



Central Bedfordshire  
**Community Safety  
Partnership**

# **CENTRAL BEDFORDSHIRE COMMUNITY SAFETY PARTNERSHIP DOMESTIC HOMICIDE REVIEW EXECUTIVE SUMMARY**

**Report into the death of Andrew**

**March 2018**

**Independent Chair and Author of Report: James Rowlands**

**Associate Standing Together Against Domestic Violence**

**Date completed: July 2019**



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# 1. Executive Summary

## 1.1 The Review Process

- 1.1.1 This summary outlines the process undertaken by the Central Bedfordshire Community Partnership (CSP) Domestic Homicide Review (DHR) Panel in reviewing the homicide of Andrew<sup>1</sup>, a resident of the London Borough of Bedfordshire.
- 1.1.2 This report of a DHR examines agency responses and support given to Andrew, a resident of Central Bedfordshire prior to the point of his death at his home in March 2018. On the night of the homicide, Bedfordshire Police received a call from the East of England Ambulance Service requesting support for paramedics who were attending a male who was in cardiac arrest following a stabbing. Upon arrival, police officers found Andrew collapsed in the kitchen of the home he shared with his partner, Olivia<sup>2</sup>. Andrew was attended to by paramedics but was pronounced dead at the scene shortly after midnight. He had sustained a single stab wound to his chest.
- 1.1.3 After Andrew's death, Olivia was arrested and charged with murder, which she denied. In January 2019, Olivia was cleared of murder but was convicted of manslaughter. She received a three-year prison sentence.
- 1.1.4 This review has been anonymised in accordance with the statutory guidance. The specific date of the homicide has been removed. Only the chair and Review Panel members are named.

The Principle People Referred to in this report						
Referred to in report as	Relationship	Age at time of Andrew's death	Ethnic Origin	Faith	Immigration Status	Disability
Andrew	Victim	54	White British	Unknown	UK Citizen	No
Olivia	Partner	73	White British	Unknown	UK Citizen	Physical

- 1.1.5 The other people referred to in this report<sup>3</sup> are:

- Dawn – Sister of Andrew;

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<sup>1</sup> Not his real name.

<sup>2</sup> Not her real name.

<sup>3</sup> Not their real names.

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- Noah – Brother of Andrew;
- Logan – Son of Andrew;
- Ethan – Son of Andrew;
- Nicholas – Nephew of the Andrew, son of Dawn;
- Matthew – Friend of Andrew;
- Neighbours 1 and 2 – Neighbours of both Andrew and Olivia;
- Emma – Daughter of Olivia;
- Luke – Son of Olivia; and
- Natalie – Daughter-in-law of Olivia, wife of Luke.

1.1.6 The Central Bedfordshire Community Safety Partnership (the CSP), in accordance with the December 2016 '*Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews*' ('the statutory guidance') commissioned this DHR. The CSP was notified by Bedfordshire Police on the 13<sup>th</sup> March 2018 and the case was discussed at two meetings of the CSP in March and then April 2018. At the second meeting, a decision was made to commission a DHR and the Home Office were notified of the decision in writing on the 14<sup>th</sup> May 2018.

1.1.7 Standing Together Against Domestic Violence (STADV) was commissioned to provide an independent chair (hereafter 'the chair') on the 4<sup>th</sup> May 2018. The completed report was handed to the CSP in July 2019. In September 2019, it was considered at a meeting of the CSP Executive Group and signed off, before being submitted to the Home Office Quality Assurance Panel in September 2019. In March 2020, the completed report was considered by the Home Office Quality Assurance Panel. In April 2020, the CSP received a letter from Home Office Quality Assurance Panel approving the report for publication. The letter will be published alongside the completed report.

## **1.2 Contributors to the Review**

- 1.2.1 This DHR has followed the statutory guidance issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004.
- 1.2.2 On notification of the homicide, agencies were asked to check for their involvement with any of the parties concerned and secure their records. A total of 24 agencies were contacted to check for involvement. Eight agencies returned a nil-contact, four agencies submitted IMRs and chronologies, and three agencies submitted Shorts Reports only due to the brevity of their involvement. The chronologies were combined, and a narrative chronology written by the Overview Report Writer. Additionally, two agencies submitted Thematic Reports describing local policy and provision.
- 1.2.3 The following agencies were contacted, but recorded no involvement with the victim or perpetrator:
- Bedfordshire Clinical Commissioning Group (CCG);

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- Central Bedfordshire Council (CBC) Children’s Services;
- Carers in Bedfordshire;
- CBC Community Safety;
- CBC Community Services;
- CBC Housing Services;
- East London NHS Foundation Trust (ELFT), provider of statutory:
  - (i) Mental Health and Wellbeing Services<sup>4</sup>
  - (ii) Drug and Alcohol Service – Path 2 Recovery (P2R)<sup>5</sup>.

