motivation was still poor and it was reported that her family did not want her to return to Oxford.

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by officers and will be found linked to Occurrences. The ACPO CAADA DASH Risk Identification and Assessment checklist which is still called the DASH one of the forms located within the SCARF. The officer completing the SCARF will select the necessary forms and complete themselves using the allocated laptop or tablet.

[19] St Ann's Hospital is a psychiatric hospital located in the Canford Cliffs area of Poole, Dorset, run by Dorset HealthCare University NHS Foundation Trust.

3.69. The following day John returned to Anita's address with marks on his neck. She thought that he had been cheating on her, so she tried to end the relationship. There was an altercation and John ripped her clothing and left the house with her phone. Police attended and identified that John's behaviour was increasingly abusive and controlling. He had attempted to strangle her over the last couple of months. Police tried to facilitate Anita going to a safe address, but she refused to go without her phone. (RIC score 14)

3.70. On the 28th July 2015, the BAT care co-ordinator received a call from Salisbury Hospital, informing them that Anita was having surgery on her wrists. The circumstances were that John was self-harming with a knife, Anita took the knife from him saying "stop doing that it hurts see," then she cut her own wrist but went too deep. The doctor did not believe that she was trying to hurt herself and that she was very upset that it had happened. No safeguarding referral was made.

3.71. On the 1st August 2015 John called 999 for the ambulance service. He stated that he was concerned that Anita may be trying to commit suicide. He was not with her. Anita was contacted and stated that she was not trying to commit suicide, and that she was just saying that because he had robbed her earlier and that she had already contacted the police.

3.72. On the 3rd August 2015 John was again taken to St Anne's (under Section 136[20] Mental Health Act 1983). He was recorded as having capacity. He stated he never finished detox due to his girlfriend but would need to start thinking about his own welfare.

3.73. On the 6th August 2015 the BAT social worker closed Anita's case due to her not engaging in any treatment. She was choosing to use drugs and stay with John. Anita no longer wanted to have an inpatient detox or relocate out of the area, she wanted to stay and have a community detox in Bournemouth. She was an adult with capacity.

3.74. The case remained open to treatment and the BAT care co-ordinator. The care co-ordinator recorded on the risk plan (issues update RF1 and RF2) that Anita had lied to the doctor when she cut her wrist, she had done it herself because she could not cope with life anymore, and that John had saved her from doing more damage to her wrist. The BAT care co-ordinator made a referral to a community service (Progress Project) to prepare Anita for detox. Despite phone contact with Anita she did not engage, and the case was closed to drug and alcohol services on 2nd October 2015.

3.75. On the 1st October 2015 the BCHA IDVA service contract ended, and the Police Maple Project took over the IDVA function using police staff referred to as Domestic Abuse Advisor's (DAA).

[20] **Section 136 – removal of mentally disordered persons without warrant.** 1) If a person appears to a constable to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons—a) remove the person to a place of safety within the meaning of section 135, or(b) if the person is already at a place of safety within the meaning of that section, keep the person at that place or remove the person to another place of safety.

3.76. On the 6th October 2015 Anita contacted police and stated that John had threatened to slit her throat. John was arrested but when Anita's version of events was checked with Close Circuit TV, it was found that her version was not correct and helped verify John's account. He was released. A few days later John contacted police. He stated that Anita had threatened him with a knife.

3.77. On the 23rd October 2015 John was reported missing by his BAT care co-ordinator and a search including air support was deployed. He was eventually found safe and well the following day with Anita.

3.78. On the 7th November 2015, Anita called police and stated that she had left her flat when John had grabbed her around the throat. She failed to attend the police station and later stated that she had lied about the assault.

3.79. A MARAC took place on the 19th November 2015. It was identified that there had been nine incidents since the previous MARAC in June 2015.
Actions identified were:

- *Police Op Maple visit*
- *DAA continue to engage with victim*
- *ASC continue to support victim*
- *Police SNT[21] I task slide re high volume DA- Positive intervention.*

3.80. The DAA made several further attempts to speak to Anita by phone. No successful contact (phone contact) was made with Anita so the case was closed on 24th November 2015.

2016

3.81. Incidents continued to be reported to police during December and January 2016. These were similar to numerous previous reports.

3.82. On the 24th March 2016 John asked a member of the public (not believed to be known to him) to contact Dorset Police over concerns for his safety. He was concerned about threats from drug dealers. They had taken control of his bank account and were intimidating him. He indicated that Anita was also under threat. Armed police entered her flat and found her safe and well and she denied being under threat.

3.83. On the 5th April 2016, John was arrested for an incident involving Anita a couple of days previously. He was served with a Domestic Violence Prevention Order (DVPO) and bailed to court for the 7th April. He failed to attend.

3.84. On the same day Anita was visited by a police domestic abuse officer. She described the hopelessness of the situation she found herself in, and she feared that she would come to some harm at the hands of John.

3.85. A MARAC was held on the 7th April 2016.
Action

[21] SNT is the Police Safer Neighbourhood Team

- *ASC consider detox for victim.*
- *Police local TP officers alerted to DVPO and to complete proactive checks.*

3.86. On the 2nd May 2016 a witness described John punching Anita in the face and her falling over and hitting her head. She later died as a result of her injuries.

4 INDIVIDUAL AGENCY LESSONS

4.1. An important element of any Domestic Homicide Review is the production by each organisation of an Individual Management Review (IMR). This process enables the agency to review their own organisation actions and identify both good practice and lessons.

4.2. The following is a summary of each organisation's Individual Management Review findings. Each organisation has produced an action plan which will look to address the highlighted concerns.

4.3. **Adult Social Care**

- Case closure should ensure that it is clearly recorded, and reason can be evidenced. To include risks still identified at closure and actions taken to mitigate.
- Improved recording evidencing risks and professional judgments. To include clarity when safeguarding alerts are made.
- Domestic abuse was viewed as a secondary underlying concern.
- Same social worker should ideally not be working with both victim and client (offender). Both should not be attending the same strategy meeting.

4.4. **Bournemouth Assessment Team (BAT)**

- The Risk Assessment and Management process was not always adhered to.
- The risk forms would benefit from more tangible actions beyond monitoring.
- Lack of detailed information within the case notes.
- The understanding and application of safeguarding procedures needs to be clear.
- Staff require a greater understanding of domestic abuse including how they contribute to MARAC.
- There needs to be a protocol for working with couples.

4.5. **Independent Domestic Violence Advisors (IDVA/DDAs)**

- IDVA's have limited knowledge on housing options.
- Missed engagement opportunities due to lack of partnership working with GP's.
- Limited actions identified in several MARAC meetings.
- Lack of clarity regarding how agencies should handle SCARFs.
- Consideration needs to be given as to how many cases an individual IDVA should have. This would indicate how many IDVAs would be required.

4.6. **Avon and Wiltshire Partnership Mental Health NHS Trust (AWP) Specialist Drug and Alcohol Service (SDAS)**

- A lack of assertive case management culture reflected in the lack of

confidence in caseworkers to ask about domestic violence and to be more assertive with other organisations.

- Initial failure to manage OST, specifically 3 monthly treatment (medical) reviews at the beginning of AWP's Contract. (This had improved by the end of the review period).
- The victim's thoughts about the on/off relationship with perpetrator could have been explored in greater detail. Focus was on OST and alcohol treatment.

4.7. **Clinical Commissioning Group (CCG)**

- Primary Care need to consider and review processes of how they transfer care between services effectively for patients who have drug and alcohol issues.
- There were opportunities where multi agency risk process could be strengthened. There are reservations from local GP's regarding resources this would take. There is a lack of understanding of roles and responsibilities.
- Continued consideration needs to be given to the interface between the Mental Capacity Act and the Mental Health Act.
- Need for continued consideration for the protection of the unborn baby and sharing of information under safeguarding.
- Primary care to review their processes to be able to identify and adjust their practice for individuals to consider if they meet the definition of vulnerable patients.

4.8. **Dorset Healthcare University Foundation Trust (DHFT) (formally Dorset Healthcare (DHC)).**

- The breach of bail conditions by John by talking to Anita should have been escalated and referred to police.
- The DHC staff should access domestic abuse training.

