Domestic Homicide Review Overview Report

'Gerry'

Died: March 2017

Tony Blockley - Chair
Paul Johnston - Report author
December 2018

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Preface

'Gerry' is not the real name of the person who was unlawfully killed in Doncaster in March 2017; the pseudonym was chosen to safeguard his identity. The Doncaster Community Safety Partnership Domestic Homicide Review Panel would like to express its profound condolences and sympathy to Gerry's family and friends.

None of Gerry's family nor the perpetrator or her family have accepted invitations to participate in the review.

The key purpose of undertaking a Domestic Homicide Review is to enable lessons to be learnt when someone is killed because of domestic abuse. For these lessons to be learnt as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change to reduce the risk of such tragedies happening again. Gerry's death met the criteria for conducting a Domestic Homicide Review under Section 9 (3)(a) of the Domestic Violence, Crime, and Victims Act 2004, in that his homicide was committed by someone to whom he had been in an intimate relationship (that person later pleaded guilty to Gerry's manslaughter).

The Home Office defines domestic violence as:

'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. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial, and emotional'.

Controlling behaviour is: *'A range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.'*

Coercive behaviour is: *'An act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.'*

The term domestic abuse will be used throughout this review as it reflects the range of behaviour encapsulated within the above definition and avoids the inclination to view domestic abuse in terms of physical assault only.

1

INTRODUCTION

1.1 This is the Report of a Domestic Homicide Review (DHR) following the death of Gerry in March 2017; his girlfriend Susan (not her real name), was charged with his murder. It provides an independent overview of the service provided to Gerry and to Susan by agencies that had contact with them. The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.2 The review has not sought simply to examine the conduct of professionals and agencies. To illuminate the past to make the future safer, the review has been professionally curious and has sought to find a trail of abuse and to identify which agencies had contact with the victim, perpetrator or family and which agencies were in contact with each other. The aim was to recommend solutions to help recognise abuse and either signpost victims to suitable support or to design safe interventions.

1.3 In an effort to view events through Gerry's eyes so as to understand the reality of his situation, the review sought, without success, to involve those around him including his family, friends and neighbours.

2

TIMESCALES

2.1 Gerry and Susan were living on-and-off together in a town within the Doncaster Metropolitan area. In line with agreed protocols, the police notified the Safer Stronger Doncaster Partnership of the circumstances of Gerry's death in March 2017. All agencies were then asked to undertake a review of their records to identify any information they had about Gerry and Susan. They were also asked to secure their records.

2.2 In consultation with local partners, all of whom understand the dynamics of domestic abuse, the Chair of the Community Safety Partnership notified the Home Office of his decision to commission a Domestic Homicide Review in March 2017. The review commenced the same day, but in consultation with the police Senior Investigating Officer, it was then suspended until the completion of the criminal proceedings against Susan. It re-commenced in June 2017 and concluded on 1st November 2018. The review panel met on nine-occasions

2.3 The CSP acknowledges that the review has taken longer to complete than usual, but the delay is due to a combination of attempts to source additional information to add to the richness of the review and to staff turnover within the CSP. There was a major transition period within the Local Authority and as a consequence there were no panel meetings between November 2017 and August 2018. The dissemination of lessons learned from the review was not adversely affected by the delays.

3

CONFIDENTIALITY

3.1 The pseudonym Gerry was chosen by the review panel with a view to protecting his true identity. He was in his teens when he died, and his self-defined ethnicity was White British.

3.2 Until the report is published it is marked: *Official Sensitive Government Security Classifications 2018.*

4

SCOPE AND TERMS OF REFERENCE OF THE REVIEW

4.1 Scope

The review panel determined it appropriate to review each agency's involvement with Gerry and with Susan from May 2015, the date their relationship commenced, until his death in March 2017.

4.2 Because both Gerry and Susan were known to services prior to May 2015, agencies were asked to provide summaries of any historical information that may have been relevant to the review.