1.2.4 The following agencies had contact with Andrew and / or Olivia and contributed as follows:

<b>Agency</b>	<b>Contribution</b>
Bedfordshire Police	Chronology and IMR
CBC Adult Social Care (CBC ASC)	Chronology and IMR
Luton & Dunstable University Hospital NHS Foundation Trust ('Luton & Dunstable Hospital') <sup>6</sup>	Chronology and IMR
West Street Surgery – General Practice (GP) for Olivia	Chronology and IMR
Bedford Hospital NHS Trust ('Bedford Hospital')	Short Report
Kirby Road Surgery – GP for Andrew	Short Report completed by the GP practice with the assistance of the Bedfordshire CCG
Victim Support – Independent Domestic Violence Advisor (IDVA) Service <sup>7</sup>	Short Report

<sup>4</sup> Bedfordshire Mental Health and Wellbeing Service provides mental health services across Bedford Borough and Central Bedfordshire. For more information, go to: <https://www.elft.nhs.uk/service/329/Bedfordshire-Mental-Health-and-Wellbeing-Service>.

<sup>5</sup> PATH 2 RECOVERY (P2R) is a one stop service which provides drug and alcohol advice, treatment and support to adults whose lives are affected, support can include the whole family. For more information, go to: [https://www.elft.nhs.uk/service/300/Path-to-Recovery-PATH-2-RECOVERY-\(P2R\)-for-Central-Bedfordshire](https://www.elft.nhs.uk/service/300/Path-to-Recovery-PATH-2-RECOVERY-(P2R)-for-Central-Bedfordshire).

<sup>6</sup> Located between Luton and Dunstable, Luton and Dunstable University Hospital is an acute hospital and also offers a range of community services. For more information, go to: <https://www.ldh.nhs.uk>.

<sup>7</sup> Victim Support provide domestic abuse support services across Bedfordshire and have Independent Domestic Violence Advisor services based in Luton, Bedford and at Bedford Hospital. For more information, got to: <https://www.victimsupport.org.uk/help-and-support/get-help/support-near-you/east-england/bedfordshire>.

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1.2.5 To inform the deliberations of the Review Panel, Thematic Reports were also sought in relation to a number of areas, addressing the strategic context, evidence of local need, pathways, provision, gaps and issues as follows:

<b>Agency</b>	<b>Thematic Report</b>
CBC Children’s Services	Men and domestic abuse
CBC Public Health	Drug & Alcohol Treatment Services

1.2.6 *Independence and Quality of IMRs:* Review Panel members were of the appropriate level of expertise and were independent, having no direct line management of anyone involved in the case. The IMRs received from Bedfordshire Police and CBC ASC were comprehensive and enabled the panel to analyse the contact with Andrew and/or Olivia and to produce the learning for this DHR. The IMRs and short reports from other agencies were more variable, although they all met a standard which allowed the Review Panel to analyse contact with Andrew and/or Olivia and to produce the learning for this DHR. Where necessary, further questions were sent to agencies and responses were received.

**1.3 The Review Panel Members**

1.3.1 The Review Panel members were:

<b>Name</b>	<b>Role</b>	<b>Agency</b>
Amanda Derbyshire	Designated Nurse for Safeguarding Adults	Bedfordshire CCG
Caroline Lewis	CEO	Mind BLMK
Ippo Panteloudakis	Operations Director	Respect <sup>8</sup>
T/Detective Chief Inspector Jerry Waite	Emerald Team: Domestic Crime & Serious Sexual Offence	Bedfordshire Police
Joy Leighton	Senior Operations Manager	Victim Support – IDVA Service
Joy Piper	Strategic Manager, Domestic Abuse <sup>9</sup>	CBC Children’s Services

<sup>8</sup> For more information, go to: <http://respect.uk.net>.

<sup>9</sup> Located in CBC Children Services but leads on domestic violence and abuse for the council which has a Corporate Domestic Abuse Board.

