Safer Lincolnshire Partnership

Domestic Homicide Review Report

Under s9 of the Domestic Violence, Crime and Victims Act 2004

Review into the death of Sam
in June 2018

Report Author: Christine Graham
May 2020

Preface

Safer Lincolnshire Partnership wishes at the outset to express their deepest sympathy to Sam's family and friends. This review has been undertaken in order that lessons can learned; we appreciate their support, and challenge throughout the process.

This review has been undertaken in an open and constructive manner with all the agencies, both voluntary and statutory, engaging positively. This has ensured that we have been able to consider the circumstances of this incident in a meaningful way and address with candour the issues that it has raised.

The review was commissioned by Safer Lincolnshire Partnership on receiving notification of the death of Sam in circumstances which appeared to meet the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004.

Tributes to Sam from his family

Sam was a much loved son, husband and daddy. He was a gentle, placid, happy go lucky man who would do anything for anyone. He was once described as a big soft teddy bear and that's just what he was. He loved his family especially his children, he loved to watch TV, go for a pint, playing pool and watching speedway.

Unfortunately, this changed when he met someone, he became withdrawn and not the person we all knew and loved.

Losing Sam in such a cruel and senseless way has had a devastating effect on all our lives, especially his parents as he was their last surviving son.

Sam will always be remembered and missed so much by all of us.

Sam was the first-born child and, as such, was special and cherished. You look to raise him correctly, sometimes strict with consequences that you later regret. The following siblings are allowed to get away (behaviour wise) with all and everything.

Then one dies, very young, seen nothing of the world or even made a mark. You are told by your elders not to grieve or be too hard on yourselves, time will heal, you are young, other children will come along. To a point they were correct, a further son is born, the first born and his brother become close, and he looks out for him. Teenage years come and both boys go racing, life goes forward. The first born marries has children, his brother becomes a godparent, a very close relationship is established (more than the parent is aware).

Then the unforeseen occurs, - the death of the younger one, the parent is left with one son, the first born. Too old this time to recreate, but a son, good, bad or indifferent, but a son to have a beer with to talk speedway, and hopefully look after the old man in his later years, to laugh, cry, and say you know where I am if you need anything.

Then the final call, your son is in ICU, critical. Nothing prepares you for the moment as you watch your first born take his last breath as the life support equipment ceases to uphold his life. Old as he is he is still the first-born.

How has this affected me - devastated, sad, lost. After all he was the first born.

This Overview Report has been compiled as follows:

Section 1 will begin with an **introduction to the circumstances** that led to the commission of this review and the process and timescales of the review.

Section 2 of this report will **set out the facts** in this case **including a chronology** to assist the reader in understanding how events unfolded that led to Sam's death.

Section 3 will **summarise the information** known to family, friends, employers, statutory and voluntary organisations and others who held relevant information.

Section 4 will analyse the issues pertinent to this case, specifically if there is a trail of domestic abuse in this relationship

Section 5 will review the approach taken to addressing domestic abuse in Lincolnshire

Section 6 will consolidate **the recommendations that arise** from the review

Section 7 will provide the **conclusion** debated by the Panel and

Appendix One provides the **terms of reference** against which the panel operated

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Section One – Introduction

1.1 Summary of circumstances leading to the review

1.1.1 On an evening in June, Sam and Beverley were having Sunday lunch with friends in a local pub. An argument ensued after Beverley accused Sam of flirting with one of the other guests. She was seen, by all in the pub, to lose her temper and go into the garden. Whilst there, she and Sam, who had joined her, continued to argue. She later alleged that he had assaulted her, this was not seen by any witnesses and there is no record of her making a call to the police as she later stated she had done. Sam asked her for the car keys so that he could go home, she refused She then went to the car, andgot in to drive away. Their car was parked in the pub car park adjacent to the garden. Sam was concerned that she was going to drive when she had been drinking so he stood with his hands on the bonnet of the car to prevent her driving away.

1.1.2 Despite Sam's efforts, Beverley drove away with Sam still holding onto the bonnet and came to halt a distance approximately 200 metres away at a junction. She then accelerated at speed and came to a sudden halt. Sam was thrown from the bonnet of the car onto the road where he was unconscious, bleeding from his head and ears.

1.1.3 She made efforts to leave the scene but was restrained by people who had come out of the pub to see what was happening. She was subsequently arrested by the police. Sam was taken by air ambulance to hospital where he died 3 days later as a result of the injuries he sustained.

1.1.4 Beverley was subsequently found guilty of Sam's manslaughter after a trial and sentenced to ten years imprisonment.

1.2 Reasons for conducting the review

1.2.1 This Domestic Homicide Review is carried out in accordance with the statutory requirement set out in Section 9 of the Domestic Violence, Crime and Victims Act 2004.

1.2.2 The review must, according to the Act, be a review 'of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

(a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death'.

1.2.3 The purpose of the DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims

- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result
- Apply these lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic violence and homicide and improve service responses to all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest possible opportunity
- Contribute to a better understanding of the nature of domestic violence and abuse
- Highlight good practice

1.3 Process and timescales for the review

1.3.1 Safer Lincolnshire Partnership were immediately notified of Sam's death which demonstrates a good understanding of the legal requirement to hold a review.

1.3.2 The Chair of the Strategic Board considered the case, in conjunction with other key agencies that had contact with the family and concluded that the case met the criteria for a Domestic Homicide Review. The Home Office were notified 12th July 2018. At this point the review was pended, awaiting the criminal trial. The family were told about the intention to hold a review on 21st January 2019.

1.3.3 The Independent Chair and Report Author were appointed in January 2019.

1.3.4 The first panel meeting was held on 18th March 2019 and was attended by:

- EDAN Lincs (Specialist domestic abuse agency)
- GP practice
- Legal adviser to Panel – Legal Services Lincolnshire
- Legal Services Lincolnshire
- Lincolnshire County Council – Adult Services
- Lincolnshire County Council – Children's Services
- Lincolnshire County Council – Education
- Lincolnshire Partnership Foundation Trust (LPFT)
- Lincolnshire Police
- National Probation Service
- South Holland District Council
- South West Lincolnshire Clinical Commissioning Group
- United Lincolnshire NHS Foundation Trust (ULHT)

1.3.5 Apologies were received from (Lincolnshire Community Health Services (LCHS) and East Midlands Ambulance Service.

1.3.6 At this first meeting, the panel discussed that both parties had engaged with services in Peterborough and Cambridgeshire. It was agreed that, before inviting them to join the panel, the level of involvement would be established. The agencies in Peterborough and

Cambridgeshire subsequently provided information to the review and were not needed on the panel. It was agreed that Adult Services no longer needed to be a panel member as they had not had significant involvement with the victim and perpetrator.

1.3.7 The panel met four times and the review was concluded in May 2020.

1.3.8 The final draft of the review was agreed electronically due to the Covid-19 lockdown.

1.3.9 The report could not be completed within the six months as it was necessary to wait for the criminal process to conclude. The review was further delayed by the Covid-19 lockdown.

1.4 Confidentiality

1.4.1 The content and findings of this review are held to be confidential, with information available only to those participating officers and professionals and, where necessary, their appropriate organisational management. It will remain confidential until such time as the review has been approved for publication by the Home Office Quality Assurance Panel.

1.4.2 In order to protect the identity of the victim and his family the victim will be known as Sam, as chosen by his family. The person responsible for his death will be referred to as Beverley.

1.5 Terms of Reference

1.5.1 The full terms of reference for this review are set out at Appendix A of this report. This review sought to concentrate upon the following specific aspects:

a. To examine whether there were any previous concerns, incidents, significant life events or indications which might have signalled the risk of violence to any of the subjects, or given rise to other concerns or instigated other interventions.

b. When, and in what way, were practitioners sensitive to the needs of the subjects, knowledgeable about potential indicators of domestic violence and abuse, and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

c. When, and in what way, were the subjects' wishes and feelings ascertained and considered? Were the subjects informed of options/choices to make informed decisions? Were they signposted to other agencies and how accessible were these services to the subjects?

d. What were the key points or opportunities for assessment and decision-making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

e. Was appropriate professional curiosity exercised by those professionals and agencies working with the individuals in the case, this includes whether professionals analysed any relevant historical information and acted upon it?

f. Were the actions of agencies in contact with all subjects appropriate, relevant and effective to the individual and collective family needs, and risks identified at the time and continually monitored and reviewed?

g. Did the agency have policies and procedures for Domestic Abuse and Safeguarding and were any assessments correctly used in the case of the subjects? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC or other multi-agency fora?

h. Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

i. Were any issues of disability, diversity, culture or identity relevant?

j. To consider whether there are training needs arising from this case.

k. To consider the management oversight and supervision provided to workers involved.

l. Did any restructuring during the period under review likely to have had an impact on the quality of the service delivered?

1.6 Dissemination

1.6.1 The following individuals/organisations will receive copies of this report:

- All of the Review Panel members
- All partner agencies who are members of the Domestic Abuse Core Priority Group (CPG)
- Organisations in Cambridgeshire who contributed to the review
- Sam's family

1.7 Methodology

1.7.1 Safer Lincolnshire Partnership was advised of the death on 26th June 2018. This was a timely notification and demonstrated a good understanding by the police of the need for a referral at the earliest opportunity.

1.7.2 The Chair of the Strategic Board considered the case, in conjunction with other key agencies that had contact with the family and concluded that the case met the criteria for a Domestic Homicide Review. The Home Office were notified on 12th July 2018. The family were told about the intention to hold a review on 21st January 2019.

1.7.3 The Independent Chair and Report Author were appointed in January 2019 and the Review Panel met for the first time on 18th March 2019. The Panel met four times, and the final meeting of the Panel was in January 2020.

1.7.4 At the meeting on 18th March 2019 apologies were received from LCHS and East Midlands Ambulance Service.

1.7.5 Information from records used in this Review was examined in the public interest and under Section 115 of the Crime and Disorder Act 1998 which allows relevant authorities to share information where necessary and relevant for the purposes of the Act, namely the prevention of crime. In addition, Section 29 of the Data Protection Act 1998 enables information to be shared if it is necessary for the prevention and detection of crime, or the apprehension and prosecution of offenders. The purpose of the Domestic Homicide Review is to prevent a similar crime.

1.7.6 Individual Management Reports, or summary reports, were provided by:

- Cambridgeshire Constabulary
- East Midlands Ambulance Service NHS Trust
- GP practice
- Lincolnshire Community Health Services NHS Trust
- Lincolnshire County Council – Children's Services
- Lincolnshire Police
- Peterborough City Hospital
- United Lincolnshire Hospitals NHS Trust

1.7.7 The Report Author had met members of Sam's family whilst attending the trial. Once the trial was complete, the Chair and Report Author met with a number of members of Sam's family, some of whom were supported by an AAFDA advocate. The Report Author also met with the landlord and landlady of the public house.

1.7.8 A copy of the report has been provided to Sam's family prior to submission to the Home Office to allow them to consider this in their own time. The Chair and Report Author would like to thank Sam's family and friends for their invaluable contribution to the review.

1.7.9 Contact was made with Beverley, but she has declined to engage with the review. Her family were also contacted by the Chair and the review respects their decision not to engage with the review.

1.8 Contributors to the review

1.8.1 Those contributing to the review do so under Section 2(4) of the statutory guidance for the conduct of DHRs and it is the duty of any person or body participating in the review to have regard for the guidance.

1.8.2 All Panel meetings include specific reference to the statutory guidance as the overriding source of reference for the review. Any individual interviewed by the Chair or Report Author,

or other body with whom they sought to consult, were made aware of the aims of the Domestic Homicide Review and referenced the statutory guidance.

1.8.3 However, it should be noted that whilst a person or body can be directed to participate, the Chair and the DHR Review Panel do not have the power or legal sanction to compel their co-operation either by attendance at the panel or meeting for an interview.

1.9 Review Panel

1.9.1 The members of the Review Panel were:

Gary Goose MBE	Independent Chair	
Christine Graham	Overview Report Author	
Jane Keenlyside	Senior Project Worker	End Domestic Abuse Now Lincs[1]
	Business Manager	GP surgery[2]
Sarah Reed	Senior Probation Officer (Offender Management)	HMP & Probation Services
Ali Balderstone	Deputy Named Nurse for Safeguarding	Lincolnshire Community Health Service
Jade Sullivan	Domestic Abuse Lead	Lincolnshire County Council
Natalie Watkinson	Domestic Abuse Project Officer	Lincolnshire County Council
Teresa Tennant	DHR Administration	Lincolnshire County Council
Yvonne Shearwood	Head of Service Regulated (South)	Lincolnshire County Council – Children's Services
Claire Saggiorato	Children's Safeguarding Lead Nurse	Lincolnshire County Council Children's Health
Detective Superintendent Jon McAdam	Head of Protecting Vulnerable Persons Unit	Lincolnshire Police
Dee Bedford	Community Safety and Enforcement Manager	South Holland District Council
Claire Tozer	Safeguarding Adults and Children Lead	South West Lincolnshire Clinical Commissioning Group
Elaine Todd	Named Nurse for Safeguarding Children and Young People	United Lincolnshire Hospitals NHS Trust

1.9.2 **Advisers to the Panel**

Toni Geraghty	Assistant Chief Legal Officer	Legal Services Lincolnshire

1.9.3 All panel members and IMR authors were independent of any direct involvement with the victim and perpetrator and were of appropriate managerial seniority.