4.3 Terms of Reference

The Terms of Reference for the review were set to determine whether:

- The incident in which Gerry died was an isolated incident or whether there were any warning signs and whether more could be done to raise awareness of services available to victims of domestic abuse
- There were any barriers experienced by Gerry or his family/friends/colleagues in reporting any abuse in Doncaster or elsewhere, including whether they knew how to report domestic abuse, should they have wanted to
- Gerry had experienced abuse in previous relationships in Doncaster or elsewhere and whether this experience impacted on his likelihood of seeking support in the months before he died
- There were opportunities for professionals to 'routinely enquire' as to any domestic abuse experienced by Gerry that were missed
- Susan had any previous history of abusive behaviour to an intimate partner and whether this was known to any agencies
- There were opportunities for agency intervention in relation to domestic abuse regarding Gerry or Susan or to any dependent children that were missed
- Any training or awareness raising requirements were identified that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and/or services in the region

5

METHODOLOGY

5.1 This overview report has been compiled from analysis of the multi-agency chronology and the information supplied by agencies that had been involved with Gerry and with Susan. The findings of previous reviews and research into various aspects of domestic abuse have also been considered as well as other relevant references including the Home Office guidance for conducting domestic homicide reviews.

5.2 Agencies that had been involved were asked to produce Individual Management Reviews (IMR's) and summary reports. They were also asked to include a comprehensive chronology that charted the involvement of the agency during the period determined by the DHR panel, to include a summary of the events that occurred, intelligence and information known to the agency, the decisions reached, the services offered and provided to the victim, the perpetrator and their families and any other action that was taken. Further, the IMRs were to be completed with the review 'Terms of Reference' in mind and consider not only whether procedures had been followed, but whether, on reflection, they had been adequate.

Comment: *The aim of an IMR is to look openly and critically at individual and organisation processes and practices and to provide an analysis of the service they provided.*

5.3 IMR authors were also asked to arrive at a conclusion about the service provided by their own agency and to make recommendations, where appropriate. Agencies with knowledge of Gerry and/or Susan before the dates set for the review, were asked to provide a summary of their involvement. In addition, they were asked to include information that came to light after Gerry's death that might identify learning for the future.

5.4 The panel determined that matters concerning the Gerry's family, the public and media would be managed by the review chair before, during and after the review.

5.5 The review panel took account of coroners or criminal proceedings (including disclosure issues) in terms of timing and attempting to contact Gerry's family and friends to ensure that relevant information could be shared without incurring significant delay in the review process or compromise to the judicial process.

6

INVOLVEMENT IN THE REVIEW

6.1 ### FAMILY ENGAGEMENT

6.2 Gerry's mother was invited by letter to participate in this review, but she did not respond. The report author has twice visited her home address, but she was not in. The Home Office leaflet about domestic homicide reviews was left for her together with a note to contact the author, but to date she has not done so.

6.3 ### INVITATION TO SUSAN TO PARTICIPATE IN THE REVIEW

6.4 Susan has not responded to an invitation to participate in this review.

6.5 FRIENDS AND WORK COLLEAGUES

6.6 No friends of Gerry were identified during the review. He was not in any form of employment.

6.7 AGENCY CONTRIBUTIONS TO THE REVIEW

6.8 As is standard practice, on notification of a potential domestic homicide, a multi-agency scoping exercise was undertaken to ascertain whether agencies had any record of involvement with Gerry or with Susan. The following agencies responded positively and were asked to provide IMRs:

- Doncaster Children's Services Trust
- St Leger Homes of Doncaster Limited
- Emma House
- NHS Doncaster
- Doncaster and Bassetlaw Teaching Hospitals NHS Trust
- South Yorkshire Police
- West Yorkshire Police
- Primary Care – GPs

6.9 The authors of all the IMRs were independent in that they had no previous involvement with Gerry or with Susan or any line-management responsibility for staff that had been involved with them.

6.10 THE REVIEW PANEL MEMBERS

6.11 The review panel consisted of the following, all of whom were independent in that they had not previously been involved with Gerry or with Susan or had line management responsibility for anyone who had:

Name	Organisation
Tony Blockley	Johnston and Blockley - Review Chair
Paul Johnston	Johnston and Blockley - Report author
Nancy Higgins	Community Safety
Dave Wade (Replaced by Andy Millar)	South Yorkshire Police
Richard Fawcett	Senior Head of Service (North and Central Localities) Doncaster Children's Services Trust
Julie Jablonski	St Leger Homes
Cal Lacey	IDVA Service, Doncaster Council
Kim Goddard	RDaSH
Ian Boldy/Jenny Rayner/Andrea Ibbeson	Doncaster CCG

Pat Johnson	Doncaster and Bassetlaw Teaching Hospitals NHS Trust
Karen Shooter	Domestic and Sexual Abuse Theme Manager – Doncaster Council
Andrea Hamshaw	Workforce Development Officer – Doncaster Council