4.9. **Ambulance Service**

- When more than one agency is on the scene, an assumption should not be made that the other agency has made a safeguarding referral.

4.10. **Police**

- Dorset Police to review the ability of the MARAC to deal with cases of this complexity.
- Increased engagement from the Neighbourhood Policing Team (NPT) for the local area where issues are taking place and a greater engagement between the SNT and the Public Protection Unit to consolidate the police activity.

4.11. **Bournemouth Borough Council Strategic Housing Options**

- On closing a case owing to no response from an agency or the individual, both the individual and the agency will be notified of the closing of the case in future, to provide a final opportunity to progress the case before closure and provide a record of the outcome.
- In future if MARAC is noted on a client's file, the Housing Options Officer will refer to those records and confirm with the client whether these risks are still current and what risk management if any may be needed around this. The

outcome of this discussion will be recorded.

4.12. Several the organisations have been restructured or decommissioned/recommissioned during the review time line or after the incident. This is particularly relevant with the change of the BAT to BEAT, (April 2016) and the secondment of the BAT social workers back into the Adult Social Care Team and the change from an IDVA service to the Maple Project. These structural changes will be commented upon later in the report.

5 ANALYSIS OF PRACTICE

5.1. The review identified that since the death of Anita, or in some cases during the period under review, several changes, both structural and procedural have taken place. These changes have been highlighted in the report and have in some instances negated the need for further recommendations. Recommendations, where appropriate, have been placed in the body of the report.

Multi Agency Working

5.2. Anita and John were subject to two processes the MARAC in response to domestic abuse and adult safeguarding.

MARAC

5.3. MARAC is a nationally agreed multi agency meeting held in response to high risk domestic abuse situations.

5.4. Anita was subject to seven MARAC's during the period under review. The IDVA and post October 2015 the Domestic Abuse Advisor (DAA) supported/represented Anita at the MARAC.

5.5. MARACs were held in:

- July 2013
- November 2013
- July 2014
- January 2015
- June 2015
- November 2015
- April 2016

5.6. Whilst most of the MARAC minutes identified risk factors, specific actions designed to reduce specific risks were limited. An example of this was the MARAC held in July 2013. 11 risks were identified including chaotic lifestyle, domestic abuse and harassment by suspect. Only two actions were recorded:

- *IDVA: update victim ref MARAC*
- *Police: Itask/briefing slide for staff*

5.7. This was replicated in MARACs over the following three years, and whilst each MARAC explored the latest set of circumstances, they did not fully consider the impact successful or otherwise of actions from previous MARACs.

5.8. For a MARAC to be effective, individual risks and desired outcomes should be identified, linked to agreed actions that might help secure the desired outcome.

5.9. The BCHA Individual Management Review summarises the impact of the MARAC in this case as follows:

The involvement of the MARAC seems to lose strength over a period and over the number of times Anita is referred to MARAC. The 2nd MARAC set a clear number of actions however following MARAC meetings actions were either not recorded or weak. such as IDVA to continue to provide support or Anita to continue to work with the BAT.

5.10. The police lead the MARAC process, and their Individual Management Review acknowledged that this case was too complex to be dealt with effectively within the MARAC structures, due to time constraints.

5.11. The [22]Pan Dorset MARAC operating protocol (February 2015) sets out the aims of the MARAC as:

- *Share relevant information to increase the safety, health and wellbeing of victims, adults and their children.*
- *Make links with other public protection arrangements in relation to children, perpetrators and vulnerable adults.*
- *Determine whether the perpetrator poses a significant risk to any individual or to the general community;*
- *Construct jointly and implement a risk management plan that provides professional support to all those at risk and that reduces the risk of harm.*
- *Reduce repeat victimisation.*
- *Improve agency accountability.*
- *Improve support for and the safety of staff involved in high risk domestic abuse cases.*

5.12. This protocol highlights the need for a detailed risk management plan. The protocol states:

> *The MARAC enables the available information to be safely shared across relevant partner agencies and multi-agency bodies including MAPPA (Multi Agency Public Protection Arrangements) and both child and adult safeguarding conferences, resulting in a clearer picture of the risk level. This also supports a more comprehensive action plan to be developed to reduce the risk of harm to the victim and their children.*

Whilst there is evidence that information was shared between adult safeguarding and the MARAC, there is little evidence that there was any coordination across the two processes.

5.13. The MARAC is an effective process, but its success has led to ever growing demand, reducing the time available to fully explore all the issues in complex cases.

[22] Pan Dorset MARAC operating protocol (February 2015)

5.14. Circumstances like these needed time for professionals to give due consideration of the issues.

5.15. **Change**
As a direct result of the lessons coming out of this review, Dorset Police have now put in place a new process. If a victim is referred to MARAC three times in 12 months the case will be allocated to a plan owner (a Detective Sergeant from the public protection team).

5.16. The plan owner will be responsible for convening a professionals meeting (MARM) where options will be considered. The introduction of the new MARM may in future help to reduce the inertia identified in this case, but it will need to be fully supported by all agencies, including housing. They can advise on all housing issues so a full range of options such as refuge can be extensively considered.

Adult Social Care Safeguarding Meetings

5.17. A number of safeguarding referrals/ alerts were referred to Care Direct (Bournemouth Local Authority Adult Social Care), resulting in safeguarding adult 'investigations' and post Care Act 'enquiry' being commenced.

5.18. A section 42 is

Section 42 Enquiries[23]
A statutory Section 42 Enquiry refers to the local authority being in receipt of information about an individual aged 18 or over who has care and support needs (whether these needs meet the National Eligibility criteria):

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

5.19. Strategy meetings and enquiry planning meetings (post Care Act) took place on:

- November 2013 (Strategy meeting)
- September 2014 (Strategy meeting)
- January 2015 (Strategy meeting)
- June 2015 (Enquiry planning meeting)

5.20. The 2013 meeting identified risks to Anita around her drug and alcohol use and exposure to domestic abuse. This led to the production of a detailed action plan, and for a short period of time Anita appeared to respond positively.

5.21. Similar risks were identified in 2014, but the meeting was influenced by the belief that Anita was pregnant and the potential risks to her unborn child. The resultant action plan was focussed on the pregnancy. The meeting did not produce a comprehensive plan that would address the other risks Anita still faced. Only the police and the BAT social worker were present at that meeting.

[23] Bournemouth, Dorset and Poole, Multi Agency Safeguarding Adults Procedures

5.22. The January 2015 meeting focused on the risks posed by drugs gangs. The only agencies represented at that meeting were the IDVA and the BAT social worker, police did not attend. The meeting concluded that Anita continued not to engage and recorded that:

…. All agencies are assured that Anita is fully aware of how to make contact with agencies as required.

5.23. The Adult Social Care Individual Management Review had the following observation:

…… *a way forward was not able to be identified due to non-engagement with services by Anita. There is no evidence in the case notes that the 'Protocol for working with adults at risk who do not wish to engage with service' was used as a basis to underpin the case closure.*

5.24. The 1st April 2015 saw the commencement of the Care Act 2014. The Care Act 2014 placed the safeguarding of adults on a statutory footing. It required the local authority to make enquires under the following circumstances.

5.25. ***Safeguarding enquiries by local authorities***

The Act also requires local authorities to make enquires, or ask others to make enquiries, when they think an adult with care and support needs may be at risk of abuse or neglect in their area and to find out what, if any, action may be needed. This applies whether or not the authority is actually providing any care and support services to that adult.

The enquiry may lead to a number of outcomes, depending on the circumstances, including to prosecution if abuse or neglect is proven. In other cases, the risk of abuse may be tackled, but the adult may have other care and support needs which require different services, and may lead to a needs assessment or review of an existing care and support plan.

5.26. An important change that the Care Act introduced was the requirement to consider domestic abuse and self-neglect as potential adult safeguarding concerns. The statutory guidance's[24] definition of self-neglect is as follows:

"*self-neglect – this covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding. It should be noted that self-neglect may not prompt a section 42 enquiry. An assessment should be made on a case by case basis."*.

In this case Anita was subject to domestic abuse but given her continual failure to neglect her health needs she might also have been also have been considered

[24] Department of Health and Social Care: Guidance Care and support statutory guidance www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1

under the category of self-neglect.