Leire Agirre	Principal Social Worker, Head of Safeguarding & Quality Improvement	CBC ASC
Lisa Scott	CSP & Communities Manager	CBC Community Safety Team
Lucy Giles	Consultant	Safe Lives <sup>10</sup>
Marcel Coiffait	Director	CBC Community Services
Martin Westerby	Head of Public Health Programmes, Drug & Alcohol and Stop Smoking Services	CBC Public Health
Mel Gunstone	Assistant Director, Nursing and Quality	Bedfordshire CCG
Michael Howe	Chief Executive	Families First Bedfordshire <sup>11</sup>
Michelle Bradley	Director	Mental Health and Wellbeing Services, ELFT
Nichola Keer	Associate Director of Nursing – Safeguarding	Bedford Hospital
Sandra Rome	Service Manager	Carers in Bedfordshire <sup>12</sup>
Toni-Marie Doherty	Adult Safeguarding Lead	Luton & Dunstable Hospital
Zara Jane	Service Manager	Path 2 Recovery (P2R), ELFT

- 1.3.2 *Independence and expertise:* Review Panel members were of the appropriate level of expertise and were independent, having no direct line management of anyone involved in the case.
- 1.3.3 The Review Panel met a total of four times, with the first meeting of the Review Panel on the 4<sup>th</sup> September 2018. There were further meetings on the 10<sup>th</sup> December 2018, the 25<sup>th</sup> February 2019 and the 3<sup>rd</sup> June 2019. The Overview Report and Executive Summary were agreed electronically thereafter, with Review Panel members providing comment and sign off by email in June and July 2019.
- 1.3.4 The chair wishes to thank everyone who contributed their time, patience and cooperation.

#### **1.4 Chair of the DHR and Author of the Overview Report**

<sup>10</sup> For more information, go to: <http://www.safelives.org.uk>.

<sup>11</sup> For more information, go to: <http://familiesfirstbedfordshire.org.uk>.

<sup>12</sup> For more information, go to: <https://www.carersinbeds.org.uk>.

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- 1.4.1 The Chair and Author of the Review is James Rowlands, an Associate DHR Chair with Standing Together Against Domestic Violence (STADV). James Rowlands has chaired and authored five previous DHRs and has previously led reviews on behalf of two Local Authority areas in the South East of England. He has extensive experience in the domestic violence sector, having worked in both statutory and voluntary and community sector organisations.
- 1.4.2 Standing Together Against Domestic Violence (STADV) is a UK charity bringing communities together to end domestic abuse. We aim to see every area in the UK to adopt the Coordinated Community Response (CCR). The CCR is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety. It is paramount that agencies work together effectively and systematically to increase survivors' safety, hold perpetrators to account and ultimately prevent domestic homicides.
- 1.4.3 STADV has been involved in the Domestic Homicide Review process from its inception, chairing over 60 reviews, including 41% of all London DHRs from 1st January 2013 to 17th May 2016.
- 1.4.4 Independence: James Rowlands has no current connection with the local area or any of the agencies involved. James has had some contact with Central Bedfordshire prior to 2013 in a former role, when he was a Multi-Agency Risk Assessment Conference (MARAC) Development Officer with SafeLives (then CAADA)<sup>13</sup>. This contact was in relation to the development of the local MARAC as part of the national MARAC Development Programme and is not relevant to this case.
- 1.4.5 James identified a requirement of the Review Panel to include agencies with particular expertise even though they had not been previously aware of the individuals involved as described in 1.5.3 below. As James has relationships with some of the agencies that would likely meet this requirement (he is an Associate for SafeLives and is a Board Member for Respect), this was declared. The CSP made the final decision as to which agencies to invite.

## **1.5 Terms of Reference for the Review**

- 1.5.1 At the first meeting, the Review Panel shared brief information about agency contact with the individuals involved. Given what appeared to be the limited contact with agencies, it was agreed to extend the period of time that would be reviewed from 1998 (when Andrew and Olivia are believed to have met) to the date of the homicide. This extended time period is consistent with recent research into domestic homicides involving adults over 60 years of age, which has suggested that in a long-standing relationship a longer timescale may be required in order to identify relevant information from the more distant past<sup>14</sup>.
- 1.5.2 *Key Lines of Inquiry:* The Review Panel considered both the 'generic issues' as set out in statutory guidance and identified and considered the following case specific issues:

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<sup>13</sup> For more information, go to: <http://www.safelives.org.uk>.

<sup>14</sup> Benbow, S.M., Bhattacharyya, S. & Kingston, P. (2018) 'Older Adults and Violence: An Analysis of Domestic Homicide Reviews in England Involving Adults over 60 Years of Age, *Ageing and Society*, pp.1–25.