6.12 The review panel met on the following dates:

22nd March 2017	2nd November 2017
20th June 2017	15th November 2017
19th July 2017	30th August 2018
9th August 2017	1st November 2018
12th September 2017	

6.13 REVIEW CHAIR AND AUTHOR OF THE OVERVIEW REPORT

6.14 The Safer Stronger Doncaster Partnership requested tenders from suitable applicants to act as chair and overview report author for this review. Following a competitive process, Tony Blockley was commissioned to undertake the role of review chair and Paul Johnston was appointed overview report author.

6.15 Tony is a senior lecturer at Derby University and is also completing a PhD in domestic violence and abuse, with a focus on risk identification and analysis. He is chair of the multi-agency child sexual exploitation strategic group within Derbyshire, the vice-chair of a domestic violence and sexual abuse services charity and the victims-lead on the advisory board for 'No Offence' CiC. Previously, he was responsible for a police department that included all aspects of public protection. He devised and delivered training for specialist services that included safeguarding and multi-agency working.

6.16 Paul is an authority on homicide review and investigation, having led over 70 murder investigations, many of which were of a 'domestic' nature. He was head of police homicide review and then the criminal investigation department and later became Deputy Director of a project investigating over 3,000 deaths associated with 'The Troubles' in Northern Ireland. He has been Chair or report author in over 60 domestic homicide reviews. He belongs to an international investigation facility that provides expertise in investigations of the worst crimes known to humanity and is a consultant and expert witness in cases at the European Court of Human Rights involving abduction, murder and domestic abuse femicide. Currently, he is one of four experts appointed by the United Nations Special Rapporteur on extrajudicial, summary or arbitrary executions to examine the murder Jamal Khashoggi within in the Saudi Arabian consulate building in Istanbul.

6.17 Both Tony and Paul are completely independent of all the agencies and individuals that have been involved in the review.

7

PARALLEL PROCESSES

7.1 There was a thorough police investigation into the circumstances surrounding Gerry's death and subsequent court proceedings which resulted in the conviction of Susan for his manslaughter.

7.2 Gerry's death was referred to the Coroner, who opened an inquest and then adjourned it because Susan had been charged with his murder. The report author understands there are no plans to re-open the inquest proceedings.

8

EQUALITY AND DIVERSITY

8.1 There has been nothing during the review to suggest that Gerry, Susan or their respective families were treated less favourably on any protected characteristics as defined by the Equality Act 2010 or that any protected characteristics had a detrimental impact on contact and response to the reported domestic abuse incidents. In fact, due to their young ages, there was probably more time and resources expended on their care than would normally be the case.

8.2 Gerry and Susan were both identified as white British with no specific ethnic, cultural, linguistic and religious identity that would make them more susceptible to being either a victim or perpetrator. In addition, there was no diagnosed disability, gender identity, marriage and civil partnership, pregnancy and maternity, or sex and sexual orientation issues identified. Both young people identified as heterosexual.

8.3 No agency held information that indicated Gerry or Susan lacked capacity and there is no indication from the material seen by the review panel that a formal assessment of capacity was ever required for either of them.

9

DISSEMINATION

9.1 Whilst key issues identified by the review will be shared appropriately, the report will not be disseminated until clearance has been received from the Home Office Quality Assurance Panel. The IMRs will not be published. The DHR report will be made public and the recommendations will be acted upon. The content of the report and executive summary is anonymised in order to protect the identity of the victim, perpetrator, their family members, staff and others, and to comply with the Data Protection Act 2018 and General Data Protection Regulation (GDPR). The report will be produced in a form suitable for publication after any Home Office approved redaction has taken place.

Comment: *Specifically, the report will be shared as follows:*

- *Gerry's family will be written to in advance of publication telling them of the date and place it is to take place*
- *Police and Crime Commissioner for South Yorkshire*
- *Susan's Offender Managers from HM Prison and Probation Service*
- *Safer Stronger Doncaster Partnership*
- *Doncaster Children's Services Trust*

- *St Leger Homes of Doncaster Limited*
- *Emma House*
- *NHS Doncaster*
- *Doncaster and Bassetlaw Teaching Hospitals NHS Trust*
- *South Yorkshire Police*
- *West Yorkshire Police*
- *Primary Care – GPs*

10

BACKGROUND INFORMATION

10.1 Through no fault of his own, Gerry did not have a fortunate start to his life; he experienced issues at home which saw him being taken into the care of the local authority. He had difficulty controlling his temper and from a young age he engaged in criminal activity and took drugs, in particular 'legal-highs'.