[1] This agency supports both female and male victims/survivors of domestic abuse
[2] Name not included to protect the anonymity of the victim

1.10 Domestic Homicide Review Chair and Overview Report Author

1.10.1 Gary Goose served with Cambridgeshire Constabulary rising to the rank of Detective Chief Inspector, his policing career concluded in 2011. During this time, as well as leading high-profile investigations, Gary served on the national Family Liaison Executive and led the police response to the families of the Soham murder victims. From 2011 Gary was employed by Peterborough City Council as Head of Community Safety and latterly as Assistant Director for Community Services. The city's domestic abuse support services were amongst the area of Gary's responsibility. Gary concluded his employment with the local authority in October 2016. He was also employed for six months by Cambridgeshire's Police and Crime Commissioner developing a performance framework.

1.10.2 Christine Graham worked for the Safer Peterborough Partnership for 13 years managing all aspects of community safety, including domestic abuse services. During this time, Christine's specific area of expertise was partnership working – facilitating the partnership work within Peterborough. Since setting up her own company, Christine has worked with a number of organisations and partnerships to review their practices and policies in relation to community safety and anti-social behaviour. Christine also delivers Partnership Health checks which provide an independent view of partnership arrangements. Christine spent seven years as a Lay Advisor to Cambridgeshire and Peterborough MAPPA which involved her in observing and auditing Level 2 and 3 meetings as well as engagement in Serious Case Reviews. She now chairs the Safer off the Streets Partnership in Peterborough.

1.10.3 Gary and Christine have completed, or are currently engaged upon, a significant number of domestic homicide reviews. Previous domestic homicide reviews have included a variety of different scenarios including male victims, suicide, murder/suicide, familial domestic homicide, a number which involve mental ill health on the part of the offender and/or victim and reviews involving foreign nationals. In several reviews they have developed good working relationships with parallel investigations/inquiries such as those undertaken by the IOPC, NHS England and Adult Care Reviews.

1.10.4 Neither Gary Goose nor Christine Graham are associated with any of the agencies involved in the review nor have, at any point in the past, been associated with any of the agencies.[3]

1.10.5 Both Christine and Gary have:

- Completed the Home Office online training on Domestic Homicide Reviews, including the additional modules on chairing reviews and producing overview reports
- Completed DHR Chair Training (Two days) provided by AAFDA (Advocacy After Fatal Domestic Abuse)
- Attended the AAFDA Annual Conference (March 2017)
- Attended training on the statutory guidance update in 2016
- Undertaken Home Office approved training in April/May 2017
- Attended the AAFDA Annual Conference (March 2018)
- Attended Conference on Coercion and Control (Bristol June 2018)
- Attended AAFDA Learning Event – Bradford September 2018

[3] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (para 36), Home Office, Dec 2016

- Attended AAFDA Annual Conference (March 2019)
- Attended AAFDA Information and Networking Event (November 2019) - Christine

1.11 Involvement of family and others to assist the Review

1.11.1 The Chair and Report Author made contact with Sam's parents and wife as well as his children, some of whom have contributed to the review. When contact was made, the family were already being supported by AAFDA[4] and Victim Support Homicide Service. A copy of the report has been shared with Sam's family allowing them to read this in their own time, supported by Victim Support Homicide Service. Sam's family were also offered the opportunity, both at the beginning and the end of the review, to meet the Review Panel but did not feel the need to do so.

1.11.2 Sam's family provided the Chair and Report Author with contact details for friends and colleagues of Sam. A number of whom were contacted and some have contributed to the review.

1.11.3 The review will also draw on evidence of those present on the day of the incident that was presented in court as well as those witnesses spoken to in person by the independent author of this Review.

1.11.4 Beverley was contacted, as were her ex-husband and daughters. Beverley declined to engage with review and no response was received from her family.

1.11.5 The review is grateful to those who have spoken to the Chair and Report Author and understands and respects the wishes of those who have chosen not to.

1.12 Parallel Reviews

1.12.1 Following the conclusion of the trial, the Coroner confirmed with the family that they were content for the inquest not to be reopened and so the Coroner closed the proceedings.

1.12.1 There were no other parallel reviews.

1.13 Equality and Diversity

1.13.1 Throughout this review process the Panel has considered the issues of equality in particular the nine protected characteristics under the Equality Act 2010. These are:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership (in employment only)
- Pregnancy and maternity
- Race

[4] Advocacy After Fatal Domestic Abuse

- Religion or belief
- Sex
- Sexual orientation

1.13.2 This is a case of violence being perpetrated on a male by a female which resulted in his death. The Review is mindful that, although domestic abuse is predominately perpetrated by men on women, this is not always the case and there is evidence in this case, provided by friends and family, that she had been abusive towards him during the relationship. She also disclosed, during the trial, that he had been abusive towards her. This dynamic will be explored in more detail within the report.

1.13.3 The review is conscious that all of Sam's family have referred to his medical history having impacted significantly on him and leaving him vulnerable. He had a medical history of ulcerative colitis resulting in ileostomy in 2006. This left him reliant on a stoma bag and regular prescriptions.

1.13.4 Throughout the report the impact of equality and diversity issues are discussed as they arise at the appropriate section .

Section Two – The Facts

2.1 Introduction

2.1.1 Sam was a white British man who was 46 years old at the time of his death. He had three children. He had undergone major health issues in the years leading up to his death and these will be discussed in more detail throughout the report as they are relevant to his vulnerability. He had separated from his wife to be with Beverley.

2.1.2 Beverley was a white British woman who was 43 years old at the time of the incident. She had been married for some time and had two children. She had separated from her husband to be with Sam.

2.1.3 Sam and his wife, and Beverley and her husband, had been two couples who were friends. It is out of this friendship that the relationship between Sam and Beverley arose.

2.1.4 Following a trial in March 2019, Beverley was found guilty of manslaughter and was sentenced to 10 years imprisonment. She was disqualified from driving for 18 months and this will come into force upon her release.

2.2 Chronology

2.2.1 The chronology covers the period between January 2013 the relationship between Sam and Beverley began in March 2013) and June 2018.

2.2.2 **2013**

2.2.3 During 2013 Beverley was seen by her GP on 27 occasions and there were 25 other communications with the GP. Many of the appointments related to gastrointestinal problems and back problems. Below are recorded those appointments in which other relevant matters were discussed.

2.2.4 In March she was seen by her GP with abdominal pain. Medication for the issue was prescribed. During the consultation, she was tearful, said she was not sleeping and disclosed that she had left her husband and was experiencing stress at home. During this extended appointment she was prescribed medication and her dose of anti-depressant was increased for the short term.

2.2.5 Later in March an ambulance was called via 999 to attend Beverley with chest pain. She was taken to hospital for further assessment. Later this same day the police were called by Beverley. She stated that her ex-husband was making death threats towards Sam. This was closed as a non-domestic incident as threats were made between unrelated persons and therefore no DASH[5] risk assessment was completed.

[5] Domestic Abuse and Stalking risk assessment

2.2.6 The following day she saw her GP again and her abdominal pains were reviewed. The GP tried to discuss her home situation, she said that she was not sleeping and then got up and left without discussing her home situation.

2.2.7 In April Beverley contacted the police with regard to a matter relating to her childhood that could have impacted on future behaviour and experiences. At the end of April, she told her GP that she was not sleeping as a result of this and was advised to take over the counter medication.

2.2.8 In May, East Midlands Ambulance Service (EMAS) received a 999 call to attend Beverley after she had a fall. She said she had slipped and fallen from the top of the stairs to the bottom. She was taken to hospital for further assessment and treatment. The GP received a discharge letter that advised that there was no action required.

2.2.9 Also in May Sam contacted South Holland District Council with an enquiry about benefits.

2.2.10 On 1st June Beverley contacted the police to say that whilst she was out of the house her landlord had been seen to enter the rear of the house through an unlocked door without authority. She was visited and spoken to the following day. It was noted that she was in arrears with her rent and was given words of advice.

2.2.11 Later in June, Sam saw his GP when it was noted that he was depressed. He was given a follow up appointment for a few days later. At this later appointment the GP completed a biosocial assessment, explored his social support which was recorded as being his partner. He was prescribed an anti-depressant and was offered a follow up appointment.

2.2.12 On 24th June Sam attended the Minor Injuries Unit with a burn to his arm which he reported had been caused by an iron. The burn was recorded as being 21 centimetres in length, extending from over the elbow to the forearm. It was noted that he attended with his wife (but no name was recorded).

2.2.13 In July, Beverley contacted the police because her shed had been broken into overnight. She said that it had occurred because of a court case she was involved with[6]. The police attended and it was established that nothing had been taken and it was reported as criminal damage with no offenders highlighted.

2.2.14 Later in July, Sam contacted South Holland District Council to make an enquiry about benefits.

2.2.15 Sam attended the follow up appointment with his GP in late July when his alcohol intake was explored. He said that he had good days and bad days and that his wife said that he was tearful. Sam was offered a gym referral which he declined as he said he would be moving out of the area in the next few weeks.

2.2.16 In September, Sam was seen by his GP following a hospital admission for epigastric pain. He was prescribed medication and had an appointment for counselling.

[6] This incident did not involve either her husband or the victim

2.2.17 In October, Sam registered with the GP where he was registered until his death. He was seen in October when smoking cessation and alcohol use were discussed.

2.2.18 Also October, Sam contacted South Holland District Council to enquire about benefits on two occasions, he made a further contact in early November.

2.2.19 On 12th October, Sam attended the Minor Injuries Unit reporting that he had tripped on the stairs and twisted his right foot. Support dressing was put in place and he was discharged.

2.2.20 Four days later Sam saw his GP following a fall where he had lost his footing on the stairs a few days earlier and had attended the Minor Injuries Unit. He reported pain in his shoulder and a foot fracture. A sick note was issued, and he was advised not to drive.

2.2.21 In November, Sam contacted the police via 999. He was concerned as he and his girlfriend had a verbal argument and she had driven off from their address having consumed several alcoholic drinks. He was concerned for her safety as she was very emotional. Whilst he was talking to the police on the telephone, she returned to the address safe and well. The police tried to contact both of them and finally were able to speak to them a few days later. A DASH risk assessment was completed with Sam and a grading of STANDARD was recorded.

2.2.22 On 24th November, Sam called 999 to ask for an ambulance. He said that Beverley was sat in the house with a knife in her hand. As the crew were advised that there may be risk of violence the police were requested to attend to support the crew. She was noted by the ambulance crew as being very distressed and the crew felt that she did not have capacity at the time of the incident. She was assessed and taken to Peterborough City Hospital for further assessment and treatment. The letter sent to her GP stated that she had refused treatment and had self-discharged.When the ambulance had left with Beverley, the Crisis Team of LPFT was contacted by the police. They spent 25 minutes talking to Sam on the phone and they confirmed to the police that they did not have any concerns for Sam, and he was given the number for the Crisis Team and was encouraged to use it if required. Children's Social Care were notified. A DASH risk assessment was completed with Sam and was graded as STANDARD.

2.2.23 In December Beverley saw her GP and they discussed her admission to hospital. She disclosed that the overdose was following an argument with her boyfriend but said that things were now stable. She did, however, say that she was low in mood and not sleeping. The link between pain and low mood was discussed with her and she was advised to self-refer for support via Single Point of Access. She said that she was working but had to leave her job early due to the pain. She was referred to a pain management clinic.

2.2.24 **2014**

2.2.25 During 2014 Beverley was seen by her GP on 28 occasions, spoken to on the telephone on one occasion and 21 communications were received by the GP. Many of the appointments related to gastrointestinal problems and back problems. During 2014 she was subject to an Admission Avoidance Care Plan[7]. Below are recorded those appointments in which other

[7] This is a Clinical Commissioning Group initiative which uses a scoring system to identify and review patients most likely to attend hospital due to illness, social or lifestyle factors in the near future – and education or take any appropriate measures to reduce the likelihood of this

relevant matters were discussed. Her GP records show that at the beginning of 2014 she was not working due to her back pain and was being issued with sick notes in order that she could claim employment support allowance. She was advised by her GP that sick notes were not a long-term prospect and was referred to a pain management clinic[8].

2.2.26 In January 2014 Beverley called an ambulance by 999 as she had fallen over the cat and had hurt her back. When they arrived, she said she had tripped and hit her head on the radiator. She was able to get herself onto the sofa but not able to move. She was taken to hospital.

2.2.27 Sam had contact with South Holland District Council during January, February, March and June to discuss benefits.

2.2.28 In March, the ambulance service received a 999 call as Sam had taken an overdose. He said he was not coping well at home and had taken 40 x 500mg paracetamol with three pints of beer/cider. He was alert throughout the attendance and the crew undertook a clinical assessment before taking him to hospital in Peterborough. When he was assessed in A&E, Sam stated that he had not intended to kill himself. He was treated for overdose and was referred to the CRISIS team for review and kept in hospital overnight.

2.2.29 His GP received notification that Sam had attended A&E in Peterborough and he was seen by his GP the following day.