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- The communication, procedures and discussions, which took place within and between agencies.
- The co-operation between different agencies involved with Andrew or Olivia [and wider family].
- The opportunity for agencies to identify and assess domestic abuse risk.
- Agency responses to any identification of domestic abuse issues.
- Organisations' access to specialist domestic abuse agencies.
- Policies, procedures and training available to the agencies involved on domestic abuse issues.
- Specific consideration of the following issues:
  - Alcohol use
  - Mental health
  - Adults at Risk
  - Carer Status
  - Identification, management and assessment of domestic abuse, including counter-allegations and 'who does what to whom'.
- Any evidence of help seeking, as well as considering what might have helped or hindered access to help and support.

1.5.3 Given the considerations in relation to Protected Characteristics, a number of agencies were invited to be part of the DHR due to their expertise even though they had not been previously aware of the individuals involved. These agencies were: Carers in Bedfordshire; Families First Bedfordshire; Respect; and SafeLives. They are listed as Review Panel members in 1.3.1 above.

## **1.6 Summary of Chronology**

### *Andrew*

- 1.6.1 Andrew had very limited contact with statutory services, with this relating to health providers and Bedfordshire Police.
- 1.6.2 In relation to health, Andrew had almost no contact with his GP, the Kirby Road Surgery. However, he did have contact with the A&E at Department at Luton & Dunstable Hospital on two occasions in 2016. He first presented following a fall and smelling of alcohol. He later presented with a knife blade injury to his leg. On both occasions his treatment was appropriate. Additionally, Kirby Road Surgery received a notification about his attendance. However, the Review Panel has identified issues with the quality and use of discharge notifications when sent from local hospitals to GPs. This has already been identified as an issue locally and work is underway to address this. The Review Panel has made recommendations to monitor the progress of this work.

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- 1.6.3 The only other substantive contact with Andrew was with Bedfordshire Police when he was arrested in January 2018. Following his arrest, Andrew made a number of disclosures relating to Olivia, including her alleged use of and threats with a knife. In relation to this contact, the focus was on Olivia as the victim. The Review Panel has made a recommendation because possible risk to Andrew was not considered and nor was this information shared. More broadly, the Review Panel has identified issues in relation to local practice about male victims and the identification, management and assessment of counter-allegations.
- 1.6.4 Although there was no contact between Andrew and CBC ASC, it is of note that when Bedfordshire Police identified concerns about Olivia, they also identified the possibility that Andrew had a caring role. These issues were considered by CBC ASC when Olivia and Andrew came to attention during an initial review of the referral from Bedfordshire Police. However, the Review Panel has identified that when the case, and accompanying recommendations, were passed to a locality team for action it was treated as a routine request for an assessment. This meant concerns around both possible domestic violence by Andrew, as well as issues around Andrew's possible carer status, were not addressed. A number of recommendations have been made by CBC ASC's IMR to improve policy, practice and case management systems as a result.
- 1.6.5 Based on the information available to the Review Panel, Andrew may have had an alcohol use issue. However, there is no evidence that he sought help for this. The Review Panel has considered local alcohol services as part of the DHR and made some recommendations in relation to the identification and offer of brief advice by professionals in relation to alcohol use.

*Olivia*

- 1.6.6 Olivia also had limited contact with statutory services, although this was more extensive than Andrew. Like Andrew, the contact Olivia did have was principally with health providers and Bedfordshire Police.
- 1.6.7 Olivia had significant contact with both her GP, West Street Surgery, as well as contact with Luton & Dunstable Hospital. This contact related to a range of issues, principally relating to her physical health. Based on the information available to the Review Panel, Olivia may have had an alcohol use issue, however this was not apparent to any professional during any of these health contacts.
- 1.6.8 A further contact is of note: In 2012 Olivia attended the A&E Department at Bedford Hospital and said she wanted to see a psychiatrist. Olivia left before seeing a medical professional and West Street Surgery thereafter received a discharge notification. Olivia also had other contacts with West Street Surgery around her mental health treatment. However, at no point was she offered a referral to other mental health support. As a result, West Street Surgery has identified some learning around the support offered to patients and their access to counselling.
- 1.6.9 The only other substantive contact with Olivia was with Bedfordshire Police, when they attended an incident in January 2018. Following the arrest of Andrew, Olivia said she would not support any charges but did speak with a police officer. This incident triggered contact by Victim Support, although Olivia declined further support.
- 1.6.10 Following this incident, a police officer identified a number of contacts and made a referral to CBC ASC in January 2018. The Review Panel has identified some differences between the approach by

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Bedfordshire Police and CBC ASC but was satisfied that this referral was appropriate. It also led to a thorough assessment being completed by CBC ASC, with a range of recommendations being made that addressed potential concerns about domestic violence and abuse. However, as noted in relation to Andrew above, when this information was passed to the locality team for action, the case was treated as a routine request for an assessment. This meant concerns were not addressed and, when Olivia did not respond to contact attempts, the case was closed. A number of recommendations have been made by CBC ASC's IMR to improve policy, practice and case management systems as a result. Additionally, the Review Panel has made recommendations in relation to local referral pathways. This is because of the potential for the duplication of support offers that were identified in this case. The Review Panel has also recommended that guidance be developed in relation to raising concerns about abuse and neglect.