10.2 He became involved with Susan, who was also in care, in May 2015. They both appeared to struggle with life in the care system and typical of many young people in their situation, despite the best efforts of professionals, their lifestyles at times became chaotic.

10.3 Gerry and Susan were still only teenagers when she stabbed him in the chest with a knife. He was taken by ambulance to hospital, but by the time the ambulance arrived, Gerry was in full cardiac arrest; Paramedics tried to save him, but despite their best efforts, Gerry died a short time later.

10.4 Susan appeared at Crown Court in June 2017, where she pleaded guilty to the manslaughter of Gerry. She was sentenced to five-years imprisonment.

11

MALE VICTIMS OF DOMESTIC ABUSE

11.1 Abuse of men takes many of the same forms as it does against women - physical violence, intimidation and threats; sexual, emotional, psychological, verbal and financial abuse; property damage and social isolation. Many men experience multiple forms of abuse. Men, more so than women, can also experience legal and administrative abuse - the use of institutions to inflict further abuse on a victim, for example, taking out false restraining orders or not allowing the victim access to his children.

11.2 Determining the true extent to which men are victims of domestic abuse is difficult because they may be more reluctant to report it, but three-quarters of domestic violence incidents reported to the police are perpetrated by men.

11.3 Numerous studies and surveys over the past several decades have shown that men of all ages and ethnicities are less likely than women to seek help for all sorts of problems, including physical health issues, depression, substance abuse and relationship issues, even though they encounter those problems at the same or greater rates than women.

11.4 Men tend to externalise distress more than women and are more likely to be destructively violent to themselves and to others. Many learn from childhood that they are not supposed to express vulnerability or caring and that they should suppress emotional responses to the extent that by the time they are adults, they can genuinely be unaware of their emotions and

how to articulate them. Men with higher levels of traditional masculinity ideology have a negative opinion of seeking help because of their denial of vulnerability, a consequence of which can be an inability to have truly intimate relationship; men often conflate sex with intimacy.

11.5 The studies do indicate though a tendency for men to discuss issues around their physical or mental health with their intimate partner before finally taking steps to seek professional support, but when it comes to domestic abuse, for obvious reasons, a man is highly unlikely to ask the person who is abusing him if she thinks it a good idea that he seek help to cope with her abuse.

11.6 Yet even when men do eventually seek help, there is evidence that less extreme forms of male distress may routinely go unrecognised because men effectively abandon psychological reflection. Consequently, men's psychological needs may go unmet until extreme behaviours come to the attention of agencies.

11.7 When relationship breakdown occurs, men are more likely to respond with any number of unhealthy coping strategies, such as using excessive amounts of alcohol, which may or may not lead to violence, using illicit drugs, working excessively long hours to avoid going home, risk-taking or attempting to take their own lives.

11.8 Victims of domestic abuse often face barriers to reporting what is happening to them. For men, there can be additional barriers such as:

- They may be told that there must be something *they* did to provoke the perpetrator's abuse
- They can suffer shame, embarrassment and the social stigma of not being able to protect themselves 'like a real man would'
- They can feel uncertain about where to seek help, or how to seek help
- Services are less likely to ask whether a man is a victim of family violence, and when they do ask, they are less likely to believe him
- Male victims can be falsely arrested and removed from their homes because of the assumption that because they are male, they must be a perpetrator and not a victim. When this happens, children can be left unprotected from the perpetrator of the violence, leading many men to suffer the abuse in silence in an attempt to protect their children.

12

CHRONOLOGY OF AGENCY INVOLVEMENT WITH GERRY AND WITH SUSAN

12.1 The next section of this report will detail what each agency knew about Gerry and about Susan before the events of March 2017. An analysis of the involvement of the agency will also be included where appropriate.

12.2 DONCASTER CHILDREN'S SERVICES TRUST (DCST)

12.3 Doncaster Children's Services Trust (DCST) is an independent organisation set up to deliver children's social care and support services to children, young people and families in Doncaster. DCST was established and started operation in October 2014 as an innovative way to provide these services following an agreement with national government and the local authority and was the first of its kind in the country. The Trust undertakes statutory responsibility on behalf of the local authority for the safeguarding and protection of children and young people through the Children Act 1989 and Children Act 2004.