5.27. The June 2015 enquiry planning meeting considered both Anita and John. The meeting was split. Each were present during parts of the meeting. The focus remained on the risk from drugs gangs. Anita was subject to a safeguarding referral in respect of domestic abuse from John, so it is questionable as to why they were still being dealt with as a couple.

5.28. This meeting was supported by a more detailed risk assessment. The Adult Social Care Individual Management Review reviewed the strategy meetings and highlighted the following:

In 2013 there was confusion in the Borough as to the roles of the strategy meeting and an enquiry-planning meeting. Steps were taken to resolve this in the Borough in 2015. The pre-2015 strategy meeting minutes reflects the confusion. The 2015 risk assessments are of improved quality and may be in response to the introduction of the Care Act 2014.

5.29. The risk assessment was revisited two months later, and the conclusion was:

At this stage there is nothing further agencies can do to support Anita.

5.30. On occasions the MARAC and adult safeguarding meetings took place close together. This should have enabled the two processes to support each other but, evidence that the meetings were coordinating responses to support each other was limited.

5.31. Whilst professionals were working to support Anita, there is a lack of clarity as to who was reviewing and coordinating support across the agencies. The conclusion from Individual Management Reviews was that there was ‘no grip’ and a ‘lack of co-ordination’.

5.32. **Change**
A recent local domestic homicide review (still to be published) recommended that a task and finish group should undertake a MARAC review, specifically to examine the alignment of safeguarding adult and MARAC agendas. This recommendation has now been actioned and the findings of the group should be followed up considering this review.

5.33. **Dorset Police have now in place an Adults at Risk Desk. This post should be able to pick up adult safeguarding issues that have an element of domestic abuse. Had this position been in place for Anita they may have provided a coordinating link between safeguarding and domestic abuse.**

5.34. The Local Government Association and Directors of Adult Social Care[25] (ADASS) has produced guidance in respect of Adult Safeguarding and Domestic Abuse. This guidance makes the following observation:

Making the links between adult safeguarding and domestic abuse.

From the above it is clear that a significant proportion of people who need safeguarding support do so because they are experiencing domestic abuse. Despite the clear overlap between work to support people experiencing domestic abuse and safeguarding adults work, the two have developed as separate professional fields. Clear strategic and practice links need to be made between approaches.

5.35. Section 11 of the Local Government Association guidance sets out what councils and organisations can do to support good practice. The author would recommend that this section is utilised by agencies as a check on what they have currently in place.

5.36. **Recommendations.**

Bournemouth Community Safety Partnership *to consider using the LGA guidance (chapter 11) to inform a multi-agency audit to establish if good practice is in place locally. (attached appendix B**).***

Bournemouth and Poole Safeguarding Adult Board and Bournemouth Community Safety Partnership *to undertake a joint audit of recent MARAC and safeguarding meetings, to establish if changes have taken place following the recent MARAC review**.***

5.37. **Additional Factors**

The previous section examined the links between the MARAC and adult safeguarding meetings the following will consider additional factors, specific to this case.

5.38. **The Abused and Perpetrator**

A major difficulty for professionals when trying to support Anita was the continued presence of John in her life. Plans to support her, needed to consider John's situation to assess how actions to support him might impact on Anita and vice versa. Whilst there is evidence of joint assessments in areas such as their detox treatment (separate detox pathways to separate them up), this was not consistently present across all multi-agency actions and was not clearly recorded in either the MARAC or safeguarding meeting minutes.

5.39. The Local Government Association guidance also highlights the need for separate consideration of abused and abuser:

Where the person causing harm has care and support needs it is best practice for

[25] LGA & ADASS: *Adult safeguarding and domestic abuse – a guide to support practitioners and managers:* Local Government Association (2015*)*

*these to be assessed and provided for **separately** to services for the adult who has care and support needs – for example the person's carer or partner. However, professionals working with an abusive person must share information relevant to the safety of others with those coordinating the safety plan for the victims/s.*

5.40. SafeLives[26] Guidance for MARACs provides the following advice:

The Chair should ensure that all information relevant to the perpetrator and factors that are likely to increase the risk of re-abuse to the victim, harm to children, other vulnerable parties and risk that agency staff could be harmed, is heard at the meeting. This would be in addition to the usual proportionate and relevant information shared on the victim and any children. It is essential that the Chair outline the risks identified from this information and invites other representatives to highlight any additional concerns that may have been overlooked.

Some examples of risks specifically relating to the alleged perpetrator may include that they are:

- *Homeless.*
- *Self-harming or threatening suicide.*
- *Misusing drugs or alcohol.*
- *Demonstrating behaviours which suggest they may be suffering from a mental illness, and those which may be exacerbating the risk of continued abuse of the victim and any children.*
- *Ignoring or breaching bail conditions or court orders.*
- *Stalking and harassing the victim or their friends/family/colleagues.*
- *Threatening the victim or their friends/family/colleagues.*

Once the Chair has outlined all risks associated with the victim, children and perpetrator, it is important to encourage actions from the representatives which both address victim safety and address the perpetrator's behaviour.

5.41. Potential opportunities to coordinate support for each individual were limited but did arise. Such an opportunity was highlighted in the Adult Social Care Individual Management Review which stated:

In July 2015 the perpetrator entered treatment, which had the potential to be an opportunity to work more intensely with the victim, however it was not listed within any MARAC actions or Safeguarding actions but was potentially a lost opportunity to work with the victim.

5.42. This was around July 2015 when he threatened to throw himself off a car park. He was taken to hospital under Section 136 Mental Health Act 1968. This led him to

[26] SafeLives: *Guidance for MARACs Addressing the abusive behaviour of alleged perpetrators*

commencing detox. There was a small window of opportunity which closed very quickly due to John returning to Anita's address when he stopped detox after three days.

5.43. John was in receipt of support from the BAT care co-coordinator and BAT social worker. He was also assessed by adult mental health for threatening suicide. These attempts were sometimes in Anita's presence. His actions could be evidence of his attempts to control her. Anita displayed similar behaviour when she cut her wrists. The actions of both individuals should have been fully assessed so that when formulating action plans the impact of a proposed action on the other person could also be taken into consideration.

5.44. As John's BAT care co-ordinator was not involved in any MARAC, updates to John's current situation, other than from police, could not be fully considered. Agencies working with victim's abusers should be invited to support the MARAC process.

5.45. There is evidence that some agencies actions, inadvertently pulled Anita and John together or negatively impacted Anita's engagement.

5.46. The Avon and Wiltshire Partnership Mental Health NHS Trust (AWP) individual management review states that on one occasion John attended the treatment appointment with Anita (12/13) but was not asked to leave. There were also other occasions when the two were at the same venue (BAT) at the same time.

5.47. A good example of this occurred when the focus of the risk to Anita and John changed with her involvement with a drugs gang. This resulted in Anita making a police statement against a gang member placing both her and John at increased risk. At one point (January 2015) the risk was so significant that police placed Anita and John in a local hotel together (at their request). They subsequently were separated due to an argument.

5.48. The potential impact of this situation on Anita's actions/thoughts was recorded in the June 2015 adult social care risk assessment. It recorded**:**

Anita remains in fear from the consequences of making a statement….. Anita has not been engaging in any treatment or groups for fear of seeing John.

In respect of the risk of domestic abuse whilst in a relationship with John it recorded:

Anita is aware that she is at risk from John …..she wants to separate from him however has stated that whilst in the chaos of her addiction is reliant on him and him on her.

5.49. Police have a duty to investigate criminal activity and Anita was potentially an important witness in respect of convicting dangerous individuals. Unfortunately, the risk to Anita, not only a physical risk from others, but the potential impact on her mental health due to fear and pressure of the situation, increased. This provided her with an excuse to stay with John, thereby reducing the chances of agencies engaging with her successfully.

5.50. She was a vulnerable adult but, it is not clear how her vulnerability was assessed, by the officer in the case when she was being asked to make a witness statements against dangerous individuals. Whilst the police officer in the case did provide a written update to the June 2015 adult strategy meeting, they were not in attendance, so any discussion of the impact of the police position or options was restricted.

5.51. At an early stage the potential impact and risks should have been assessed in a multi-agency environment. Options and possible consequences could then be explored across agencies, including the impact of a proposed action by one agency on another agency's action. In this case police actions impacted on Anita's response to health needs and ability/desire to distance herself from John.