## 1.7 Analysis

- 1.7.1 The cross-government definition of domestic violence and abuse refers to “*any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality*”.
- 1.7.2 In relation to the first part of this definition (“*any incident*”), Andrew was clearly the victim of a fatal act of domestic violence and abuse. He died from a stab wound inflicted by Olivia; his death is the reason that this DHR was initiated and Olivia has since been found guilty of manslaughter.
- 1.7.3 However, when considering the definition in its broader sense (“*pattern of incidents*”), the picture is less clear. The information available to the Review Panel (some known at the time, some with the benefit of hindsight) is both limited and contradictory.
- 1.7.4 Indeed, there is information that could suggest that either Andrew or Olivia were experiencing domestic violence and abuse:
- For Andrew – after the incident on the 6<sup>th</sup> January 2018, Andrew told the police that Olivia had said to him that: “*I’ll knife you then*”. Andrew also said that threats by Olivia to “*knife*” him had happened in the past although he described these as “*off the cuff*” comments.
  - Additionally, Andrew attended the A&E Department at Luton & Dunstable Hospital for treatment after a fall in June 2016, and then for a blade injury to his leg after a fall in November 2016. While there is no information available that would indicate domestic violence and abuse was a cause for concern at the time, and Andrew provided a plausible account for the blade injury, it is of note that one of these incidents involved a knife.
  - For Olivia – During a 999 call to Bedfordshire Police on the 6<sup>th</sup> January 2018, the call handler could hear sounds of disturbance and a female screaming in the background. Olivia later told police officers that she had been physically held and restrained by Andrew following an argument.

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- Additionally, after the incident on the 6<sup>th</sup> January 2018, Andrew told police officers during an interview that he would frequently “wind up” Olivia. Andrew stated he had been doing this for some 22 years, and from his account, this related to Olivia’s former relationships. As part of the murder enquiry, Olivia’s daughter told police officers that Andrew would “wind-up” her mother. Meanwhile, there was a single report that Andrew was not welcome to see Olivia’s son, because he had once made a threat to his child.

1.7.5 This conflicting information is also reflected in the account given by Andrew’s sister (Dawn) and a friend (Matthew). Additionally, there were also some incidents that were considered by the Review Panel where there is simply not enough information to know what happened.

1.7.6 Finally, two further issues were noted:

- Clearly money was an issue. Andrew had lost his job in 2016, although he had some casual employment thereafter, while Olivia did not work. Additionally, the home that Andrew and Olivia shared was owned by Olivia. Consequently, the Review Panel considered whether there was any evidence of financial abuse. While there were possible indicators, the Review Panel felt it had insufficient information available to reach a determination; and
- The F750 completed by Bedfordshire Police included a report that the property was “freezing”, and that Olivia had said that she hadn’t eaten as “Andrew is responsible for this”. These issues are explored further in relation to vulnerability and adult safeguarding below.

1.7.7 Given these factors, the Review Panel was unable to reach a determination as to the presence of a broader pattern of domestic violence and abuse in the relationship. This is because:

- Andrew may have been a victim of domestic abuse from Olivia, particularly given reports that Olivia had threatened to use a knife in the past, and this could have been the cause of an injury on a previous occasion. Andrew was also knocked unconscious at least once. Finally, his sister (Dawn) reported that he was punched and kicked by Olivia and was fearful that Olivia would kill Andrew; but alternatively,
- Olivia may have been a victim of domestic violence and abuse from Andrew. Dawn said that Olivia told her that Andrew was beating her up. Additionally, there are reports that Andrew would make comments about past relationships (jealousy is a risk indicator in domestic abuse<sup>15</sup>) and that a male was heard shouting at the property (although Andrew told Bedfordshire Police that this was because Olivia found it hard to hear). The significant age gap, as well as her long-term illness and possible concerns relating to vulnerability, may have also increased Olivia’s risk of experiencing domestic violence and abuse<sup>16</sup>. In

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<sup>15</sup> Campbell, C., Glass, N., Sharps, P., Laughon, K and Bloom, T. (2007) Intimate Partner Homicide: Review and Implications of Research and Policy, Trauma, Violence and Abuse, 8(3), pp. 246-269.