12.4 WHAT DONCASTER CHILDREN'S SERVICES KNEW OF GERRY AND SUSAN PRIOR TO 1ST MAY 2015

12.5 GERRY

There was nothing recorded by Doncaster Children's Services (CSC) prior to 1st May 2015 to indicate that Gerry was either a perpetrator or a victim of domestic abuse, but there were two contacts with Children's Social Care before September 2012.

12.6 The police had found Gerry after he had gone missing from home after causing damage to his father's car in September 2012. He had then refused to go home.

12.7 Gerry's parents made a referral in January 2013 and an assessment concluded that Gerry was of an age where he was seeking an increased level of independence and freedom. His mother appeared to accept it whereas it was noted that his step-father was less tolerant and had unrealistic expectations. It was also noted that the situation was causing conflict and tension within the home.

12.8 There was another referral in May 2013, this time by Gerry's grandparents. He was living with them, but they felt unable to cope with his challenging behaviour. Following an assessment, Gerry became a 'looked after child' when he was 14 (until he was 18). During that period, he committed acquisitive crime and his status changed for a short period when he was remanded to the local authority under a Youth Offending Order, but effectively he remained a 'looked after child'.

Comment: *Under the Children Act 1989, a child is looked after by a local authority if a court has granted a care order to place a child in care, or a council's children's services department has cared for the child for more than 24 hours. On reaching the age of 18, children cease to be considered looked-after by a council.*

12.9 Various attempts throughout the care period were made to engage with Gerry's mother and stepfather to return him to their care. However, both parents refused to have him back and at times they didn't attend meetings in respect of his wellbeing (Gerry was not in contact with his birth-father).

12.10 The previous good relationship with his maternal grandparents became irreparably damaged because of Gerry's ongoing bad behaviour; they refused to have him live with them again.

12.11 Throughout the period of care leading up to 1st May 2015, Gerry was accommodated in several placements, both residential and foster care; he was moved several times due to 'placement breakdown'.

Comment: *Gerry was accommodated in several towns and cities. Throughout that time, he was reported missing on 77-occasions. Changing placements is something that is avoided wherever possible, but if a foster carer (or residential provider) gives notice that they wish a child's placement to end there is often little that can be done about it and alternative arrangements need to be identified. As a result, some young people, particularly those with more challenging behaviours can experience more frequent placement moves.*

12.12 SUSAN

Susan first came to the attention of Children's Social Care in July 1999 when she was made subject of a Child Protection Plan (CPP) for neglect, until November 1999. She had two-more periods where she was subject of CPP – August 2000 to February 2002, again for neglect and in May 2008 to December 2008 for neglect, parental mental health and parental substance misuse.

12.13 Susan became a 'looked after child' in March on 2009, when she was ten, initially through an Interim Care Order and then a final Care Order under the Children Act 1989. The order was sought because Susan had suffered considerable neglect from her family, including concerns about parental drug misuse, parental domestic abuse and a general lack of parental supervision. She remained in care until she was 18.

12.14 While she was in care, Susan was accommodated in both residential and foster settings; she also moved several times due to placement breakdowns, living in five different towns. During that time, she was reported missing on 46-occasions.

Comment: *As mentioned previously, some placements end at the request of the placement providers. Although efforts are made to enable a placement to continue through offers of support, providers cannot be compelled to carry on. Sometimes, the only available alternative is for a young person to be placed outside their own district and occasionally, a deliberate choice is made to move a young person away from the area based on assessment of their specific needs.*

12.15 In early 2015, Susan gave birth. Due to concerns about her during her pregnancy, her unborn child had been made subject of a Child Protection Plan and later became cared for under a Special Guardianship arrangement with its paternal grandmother.

Comment: *Gerry was not the father of the child.*

12.16 It is known that Gerry and Susan formed an intimate relationship soon after they met in May 2015. Concern was raised by a support worker about arguments between the two of them which appeared to be escalating.