5.52. This review also highlights that the risk of domestic abuse must be continually assessed and remain on the radar when other risk factors are identified. In this case they sometimes got lost when other risks arose.

5.53. Whilst this review has highlighted the need to fully assess the situation of the abused and the perpetrator, conclusions recorded in the June and August 2015 adult social care risk assessments emphasise the difficult situation that agencies found themselves in when trying to support Anita and separate her from John.

June 2015:
Anita has stated that she does wish to accept an out of area residential treatment and wants to separate from her partner John who is also open to SWBAT due to safeguarding concerns due to same drugs gang.

August 2015:
Anita has capacity to make decisions regarding her treatment and safety. All agencies have tried to engage with Anita to work with agencies for her own health. Anita is however continuing to use substances and be in a relationship with John despite being aware of the risks. At this stage there is nothing further agencies can do to support Anita. Agencies will however remain available to Anita until she is ready and able to engage.

5.54. There were positive signs from Anita in June by August she had reverted to a negative mind set.

5.55. ***Recommendations***

Dorset Police *to advice officers investigating serious crime that they should ascertain if victims/ witnesses are already open to any safeguarding processes. This is to work with agencies already involved with the individual and assess the impact of their continued involvement in the investigation on the any safeguarding concerns.*

Bournemouth Community Safety Partnership *to reinforce that it is good practice for staff from statutory agencies to ascertain if individuals they are working with are already open to any safeguarding processes.*

Family Support Networks

5.56. There were several occasions when Anita showed some signs of improved engagement, late 2014 being an example. Entries in the IDVA chronology support this:

15/12/14 *Anita spoke with IDVA on the phone and said that the perp had turned up last week, but her son was still there, and he kicked him out. ….. Anita told IDVA that if her son had not been there she would have let John in …Anita also told IDVA that her methadone had been reduced and she was struggling but would not use as her son was with her.*

21/12/14 IDVA spoke to Anita. Her son was still with her. Anita told IDVA that she was now off the methadone script and was struggling; her son caught her taking drugs the previous week and was watching her closely and limiting her alcohol intake.

29/12/14 Anita stated that she had not seen or heard from John and felt safe but was struggling not being on methadone. Son still with her. Anita said she is thinking more clearly not drinking and is aware of the health risk if she drinks again.

6/1/15 …Her son was still with her and she felt safe. …… IDVA tried to discuss safety planning for when her son left …

5.57. These positive comments coincided with her son staying with her. They indicate that he might have had a good influence on Anita's mood. When her son left, she reverted to relying on John to keep her safe, reducing her positive engagement.

5.58. The IDVA had a meeting with Anita in December 2014. Her son was present and indicated that a non-molestation order would be a good option but believed that she would just go back to John as she normally did.

5.59. It was identified at a MARAC (8th January 2015) that her son was a protective factor, probably because of feedback from the IDVA. He is not referred to in the adult strategy meeting minutes of the 28th January 2015. No action linked to engaging with him were recorded in either the strategy minutes or the MARAC minutes.

5.60. Given the evidence that Anita appeared to respond better when her son was present, options as to how to engage him could have been considered and conclusions (positive and negative) recorded. Anita's son's criminal history may have led agencies to perceive that he was not an appropriate individual to support her. Whilst this may be the right conclusion there is no evidence recorded that indicates that this was fully assessed.

5.61. Anita's support networks were very limited, so not fully exploring the possibility of her son was a missed opportunity. This review highlights the need to consider the role friends and relatives could play in a support network.

5.62. ***Recommendation:***

Bournemouth Community Safety Partnership *to advise that MARAC,* must also explore the family/friend networks of a victim, to ascertain if they might be able to provide additional support and ensure this is included in the action plan.

6 OTHER ISSUES

Information Sharing

6.1. The effectiveness of multi-agency working is reliant on good information sharing. The main process for the notification of incidents of domestic abuse across agencies was, and is, the Public Protection Notice (PPN) (formally SCARF, DV1). In respect of adult safeguarding it is the safeguarding alert/ referral form.
The oversight of high-risk domestic abuse cases is the Multi Agency Risk Assessment Conference. (MARAC).

DASH/PNN

6.2. Domestic Abuse Stalking and Honour Based Violence and Harassment (DASH) risk identification check list is a nationally used model that indicates a level of risk. It is based on the responses to several questions along with the attending officer's assessment. The level of risk is then graded as Standard, Medium or High. The DASH forms part of the PPN formally (SCARF) which is the form used by Dorset Police to report all safeguarding incidents regarding children, adults etc.

6.3. A DASH is required to be completed by the officer attending any domestic abuse incident. In most cases the DASH was completed.

6.4. The DASH is an indicator of risk, based on the number of ticked boxes. Further detailed assessments need to support the DASH RIC. This has been acknowledged by Dorset Police, who have in place a Safeguarding Referral Unit (SRU) that reviews the initial RIC and considers additional information. This process led to several incidents being upgraded from medium to high. Those that are graded 'high risk' are automatically referred to the MARAC, those who are graded standard or medium with additional assessed risk factors are also referred to MARAC. The assessed PPN/DASH form is forwarded to other agencies such as Adult and Children Social Care and some health providers.

6.5. **The Pan Dorset MARAC Operating protocol states:**
Agencies should follow their own procedures for screening cases for domestic abuse and subsequent risk assessment using the CAADA DASH, and those that are identified as high risk should be referred forward to the MARAC process by completion and submission of a MARAC referral form. Whilst, the police's specialist domestic abuse team can advise on risk assessment and the MARAC referral process to support agencies making a referral, it is not the Police's responsibility to complete MARAC referrals on behalf of other agencies.

There is a clear expectation that agencies will utilise DASH where there has been a

disclosure or identification of abuse to ascertain whether a referral to MARAC is required. It is the recognised assessment tool for the MARAC process and should be used by all agencies within Bournemouth, Dorset and Poole wherever there is a disclosure or identification of domestic abuse. The DASH RIC should provide practitioners with a structure to inform judgement and act as prompts to further questioning, analysis and risk management whether via a MARAC or in another way.

6.6. When discussed with the review panel and the Individual Management Review author's, it was identified that there was a lack of understanding by some agencies as to how the PPN/DASH was used and how the grading system worked. When explored there was a lack of clarity as to whom the PPN/DASH is circulated and how any agency should react.

6.7. It was also identified, that some agencies working with these individuals had minimal knowledge of the level of domestic abuse taking place. Dorset Healthcare University Foundation Trust (DHFT) had no knowledge at all of domestic abuse. This was of concern and evidenced a problem with information sharing across all services. In respect of the MARAC, information should be being shared with all relevant agencies.

6.8. **Change**
The Dorset Information Governance Group have in place Dorset Information Sharing Charter[27] (DISC) 2015. The charter aims;

to provide Dorset partner agencies with a robust foundation for lawful, secure and confidential sharing of information between themselves and other public, private or voluntary sector organisations that they work or wish to work in partnership with.

6.9. **Recommendations**

Bournemouth Community Safety Partnership *to be assured that within current local policy and procedures there is clarity about the function of the police PPN/ DASH (formally SCARF), to include who should receive such a notification and how they should respond*.

6.10. An issue highlighted in the Dorset Healthcare University Foundation Trust Individual Management Review, was the information sharing between Police and the Court Diversion Schemes and the Criminal Justice Mental Health Liaison Schemes (CJLDS). This scheme is concerned with the assessment of people with mental health problems within the Criminal Justice system. They manage the interface between criminal justice and social care.

6.11. In this case, they became involved in 2015 when Anita was arrested in respect of drugs offences. The CJLDS were not informed that Anita had been subject to domestic violence. They therefore could not take this into account when making an

[27] Dorset Information Governance Group: *Dorset Information Sharing Charter*[27] (DISC) 2015.

assessment in respect of her mental health.

Criminal Justice

6.12. Police officers who attended the domestic abuse reports responded positively in most cases. This was good practice and led to the arrest of John and Anita on several occasions. The difficulty officers faced, was that Anita was never able to support a prosecution either declining to make a written statement or failing to attend court to give evidence.