<sup>16</sup> Smith, K (ed) (2014) *Homicides, Firearm Offences and Intimate Violence 2009/10*: Supplementary Volume 2 to Crime in England and Wales 2009/10. Available at: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/116512/hosb0111.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/116512/hosb0111.pdf) (Accessed 30<sup>th</sup> January 2019).

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this context, it is possible that Olivia may have used 'violent resistance' (i.e. violence utilised in response to domestic abuse) against Andrew.

- 1.7.8 However, it is also possible that both Andrew and Olivia had experienced violence and abuse, with the pattern of abuse changing over time. Alternatively, the relationship may have consistently featured bi-directional violence which would mean the relationship was marked by 'situational couple violence' (i.e. violence that is not embedded in a general pattern of power and control but is a function of the escalation of a specific conflict or series of conflicts). These definitions for 'typologies' of intimate partner violence are most commonly ascribed to the work of Michael Johnson<sup>17</sup>.
- 1.7.9 Whatever the nature of the relationship, it is also likely that alcohol use was an issue, featuring in the accounts given to Bedfordshire Police by family and friends.
- 1.7.10 Because the Review Panel was unable to reach a determination as to the presence of a broader pattern of domestic violence and abuse in the relationship, it agreed to use the learning from this case to explore practice more broadly. The Review Panel explored three areas:
- Male victims of domestic violence and abuse;
  - Identification, management and assessment of domestic abuse, including counter-allegations and 'who does what to whom and with what effect'; and
  - Older people and domestic violence and abuse.

## **1.8 Conclusions and Key issues arising from the review (Add issues as required)**

- 1.8.1 Andrew's death was a tragedy. He was a dearly loved brother, and his death has affected his family deeply. Andrew had limited contact with services, and the lessons to be learnt from this contact are discussed below. The Review Panel is grateful to Dawn for her contribution to the DHR, as it has allowed this DHR to have a picture of Andrew as a person – for example his sense of humour, as well as his affection for his nephews.
- 1.8.2 However, this DHR has been complicated by the limited information available to the Review Panel about the relationship between Andrew and Olivia. What's more, the information that is available is open to a range of different interpretations. Although Andrew was clearly the victim of a fatal act of domestic violence, looking beyond this, it has not been able to determine whether he experienced domestic violence and abuse in the broader sense of an ongoing pattern of behaviour. It is possible he did so. However, as discussed in the analysis, it is also possible that Olivia was the victim of violence and abuse. If Olivia had experienced violence and abuse from Andrew prior to the homicide, this has significant implications for the lessons to be learnt in this DHR. As a final consideration, it is also possible that both Andrew and Olivia may have been using violence and abuse. Acknowledging the complexity of this case, as well as these different possible scenarios,

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<sup>17</sup> Johnson, M. P. (2008) *A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and Situational Couple Violence*. Boston: Northeastern University Press.

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does not however diminish Olivia's responsibility for the fatal act of violence that killed Andrew, an act which led to her conviction for manslaughter.

- 1.8.3 There is lastly the wider context of Andrew and Olivia's lived experience, which included issues such as alcohol use, but also concerns around possible vulnerability and / or care and support needs.
- 1.8.4 Given these issues, the Review Panel has sought to try and understand what happened and consider the issues in Andrew and Olivia's lives that might help explain the circumstances of the homicide.
- 1.8.1 The Review Panel expresses its sympathy to all those affected by the death of Andrew, in particular Andrew's family and friends.

**1.9 Lessons to be learned**

- 1.9.1 The learning in this case includes learning which is related specifically to agencies and their interactions with Andrew and / or Olivia. There has also been broader learning that has come about by using this tragic case to reflect on issues in relation to male and older victims, as well as alcohol use.
- 1.9.2 In relation to this specific case, the most substantive learning relates to Bedfordshire Police and CBC ASC. In relation to the former, the Review Panel has identified a specific issue with the timeliness of onward referrals once a case has come to the attention of Bedfordshire Police. The good practice demonstrated by Bedfordshire Police in identifying concerns relating to Olivia following the incident on the 6<sup>th</sup> January 2018 could have been compromised by the length of time it took for their referral to reach CBC ASC. More concerningly, although Andrew made disclosures about possible risk, these were not addressed. This meant no DASH RIC was completed, counter-allegations were not considered, and this information was not shared. In relation to CBC ASC, while the Review Panel has identified examples of good practice in the initial assessment, a breakdown of internal communication meant that ultimately neither Olivia nor Andrew were assessed. CBC ASC is to be commended for making a significant number of single agency recommendations to address policy, practice and case management systems as a result of its participation in this DHR. There has also been learning for health providers, including hospitals and GPs, particularly in relation to the quality and response to discharge notifications.
- 1.9.3 The Review Panel was mindful that, even if agencies had responded differently to this case, Andrew and Olivia had limited engagement with services. This could have presented considerable challenges to agency involvement. As a result, while different responses (including a carer's assessment or a Section 42 assessment) could have created opportunities for engagement, they may not have led to a different outcome. However, this is not to suggest that Andrew and Olivia could not have been helped. Professionals and agencies must be able to identify, and take proactive steps to respond to, concerns. Even if someone is not able to take up offers of support, agencies should be seeking ways to ensure that people are aware of what help and support is available and take, where possible, measures to provide a 'safety net' should they seek help in the future.