2.2.30 In May, Beverley attended her GP with her partner[9]. She reported that her leg had given way and she had fallen on the stairs and had landed on her hip which was now painful

2.2.31 On 8th May Sam had a medication review with his GP and reported that he was feeling much better and did not want to complete the online self-help workbook or self-refer to SPA.

2.2.32 On 19th May, Beverley contacted the police from a local public house to state that she had been at home with Sam when he had assaulted her, and she had left the house to contact the police. She said that he had been violent in the past, the last time being six months previously when he had also self-harmed. She said that she was bleeding from her ear and couldn't hear from it. She said she was 'seeing stars'. The police requested the ambulance service to attend. She was taken to hospital. When the police arrived, the ambulance service were already attending her. She told the police that Sam often became aggressive under the influence of alcohol and that he had actually punched her twenty times. Sam was arrested for Actual Bodily Harm and was taken into custody where he was later interviewed under caution when he said that he had become involved in an altercation with Beverley. He was cautioned for Common Assault as she said that she wanted him back and declined to support a prosecution.

2.2.33 A DASH risk assessment was completed with Beverley which was graded as STANDARD. During the assessment she said that the violence was getting worse and she was afraid of Sam and that the violence occurred when he had been drinking.

[8] There had been previous referrals and she was encouraged to engage with the service
[9] The GP records only that Beverley attended with her partner, although it is presumed that this was Sam

2.2.34 There is a statement in Beverley's medical records on 13th May whereby the clinic nurse, at Peterborough hospital, has recorded that Beverley appears to have falsified a prescription given to her by a surgical consultant. It was recorded that she had taken a prescription to a community pharmacy and it is alleged that 'Oramorph' had been handwritten onto the bottom of the prescription.

2.2.35 Towards the end of May, Beverley attended her GP with severe ear pain following the assault by her partner on 19th May (as set out in paragraph 2.2.41 onwards). She said she had been punched repeatedly in the head causing a perforated ear drum. She was given an extended appointment time to allow her to discuss the incident and offered support and signposting to agencies who provide domestic abuse support. She said that she was being supported by Victim Support and that her partner was going to Alcoholics Anonymous. She told the GP that she had dropped the charges as he had been drunk, and it had never happened before.

2.2.36 Sam saw his GP on 23rd June with his partner with fatigue.

2.2.37 On 6th July, Sam called EMAS for an ambulance for Beverley who had fainted. He said he had heard a noise in the kitchen and had gone in to find her unconscious on the floor. She was taken by ambulance to hospital.

2.2.38 Later in July, Beverley saw her GP regarding the ongoing dizziness and collapse. She reported there had been an incident when she had felt dizzy on the stairs and when she had collapsed in the kitchen and hit her head and neck.

2.2.39 In August, Beverley was seen for a review appointment in the Pain Management Clinic.

2.2.40 At a GP appointment in mid-August the GP spoke to her about the assault by her partner three months previously and ongoing depression. She said that she was finding things difficult to manage and that her family had said that if she went back to her partner[10], they would disown her. She said that she had gone back, and her family had not had contact with her, and she felt isolated, although she did have occasional contact with her daughters. She was given details about how to access counselling support and the GP printed out a leaflet on depression for her and encouraged her to engage in daily activity and exercise.

2.2.41 Beverley attended A&E on 31st August following an unwitnessed collapse in the bathroom. She was found by Sam on the floor. She then had a second episode an hour later whilst lying on the sofa.

2.2.42 In October, Beverley was seen by her GP and declared fit for work.

2.2.43 In November Sam had a medication review with his GP and he told the GP that he had attended the sleep clinic and had been diagnosed with mild sleep apnoea[11].

2.2.44 In December, Beverley contacted the police to report an argument between her and Sam. She said that the argument was about his 'other partner'[12]. She said that she had been

[10] The GP was aware that she was referring to Sam
[11] A condition where the walls of the throat relax and narrow during sleeping and interrupt normal breathing
[12] This does not refer to his wife

assaulted by him previously and was concerned that it might be repeated. There were no allegations of offences made and no DASH form was submitted.

2.2.45 Also during December, Sam contacted South Holland District Council with a benefits enquiry and contacted Children's Services requesting help with food and electricity. He was referred to the food bank.

2.2.46 **2015**

2.2.47 During 2015 Beverley was seen by her GP on 17 occasions, spoken to on the telephone on 3 occasions and 5 communications were received by the GP. Many of the appointments related to gastrointestinal problems and back problems. During 2015 she continued to be subject to an Admission Avoidance Care Plan[13]. Below are recorded those appointments in which other relevant matters were discussed.

2.2.48 Sam had a number of appointments with his GP about non-related medical issues, he also continued contact with South Holland District Council for benefit information.

2.2.49 In March, Beverley contacted Children's Services requesting assistance with food and electricity. She was referred to the food bank. She then notified South Holland District Council, the next day, of a change of address.

2.2.50 In July, Beverley saw her GP with a history of headaches. She also reported she did not sleep well at night due to stress which had been present for many years. She said that she was currently the sole carer for her daughters[14] who were now living with her in her one-bedroom accommodation, and she was sleeping in the lounge. The GP recorded that she was low in mood but had no suicidal thoughts and, whilst she was tearful, she was appropriately dressed. She was given medication and advised to self-refer to IAPT[15]. She said that she would contact Citizens' Advice Bureau.

2.2.51 In August, Beverley twice reported to her GP that her depression was no better and her anxiety remained. She said that she had sent off the IAPT form but had not yet heard anything.

2.2.52 In October, Beverley attended the GP for a review of her Admission Avoidance Care Plan and was given a printout of the discussion.

2.2.53 In November, Beverley reported to the police a crime of 'malicious communication'. She told the police that she was in a relationship with Sam, but he began a short-lived relationship with a third party before moving back in with her. She reported the nuisance messages were being sent between herself and the third party[16].

[13] This is a Clinical Commissioning Group initiative which uses a scoring system to identify and review patients most likely to attend hospital due to illness, social or lifestyle factors in the near future – and education or take any appropriate measures to reduce the likelihood of this

[14] They had been living with their father

[15] Improving access to psychological therapies

[16] This is not his wife

2.2.54 **2016**

2.2.55 During 2016 Beverley was seen by her GP on 5 occasions, spoken to on the telephone on 2 occasions and 17 communications were received by the GP. Many of the appointments related to gastrointestinal problems and back problems. Below are recorded those appointments in which other relevant matters were discussed.

2.2.56 In January, Sam attended the Minor Injuries Unit complaining of right sided pain but reporting that no injury had taken place. A diagnosis of muscular strain was recorded.

2.2.57 Throughout 2016, Sam's involvement with his GP continued in relation to general health conditions.

2.2.58 In June, Sam was the victim of an ABH[17] outside of his address. The assault followed an argument with a neighbour and was reported by Beverley. No further action was taken by the police as there was insufficient evidence.

2.2.59 The next day, Sam attended A&E with facial injuries sustained in the assault. The documentation records that he was assaulted (punched in the face, kicked and bitten on the ear) the previous evening.

2.2.60 In July, Beverley was admitted to A&E following an intentional overdose of paracetamol. Her mother-in-law alerted the emergency services to the incident. An assessment by the Mental Health Liaison Team (MHLT) was undertaken. During this it was established that the overdose attempt was in response to finding messages on Sam's phone from a woman with whom he had previously had a relationship. She was discharged with the offer of ongoing support which she declined. In her face-to-face meeting with the MHLT, Beverley said that the overdose had been a reaction to ongoing life stressors. She said that she was having difficulties where she was living because her neighbours had said that her partner had been tampering with the electrics and had cut the power supply to other properties. She felt that they would have to move. She was offered further support which she declined.

2.2.61 In August, South Holland District Council were advised that they had moved to a new address as they had been asked to leave.

2.2.62 **2017**

2.2.63 During 2017 Beverley was seen by her GP on 11 occasions and 12 communications were received by the GP. Many of the appointments related to gastrointestinal problems and back problems. Below are recorded those appointments in which other relevant matters were discussed. Sam also continued engagement with his GP over general, non-relevant, health matters.

2.2.64 In January, Beverley was seen in A&E with an ear problem with her eardrum. She said that her eardrum pops every 2-3 weeks and was perforated in childhood. A referral to a specialist was made.

[17] Actual Bodily Harm

2.2.65 In May, the couple moved to live in a static caravan.

2.2.66 In June, Beverley contacted the police via 999 to say that her father was threatening to go to her address and shoot her. It was alleged that an argument had occurred between family members on the telephone about the erection of a fence. He is alleged to have said, 'don't shout at me or I will come there with my shotgun and shoot you in the knees'. There were no offences disclosed. The officer completed a DASH risk assessment which was graded as MEDIUM. A safe and well check was undertaken to her father and the weapons were seized but the officers reported no signs of dementia. The weapons were returned later.

2.2.67 During July the owner of the static caravan in which the couple were living was advised by South Holland District Council that living on the site was in breach of his planning permission. The owner notified the council of his intention to appeal.

2.2.68 In September, Beverley visited her GP and requested morphine as the pain in her back was unbearable. She said that she had been told that she needed a fusion and was waiting for a MRI on her back on 12th October, followed by an appointment with the consultant on 31st October. At this appointment she asked for a letter for the council to support her being able to continue to live in the static caravan as it was on one level and she could not manage stairs. This was provided free of charge. On 28th September the GP received a letter from the hospital advising that surgical intervention (spinal fusion) was not appropriate and requested that her GP refer her to the pain management clinic.

2.2.69 In November, South Holland District Council wrote to the owner of the caravan park advising him that the couple should be asked to find alternative accommodation and that they should be given reasonable notice of 3-4 months.

2.2.70 **2018**

2.2.71 From January 2018 to the date of the incident, Beverley was seen by her GP on 3 occasions, spoken to on the telephone once and 12 communications were received by the GP. Many of the appointments related to gastrointestinal problems and back problems. Below are recorded those appointments in which other relevant matters were discussed.

2.2.72 On 4th January, Beverley saw her GP and asked for a second opinion about her back as she was not happy with the advice given. There was a comprehensive discussion with her about her use of morphine and how she might reduce her dependency on this.

2.2.73 On 29th January, Beverley made a homeless application to South Holland District Council. She was identified as being eligible for assistance and in priority need. She was provided with interim accommodation. She contacted the council, the same day, about benefits. On 2nd February the housing department noted that they had spoken to her about income and benefits, and she had advised that she was now redundant.

2.2.74 On 26th February, both Sam and Beverley spoke to South Holland District Council about their benefits. On 2nd March Beverley made contact about housing repairs.

2.2.75 On 22nd March, Beverley completed a housing registration form on which she stated that she was the main applicant and Sam was the joint applicant.

2.2.76 On 27th March, Beverley attended the Minor Injuries Unit with left thumb pain. She said she had bent it back on the side of the bed four days earlier.

2.2.77 On 27th March, Beverley made an appointment with South Holland District Council to discuss her benefits. She then cancelled this appointment the next day. On 29th March the couple wrote to South Holland District Council to confirm that they intended to make a payment on 9th April in respect of their rent arrears. There is a record that the council tried to speak to them over a number of days. Beverley then spoke to the council on 5th April.

2.2.78 On 11th April, a home visit was undertaken by the council to check the condition of the property. Sam advised the officer that he was not able to work at the present time due to the condition of the fields. Beverley rang the council the same day to discuss benefits. The Housing Officer tried to call Beverley on 17th April to discuss their housing application and benefits, but the phone went to voicemail.

2.2.79 In May, Sam's GP received notification of his attendance at A&E with head laceration and back pain after driving his tractor into a drainage ditch.

2.2.80 On 4th June, the ambulance service was requested by the police to attend a serious road traffic collision. Beverley had back pain and her neck was being held in place by Sam. She was the front seat passenger in the car that was hit in the back by another car.

2.2.81 Beverley saw her GP on 11th June and said she had been struggling to manage her pain recently which was getting worse since the recent car accident. She said that her mood had been worse, and she was prescribed medication.

2.2.82 **The day of the incident**

2.2.83 At 8.04 pm on the Sunday evening the police received a call from Beverley stating that she had hit her partner, Sam whilst driving her car, attempting to flee domestic violence. She said that they had spent the afternoon drinking in the pub. She alleged that Sam had been flirting with another woman at the pub which caused an argument. She also alleged that Sam had assaulted her and therefore she had tried to leave the area in the car, but he would not let her do this. She then drove off with Sam clinging to the bonnet of the car. After about 200 metres the car braked suddenly and Sam was thrown from the bonnet of the car, leaving him unconscious in a pool of blood on the road.

2.2.84 Whilst witnesses described the incident, no-one described Sam assaulting Beverley and they described her 'wheel spinning' out the car park with Sam trying to stop her because she had been drinking. The witnesses described Sam as pleading with her as she drove away with him clinging to the car bonnet.

2.2.85 The witnesses described Sam as being unconscious on the road with blood coming from his ear and eye area and stated that she was about to drive off as she thought she would be arrested for drink driving and that she was in a distressed state.

2.2.86 Beverley was arrested for failing to provide a breath sample and taken to the local police station where she was later arrested for attempted murder. When interviewed she

continued to state that she feared for her safety and that was the reason that she drove away with him on the bonnet. Sam died 3 days later as a result of the injuries sustained.

2.2.87 A post-mortem examination found that Sam had died due to a 'head injury consistent with falling or being precipitated from a car bonnet, landing on the rear of his head causing significant impact injury.