6.13. Specialist domestic abuse officers (DAO's) worked with other agencies to try and persuade Anita to support a prosecution, this was good practice, but they were never able to maintain her support through to the final court appearance.

6.14. John was charged on several occasions. This placed him on both police and court bail. An example was in December 2013 John was arrested and charged and was taken to court with the police making an application for a remand in custody. The court refused the application and he was released and granted bail.

6.15. John breached his bail condition not to contact Anita on several occasions. No action was taken in response to his breach of bail. This was it appears, because on occasions Anita initiated the contact, turning up at John's address, along with Anita's reluctance to support the prosecution. A review of the circumstances and history of the case through experienced eyes might have helped to improve the chances of breach of bail prosecution.

6.16. Pre-2014, Dorset Police had in place Evidential Review Officers (ERO). These were experienced officers who advised on charging decisions. In 2014 this role was removed, and the function passed to the Patrol Sergeants. This may have removed a level of expertise which will take some time to instil in busy Patrol Sergeants. The prosecution of breaches of bail is a powerful tool which 'might' in this case have led to a remand in custody rather than bail. This may have provided Anita with space free from John's influence, during which time agencies may have been able to support her.

6.17. It is not unusual for victims to be reluctant to support prosecutions, so a prosecution without victim support (victimless prosecution) can be taken. It requires the support of the Crown Prosecution Service. There is evidence that on two occasions the Crown Prosecution Service authorised charging despite indications that Anita was not engaging. When she failed to appear at court there was again evidence to indicate that Special Measures were considered, but Anita still would not attend court. This was good practice.

6.18. John was always correctly bailed to a Domestic Abuse Court. The difference this court made due to its increased understanding of domestic abuse is hard to gauge given the previously noted reluctance to remand John when requested by police.

6.19. **Recommendations**

Dorset Police *to reinforce the requirement by officer to respond positively to breaches of bail conditions in cases of domestic abuse, with a view to prosecution. To assist decision making,* officers should seek advice from the experienced domestic abuse officers.

IDVA Service

6.20. The National definition of IDVA as described by SafeLives[28] is:

The main purpose of independent domestic violence advisors (IDVA) is to address the safety of victims at high risk of harm from intimate partners, ex-partners or family members to secure their safety and the safety of their children. Serving as a victim's primary point of contact, IDVAs normally work with their clients from the point of crisis to assess the level of risk, discuss the range of suitable options and develop safety plans.

They are pro-active in implementing the plans, which address immediate safety, including practical steps to protect themselves and their children, as well as longer-term solutions. These plans will include actions from the MARAC as well as sanctions and remedies available through the criminal and civil courts, housing options and services available through other organisations. IDVAs support and work over the short-to medium-term to put them on the path to long-term safety.

6.21. Anita was referred to the IDVA service on several occasions. This service was restructured in October 2015 from BCHA to Maple Project. The IDVA's role was then undertaken by Domestic Abuse Advisors (DAA's).

6.22. During 2013 until the case was closed in January 2014, it is evidenced that Anita had significant contact with the same IDVA. This was both telephone and personal contact between Anita and the IDVA. There is also recorded a significant level of contact with other services and good information sharing between the IDVA and the other services.

6.23. This level of contact was not replicated in later referrals. Between July 2014 when a case was opened, and in September 2014 when the case was closed there was no contact with Anita. It is accepted that Anita was hard to contact at times. The IDVA was advised that she could be contacted via a pharmacy but there was no follow up prior to the case being closed. The GP might have been another route but that was not explored either.

6.24. A lack of immediate response is also evidenced in February 2016. It was recorded on the SCARF that Anita had requested support to be placed in a refuge away from Bournemouth. There was no contact with Anita until the end of March.

6.25. The BCHA Individual Management Review concludes:
There is little evidence of dynamic engagement with Anita, standard practices were

[28] http://www.safelives.org.uk

utilised i.e. arranging appointments which were not attended or request for Anita to contact services not considering that on multiple occasions she states she had no credit on her phone.

These engagement methods do not take account of the chaotic nature to Anita's lifestyle which reduces the likelihood of her engaging in this method.

6.26. As previously highlighted, the IDVA service ceased in October 2015 and was replaced by the Maple Project.

6.27. Safer Poole Partnership Annual Report 2015 described the Maple Project as follows:

The Maple Project is a single, multi-functional domestic abuse team employed by Dorset Police, which went live on Thursday 1 October 2015. The Maple Project was formed after an in-depth review of local domestic abuse victim service arrangements, which has resulted in the restructure of the Dorset Police Domestic abuse team and the Independent Domestic Violence Advisor Service (IDVA).

The Maple team will now consist of 10 Domestic Abuse Advisors who will be trained to IDVA standards and 4 Office based domestic abuse support officers who will provide a virtual contact for victims and coordinate the MARAC process. The team is overseen by a domestic abuse supervisor who will also be trained to IDVA standards.

6.28. There is no evidence that indicates that the provision of support for Anita changed upon the commencement of the Maple Project.

6.29. The impact of the Maple Project has been to move the IDVA service under the control of Dorset Police (previously this service was with a 3rd sector provider). The IDVA role is now undertaken by Domestic Abuse Advisors (DAAs). All staff are employed by Dorset Police and work within the Safeguarding Referral Unit. This has major advantages in respect of their access to multi agency information.

6.30. The IDVA service was designed to provide independent advice and support to victims. The **author** has concerns that the new DAA's being police staff may be seen by victims as part of the police service. This could make victims, who are often difficult to engage, reluctant to work with a DAA. DAA's need to consider the impact that them being directly linked to police may have on a victim. Despite these concerns, it is acknowledged that early feedback indicates that engagement rates are now higher than before the change. This should be monitored to ensure the level of engagement is maintained.

6.31. A report in 2009 [29]Safety in Numbers: A Multi-Site Evaluation of IDVA Services, made the following observations:

The way in which IDVAs worked with victims had a direct bearing on the chances of achieving improved safety and well-being. Victims receiving more intensive support

[29] Howarth, Barron etal [29]*Safety in Numbers: A Multi-Site Evaluation of IDVA Services*, 2009

were more likely to do better than those receiving limited support; and victims who received multiple forms of intervention fared better than those receiving none, or a single form of intervention. These findings suggest that the intervention that IDVAs provide is causal in bringing about positive changes for victims.

6.32. It is of note that the DAAs make initial contact with victims on the phone then will meet the individual if necessary. Anita was difficult to contact by phone and could explain why contact with her failed to improve at the commencement of the Maple Project. It is also possible that victims when offered a service on the phone, may react differently to when they have a face to face contact. Alternative ways of contacting victims need to be considered before a conclusion that a victim does not want to engage is reached.

Support Options

6.33. Anita's behaviour/life style resulted in her appearing to some professionals not to be eligible for some support that she required to enable her to make changes in life.

6.34. An example was placement in a refuge. At the multi-agency meeting held in July 2013, Anita stated that she would be willing to accept a refuge place. This was an opportunity to try and (accepting that she may not have taken up a place) remove her from the controlling behaviour of her partner at the time. Unfortunately, Anita was informed that she would not pass the risk assessment for a placement as she was still drinking heavily. The request Anita had proactively made was closed down.

6.35. The BCHA Individual Management Review commented upon this:

Anita requested refuge provision on several occasions initially in 2013… Refuge was discussed however IDVA at the time stated that Anita would not pass the risk assessment to access refuge due to alcohol consumption misuse. This seems to have created a barrier for Anita, as demonstrated in later cases when Anita herself stipulates that she knows refuge is not an option due to risk factors.

….on the 05.02.16 that Anita requested DV support to be placed in refuge away from Bournemouth stating that she is done with John.

Refuge provision was not fully explored throughout BCHA[30] and Maple project engagement with Anita.

6.36. Anita at one stage, wanted to go into bed and breakfast, but was informed that it was too late to arrange and that she could not be supported to housing for a couple of days. There is no evidence that the housing out of hours service were contacted.

6.37. Accommodation options needed to be explored, but housing officers where not invited to the meetings and there was no action for the Housing Options Officer to be contacted for guidance and advice.