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- 1.9.4 Considering broader learning, the Review Panel has made recommendations relating to the importance of a gendered approach to domestic violence and abuse as this allows for the specific consideration of the needs of male victims. In this context, while it is positive that CBC has a Corporate Domestic Abuse Board, the Review Panel has recommended that local strategic arrangements are reviewed to ensure these can support the delivery of a robust CCR.
- 1.9.5 Additionally, the Review Panel has identified learning around a range of other issues. This case illustrates how different agencies can have a very different understanding of vulnerability, and a recommendation has been made to ensure that there is a good understanding of how local agencies raise concerns about abuse and neglect.
- 1.9.6 In relation to specialist domestic abuse service, the Review Panel has recommended that local providers (and their commissioners) address a gap locally by developing shared policy, procedure and training for the identification, management and assessment of counter-allegations across domestic abuse services. A disparity in HIDVA provision was also the subject of a recommendation. While neither Andrew nor Olivia engaged with a HIDVA, both attended A&E departments at different times, which is an important reminder of the opportunity that a HIDVA service may represent.
- 1.9.7 Following the conclusion of a DHR, there is an opportunity for agencies to consider the local response to domestic violence and abuse in light of the learning and recommendations. This is relevant to agencies both individually and collectively. Many of the recommendations made in this DHIR will help develop local processes, systems and partnership working. The Review Panel hopes that this work will be underpinned by a recognition that the response to domestic violence is a shared responsibility as it really is everybody's business to make the future safer for others.

**1.10 Recommendations from the review:**

**IMR Recommendations (Single Agency)**

- 1.10.1 The following single agency recommendations were made by the agencies in their IMRs:

*CBC ASC*

- 1.10.2 Case allocation and case closure sections within the operational policy will be updated by Integrated Services to reflect any revisions/improvements made within the system.
- 1.10.3 When practitioner/ supervisor case closure discussions occur narrative, risk assessment and outcome will be recorded on the customer database. Team managers will highlight this expectation to all practitioners via individual team meetings to aid reflection and learning and ensure that practitioners are not reliant of systems and processes and are using mechanisms such as peer discussions, reflective practice, auditing and reflective case supervision and utilising available managerial support in their day to day practice.
- 1.10.4 A corporate letter template will be drafted by Integrated Services and sanctioned for use when corresponding with the public around engagement/contact obstacles.
- 1.10.5 The current customer database training will be reviewed by learning and development with practitioner involvement to ensure training modules are available to the workforce until the

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replacement system is in situ. Locality teams will identify system champions who can offer assistance to less experienced practitioners when required.

- 1.10.6 The programme that is overseeing the procurement of a new electronic client database will ensure that robust training and operational guidance is available to the workforce prior to introduction of the new customer database system.
- 1.10.7 Manager within Integrated Services will present this and other similar cases as a reflective case study so that team discussions can take place and assist in developing confidence and competence in this area of social work practice. The Practice surgeries and the Practice Forum will be used for further learning and to inform how we approach cases where there are indications of domestic abuse.
- 1.10.8 Policies and procedures relevant to safeguarding and domestic abuse will be highlighted to all practitioners via practice surgeries.
- 1.10.9 To ensure all workers are equipped and supported to have conversations about domestic abuse it is recommended that the learning needs analysis captures and is agreed as a priority for this topic.
- 1.10.10 All practitioners undertaking safeguarding activity to continue to have access via the domestic abuse partnership to a variety of domestic abuse training modules, including training relating to male victims.
- 1.10.11 'Research in Practice for Adults' have been commissioned to deliver Safeguarding- Coercive and Controlling Behaviour training in March 2019. This subject was the 'topic of the month' in July 2018 following practitioner interest in additional learning in this area".
- 1.10.12 Where referrals are received from the Police relating to a domestic incident arrest and information and detail is sparse, the Safeguarding Team will make attempts to contact the PPU. The PPU will receive an email requesting urgent contact and further detail be shared with the safeguarding team and relevant locality team.
- 1.10.13 The Head of safeguarding will review the Pan Bedfordshire Safeguarding Policies and Procedures by end of December 2018 and the Operational subgroup of the board will ratify the proposed changes.