2.2.88 Beverley was found guilty of Sam's manslaughter and sentenced to ten years' imprisonment.

Section 3 –
3.1 Information shared by Sam's family and friends

3.1.1 Sam's mother was spoken to by this Review. She said that, since Sam was born, he had always been the man that even the court described as a 'cuddly teddy bear'. He had 'bumbled through life', getting into scrapes although they were not serious or illegal. He was a happy go lucky person. She said that she had moved to Spain towards the end of 2002 and this is the time when she first noticed him change. She described him as a loyal son who went out of his way to take care of her. She cited the example of him helping her to relocate back to this country after the death of her husband. He was described as having lots of girlfriends when he was growing up and being a young man who did not bear a grudge. He was described as a man who did not like confrontation. It was said that he would have his say and then walk away.

3.1.2 As has already been noted in this report, Sam had suffered from colitis leading to an ileostomy which led to him using a stoma bag and having a large scar down the middle of his body. A number of people referred to the time of his operation being the time when Sam changed. His family said that his life 'went downhill', and he lost all of his confidence. One person described him as having 'lost his sparkle and bubble'. He expressed to family that he did not think that women would find him attractive with his condition. His friends in the pub knew that he was embarrassed by his stoma bag and knew that it got him down.

3.1.3 Despite his many physical problems, Sam was described as a man who had a good work ethic who would become depressed if he could not work. The review has been told that whilst he was having ongoing hospital treatment which resulted in his stoma bag being fitted, his employer had sacked him due to his absences and this had 'got him down'.

3.1.4 Sam's father described him as a man beset by self-esteem since his illness but also described him as a man who would 'flirt' with anyone. His wife also said that he was a flirt, but that he was a harmless flirt who would not do anything about it. It is important to say that this is the description used by those who loved him. It is a descriptor of his overt friendliness and is not to be taken as a negative character trait. When one looks at the other information about his lack of confidence following his illness, then it may well be that this descriptor is indicative of a friendliness that masks his inner lack of confidence.

3.1.5 As a couple, Sam and Beverley had become regulars at the pub where the incident occurred. This pub is one that has lots of regulars who are like family. People tend to go to the pub for Sunday lunch and then spend the rest of the day together there. The couple had been attending the pub for about 18 months. Sam was described as a 'puppy who wanted to be liked'. He was quite loud but there was no nastiness in him. He was described as jokey in the pub where there would be jokes and innuendos but that he was never inappropriate and never overstepped the line. He was described as just as happy speaking to men as women.

3.1.6 The review believes that the information provided by family and friends helps us to understand Sam a little more. It provides an insight into his feelings, in particular the long-term effects of the stoma. However, it is acknowledged that he had a different relationship with those spoken to and therefore their perception and recollections of him may vary.

Information from family and friends about the couple's relationship is contained within the section entitled 'evidence of domestic abuse' at Section 4.1.

3.2 Detailed analysis of agency involvement

The chronology set out in Section 2 details the information known to agencies involved. This section summarises the totality of the information known to agencies and others involved during the years leading up to the incident. The detailed chronology will not be repeated here; rather this section will provide an analysis of agency involvement. A number of agencies completed a full Individual Management Review (IMR) whilst others were asked to submit a summary of their involvement.

3.2.1 Lincolnshire Police

3.2.1.1 Prior to the incident which resulted in Sam's death, there are five separate police incidents involving Sam and Beverley during the period of the review although the police were contacted by either party over non-domestic violence matters such as reporting burglaries or road traffic collisions. All of these five incidents were reported as domestic incidents where violence was either used or threatened, although upon investigation one of these was not considered to be a domestic incident. Four of the incidents had a DASH risk assessment completed. All of the incidents occurred at the address where Sam and Beverley were living.

3.2.1.2 **18th March 2013**

3.2.1.3 This incident occurred three weeks after the couple had started living together. At 8pm Beverley called the police stating that her ex-partner was making death threats towards Sam. She told the police that her daughters were living with him and she had concerns for them as he had access to air rifles. She said that the threats had been made on the telephone and in text messages, all of which were instigated by her ex-partner.

3.2.1.4 The police attended and found that the circumstances were not as had been initially reported. There had been a conversation between Beverley and her ex-partner in relation to their daughters and she had become upset. Sam had therefore decided to text him asking him to leave her alone. This quickly escalated into both parties becoming abusive to each other. There was some doubt about whether a death threat had been made as Sam had initially said he could not remember hearing it, although he later said he had heard the threat. The officer attending viewed the text messages and stated that Beverley's text messages to her ex-partner were 'quite nasty'.

3.2.1.5 Sam and Beverley were asked how they would like to proceed, and they asked that words of advice be given to Beverley's ex-partner, which the officer subsequently did. The incident was closed and described as a non-domestic as threats made were between non-related persons and therefore a DASH risk assessment was not completed.

3.2.1.6 **10th November 2013**

3.2.1.7 Sam contacted the police on 999 at 7.16pm stating that he and his girlfriend, Beverley, had a verbal argument and that she had driven off from their address having consumed several

alcoholic drinks. He said that he was concerned for her safety due to her state of mind as she was very emotional. Whilst he was speaking to the police, Beverley returned to the address safe and well, four minutes after the call had been instigated.

3.2.1.8 There were no officers free to attend during the evening but, due to the domestic nature of the call, it was decided that an officer should attend and speak to both parties. Several attempts were made to contact them over the next day or so, but it was not until 12th November that the police actually spoke to both parties.

3.2.1.9 The officer who attended noted that although the incident had been recorded as a possible drink driver it was actually a domestic argument between two parties and therefore a DASH risk assessment was completed where Sam was asked the 27 questions in relation to domestic abuse and a grading of STANDARD was the outcome. The officer noted that neither party wished to engage with the officers and said that Beverley was undergoing some stress due to an upcoming court case within which she was a witness.

3.2.1.10 **24th November 2013**

3.2.1.11 At 6.38pm the police received a call from the ambulance service stating that they had received a call for a male, Sam, who was armed with a knife cutting himself and trying to commit suicide. A police officer attended and established that the wounds were superficial and that there was no knife present. It was established that Sam had picked up a knife earlier and intimated that he was going to kill himself. He ran the knife over his wrist which led to Beverley calling an ambulance. Both parties had been drinking alcohol throughout the day and had an argument about Sam's new job and the fact that Beverley was texting his boss. Sam felt that she was becoming over-familiar with him which made him jealous. This had led to him picking up the knife and intimating that he was going to kill himself.

3.2.1.12 Officers found Beverley's ex-partner at the address as she had contacted him. Beverley indicated that she had taken some paracetamol, so she was taken to hospital by ambulance, accompanied by her ex-partner. The ambulance decided that Sam did not need any hospital treatment.

3.2.1.13 After Beverley had left for hospital and Sam was still at the address, the crisis team were contacted in police presence and they confirmed to the police that they did not have any concerns but arranged for a further intervention on 25th November. No offences were disclosed to the police, but the officer requested that checks were made on Beverley's children. Children's Social Care were also notified.

3.2.1.14 A DASH risk assessment was completed with Sam and graded as STANDARD.

3.2.1.15 **19th May 2014**

3.2.1.16 At 11.37pm Beverley contacted the police from a local public house to state that she had been at home with Sam when he had assaulted her, and she had left the house to contact police. She said he had been violent in the past. The last time had been six months ago when he had also self-harmed. She stated that she was bleeding from her ear and couldn't hear from it and was 'seeing stars' as she described it.

3.2.1.17 Police attended and found the ambulance service were treating her injuries. Sam was arrested for Actual Bodily Harm and taken into custody where he was later interviewed under caution.

3.2.1.18 Beverley was taken to hospital for examination as she had a bruise around her right eye and swelling to her right cheek. She told the police that Sam often became aggressive under the influence of alcohol and that he had actually punched her twenty times.

3.2.1.19 Sam was interviewed under caution and stated that he had become involved in an altercation with Beverley. He had slapped her twice around the head but denied hitting her on as many occasions as she had stated. He did accept that he was responsible for her injuries. Sam had no previous convictions for violence and had not been in trouble with the police for many years therefore he was cautioned for Common Assault as she would not support a prosecution saying that she wanted him back.

3.2.1.20 The officer attending completed a DASH risk assessment which was graded as STANDARD, with several questions being answered as yes which included Beverley telling the police that the violence was getting worse, she was afraid of Sam and this occurred when Sam had been drinking.

Whilst the IMR author noted that, in his view, the DASH risk assessment should have been MEDIUM given the answers that were given and Beverley saying she was afraid, it is noted that this would have had no impact on the support that was provided to her as only HIGH risk assessments are brought to the attention of a Domestic Abuse Officer or MARAC.

There is no specific mention that Beverley was signposted to agencies that could support her. This Review believes this would have been an opportunity to provide her with support to leave the relationship, if this was her wish.

3.2.1.21 **3rd June 2017**

3.2.1.22 At 2.57pm a call was received via 999 by Cambridgeshire Police and was transferred to Lincolnshire. Beverley contacted the police stating that her father was threatening to go to her address and shoot her. It was alleged that an argument had occurred between family members on the telephone about the erection of a fence. He is alleged to have said, 'don't shout at me or I will come there with my shotgun and shoot you in the knees'.

3.2.1.23 Beverley was advised by the police to move to an area away from her home whilst officers attended. As her father lived in Cambridgeshire, the police there were contacted in relation to his access to firearms. Once the police had attended and spoken to Beverley it was ascertained that her father had gone to her caravan the previous day to erect a fence. There was then a conversation on the phone between Beverley, Sam and her father and an argument followed. It is alleged that her father made threats. She then came to realise that he did not have any shotguns (only an air rifle and display pistol) and she was happy that he was not planning to go to her address. She then told the police that her father was suffering with dementia and she was concerned for him.

3.2.1.24 No offences were disclosed, and the officer completed a DASH risk assessment which was graded as MEDIUM. A safe and well check was undertaken by Cambridgeshire Police on her

father. Weapons were seized but the officers reported no signs of dementia. The weapons were later returned as there were no offences disclosed.

3.2.1.25 All of the conversations were recorded on Body Worn Video and the DASH assessment was passed to the Sergeant for review. The Sergeant agreed with the assessment and also checked the police systems to ensure there was nothing else that would alter the grading.

Whilst the review agrees with the IMR author that the incidents were correctly identified as domestic in nature and DASH risk assessments were completed, there is no evidence that details of support agencies were provided to the victim.

There are no specific recommendations for this organisation.

3.2.2 Cambridgeshire Constabulary

3.2.2.1 **April 2013**

3.2.2.2 Beverley reported an incident that had occurred in her childhood that may have affected her into adulthood. No action was taken by the police.

3.2.2.3 **August 2013**

3.2.2.4 Beverley and her ex-husband were recorded as offenders in a theft offence. She was found guilty and sentenced, on 8th July 2015 to a 12-month term of imprisonment, suspended for 12 months, plus sundry compensation, costs and orders.

3.2.2.5 **August 2015**

3.2.2.6 Beverley reported theft of fish from her pond by an unknown offender.

3.3.2.7 **November 2015**

3.2.2.8 Beverley reported a crime of 'malicious communication'. She told the police that she was in a relationship with Sam, but he began a short-lived relationship with a third-party before moving back in with her. She reported that nuisance messages had been sent between herself and the third-party. It was evident that messages were going both ways, so words of advice were given, and no further action was taken.

3.2.2.9 **17th December 2015**

3.2.2.10 Beverley contacted the police to report an argument between her and Sam. She said that the argument was about him contacting his 'other partner'[18]. She said that she had been assaulted by him previously in Lincolnshire and was concerned that it might be repeated. There were no allegations of offences made and a DASH form was submitted.

3.2.2.11 **24th December 2015**

[18] Not his wife

3.2.2.12 Sam reported to the police that he was the victim of a public order incident following an argument with a taxi driver in Peterborough city centre. Beverley was with Sam and witnessed the incident. This was recorded as an incident and a crime report, but no further action was taken due to insufficient evidence.

3.2.2.13 **June 2016**

3.2.2.14 Sam was the victim of an ABH[19] assault outside his address. The assault followed an argument with a neighbour and was reported by Beverley. No further action was taken due to insufficient evidence.

There are no specific recommendations for this organisation.

3.2.3 **East Midlands Ambulance Service NHS Trust (EMAS)**

3.2.3.1 **February 2013 – August 2013**

3.2.3.2 EMAS received six calls to Beverley made by 999 and one by NHS 111 in this period. She presented with symptoms such as abdominal pain and vomiting, chest pain and a fall. On each occasion she was taken to Peterborough City Hospital for further assessment and treatment.

3.2.3.3 On one of these occasions, 7th May 2013 Beverley reported that she had slipped and fallen from the top of the stairs to the bottom. The IMR author notes that if the crew had any concerns about the way in which the injury occurred then further questions would have been asked. There is no evidence of domestic abuse and Beverley was taken to hospital for further assessment and treatment.

3.2.3.4 **24th November 2013**

3.2.3.5 At 6.36pm Sam called 999 and advised that Beverley was sat in the house with a knife in her hand. As the crew were advised that there may be risk of violence, the police attended to support the crew.