Comment: *They met at one of a number of local third-sector providers of accommodation for young people aged 16+ who have nowhere else to live and for whom supported independence is the most appropriate form of provision. Referrals are made primarily by children's social care providers directly to the organisations, based on the needs of the young person being matched to the type of provision and support that is available.*

There is no record of DASH risk-assessments (Domestic Abuse, Stalking, Harassment and 'Honour Based Violence') being completed, but at the time it was not as commonplace for social workers to undertake them. It is now expected that in cases involving domestic abuse (regardless of the ages of the perpetrator or victim) that a DASH assessment will be completed by the Social Worker alongside the statutory assessment of need. There is also an expectation however, that the level of analysis within the statutory assessment of need (which for children in care is updated every six-months) would be greater than that contained within a DASH assessment.

DASH risk-assessment tool questions are based on extensive research of domestic abuse. The aim is to make an accurate and fast assessment of the danger a person is in, so the right help may be provided as quickly as possible.

12.17 There had been an incident in late-August 2015 when Susan had initially made an allegation of assault against Gerry but had then said it had only been a verbal altercation, (assessed as DASH Medium-risk).

Comment: *The risk-assessment was completed by the police.*

12.18 Then in early September 2015, Susan suggested that her relationship with Gerry was over because there had been numerous arguments between them over the previous weekend and in early October 2015, it was reported that Susan was in another relationship and that she had said the new partner was verbally abusive towards her and that she hit him when he refused to stop.

Comment: *Throughout this period, both Gerry and Susan were known to be using drugs and their behaviour became more aggressive as a result of it. There was a risk-management meeting on 13th July 2015 in respect of all the young people in the same placement. Key actions included:*

- *Additional support in respect of substance misuse within the placement*
- *Placement planning so that they would not all remain placed together*
- *Placements to have their allowances split (rather than receiving it in one lump sum) and to have supervised shopping to reduce the ability to purchase drugs*

Domestic Abuse Navigators (DANs) were created by the Doncaster Children's Services Trust to support children and young people affected by domestic abuse, but they did not exist at the time. It is clear however, that abuse between Gerry and Susan was a factor in assessments, but that no specific services were engaged. That would not happen now.

12.19 In mid-October 2015, Gerry was in Susan's flat when he was overheard to say, *"I'm sick of you punching me all the time. You're mental and I am not losing my tenancy over you".*

Comment: *When staff later asked Gerry about it, he said it had only happened once that and there was no violence in their relationship.*

12.20 On the same day, Gerry was reported to have had a small cut to his forehead, but he would not say how it had happened. Three-days later, Gerry was seen being verbally aggressive towards Susan, standing over her in an intimidating manner and on another occasion, Gerry was reported to have had a flick-knife that belonged to Susan. He had allegedly used it to slash the tyres of a car owned by a member of staff after he had been asked to leave his accommodation.

12.21 The accommodation provider's records also contained entries to the effect that Gerry had been verbally abusive towards Susan, accusing her of being in a relationship with someone else (November 2015), that Susan had said she was finding it difficult to end her relationship with Gerry (also November 2015) and that both of them had been arrested for assaulting a train conductor (December 2015).

12.22 Doncaster CST received a call from Social Care in January 2016, about an incident that occurred after Susan had gone to Gerry's placement in another city in South Yorkshire. The police had been called and Susan had told them that she had been in a relationship with Gerry for nine-months and that he had always been verbally aggressive towards her. She also said he had turned physically violent and that he had bruised her elbow, arm and leg. Children's Social Care recorded that the police had spoken to Gerry and to Susan and that they had been obstructive, but otherwise there were no issues other than two-young people being in a flat together and who were having an argument.

12.23 A Strategy Meeting was convened in early-February 2016 which was attended by DCST social work staff responsible for both Gerry and Susan, an LAC Nurse and the police (please see analysis section, below).

12.24 The records also indicate that in mid-February 2015, Susan left her accommodation with Gerry, even though he was not meant to be there. It was reported to West Yorkshire Police (See West Yorkshire Police section later), with a note being made that the 'Police Officer appeared unconcerned for [Susan's] welfare'. At the same time the police in West Yorkshire disclosed two incidents at Gerry's registered address that had taken place within two-days of one another. They said that Susan had threatened to stab Gerry with a kitchen knife and that she had punched him in the face. It was also known that Susan had stayed with Gerry over the previous weekend.