*Bedford Hospital*

- 1.10.14 Continue with awareness raising through structured training, and team training events of Domestic Violence.
- 1.10.15 Development of an e-learning package.
- 1.10.16 Aide Memoire being developed for nursing and medical professionals in regard to identifying signs of domestic violence.

*Luton and Dunstable Hospital*

- 1.10.17 The DHR findings will be shared with trust staff via departmental meetings and clinical governance
- 1.10.18 A summary of the findings of this investigation will be discussed within Children's and Adults Safeguarding training sessions provided by the Trust".



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*West Street Surgery*

1.10.19 Refresher Domestic Abuse training as incorporated in the Level 3 Safeguarding Training for all Clinical staff.

1.10.20 Review Mental Health/Counselling Pathway.

**DHR Recommendations:**

1.10.21 The Review Panel has made the following recommendations:

1.10.22 **Recommendation 1:** The Ministry of Justice to develop guidance for prisons in relation to their role in the DHR process, including the pro-active steps they should take to enable engagement with perpetrators.

1.10.23 **Recommendation 2:** The CSP to work with partners in the BDAP to agree a mechanism for collating and sharing findings and recommendations systematically from local DHRs.

1.10.24 **Recommendation 3:** The Corporate Domestic Abuse Board to ensure that its review of CBC's Domestic Abuse Strategy takes a gender informed approach, and that the revised strategy identifies the specific actions that will be taken, proportionally to need, to support male victims.

1.10.25 **Recommendation 4:** The CSP should review existing strategic arrangements with local partners to ensure that these can support a robust multi-agency CCR locally.

1.10.26 **Recommendation 5:** CBC Children Services to ensure that the 'get help' section of the BDAP website is reviewed to make it more easily navigable.

1.10.27 **Recommendation 6:** The CSP and the relevant commissioners to work with Victim Support and the Signpost Hub to develop shared policy, procedure and training for the identification, management and assessment of counter-allegations across domestic abuse services locally.

1.10.28 **Recommendation 7:** The Corporate Domestic Abuse Board to ensure that its review of CBC's Domestic Abuse Strategy identifies the specific actions that will be taken to support older victims.

1.10.29 **Recommendation 8:** Bedfordshire Police to ensure there is a consistent and robust process for the subversion all of domestic abuse incidents / crimes, with this supported by a training package that ensures that Police Officers and their supervisors are confident in the use of risk tools.

1.10.30 **Recommendation 9:** Bedfordshire Police to audit the timeframes for referrals made at periods of peak demands and identify mitigating actions to ensure prompt onward referral to partner agencies.

1.10.31 **Recommendation 10:** The SAB to develop guidance on raising concerns about abuse and neglect.

1.10.32 **Recommendation 11:** The SAB to audit local referral pathways for adults who are victims of domestic abuse, and for whom there may be vulnerability or safeguarding concerns, to ensure these offer a robust response regardless of whether someone meets the level for statutory intervention.

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- 1.10.33 **Recommendation 12:** Within the Better Care Fund Plan for Central Bedfordshire, the Bedfordshire CCG and CBC review funding for local HIDVA services to ensure that there is a consistent and equitable service offer.
- 1.10.34 **Recommendation 13:** Bedfordshire CCG to work with GPs to monitor the impact of the changes to the discharge notifications from local hospitals and ensure that this GPs take follow up action if required.
- 1.10.35 **Recommendation 14:** Public Health Commissioners to develop a programme to raise awareness of best practice in relation to the identification and offer of brief advice by local services in relation to alcohol use
- 1.10.36 **Recommendation 15:** The Pan Bedfordshire Learning Academy to review the current training available in relation to male victims of domestic abuse and ensure that:
- (a) Key messages are integrated across all introductory training
  - (b) Staff can access intermediary and advanced level training.
- 1.10.37 **Recommendation 16:** The Pan Bedfordshire Learning Academy to ensure that domestic abuse training content addresses typologies of domestic violence and abuse.
- 1.10.38 **Recommendation 17:** The Pan Bedfordshire Learning Academy to review the current training available locally and ensure it addresses the identification, management and assessment of counter-allegations. This should include integrating key messages across training content and also developing bespoke training content.