6.38. When the refuge option was discussed at the Domestic Homicide Review Panel, it was confirmed that the advice given was in fact incorrect. There are refuges that will

[30] BCHA: Bournemouth Churches Housing Association. Managed the IDVA service until October 2015

accept individuals with complex needs. The advice given may have, in Anita's mind, removed the possibility of being able to go to a refuge at any stage. Her mind set was evidenced during her conversation with the police Domestic Abuse Officer in December 2014 when she stated that she had had enough. Anita was desperate to move away but she explained that she could not go into refuge as she was an alcoholic.

Detoxification Treatment

6.39. There were times when Anita expressed a desire to be detoxed. The Multi-Disciplinary Team[31] (MDT) panel agreed to a 21-day in-patient detoxification with a view to her moving away from the area upon completion for aftercare.

6.40. She did attend sessions to prepare for detox but changed her mind around an in-patient detox and relocating, wanting to stay in Bournemouth. This change in mind resulted in a cancellation of the in-patient option; a community alternative was offered to help with preparation, but Anita did not engage.

6.41. Prior to the change in detox options, Anita was offered 1 to 1 sessions (she feared she may be in groups with John). However, once the plan changed she was offered group work in the community, and one time phoned the service to ask if John could come with her (she was told "no"). Anita could not successfully reach a point where she could demonstrate her commitment to undertake a detox.

6.42. Detox preparation sessions, whilst being an opportunity to assess commitment and plan for continuing support, for Anita were always going to prove problematic. Whilst the Multi-Disciplinary Team panel had agreed that she required residential detox, an option not considered, was to allow Anita to attend residential detox without preparation.

6.43. The local Drug and Alcohol Commissioning Team have advised the review that a placement without preparation could increase the risk of harm for the individual in terms of relapse, overdose, blood borne viruses and the ability to reengage with services and support and in the community when walking out of a detox early. Housing options may also be put at risk. Whilst these are understandable concerns, for Anita's placement without preparation may have provided her with an opportunity to move away from her chaotic life style. If she did walk out, then at least this option would have been attempted.

6.44. It must be acknowledged, that it was Anita's issue of her post treatment location that proved difficult to resolve. She was offered in- patient detox out of the area and then aftercare in Oxford. She declined this offer as she stated she wanted to remain in the Bournemouth area. This option could not be progressed as she then did not continue to engage.

[31] There is a well-established MDT (multi-disciplinary team) panel approach which reviews applications from service providers for community detox, inpatient detox and residential rehabilitation and assesses them against agreed criteria. Commissioners and service providers are involved in the panel process and once a placement has been agreed, the service user is matched to the most appropriate registered provider based on need, cost and preference.

6.45. **Change**
The Multi-Disciplinary Team panel now, in evidenced complex cases, consider the option of a non-preparation placement considering the balance of current risk to the individual.

6.46. The current Public Health Dorset referral form (revised 2017) requires detailed information. It currently does not have a specific space to highlight that the subject of the referral is an open case to other processes, such as adult safeguarding or MARAC. This information should be included in the narrative, but a specific prompt would ensure the panel have full information and the other processes could make recommendations.

6.47. **Recommendation**

Bournemouth Borough Council Drug & Alcohol Commission Team *to review the current MDT panel Public Health Dorset referral form, to ensure it enables additional information from other processes such as safeguarding and MARAC to be clearly referenced.*

General Practitioner (GP) Responses

6.48. Anita and John were registered with two different GP practices. Both practices made referrals to the BAT and the local Mental Health Services. The GP's Individual Management Review identified that each practice had different approaches.

6.49. In respect of Anita's GP, information was shared when she moved practices. Her vulnerabilities were identified, and attempts were made to ensure she saw the same GP. The practice did have in place a vulnerable patient list, but it was restricted to patients with learning disabilities and those at risk of repeated hospital admissions. Persons on the list were more routinely discussed. Anita's vulnerability did not come under the above remit, so her case was not regularly discussed. The vulnerability list is good practice but is of limited use for people with more complex health and wellbeing needs, such as dual diagnosis, drug and alcohol and domestic abuse.

6.50. It appears that her records contained detailed information including domestic abuse concerns with reference to the IDVA, actions from MARAC and her cycle of returning to the perpetrator. There was also reference to a SCARF. Despite these references the Individual Management Review author stated that:

The surgery deals with the presenting issues which is understandable given each appointment is only 10 minutes in duration. This does however make it difficult for the GP's to be able to undertake a full holistic assessment of need.

6.51. In comparison, John's GP practice gave more consideration to the wider environmental factors, identifying that interventions such as detox were compounded by his relationship with Anita. This practice has a complex cohort of patients, and there was an open and transparent policy for GP's to discuss and share their concerns (respecting confidentiality and information sharing).

6.52. Information sharing between hospitals was also highlighted in the Individual Management Review. The GP was made aware of John attending Royal

Bournemouth Hospital in November 2014. He had been found unconscious on the ground. In December 2014, John attended Poole Hospital twice for self-poisoning. Whilst it was not possible to share information between hospitals, the GP who was notified had opportunities to consider John's increasing demand of emergency services.

6.53. What this review has identified is the differing approaches and support given to vulnerability and complex patients across GP practices. It has also highlighted the lack of direct involvement by the GP's in the safeguarding and MARAC process, and the difficulties of information sharing across the GP and the hospital network.

6.54. The author fully appreciates the differences between practices in respect of size, funding, local environment and priorities, but good practice has emerged especially in respect of John's GP practice. This good practice should to be shared across the GP cohort, especially in respect of vulnerability and response to the Care Act 2014 and self-neglect.

6.55. **Recommendations**

Bournemouth Community Safety *Partnership to work with NHS Dorset Clinical Commissioning Group to consider how to improve the involvement of GPs with the MARAC process.*

Capacity/ Coercion and Control

6.56. Professionals face a major challenge when working with adults at risk, like Anita, assessed to have capacity.

6.57. **The Local Government Association guidance states:**

Assessing capacity can be particularly challenging in domestic abuse situations, where the person is cared for by, or lives with, a family member or intimate partner and is seen to be making decisions which put or keep themselves in danger.

Skilled assessment and intervention is required to judge whether such decisions should be described as 'unwise decisions' which the person has capacity to make, or decisions that are not made freely, due to coercion and control. For example, a decision to continue to live with an abusive partner might be a free and informed decision based on a full appreciation of the risks and the alternative courses of action, including support available. However, a victim may also be caught in the 'Stockholm Syndrome', a psychological defence mechanism that creates attachment to a perpetrator as a cognitive strategy for staying safe.

A decision not to leave may also be based on a realistic fear of the behaviour the perpetrator has threatened if the victim were to disclose abuse or try to leave the relationship.

6.58. Risk assessments concluded that Anita had capacity. What is not recorded is how her capacity was evidenced. The important point to highlight, is that capacity can fluctuate and affect an individual who may be in a controlling relationship and who is being coerced.

6.59. Case law is emerging that might provide different options. A recent case (A[32] Local Authority v DL [2010] EWHC 2675 (Fam)) has ruled that local authorities can *use section 222 of the Local Government Act 1972* to commence proceedings in the High Court to safeguard people who do not lack capacity, but whose ability to make decisions has been compromised because of constraints in their circumstances, coercion or undue influence.

6.60. In this case there is evidence that Anita had been subject to controlling and coercive behaviour. This case law would now provide a possible additional option for consideration.

6.61. A further option is Section 76 of the Serious Crime Act 2015. This created a new offence of controlling or coercive behaviour in an intimate or family relationship. The act came into force on 29th December 2015. In this case it would only have covered the last few months before the fatal incident but, is an offence that should now be considered when there is emerging evidence of controlling or coercive behaviour as well as traditional signs of domestic abuse.

6.62. ***Recommendation***

Bournemouth Community Safety Partnerships *to raise awareness of and promote the use of the Serious* Crime Act 2015, when evidence of coercion and control of a victim is identified.

7 NOTABLE PRACTICE

7.1. All reviews are written with an element of hindsight, so it is important to highlight notable practice evidenced over several years. This includes the work of professionals from all agencies to try and support both Anita and John. The difficult changing circumstances they faced has been set out in the report, but as identified in the chronology they continued to work with Anita.

7.2. The chronology evidences good contact between professionals, for example the BAT care co-ordinator, IDVA the BAT social worker and police.