3.2.3.6 When the crew arrived, they completed a patient report for Beverley who said that she had taken an overdose of 24 paracetamol, 2 ibuprofen and 2 Tramadol tablets. It was recorded that the police were on scene along with her partner who had cuts to his wrists. These were superficial and he was being dealt with by the police. Beverley was noted as being very distressed and the crew felt that she did not have capacity at the time of the incident. She was assessed and taken to Peterborough City Hospital for further assessment and treatment.

The review agrees with the IMR author that had the professionals present exercised more professional curiosity they may have gathered further information which might have indicated domestic abuse. This is an incident that occurred in 2013. The partnership is assured that current work practices would enable greater professional curiosity.

[19] Actual Bodily Harm

At the time of this incident, the hospital would have notified the GP of the discharge of Beverley. It is noted that EMAS now use electronic patient record forms and therefore the GP would have been automatically notified that EMAS had attended.

It is noted that it was recorded that 'partner' was on scene rather than the name of the person. It is good practice to record the names of everyone on scene as well as their relationship to the patient. The review is advised that EMAS have worked hard to promote this message to all staff. Communications have been posted on the Trust Intranet page as well as publications being displayed in staff areas.

3.2.3.7 **13th January 2014**

3.2.3.8 Beverley called an ambulance by 999 at 2.15pm as she had fallen over the cat and hurt her back. When the crew arrived, she said when she tripped, she had hit her head on the radiator. She was able to get herself onto the sofa but was not able to move. She was taken to Peterborough City Hospital.

3.2.3.9 **12th March 2014**

3.2.3.10 At 11.37 pm EMAS received a 999 call for a male who had taken an overdose. The patient was said to not be coping at home and had taken 40 x 500 mg paracetamol with three pints of beer/cider. He was alert throughout the attendance and the crew undertook a clinical assessment. He was taken to Peterborough City Hospital.

The review feels that the crew showed a lack of professional curiosity and that no questions were asked about the reason for the overdose. Had these questions been asked this may have elicited a referral to appropriate support agencies.

3.2.3.11 **19th May 2014**

3.2.3.12 Lincolnshire Police requested that EMAS attend a female who had been assaulted. The request was received at 11.39 pm. The crew recorded that Beverley had been assaulted by her partner at home, punched several times in the face/head and kicked in the leg. She said that she had gone to the pub to call for help. She was, when the crew arrived, alert and orientated, complaining of pain and loss of hearing to her left ear. The crew recorded that she had swelling to her cheek bones. A full clinical assessment was undertaken. She said that she was aching and stiff as she had been involved in a road traffic collision the day before. She was taken to hospital.

It is evident that the crew were aware of the presence of domestic abuse during this call. The review has been advised that it is expected that in these circumstances domestic abuse would be discussed with the patient and information obtained. This would lead to them then advising about support that is available. It is also expected that, had consent been received, a referral would have been raised and, at the time, this would have been shared with Adult Social Care and the GP. As none of this is recorded, the review feels that there is more work to be done to ensure that crews fully understand the importance of full notes as, in this instance, because there are no notes, we are unable to say if this policy and practice was followed.

Recommendation 1

It is recommended that all crew are reminded about the importance of recording the details of all conversations held with patients.

3.2.3.13 **6th July 2014**

3.2.3.14 At 10.04 am EMAS received a 999 call to attend Beverley who had fainted. Sam said that he had heard a noise in the kitchen and had gone in to find her unconscious on the floor. She was alert and complaining of severe headache, back pain and parenthesis on the right side. The crew recorded movement and sensation. It was reported by Sam that she had been unconscious for about 2 minutes. She was taken to hospital.

3.2.3.15 **4th June 2018**

3.2.3.16 The police requested that EMAS attend a serious road traffic collision at 8.21 pm. Beverley had back pain and that her neck was being held in place by Sam. She was the front seat passenger in a car that was hit in the back by another car. She was taken to Boston Pilgrim Hospital.

3.2.4 GP practice[20]

3.2.4.1 Sam had been registered at the practice since October 2013. Sam had a medical history of ulcerative colitis resulting in ileostomy in 2006. This left him reliant on a stoma bag and regular prescriptions. The impact that this had on Sam is discussed elsewhere in the report.

3.2.4.2 **May – September 2013**

3.2.4.3 During this time he was registered at his previous practice and was seen six times. It was noted in his first appointment on 17th June that Sam was depressed, and he was given a follow up appointment for a few days later. At this appointment on 21st June, the GP completed a biosocial assessment, explored his social support which was recorded as being his partner (but her name was not recorded). He was prescribed an anti-depressant and was offered a follow up appointment on 25th July.

The review is aware that all practice staff have since undergone safeguarding training and are aware of recently published safeguarding reviews which highlight the need to record names of attendees at a consultation and this is now expected practice.

3.2.4.4 The GP was notified of a hospital attendance on 24th June with a burn to his arm and an Out of Hours attendance on 8th July with sunburn on his shoulders.

3.2.4.5 The follow up appointment was on 25th July where his alcohol intake was explored. He reported that he had reduced his drinking from 3 litres of cider to two cans daily. He reported that he had good and bad days and said that his wife said he was tearful. (There is no name recorded so it is not known if this was the same partner as referred to at the

[20] The IMR has been completed by the GP surgery at which Sam was registered at the time of his death. The entries relating to his prior GP have been taken from his records but cannot be commented upon as this GP practice is no longer operating

previous appointment). Sam was offered a gym referral which he declined as he said he would be moving out of the area in the next few weeks.

3.2.4.6 On 12th September Sam was seen following a hospital admission for epigastric pain. He was prescribed medication and had an appointment for counselling. The last time he was seen at this surgery was 25th September.

3.2.4.7 Sam registered at his new GP in October 2013. He was seen twice in this month – once where smoking cessation and alcohol use were discussed. On 16th October he saw the GP following a fall where he had lost his footing on the stairs a few days earlier and had attended A & E. He reported pain in his shoulder and a foot fracture. A sick note was issued for 3 weeks and advised not to drive.

3.2.4.8 In December Sam was not seen in the surgery but they were advised of an attendance at Peterborough City Hospital A & E with chest pain, but he had not been admitted. A chest x-ray report was also provided to the GP which required no action.

3.2.4.9 On 17th March the GP received notification from Peterborough City Hospital that Sam had attended A & E on 12th March having taken an overdose of paracetamol. He was seen by the GP on 18th regarding the depressive episode and being generally low long term. He said that no event had caused him to take the overdose. He said that he woke in the night, took 40 paracetamol and told his partner (no name recorded). He was not assessed by the Crisis team and he still felt low and was sleeping all of the time. As he was a driver, he accepted that he was not fit to work. He was given an online self-help workbook, chose to self-refer to Single Point of Access (SPA) and was given a short-term increase in his antidepressants. Alcohol consumption was discussed, and he declined a referral to DART[21].

3.2.4.10 On 8th May Sam reported to his GP, when he was seen for a medication review, that he felt better and did not want to complete the online self-help workbook or self-refer to SPA. He was working which he said had helped. The GP recorded that they had a longer discussion about his alcohol intake which reported was down to 6 units per week.

3.2.4.11 On 29th May Sam saw his GP with ulnar neuritis[22] and was given exercises and bloods were taken on 4th June and no abnormalities were found.

3.2.4.12 On 24th June, Sam was then seen, with his partner, with extreme fatigue. He said he was sleeping 10 hours each night but could not stay awake and had nearly crashed his lorry the week before. The GP arranged for tests and referred him to the sleep clinic. His alcohol consumption was discussed, and he was given a sick note until 7th July.

3.2.4.13 Sam saw his GP for a medication review on 21st November and advised the GP that he had attended the sleep clinic and had been diagnosed with mild sleep apnoea[23] and for which he was going to try a treatment. Sam saw the GP in February 2015 as he had a lesion on his nose from wearing the mask for his sleep apnoea. This month he also saw the GP on two occasions with diarrhoea causing issues with his ileostomy.

[21] Drug and alcohol support services
[22] An inflammation in the nerve in his arm
[23] A condition where the walls of the throat relax and narrow during sleeping and interrupt normal breathing

3.2.4.14 In March 2015 Sam was diagnosed with angina. He was then off sick from work for approximately 12 weeks. In October 2015 the GP were advised that his angiogram was normal, and he was discharged by cardiology. When Sam's symptoms continued his GP re-referred him to cardiology and chased this on 14th January 2016 when he was still waiting to be seen and was advised that they were working through their waiting list.

3.2.4.15 From February 2016 – June 2018 Sam saw the GP less frequently. The contact was predominantly for review of his medication and injuries sustained at work in June 2017 and May 2018.

3.2.4.16 Beverley had been registered with the practice since May 2010 and was seen very regularly by the practice.

3.2.4.17 She attended face to face or telephone consultations on 52 occasions during 2013 and 2014. This is beyond the expected use of appointments by a typical patient. She attended with a number of recurring problems including urinary tract infections, constipation and sickness, back pain, chest pain and problems with her ear. Beverley was part of the Admission Avoidance Care Plan with a view to her understanding when to seek support and the preferred place of care[24].

3.2.4.18 Her consultations reduced during 2015 – 2018 to 33 attendances, whilst her hospital attendances increased.

3.2.4.19 It is noted that Beverley was frequently seen at the GP practice at short notice or on the same day as requested. She was frequently provided with extended appointment lengths to discuss her concerns. Clinical staff frequently accommodated multiple problems/concerns at single appointments in order to help her physical and emotional well-being. Letters were also written to expedite and chase referrals on her behalf.

3.2.4.20 There were times when she declined referrals offered. For example, she was offered a referral to a dietician and a referral to a pain management clinic, both of which she declined. The following paragraphs will focus upon the consultations that included reference to domestic abuse.

3.2.4.21 On 18th March 2013 Beverley saw her GP. As she had disclosed at an earlier appointment that she was experiencing stress having left her husband, the GP attempted to discuss her home life and she walked out of the consultation.

It is noted that the GP attempted to discuss her home situation, and this was appropriate and good practice, as was the decision to accept her choice not to discuss it further.

3.2.4.22 The first time that the GP was aware of any domestic abuse was in November 2013 when Beverley was seen by the GP following her admission to hospital after taking an overdose of paracetamol. She disclosed that this was as a result of an argument with her partner. The GP discussed this with her, and she made no report of violence at this point. She was advised to self-refer to the counselling service.

[24] Admission Avoidance Care Plans area CCG initiative which uses a scoring system to identify and review patients most likely to attend hospital due to illness, social or lifestyle factors in the near future and education about the appropriate measures to reduce the likelihood of this.

3.2.4.23 In May 2014 Beverley reported that she had fallen downstairs when her leg gave way. She also saw her GP with severe pain in her ear which she said was following an assault by her partner. She said that he had punched her repeatedly in the head causing a perforated ear drum. During this appointment, which was extended to allow her time to relax and confide in the GP, she was signposted to agencies that could help. She said that she was getting support from Victim Support and that her partner was going to Alcoholics Anonymous. She told the GP that she had dropped the charges as he was drunk, and it had never happened previously.

It is noted that if this conversation had taken place now, a DASH risk assessment would have been completed, followed by signposting to support services or a referral to MARAC but this was not usual practice at the time.

3.2.4.24 In August 2014 Beverley spoke to her GP again and the GP specifically asked about her home situation and she disclosed that she had been disowned by her immediate family. She spoke with the GP about the assault and her ongoing depression. She was encouraged to engage with counselling support and to do daily activities.

The review notes that there is no record that Beverley was given any information about domestic abuse services. The review believes that there was an opportunity here to have done so.

3.2.4.25 Beverley reported to the GP in July 2015 that she was experiencing low mood. She explained that she was particularly stressed as she was now caring for her two daughters in her one-bedroom house and was sleeping in the lounge. She was given details about how to self-refer to IAPT[25] but at a later appointment she said that she had said that she had sent the form but had not yet heard anything. It is not known if she accessed this service.

It is noted that, as she attended the surgery frequently, the GP took every opportunity (on two further appointments in August) whatever the reason for the appointment, to ask about her mood and to continue to encourage her to access services.

3.2.4.26 In July 2016 a discharge note was received by the surgery following an intentional overdose. She was seen on 27th July when she said that she could not tolerate the constipation anymore. It was noted that, due to an oversight at the hospital, her referral had not been expedited. This was taken up by the GP and an appointment was provided for 11th August.

3.2.4.27 27th September 2017 provided the next opportunity to assess Beverley's home life when she attended regarding pain management. She asked for a letter for the council to support her staying in the caravan as it was on one level and this was provided, free of charge.

3.2.4.28 At her final attendance at the practice on 11th June 2018 Beverley said that her mood was worse. The GP understood, from conversation with her, that this was as a result of the pain and therefore it was not felt that this was an appropriate time to ask about her home life.

The review notes that professional curiosity was exercised in contacts with Beverley.

[25] Improving Access to Psychological Therapies

It is noted by the review that, as a result of this incident, the GP practice is actively coding assault or domestic abuse as an issue on patient records. A protocol is being applied that searches for any second or more history of assault and raises an alert to the coder to then refer the patient to the Safeguarding lead in the practice for further review and action. Additional training has been provided to the code reader to ensure that this protocol is used.

3.2.5 Lincolnshire Community Health Services NHS Trust (LCHS)

3.2.5.1 LCHS provides health care services including community nursing, therapy services, in patient community hospital patient services, Urgent Care, Minor Injuries and Out of Hours Services.

3.2.5.2 On 24th June 2013 Sam attended the Minor Injuries Unit with a burn to his left arm which he reported had been caused by an iron. The burn was recorded as being 21 centimetres in length extending from over the elbow to the forearm. It was noted that he attended with his wife, but no name was recorded. A dressing was applied. He attended for review and change of dressing on 26th June and was discharged with no further treatment needed.

The review notes that there is no record of the conversation about how the injury had occurred, or any attempt to speak to Sam alone. It may be that this was done and not recorded. It is also possible that, due to a lack of understanding about male victims of domestic abuse, that this was not considered. The review is aware that since 2015 domestic abuse training has explicitly identified males as potential victims of domestic abuse. There is information available to staff about support details for male victims.

3.2.5.3 On 12th October 2013 Sam attended the Minor Injuries Unit reporting that he had tripped on the stairs and twisted his right foot. Support strapping was put in place and he was discharged.

3.2.5.4 Sam attended the Minor Injuries Unit on 11th January 2016 complaining of right sided pain but reporting that no injury had taken place. A diagnosis of muscular strain was recorded, analgesia was advised and to see his GP if the symptoms continued and he said that he had an appointment with his GP the next day.

The review is advised that, since 2017, the name of the accompanying person, along with their relationship to the patient, is recorded.

3.2.5.5 Beverley had seven contacts with the Minor Injuries Unit and Out of Hours Service. Two of these attendances related to an injury. On 27th March 2018 she attended with left thumb pain. She said that she had bent it back on the edge of the bed four days earlier. A soft bandage was applied. She was advised to return if the pain became worse or there was loss of sensation, or to see her GP for review. She attended with her mother-in-law, but no name was given.

3.2.5.6 She returned to the Unit on 3rd April as she said she had been unable to get a GP appointment. She had removed the bandage three days earlier. A further support dressing was applied, and she was advised to leave this in place until reviewed by her GP. She was advised that a sprain may take up to 6 weeks to resolve. She was accompanied by her husband, but no name was recorded.

The records do not show that staff tried to see Beverley alone when she attended on this occasion. This may have been an opportunity for her to disclose domestic abuse in her relationship.

3.2.6 **United Lincolnshire Hospitals NHS Trust**

3.2.6.1 The United Lincolnshire Hospitals NHS Trust provides services from three acute hospitals along with a variety of outpatient, day case and inpatient services from a range of community hospitals.

3.2.6.2 Sam accessed services from September 2013 until May 2017. With the exception of one A&E attendance of relevance in June 2016, Sam's main association was via the Respiratory, Cardiology and Gastrointestinal Departments, due to medical conditions for which he was undergoing investigation and/or receiving ongoing monitoring.

3.2.6.3 On 3rd June 2016 Sam attended A&E with facial injuries following an assault. Documentation records that he was assaulted (punched in the face, kicked and bitten on the ear) the previous evening. He was noted to have sustained a bite mark to his left ear; swelling to his lips and cheek and grazes/bruises to his elbow and hip. Beverley was with him during his attendance. No medical intervention was needed, and he was discharged home.

3.2.6.4 The IMR author notes that there was no apparent exploration of this incident and therefore it is difficult to determine whether there was a lack of adherence to the Trust domestic abuse processes was an omission or unwarranted on this occasion. As local domestic abuse processes had been shared with Trust staff, via mandatory training since 2013, it would not be unreasonable to expect staff to ask relevant questions to ascertain whether the implementation of such processes was warranted on this occasion.

The review specifically asked whether the Trust was satisfied that a male attending with these injuries would be treated in the same way as a female, such as seeking to ask about the injury away from the accompanying partner. The review was assured that the training provided makes it very clear that men can be victims and should be treated in the same way as women.

3.2.6.5 Beverley accessed services from June 2013 until June 2018. With the exception of two relevant A&E attendances her main association was with Cardiology, Pain Management and A&E in relation to pre-existing medical conditions for which she was receiving ongoing management.

3.2.6.6 On 20th May 2014 Beverley attended A&E (via ambulance) with a facial injury sustained following an assault by her partner. Documentation indicates that she had been punched and slapped in the face and kicked in the shin. Following examination, she was noted to have a perforated tympanic membrane (eardrum). The police were in attendance. Follow-up was arranged and she was discharged, with records confirming that 'partner' had been arrested.

The IMR notes that there was no evidence of 'partner's' name having been recorded, a DASH risk assessment being completed, or any signposting or referrals being made. It might be that this was because the police were present, but there is no clarification that they had undertaken this. Although subsequent access to police information, confirms that this was done it is good practice

(and current Trust policy, published in 2015) to repeat a DASH in order that, when information is shared, it is clear if this, and the risk assessment are consistent.

3.2.6.7 Beverley attended A&E (via ambulance) on 9th July 2016 following an intentional overdose of paracetamol. Her mother-in-law reportedly alerted emergency services to the incident. Documentation suggests a history of depression with her recording an attempt to self-harm due to her current low mood. She denied any previous overdose attempts and said that she would not repeat such an action. An assessment was done by the Mental Health Liaison Team (MHLT) during which it was ascertained that this overdose attempt was in response to finding messages on Sam's phone from a woman with whom he had previously had a relationship. She was then discharged with the offer of ongoing support which she declined.

3.2.6.8 The IMR author notes that there is no documentation to evidence that, whilst waiting for MHLT to arrive, staff sought to ascertain the reason for the overdose attempt.

The review accepts that, at the time, there was no specific policy in place to mandate such an action. Since this time, considerable work has been undertaken to reiterate to staff the need to be professionally curious in their contact with patients.

3.2.6.9 From June 2013 until June 2018 Beverley was subject to the intermittent care of the Pain Management and Cardiology teams receiving ongoing investigations and management for pre-existing medical conditions. She also presented at A&E a number of times with symptoms related to these conditions.

3.2.6.10 The review notes that there is no indication, in the documentation, that she made any further disclosures of domestic abuse or reported difficulties in relation to the impact of her ill-health upon her domestic situation, which would warrant further exploration.

The review notes that the Trust has recently sponsored the appointment of two Hospital IDVAs[26] both of whom are located within the A&E departments. Furthermore, the concepts of professional curiosity and 'Think Family' have been extensively communicated to all staff in recent years. The review is assured that, if a patient were to attend A&E under similar circumstances to which Sam and Beverley attended, the care management would be significantly different.

Recommendation 2

It is recommended that the Named Nurse for Safeguarding commissions an audit of assault-related attendances, in each of the A&E departments, in order assess compliance with the Trust and local Domestic Abuse processes.

3.2.7 **Peterborough City Hospital (PCH)**

3.2.7.1 During the period of the review, Sam attended PCH six times.

3.2.7.2 On 12th March 2014 Sam attended A&E having taken a 40-paracetamol overdose with alcohol. He stated that he had not intended to kill himself but did require a N-acetyl cysteine (NAC) infusion[27] to reverse his toxicity level. He was treated on a clinical pathway for

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[26] Independent Domestic Violence Advocates

[27] Intravenous **N-acetylcysteine**, given within 24 hours of ingestion of a potentially hepatotoxic overdose of paracetamol, is indicated to prevent or reduce the severity of liver damage. It is most effective when administered within 8 to 10 hours of a paracetamol overdose.

overdose and referred to the CRISIS team for review and kept in hospital overnight. He stated that there had been a recent issue with 'mum' and 'daughter problem at school' and he said that he felt that it was too much to handle. He reported being low in mood despite being on anti-depressant medication from his GP.

3.2.7.3 He was seen by ASPIRE drug and alcohol service with regards to his alcohol intake and was given advice. The CRISIS team declined to see him whilst he was in hospital as this was his first occasion of overdose and he was referred back to his GP for assessment.

The review is advised that services have, since that time, developed and there is now an Adult Psychiatric Liaison Team based in A&E who are now able to see patients.

3.2.7.4 During the period of the review, Beverley was seen 48 times at PCH and has a significant medical attendance record outside of the timeframe. It is recorded that she had chronic back pain and was referred to the pain clinic on a number of occasions, some of the appointments she attended and some she did not.

3.2.7.5 There is a statement in her medical records about a 'serious incident' which is recorded on 13th May 2013 whereby the clinic nurse has recorded that Beverley appears to have falsified a prescription given to her by a surgical consultant. It is recorded that she had taken a prescription to a community pharmacy and it is alleged that 'Oramorph[28]' had been handwritten onto the bottom of the prescription. A community pharmacist picked this up as unusual and checks were made with the hospital and it was clarified that this was not part of the prescription drawn up by the consultant. The prescription was not filled, despite Beverley attending the hospital to challenge this.

The review has not been able to ascertain more detail about action taken by the pharmacist as, due to the time lag, it was not possible to identify the pharmacy. It is noted that Beverley's GP was not notified of the incident.

3.2.7.6 Beverley had a surgical procedure to remove a gall stone on 5th February 2014 and returned for her follow up appointment on 11th March which is the same night that Sam took his significant overdose. It is not known if there is a significant connection between these two events.

The review notes that at no point in her interactions with PCH did Beverley make any disclosure of domestic abuse.

3.2.8 Lincolnshire County Council - Children's Services

3.2.8.1 The contact between all members of the family with both Children's Services and Children's Health has been very limited.

3.2.8.2 There have been two notifications by the police of domestic abuse occurring between Sam and Beverley – on 28th November 2013 and 8th June 2017. On both times, no further action was taken as there were no children present.

[28] A liquid morphine solution

3.2.8.3 On 14th May 2013 Sam's daughter expressed to the school nurse her anxieties about the prospect of him returning to the family home. She spoke of him having hit her and her mother having asked him to stop. Emotional support was provided by the school nurse and a referral was made to Children's Services. Whilst the information was recorded, no action was taken as Sam was not part of the household at the time and he was not having contact with his daughter therefore there were no safeguarding concerns.

3.2.8.4 Sam's daughter had a conversation with a worker at Lincolnshire Young Carer's on 5th August 2015 in which she referred to her father 'hitting' her before he left the family home in 2013. She indicated that she wanted to see her father more often. This was referred to Children's Services and again there was no safeguarding concern and therefore no further action was taken.

Section 4 – Analysis

4.1 **Evidence of domestic abuse**

4.1.1 We know that Beverley was responsible for Sam's death. We also know that she claimed in her trial that she had been a victim of violence at the hands of Sam. The role of this review is to seek to identify if there is a trail of domestic abuse in this relationship. As will be discussed here, there is evidence to suggest that Sam had been violent towards Beverley. There is also information from Sam's family and friends that she was manipulative and controlling of Sam, as well as violent on at least one occasion prior to the incident that took his life. Ultimately there are only two people who know the truth about the relationship, but we will seek to explore the evidence that is available to the review without seeking to stray too much into the realms of speculation.

4.1.2 **Information available to the review about abuse by Beverley towards Sam**

4.1.3 **Physical abuse**

4.1.4 There is one incident, in June 2013 when Sam attended the Minor Injuries Unit with a significant burn to his arm. This, he said, had been caused by an iron and 21 centimetres in length extending from over the elbow to the forearm. It was recorded that he attended with his wife, but this is assumed to be Beverley. Three members of Sam's family independently told the review that this had been caused by Beverley. One said that when they first saw him with a bandage on his arm and asked him how it happened, he just said, '[Beverley], iron'. The actions within the hospital are examined previously at 3.2.5.2.

4.1.5 **Coercion and control**

4.1.6 Sam's family all talked about the coercion and control that Beverley exerted over Sam. They are of the view that this began as soon as the relationship started. It has been suggested that once the relationship started, she was not going to let him go. Before Sam and Beverley's relationship was public, the two couples were friends together and Beverley would be always coming up with reasons why Sam needed to take her on different errands.

4.1.7 The family have spoken of how Beverley was charming when they first met her. She spent time with Sam's mother caring for her and taking her out in her wheelchair. She said that, when the couple lived with her, Beverley was very dominant – she had her way no matter what. She would take herself off to bed and go for days without speaking to anyone, thus causing an atmosphere in the house.

4.1.8 The control exerted on Sam impacted upon him maintaining a relationship with his children. His wife said that when he was visiting them, she would, the review has been told, sit outside the house and sound the horn periodically whilst continually texting him about how long he was going to be. She would not allow Sam to see his girls alone.

4.1.9 The review has been told that Beverley controlled when Sam could work. A number of people told the review that Beverley would get in touch with Sam's boss to tell him when he could work. Towards the end of his life, he had a good job working for a friend of his father.

Beverley would send his boss texts that were unpleasant and gave him the impression that Sam was afraid of her.

4.1.10 Sam's family have also spoken of how they were subject to her control of Sam and the outbursts that went with this. His mother has described how she would scream down the phone that Sam had left her, and she did not know where he had gone. His mother says that he had not left her but, if they argued, he would go off and drive around to be away from her as he did not like confrontation. She would become angry if she did not always know his whereabouts.

4.1.11 **Economic abuse**

4.1.12 Things were difficult for Sam and Beverley when they first got together. They lived with his mother for a couple of months.