7.3. Other examples include John's GP whose practice considered the wider environmental factors, identifying that interventions such as detox were compounded by his relationship with Anita.

7.4. The original IDVA recorded many contacts with Anita both by phone and in person. She also recorded a significant level of contact with other services and good information sharing between the IDVA and the other services.

7.5. There were several occasions when professionals made adult safeguarding alert to

[32] Family Law Week http://www.familylawweek.co.uk/site.aspx?i=ed69920

Care Direct. This was good practice.

7.6. The improvement in the safeguarding adult assessment recording post the Care Act is to be welcomed and noted.

7.7. Police on most occasions took positive action arresting John and when appropriate Anita, and whilst they struggled to prosecute due to Anita not being able to support their attempts, they considered and used other tools such as cautions and DVPN/O.

7.8. These examples of notable practice evidence the work of professionals to manage these difficult circumstances.

8 ORGANISATIONAL CHANGES

8.1 Several the agency structures in place in 2013 have been changed. This section will briefly set out those changes.

Avon and Wiltshire Partnership Mental Health NHS Trust (AWP)

8.2 Avon and Wiltshire Partnership took over as the specialist substitute prescribing provider in April 2013. They identified that there was a need for a change of culture and philosophy amongst staff and patients accessing the Specialist Prescribing Service. It was acknowledged that any cultural change would take time, and that some of the previous culture practices were present when working with Anita and John post April 2013. By the end of the period they were in treatment, the improved culture and philosophy had been implemented and demonstrated and this resulted in:

- Improved assertive case management
- Recovery philosophy
- Improved communication
- Improved recording of team and clinical discussions
- Safeguarding concerns now a standing item at SDAS MDT

Bournemouth Assessment Team (BAT) and Adult Social Care (ASC)

8.3 Bournemouth Assessment Team (BAT) during the period of this review, were responsible for the assessment of need and overall care co-ordination of individuals with drug and alcohol requirements. At that time Adult Social Care social workers were seconded into the BAT service. When safeguarding referrals or alerts were passed to Adult Social Care (Care Direct), if the individuals who were subject to any alert were already under the care of the BAT, then the alert would be passed to the BAT social workers seconded to the service to undertake a safeguarding response.

8.4 Over the last two years these services have changed. The social workers were moved back to Adult Social Care, and now sit within a safeguarding adults team. Bournemouth still has two specific drug and alcohol safeguarding social workers, who only look at drug and alcohol cases (Drug and Alcohol Safeguarding Team).

8.5 The Assessment of need and care co-ordination element of the treatment system was merged with the engagement element of treatment to become the Bournemouth Engagement and Assessment Team (BEAT). This has become the single point of contact for anyone seeking support for drug and alcohol problems.

They will screen, assess, offer low threshold groups, prepare people for higher threshold services and care coordinate individuals through their treatment journey.

8.6 Since the changes, all safeguarding alerts which meet the criteria for individuals with substance misuse issues, (whether the person is in treatment, previously been known to treatment or never been in treatment) are passed through Adult Social Care (Care Direct) to the Drug and Alcohol Safeguarding Team (DAST). DAST assess the individual and if the individual wishes to access treatment.

8.7 DAST and BEAT work in partnership to encourage the individual to engage with treatment. DAST will continue working with the safeguarding element, whilst the BEAT concentrate on treatment. In cases where there is low level safeguarding, the BEAT will work with individuals if they are in the treatment system and liaise with the DAST social workers if necessary.

8.8 The BEAT hold their own weekly safeguarding meetings for individuals with assessed risk within the treatment system, and the DAST social workers attend when necessary. Weekly communication takes place on individuals to be discussed, so information can be given if the DAST social workers are unable to attend. (Each individual within the treatment system has their risks updated on a 12-weekly basis, unless risk has increased, and this will be updated immediately).

9 CONCLUSION

9.1 Anita was a victim of domestic abuse, but there were many other factors that influenced how Anita and John lived their lives and how they reacted to professionals attempts to support. These included:

- Substance misuse
- Domestic abuse/violence
- Criminal activity
- Gang threats
- Mental Health issues

9.2 The following comments contained within Individual Management Reviews, sums up the difficulties the professionals faced:

- *Safeguarding plans were in place but almost impossible to implement with clarity due to the chaotic life style of A and B.*
- *Anita declared "I would rather be in a relationship with someone who hits me than be on my own.*
- *They described the sense of hopelessness in that Anita was almost accepting of her situation, impossible to reach out to and impossible to keep safe.*

9.3 Both John and Anita were in receipt of a significant level of support from several agencies and there is plenty of evidence that professionals worked with each other. This case highlights that to maximise the impact of the interventions by individual agencies, it is essential that the domestic abuse and safeguarding adult processes work together, to coordinate approaches to support the victims. and to work with

abusers to reduce their impact on the abused.

9.4 As identified in the report there have been several changes in processes and agency structures that should address some of the issues. These changes have reduced the number of recommendations in this report.

9.5 Changes are supported by the commencement of the Care Act 2014, which now requires a joined-up approach to safeguarding and domestic abuse. This requires good assessment of risk, good planning linked to the risk reduction, ownership and good coordination and review and reassessment if actions are not working.

9.6 The circumstances of this case would have been challenging to any set of professionals, hence the need to maximise the opportunity for professionals to work together, and it must be acknowledged that whilst issues identified in this review may have improved Anita's long-term chances, there is minimal evidence to suggest that this would have been the case. Nothing in this review suggests that the manner of Anita's death could have been predicted.

10 RECOMMENDATIONS

R1 ***Bournemouth Community Safety Partnership*** *to consider using the LGA guidance (chapter 11) to inform a multi-agency audit to establish if good practice is in place locally. (attached appendix B)*

R2 ***Bournemouth and Poole Safeguarding Adult Board and Bournemouth Community Safety Partnership*** *to undertake a joint audit of recent MARAC and safeguarding meetings, to establish if changes have taken place following the recent MARAC review.*

R3 ***Dorset Police*** *to advice officers investigating serious crime that they should ascertain if victims/ witnesses are already open to any safeguarding processes. This is to work with agencies already involved with the individual and assess the impact of their continued involvement in the investigation on the any safeguarding concerns.*

R4 ***Bournemouth Community Safety Partnership*** *to reinforce that it is good practice for staff from statutory agencies to ascertain if individuals they are working with are already open to any safeguarding processes.*

R5 ***Bournemouth Community Safety Partnership*** *to advise that MARAC, must also explore the family/friend networks of a victim, to ascertain if they might be able to provide additional support and ensure this is included in the action plan.*

R6 ***Bournemouth Community Safety Partnership*** *to be assured that within current local policy and procedures there is clarity about the function of the police PPN/ DASH (formally SCARF), to include who should receive such a notification and how they should respond.*

R7 ***Dorset Police*** *to reinforce the requirement by officer to respond positively to breaches of bail conditions in cases of domestic abuse, with a view to prosecution. To assist decision making,* officers should seek advice from the experienced domestic abuse officers.

R8 ***Bournemouth Borough Council Drug & Alcohol Commission Team*** *to review the current MDT panel Public Health Dorset referral form, to ensure it enables additional information from other processes such as safeguarding and MARAC to be clearly referenced.*

R9 ***Bournemouth Community Safety Partnership*** *to work with NHS Dorset Clinical Commissioning Group to consider how to improve the involvement of GPs with the MARAC process.*

R10 ***Bournemouth Community Safety Partnership*** *to raise awareness of and promote the use of the Serious* Crime Act 2015, when evidence of coercion and control of a victim is identified.

APPENDIX A

Terms of Reference for Review Panel

1. Context

This Domestic Homicide Review is commissioned by the Bournemouth Community Safety Partnership in response to the death of Anita.

This Domestic Homicide Review (DHR) was commissioned because it meets the definition detailed in paragraph 12 of the Multi-Agency Guidance for the Conduct of Domestic Homicide Reviews (Home Office 2013). The review will follow the Statutory Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004.

The Review Panel will conduct the review in accordance with the Multi-Agency Guidance for the Conduct of Domestic Homicide Reviews (Home Office 2013). The Panel will provide an Overview Report, Executive Summary and Action Plan to the Bournemouth Community Safety Partnership within the timescales listed in Section 4 of this document.