4.1.13 Sam's family gave examples of Beverley controlling the money that Sam earned. It is alleged that every pay day she would take the money out of his bank account and put it into her account. The tenancy for each of their homes was in her name. The full extent of the finances within the relationship are not known but we do know that they sought help from the Lincolnshire Community Assistance Scheme with money for electricity and food. The review has been told that Sam would ask family members for money for food or diesel to allow him to get to work because he said Beverley controlled the finances and did not provide him with enough money for food at work and fuel. They were aware that he was earning good money for his line of work and therefore believed that she was preventing him from having access his earnings.

4.1.14 When Sam had died the family found that he had no money and they were particularly surprised to find that he had pawned his watches, which he collected, especially as one had belonged to his brother which was given to him after his death and they felt he would never be parted from. Whilst this may be evidence of coercion and control and economic abuse, the panel feels that it might have reflected their financial situation.

4.1.15 **Information available to the panel of abuse by Sam towards Beverley**

4.1.16 As part of her defence, Beverley claimed that Sam had regularly hit her whilst in drink. We only have the police calls for service to draw on, but we know that 19th May 2014 Beverley called the police from a local public house to report that Sam had assaulted her, and she had left the house to call the police. She told the police that he had been violent in the past the first time being six months earlier (this will be discussed in the next paragraph). She said that she was bleeding from her ear and could not hear and was 'seeing stars'. She was treated for her injuries by an ambulance and taken to hospital. When in hospital she said that he had punched her twenty times whilst under the influence of alcohol. She had a bruise to her right eye and swelling on her right cheek.

4.1.17 Sam was arrested for Actual Bodily Harm and interviewed under caution. He said that he had been involved in an altercation with Beverley and said that he had slapped her twice around the head but denied hitting her as many times as she stated. He accepted that he was responsible for her injuries. He was cautioned for Common Assault as he had no

previous convictions for violence and the victim would not support a prosecution and wished to resume the relationship.

4.1.18 The officer attending completed a DASH risk assessment which was graded as STANDARD. She did say, whilst answering the questions, that the violence was getting worse, she was afraid of Sam and this occurred when he had been drinking.

4.1.19 When Beverley discussed this with her GP on 14th August, she said that she was finding things difficult to manage and her family had said that if she went back to Sam, they would disown her. She had gone back, and her family had not had contact with her, and she felt isolated, although she did have occasional contact with her daughters.

4.1.20 Beverley then contacted the police in December 2015 to report an argument between her and Sam. She said that the argument was about him contacting his 'other partner'. She said that she had been assaulted by him and was concerned that it would happen again. There was no allegation of offences made and a DASH risk assessment was not completed.

4.1.21 In November 2013 Beverley attended the GP after her admission to hospital after taking an overdose of paracetamol. She told the GP that this had been as a result of an argument with Sam, but she made no reference to violence.

4.1.22 There are three incidents where Beverley sought medical help following an injury. On 7th May 2013 she rang the ambulance service via 999 as she had fallen down the stairs. She was taken to hospital for assessment and treatment. On 13th January 2014 she called an ambulance via 999 as she had tripped over her cat and hurt her back and on 7th May 2014, she said that her leg had given way and she had fallen down the stairs and now had pain in her hip. In March 2018 she went to the Minor Injuries Unit as she had pain in her thumb, having bent it back on the edge of the bed. Whilst we cannot know for certain, if we were considering her to be the victim of abuse, we would question whether these were excuses given when she had, in fact, been a victim of abuse.

4.1.23 Beverley had made reference to Sam having left her during their relationship as he was having an affair. The review has not been able to corroborate this. All we know for certain is that he left her for a short time and went to stay with his father.

4.1.24 Some of the allegations/disclosures of both Sam and Beverley suggest that there was situational couple violence in the relationship which has been described as 'intimate partner violence [….] when specific conflict situations escalate to violence' (Samson et al, 2005[29]). According to Samson et al the scale of violence can range from pushing and shoving to life threatening attacks. Research indicates that situational couple violence is likely to be more or less equally perpetrated by men and women in heterosexual relationships (Samson et al, 2005[30]). Samson et al also state that situational couple violence is not connected to a pattern of control[31].

4.1.25 The review cannot fully understand the extent to which control was a pattern of the relationship, albeit the evidence provided consistently by Sam's family and friends is that

[29] Michael P Samson and Janel M Leone, Journal of Family Issues, April 2005, Vol 26, No 3, p 324
[30] ibid
[31] Michael P Samson and Janel M Leone, Journal of Family Issues, April 2005, Vol 26, No 3, p 323

Beverley was completely controlling of him. We can see evidence of violence on both sides of the relationship.

4.2 **How were the couple perceived by those outside of the family who knew them?**

4.2.1 The review tried to seek the views of those who knew Beverley prior to and during her relationship with Sam. No-one wished to engage with this review in respect of this. However, we did visit and speak to those who could be described as mutual friends who frequented the same pub and we have the views of Sam's family.

4.2.2 Friends in the pub, described Sam as being a man who was very loud and wanted everyone to like him. He was generally well liked whilst this was not true of Beverley. She, on the other hand, was described as being 'nasty and capable of stabbing people in the back'. She was described as attention seeking and dramatic. A couple of incidents were cited to demonstrate this. On one occasion, they all had Christmas dinner in the pub and Beverley got into a spat on social media with another pub about which had the best event. She was described as getting a buzz out of it. Everyone was embarrassed and she had to be asked to stop. On another occasion, she had arrived in the pub being pushed in a wheelchair by Sam. During the afternoon a group of people came into the pub and were politely asked to leave as it was a private party. They were turning to leave without any fuss when Beverley jumped up out of her wheelchair and accused them of being thieves and drug dealers. Some of the customers joked with her saying, 'Beverley have you forgotten your wheelchair'.

4.2.3 The regulars in the pub felt that she was a 'drama queen' and it was not unusual for her to be crying in the pub. They felt that she would talk down to Sam and that he would do anything for an easy life. He was always embarrassed by her behaviour and apologetic before taking her home. She was described by the Judge in his sentencing remarks as 'quite prone to having a sulk, quite easily got the hump, she can be hard work and would fly off the handle easily'.

4.2.4 This review is conscious of the lack of additional context around Beverley's background including any difficulties may have affected her mental health or indeed her physical health. We are conscious that there is evidence of multiple admissions to hospital unrelated to this relationship, it is not always apparent what caused those, the symptom being the attendance or the admission. There is, therefore, the potential for this element to appear unbalanced. Beverley also chose not to assist this review and thus her views are not represented. However, the consistency of evidence both to this review and that which was tested in court, relevant because it was tested and goes to the nature of the relationship, as to her character is clear; she was felt to be dominant and controlling of Sam. Whilst it is the case that statistically this type of behaviour has been more evidenced in men, the fact is here that the behaviour is attributable to a female perpetrator before she killed her partner.

4.2.5 This review also considered whether the couple's use of alcohol or their mental health should be subject of particular scrutiny. The review gathered as much information as was possible; this included scrutiny of all of the available information that could assist in this area, including speaking with family and friends. There is simply a lack of existing information that would enable this review to make a valid analysis without straying into the realms of speculation as to what 'may' have happened. Such speculation would be

unhelpful, and potentially unfair and disrespectful to both the victim and the perpetrator in this case.

4.3 **The day of the incident**

4.3.1 It is important that we consider what happened on the day of the incident in an attempt to understand the dynamics in this relationship. We can draw on the evidence of witnesses and the judge's sentencing remarks.

4.3.2 Sam and Beverley had gone to the pub for Sunday lunch as they did regularly. It was common practice for all the customers to sit and chat together. On the day of the incident a woman who had only attended relatively recently sat with the couple and other regulars. Beverley and this woman were chatting, and she became embarrassed as she felt that Beverley was trying to pair her off with another regular. She, therefore, said quietly to Sam, 'could you ask your wife to stop' to which Sam replied that she was not his wife and they were not married.

4.3.3 Beverley heard this comment and reacted angrily, telling Sam that he would not be sleeping inside anymore and that he could sleep in the car. She was described as 'quite aggressive whilst he was placid'. She then got up and moved to another area of the pub and sat by herself. She was described as wailing 'like a kid having a tantrum'. Sam went to try to speak to her and she went into the garden. She was described as being 'awful, loud, aggressive, disgraceful and totally unnecessary'.

4.3.4 In the garden Beverley was described as in 'quite a state' and 'very angry'. She was arguing with Sam who apologised to staff. He was described as 'frustrated with her behaviour but not in any way angry or threatening'.

4.3.5 In defence Beverley alleged that she had been assaulted by Sam and that she had rung the police although there is no record of such a phone call. Sam asked Beverley for the car keys so that he could go home but she refused to give them to him. Beverley then went to the car and tried to leave so that he could not get home. Sam knew that she had too much to drink and tried to stop her leaving by placing both hands on the bonnet. She tried to drive round him, but he continued to try and stop her leaving. She then began to drive off from the car park with Sam clinging to the bonnet. She left the car park and headed up the road. At the junction, the car stopped, and Sam pleaded with her, 'I want you to stop' and she was described as 'angry'. Sam managed to call the police on his mobile phone and said, 'police please'. The car then accelerated forward, braked and the car came to a rapid stop, the force of which propelled Sam from the bonnet onto his back on the road where the back of his head impacted the ground.

4.3.6 The actions of Beverley, and the sentencing remarks of the judge, assist us in understanding her view of her relationship with Sam. As Sam lay on the ground being helped by staff from the pub who had arrived, she was seen to be talking on her mobile phone. After having prodded Sam with her foot a couple of times saying he was asleep not unconscious, Beverley was asked to move away. She then took her handbag from the car and walked away saying, 'he's not my fucking husband, why don't you ask the girl he was flirting with in the pub, I don't care if he fucking dies.'

4.3.7 The bodycam footage of the police who attended the scene described Beverley as 'indifferent to the fate of Sam, repeatedly aggressive to the police and clearly affected by alcohol'. At one point she threw herself on the grass verge and accused the police of having put her there. She refused to give a specimen of breath when she eventually did, she was over the drink drive limit.

4.3.8 The judge said that, having listened carefully to the evidence, he was satisfied that she had not been assaulted by Sam that afternoon.

4.3.9 The court accepted the psychiatric report that stated that there was, in Beverley, no history of mental illness nor any learning disability. It was noted that whilst she had experienced recurrent depressive episodes, they had been mild in severity and in the months and weeks prior to the offence she had been in brighter mood. The psychiatrist did regard Beverley as having some traits of emotional instability in her personality structure although a formal diagnosis of emotionally unstable personality disorder could not be made. This was because the types of behaviour that she displayed were relatively infrequent and limited to when she was exposed to stress. She was described as being prone to behave in a childish manner when stressed or annoyed.

4.4 Given that he told his family that he regretted being with Beverley, what barriers prevented Sam feeling able to leave the relationship or seek support?

4.4.1 All of those spoken to as part of the review, speak of Sam as being beset with low self-esteem following his illness and operation. They speak of this affecting his confidence with women and feel that Beverley exploited this. Bates' in her research[32], found that men would not report because they were 'embarrassed' and 'ashamed'.

4.4.2 The family also suggest that Sam felt that the relationship had gone further than he intended and that he did not divorce from his wife as if he did, 'she (Beverley) will expect me to marry her'.

4.4.3 After the incident with the iron, Sam was asked why he did not leave and he said, 'where will I go?' A recent report by Women's Aid[33] (whilst looking specifically at women's situations) highlights that concerns about housing are a barrier to leaving an abusive relationship. Survivors reported that they sometimes had to weigh up staying in a home shared with an abusive partner against leaving for another potentially unsafe situation due to the lack of housing options available to them. We have seen that, since he left his family home, Sam's housing situation had been somewhat precarious, and it has been suggested that she had controlled his finances, so he probably felt that to rent a place on his own was unobtainable. It is understandable that a man who had his own home would not wish to go back to stay with family.

4.4.4 Research has found that men experiencing domestic abuse have found it difficult to leave their relationship and have encountered barriers to seeking help. Tsui et al[34] (2010) found that 66.7% of the men they surveyed felt that domestic abuse services were targeted at

[32] Bates Elizabeth A (2017), Hidden victims: men and their experience of domestic violence, Coventry University
[33] The Hidden Housing Crisis, Women's Aid, 2020
[34] Tsui et al (2010) cited in Bates Elizabeth A (2017), Hidden victims: men and their experience of domestic violence, Coventry University

women clients and a further 25.7% felt stigmatisation was the greatest obstacle they faced and they were worried that the police would not believe them. Machado, Hines and Matos[35] (2016) found that the sources of help that men approached were unhelpful whilst Douglas and Hines[36] (2011) found that the formal domestic abuse agencies and police were the least helpful sources of support. Victims spoke of a lack of validation of their experience and judgement of their legitimacy as victims. This may well have contributed to the reason that Sam did not feel able to seek support or report the abuse he was experiencing.

Recommendation 3

It is recommended that all public facing agencies in the partnership review their training for staff and volunteers to ensure that appropriate responses are given to men when reporting domestic abuse

[35] Bates Elizabeth and Taylor Julie (2019) 'I had no idea how painful it would be', University of Cumbria
[36] Ibid

Section 5 - Lincolnshire's approach to domestic abuse

5.1 As part of the review, the work being undertaken in Lincolnshire to tackle domestic abuse, preventing it by changing attitudes, supporting victims and bringing perpetrators to justice was considered. The Lincolnshire Domestic Abuse Strategy and Delivery Plan, owned by the Lincolnshire Domestic Abuse Partnership, are current (2017-2021), relevant and address these issues. This strategy is attached as an appendix.