Barrie Crook, Independent Chair BPSAB and DSAB has been appointed as Temporary Chair of the review panel in accordance with paragraph 32-34 of the Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews. This was agreed at the Review Panel meeting held on 9 August 2016.

2. Purpose of the review

The purpose of the review is to:

- Establish the facts that led to the incident and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family
- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic violence and abuse and homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working

3. Scope of the review

The review will:

- Seek to establish whether the events could have been predicted or prevented.
- Consider in detail the period of 2013 to 2016 prior to the events leading to the death of Anita.
- To highlight any relevant information prior to 1 May 2013 which could be considered important for the review.
- Request Individual Management Reviews by each of the agencies defined in Section 9 of the Act and invite responses from any other relevant agencies or individuals identified through the process of the review.
- Seek the involvement of the family, employers, neighbours & friends to provide a robust analysis of the events.

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

In addition, the following areas will be addressed in the Individual Management Reviews and the Overview Report:

- *In the knowledge that both the victim and the perpetrator were known to services, was the information available acted upon in a timely manner.*
- *The involvement of the Multi Agency Risk Assessment Conference.*
- *In services where there was involvement with the victim or perpetrator were there adequate safeguarding and domestic abuse policies and procedures and were they followed.*
- *Was there sufficient good quality information sharing and communication between agencies in place to address the level of risk and safeguarding concerns?*
- *Were the appropriate actions taken to identify risk and were risk assessments conducted and robustly managed.*
- *If family, friends and colleagues are participating in the review, were they aware of any abuse that may have been taking place.*
- *Were there any barriers experienced by the victim or family, friends and colleagues in reporting the abuse.*
- *Was abuse present in any previous relationships, did this affect the victim's decision on whether to access support.*
- *Were there any opportunities for professionals to routinely enquire as to any domestic abuse experienced by the victim that were missed.*
- *Are there any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of the services available?*
- *Give appropriate consideration to any equality and diversity issues that appear pertinent to the victim, perpetrator and dependent children.*

4. Timescales for the review

The first meeting of the review panel will be 9th August 2016. Subsequent meetings will be arranged as appropriate.

The review panel will aim to produce the overview report by 31 March 2017 subject to criminal proceedings being completed, the individual management reviews being submitted and the potential for identifying matters which may require further review.

5. Family involvement

The review will seek to involve the family of the victim in the review process, taking account of who the family wish to have involved as lead members and to identify other people they think relevant to the review process.

We will seek to agree a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

6. Legal advice and costs

Each statutory agency will be expected and reminded to inform their legal departments that the review is taking place. Each statutory agency may seek their own legal advice at their own discretion and cost.

An Independent Overview Author is required of this DHR and the costs of this will be met through the Bournemouth and Poole Safeguarding Adult Board.

7. Panel members, expert witnesses and advisors

The following agencies and individuals are suggested to participate in the review panel:

- Dorset Clinical Commissioning Group – Pamela O'Shea
- Dorset Police – DCI Jez Noyce
- Borough of Poole Adult Social Care - Barbara O'Brien
- Partnership Officer, Bournemouth Borough Council - Sian Jenkins
- Bournemouth and Poole Adult Safeguarding Board - Anne Humphries
- Dorset Healthcare University Foundation Trust – Fiona Holder
- Bournemouth Adult Social Care –
- SWAST – Debbie Bilton

Other appropriate agencies and people may be identified through the course of the review.

8. Media and communication

The CSP will lead the communications work regarding this review and will liaise with the communication leads from other agencies represented on the panel, as necessary, during the review.

There will be no presumption to inform the public via the media that a review is being held in order to protect the family from any unwanted media attention.

However, a reactive press statement regarding the review will be developed to respond to any enquiries to explain the basis for the review, why and who commissioned the review, the basic methodology and that the review is working closely with the family throughout the process. An executive summary of the review will be published on the CSP website, with an appropriate press statement available to respond to any enquiries.

9. Sign Off and Governance Arrangements

Bournemouth Community Safety Partnership have commissioned the Safeguarding Adults Review (SAR) Panel to oversee this review. The DHR Panel has been selected by the SAR panel to conduct the review and produce the overview report, executive summary and action plan.

Once complete the Chair of the DHR Panel will forward the report, executive summary and action plan to the Chair of BPDSAB SAR Sub Group. Once they have been sighted on the review the Chair of the DHR Panel will forward the reports to the Chair of the CSP for sign off.

If the Chair of the CSP is satisfied with the overview report the CSP Lead Officer will forward to the Home Office Quality Assurance Panel. Once the Quality Assurance

Panel has agreed the report the full overview report will go to the CSP for noting prior to publication.

10. Publication

The Home Office recommends that in all cases the anonymised Overview Report and Executive Summaries should be published unless there are compelling reasons why this should not happen, for example where the welfare of children or other persons directly concerned may be affected.

Publication can only take place following agreement from the Quality Assurance Group at the Home Office and should be published on the CSP web site. The CSP consider the individual circumstances of each review when making a decision regarding publication.

APPENDIX B
Chapter 11 extract from:

LGA & ADASS

Adult safeguarding and domestic abuse – a guide to support practitioners and manager.

11. What councils and organisations can do to support good practice
This is primarily a practice guide. However, in order for good practice to develop and flourish, there are steps that organisations can take to provide the best environment to support good practice.

- ensure that staff understand that many circumstances are both safeguarding situations and domestic abuse, and that they have a range of social work and legal options with which to work with people

- ensure that organisational policies, protocols and procedures about safeguarding explain the links with domestic abuse and, similarly, policies, protocols and procedures about domestic abuse refer to safeguarding. One example is from Cheshire and Wirral Partnership, NHS Foundation Trust: www.cwp. nhs.uk/policies/1227-cp10-safeguarding- adults-policy-including-domestic-abuse

- ensure that there are effective and clear links and arrangements between safeguarding services and MARACs

- develop protocols, policies and ways of working to enable safe enquiry within assessments of domestic abuse and safeguarding

- provide or commission services based on a local needs assessment to meet the needs of people needing safeguarding

- develop protocols to support staff at risk of domestic abuse, for example from harassment by abusers at work

- ensure all relevant sectors of the workforce have access to training and awareness raising

- including integrated training that covers both safeguarding and domestic abuse rather than treating them as separate issues

- contribute effectively to, and learn from, Safeguarding Adults Reviews, Serious Case Reviews and Domestic Homicide Reviews identifying what

organisational changes can be made in order to reduce the risk of death and serious harm occurring in the future.

NICE have provided specific guidance for health and social care organisations to support best practice around domestic abuse. The “Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively” guidelines cover seventeen areas of activity and can be found at www.nice.org.uk/guidance/ph50

Supporting adults who have care and support needs who are experiencing domestic abuse involves all health and social care providers, housing and criminal justice agencies, as well as specialist domestic abuse and advocacy services. Partnership working is key to success. In most areas multi-agency working to address domestic abuse is incorporated in the work of three separate partnerships: The Community Safety Partnership, the local Safeguarding Children’s Board (LSCB) and the Safeguarding Adults Board (SAB). Local areas should agree how the inter-relationship between the three will work.

There is a need to ensure all three partnerships have consistent approaches and are able to carry out joint initiatives. There are some good examples of domestic abuse strategies that include safeguarding adults at risk, for example Bournemouth http://tinyurl.com/me7v448 and Leeds http://tinyurl.com/kahvd9m

Such strategies should:

- be based on a victim/person centred approach
- be developed with the involvement of local people who have experience of domestic abuse and the services available, including adults who have care and support needs
- have strong and effective links with specialist domestic abuse services and disabled/older peoples organisations
- develop joint funding and commissioning arrangements, based on a comprehensive mapping of local services and evidence of local need to identify gaps
- support the development of domestic abuse services that are accessible to people with care and support needs
- develop multi-agency initiatives aimed at prevention, early identification, advice and support for victims, and dealing with perpetrators, including

awareness raising and provision of information

- develop clear pathways by which adults at risk experiencing domestic abuse can access support to prevent abuse

- develop robust information sharing protocols in line with the Care Act

ensure organisations have access to training and information including up-to-date practice developments and legal advice.