5.2 These documents are further supported by a comprehensive multi-agency domestic abuse protocol which also covers the areas of prevention, support and enforcement. The stated vision of the protocol is 'to prevent anyone in Lincolnshire suffering domestic abuse'.

5.3 Lincolnshire County Council currently commissions a number of domestic abuse services and since the 1st August 2018 these include:

- Countywide Outreach support for children and adults. This service is currently being delivered by EDAN (Ending Domestic Abuse Now) Lincolnshire, formerly West Lincolnshire Domestic Abuse Services.

- Independent Domestic Violence Advisor (IDVA) Service to support high risk victims of domestic abuse referred to a Multi-Agency Risk Assessment Conference, including a hospital-based IDVA provision (as recommended in the November 2016 Safe Lives publication 'A Cry for Health'[37].

- Supported accommodation for people fleeing domestic abuse.

5.4 In addition, there are a considerable amount of resources dedicated to supporting the Safer Lincolnshire Partnership through the Domestic Abuse Core Priority group, including the County Domestic Abuse Team employed by Lincolnshire County Council who manage the DA Delivery Plan (2017-2021) and all associated activity.

5.5 This delivery plan is further supported by a comprehensive multi-agency domestic abuse protocol which also covers the areas of prevention, support and enforcement. The stated vision of the protocol is 'to prevent anyone in Lincolnshire suffering domestic abuse'. In addition, there is a specific domestic abuse resource pack for schools and educational settings in Lincolnshire.

5.6 The process for learning from domestic homicide reviews is well embedded through the Domestic Abuse Strategic Management Board and its Delivery Plan.

[37] http://safelives.org.uk/sites/default/files/resources/Cry%20for%20Health%20full%20report.pdf

Section Six – Recommendations

The review is grateful to the organisations for their thorough IMRs and the recommendations that they have made for their organisations. These are listed below:

6.1 **East Midlands Ambulance Service NHS Trust**

6.1.1 That all crew are reminded about the importance of recording the details of all conversations held with patients.

6.2 **United Lincolnshire Hospitals NHS Trust**

6.2.1 That the Named Nurse for Safeguarding commissions an audit of assault-related attendances, in each of the A&E departments, in order assess compliance with the Trust and local Domestic Abuse processes.

In addition, the review has made the following recommendation:

6.3 **Safer Lincolnshire Partnership**

6.3.1 That all public facing agencies in the partnership review their training for staff and volunteers to ensure that appropriate responses are given to men when reporting domestic abuse .

Section Seven – Conclusions

7.1 This Review has learnt that from the evidence of family and friends that they believe this perpetrator was controlling of Sam within the relationship. The extent to which there was violence and control between both parties we cannot be certain. Sam was known to be violent towards Beverley on one occasion. We do know, from the remarks of the Judge in sentencing, that Beverley had no regard for Sam, the man she claimed to love, on the day of the incident and was, at least disrespectful to him when he was laying in the road. We know that she continued to exacerbate the situation by causing messages to be posted on Facebook blaming others for Sam's death.

7.2 Those who were present when the argument occurred in the pub said that what happened was not in the heat of the moment but was 'a control thing with her'.

7.3 On balance, with the caveats set out earlier, the review feels that there is information that Beverley behaved towards Sam, both on the day of the incident and throughout their relationship in a way that was manipulating, controlling and coercive.

7.4 This Review has learned of good examples of work in some local agencies that has showed professional curiosity in relation to domestic abuse. However, there is more to be done in particular in relation to the messaging around male victims of abuse, and professional curiosity across all those agencies charged with the responsibility for safeguarding the vulnerable. We believe the recommendations in Section Six will make others safer.

Appendix One - Terms of reference

CONTAINS CONFIDENTIAL INFORMATION

Restricted use only

DHR2018Q Terms of Reference[38]

1. REASON FOR DOMESTIC HOMICIDE REVIEW

In June 2018 Lincolnshire Police attended an incident in Lincolnshire.

In June 2018, Lincolnshire Police notified the Chair of the Safer Lincolnshire Partnership that the incident was being investigated as a homicide, as per the Lincolnshire Domestic Homicide Review Protocol. The Chair of the Strategic Board considered the case, in conjunction with other key agencies that had contact with the family, and concluded that the case did meet the criteria and justification for a Domestic Homicide Review; the Home Office were notified accordingly.

2. SUBJECTS

Removed to maintain confidentiality

3. PURPOSE OF THE REVIEW

The purpose of the 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 procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

4. SCOPE

The review will cover the individuals listed at Section 2 above. The historical period for the review will be from beginning of January 2013 to end of June 2018. However, if during the review any Agency feels there is relevant information pertaining to other individuals or relevant

[38] These have been abridged in order to maintain the confidentiality of those involved

information outside the time period under review, they should include this information in their IMR. This should be provided in summary form rather than on the chronology template.

The Domestic Homicide Review must not undermine any other inquiry. The DHR is cognisant of other parallel processes such as the criminal trial and coroner's inquest and will ensure appropriate liaison with those processes is established.
Agencies must ensure that work to address any issues or learning that has been identified at an early stage begins immediately and should not wait until the production of IMR's or the overview report and action plan.
Further in-depth information to include within the Scope of the review can be found on page 13 of the Home Office DHR Guidance.

5. PANEL AND ADVISORS

Agency	Advisor
United Lincolnshire Hospitals Trust	Elaine Todd
Lincolnshire Community Health Services	Gemma Cross
Lincolnshire CCG's	Claire Tozer
GP	Not named to avoid identification of practice
Lincolnshire Police	Jon McAdam
East Midlands Ambulance Service	Zoe Rodger-Fox
EDAN Lincs	Jane Keenlyside
South Holland District Council	Dee Bedford
LCC Children's Health	Claire Saggiorato
LCC Children's Services	Yvonne Shearwood

- Independent Chair/Author – Gary Goose /Christine Graham
- Legal Adviser – Toni Geraghty
- Domestic Abuse Coordinator – Jade Thursby, Lincolnshire County Council
- Domestic Abuse Advisor – Natalie Watkinson, Lincolnshire County Council
- Administrator – Teresa Tennant, Lincolnshire County Council

6. INDEPENDENT MANAGEMENT REVIEW (IMR) AUTHORS

Agency	Author
United Lincolnshire Hospitals Trust	Elaine Todd
Lincolnshire Community Health Services	Ali Balderstone
GP	No named to avoid identification of the practice
Lincolnshire Police	Martin Holvey

Cambridgeshire Police	David York
East Midlands Ambulance Service	Lucy Gascoigne
LCC Education	Jill Chandar-Nair
LCC Children's Services	Yvonne Shearwood
LCC Adult Care	Linda MacDonnell
Peterborough Hospital (North West Anglia NHS Foundation Trust)	Donna Phipps

7. IMR STRUCTURE

The aim of the IMR is to:

- Allow agencies to look openly and critically at individual and organisational practice and the context within which people were working to see whether the homicide indicates that changes could and should be made.
- To identify how those changes will be brought about.
- To identify examples of good practice within agencies.(Multi-Agency Statutory Guidance for the conduct of DHR's , para 8.2)

Please follow the template layout as set out in Appendix A when writing your IMR.

8. INDEPENDENT AUTHOR AND CHAIR

The Independent Author/Chair is:
Christine Graham and Gary Goose

9. TIMELINE FOR THE DOMESTIC HOMICIDE REVIEW

The following may be subject to review and will be dependent on criminal/legal proceedings:

March 2019

- 18/03/19 - Initial panel meeting with appointed Chair/Author to agree Terms of Reference
- Name of IMR authors to be sent to DHR Administrator
- Family and friends informed of DHR (in consultation with Senior Investigating Officer)

May 2019

- 03/05/19 - Deadline for submission of completed chronologies
- 22/05/19 – Panel meeting held to discuss IMR/QA deadlines

September 2019

- Deadline for submission of completed IMRs to DHR Chair by 02/09/19
- Deadline for QA return by 16/09/19
- IMRs to be circulated to panel members 23/09/19

October 2019
- 25/10/19 - IMR presentation meeting

November/December 2019
- Draft Overview Report and action plan to be circulated to panel members

January 2020
- 29/01/20 - Panel meeting to present draft Overview Report

November 2021
- 10/11/21 - Overview report, Executive summary and action plan signed off by all agencies and the Chair of the Community Safety Partnership
- Report submitted to the Home Office

10. COMMUNICATION & MEDIA ISSUES

Lincolnshire County Council will lead on media and communication's issues together with representatives from partner agency communication teams.

11. ANONYMITY

The overview report and executive summary is to be anonymised for publication and dissemination. IMR authors should use full names which will be anonymised at a later time by the administrator.

12. INVOLVEMENT OF FAMILY AND RELEVANT OTHERS

The DHR Panel recognise the value and importance of involvement of friends, family members and other support networks to the learning in this review and will consider their involvement with the Panel Chair and Author.
No interviews will take place until after the trial.

Appendix A – IMR Template

1. INTRODUCTION

Brief factual/contextual summary of the situation leading to the DHR and date for completion:

• Identification of person subject to review
• Date of Birth:
• Date of death /date of serious injury/offence

Victim, perpetrator, family details if relevant

Include family tree or genogram if relevant.

Please set out what service your Agency provides, population it covers etc. and indicate which part of the service was provided to the individuals subject to the review. This 'scene setting' about your Agency and what services were offered is helpful context for the reader before moving into detailed analysis of involvement later in the IMR.

2. AUTHOR & METHODOLOGY

Name, job title and contact details of person completing this IMR (include confirmation regarding independence from the line management of the case).

Record the methodology used including extent of document review and interviews undertaken.

Explain what records have/have not been reviewed together with the rationale and consideration of the impact on the review.
Explain who has/has not been interviewed together with the rationale and consideration of the impact on the review.

3. DETAILS OF PARALLEL REVIEWS/PROCESSES

IMRs will be requested when appropriate so that it does not interfere with criminal proceedings. Interviews are not to be undertaken until after the trial. However, agencies should ensure that any learning that has been identified at an early stage should be acted upon and must not wait until the production of the IMR, the overview report or the action plan.

4. CHRONOLOGY OF AGENCY INVOLVEMENT

What was your Agency's involvement with the victim?

Construct a comprehensive chronology of involvement by your agency over the period of time set out in the review's terms of reference. State when the victim/child/family/perpetrator was seen including antecedent history where relevant.

Construct the chronology in a separate document taking account of the above advice and refer under this section. It is not an appendix to the IMR.

5. ANALYSIS OF INVOLVEMENT

Depending on the period under review you may find it helpful to breakdown the period under review into 'episodes of service provision'. Agencies must ensure that practice is evaluated against policies and procedures that were current during the period of time being reviewed.

The Review should consider the events that occurred, the decisions made and the actions taken or not taken. Where judgements were made or actions taken that indicate that practice or management could be improved, the review should consider not only what happened but why. Each homicide may have specific issues that need to be explored and each review should consider carefully the individual case and how best to structure the review in light of the particular circumstances.

To provide a comprehensive response to the above specific terms of reference for this DHR the following areas, taken from the statutory guidance, should be considered by the IMR author, and the report set out using these headings.

a) To examine whether there were any previous concerns, incidents, significant life events or indications which might have signalled the risk of violence to any of the subjects, or given rise to other concerns or instigated other interventions.

b) When and in what way were practitioners sensitive to the needs of the subjects, knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

c) When, and in what way, were the subject's wishes and feelings ascertained and considered? Were the subjects informed of options/choices to make informed decisions? Were they signposted to other agencies and how accessible were these services to the subjects?

d) What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

e) Was appropriate professional curiosity exercised by those professionals and agencies working with the individuals in the case, this includes whether professionals analysed any relevant historical information and acted upon it?

f) Were the actions of agencies in contact with all subjects appropriate, relevant and effective to the individual and collective family needs and risks identified at the time and continually monitored and reviewed?

g) Did the agency have policies and procedures for Domestic Abuse and Safeguarding and were any assessments correctly used in the case of the subjects? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC or other multi-agency fora?

h) Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

i) Were any issues of disability, diversity, culture or identity relevant?

j) To consider whether there are training needs arising from this case

k) To consider the management oversight and supervision provided to workers involved

l) Did any restructuring during the period under review likely to have had an impact on the quality of the service delivered?

6. EFFECTIVE PRACTICE/LESSONS LEARNT

Use this section to identify any effective practice or lessons that you feel should be highlighted in the report.

In addition, the Independent author will use your analysis of involvement, engagement of family and friends to identify ways of working effectively that could be passed on to other organisations or individuals.

The panel will identify any lessons to be learned from this case relating to the way, in which all agencies worked to safeguard victims and promote their welfare, or the way they identify, assess and manage the risks posed by perpetrators.

7. RECOMMENDATIONS

Recommendations should be focussed on the key findings of the IMR and be specific about the outcome which they are seeking. Please do not make recommendations about practice that has already changed but you can indicate that as a result of those practice changes that is why there is no longer a need to make a recommendation. Recommendations should be SMART.