Comment: *Gerry had been moved to West Yorkshire in an attempt to keep him and Susan apart. Records indicate that on 29th February 2016, the police from West Yorkshire interviewed Susan about assaulting Gerry, but that no further action was taken because neither would pursue a complaint.*

12.25 Another Strategy Meeting took place at the beginning of March 2016 after a CSC in West Yorkshire had raised concerns with their counterparts in Doncaster about the behaviour of the couple. The meeting notes detail the recent history of incidents between them and demonstrate a comprehensive understanding of complicating factors involved, including drug use, offending, anti-social behaviours, absconding and placement breakdown. By this time, both had been moved from their previous placements to different towns.

12.26 There is no record of a DASH risk-assessment or the police notification on CSC files for either Gerry or Susan. Action from the meeting included:

- Social Workers to continue to make attempts to engage both young people in work around relationships, actively continue to offer support via services such as CAMHS and substance misuse services. Also, to progress securing a DANs worker for both young people
- Both Social Workers to complete a joint chronology of incidents of DV and other concerns in respect of Gerry and Susan
- Susan to be encouraged to visit Women's Aid and to progress the Freedom programme
- Gerry to be encouraged to consider the Foundation for Change programme

Comment: *Gerry and Susan both refused to engage with relationship work with either social workers or with DANs. Further efforts were made to engage Gerry with CAMHS services, which proved to be especially difficult because they are geographically bound and as soon as a referral was made to one CAMHS service Gerry was moved, meaning that the case was closed in the original area and the process had to start again.*

The encouragement given to Susan to engage with Women's Aid/Freedom programme and to Gerry to consider the Foundation for Change programme was not acted upon by either of them.

12.27 In mid-April 2016, a Children Missing Operations Group (CMOG) raised concerns about Gerry, following the completion of a vulnerability checklist. The concerns included ongoing substance misuse and access to money for drugs, not seeking medical attention when it was required and continued episodes of going missing. There followed a strategy meeting four-days later attended by the police, Gerry's social worker, the current placement provider and an 18+ worker who was supporting transition from care services. It was identified that Gerry had visited Susan at her placement in another town and among the list of actions was for Susan's social worker to be updated if there were reports that Gerry was with her.

Comment: *The Children Missing Operational group was established to ensure a coordinated response to those most at risk through Child Sexual Exploitation and going missing.*

12.28 Records indicate that over the following weeks, there were several occasions when the couple were attempting to resume their relationship:

- April – Gerry arrived at Susan's placement asking to see her, but he was refused entry
- April – Gerry's social worker reported that the relationship was definitely back on
- June – Information was received that they were once more in a relationship. Susan denied it but admitted meeting him recently. She was warned that her tenancy did not allow Gerry to be in her flat. Gerry's social worker reported that he had stayed there over the weekend
- June – Susan's mother confirmed that Gerry had moved into the flat
- June – During a statutory visit, Susan was verbally abusive, and Gerry was found hiding in the toilet
- August – A statutory visit had to be abandoned after both Susan and Gerry had become abusive.

12.29 ANALYSIS OF THE SIGNIFICANT CONTACTS MENTIONED ABOVE

12.30 Although there were several contributing factors which hindered progress with Gerry and Susan in respect of domestic abuse (and many other aspects of their care), there is ample evidence that practitioners tenaciously pursued better outcomes for them with genuine care for their wellbeing. The prioritisation of needs was uppermost in workers minds within the context of their roles and domestic abuse was identified as an issue, even if this wasn't always the main priority.

12.31 It is clear that the strategy of physical disruption to prevent Gerry and Susan from maintaining a relationship did not work, despite the considerable effort and hard work to achieve it. The pair shunned efforts to educate and support them about domestic abuse and healthy relationships, even to the extent of deploying tactics to avoid discussing it.

12.32 CSC staff considered Gerry and Susan to have chaotic lifestyles, but they also acknowledged that to them, their behaviour may well have felt normal. There were occasions however when there was some recognition by both Gerry and Susan that taking drugs and resorting to physical and verbal abuse was not healthy. When they did appear to want to change their ways, they were unable to sustain their engagement with services. The side effects of the drugs they were both taking was considered to have been the probable cause of their non-engagement, as was their inability to disengage from each other; they said they had a *"Shared history"* and they *"Understood each other"*

Comment: *It is not known what was really meant by the terms 'shared history' and they 'understood each other', but the likelihood is that they felt they had endured similar life experiences to one another.*

12.33 A significant amount of time and effort was put into securing accommodation for Gerry and Susan as the primary concern. Staff were frustrated by the failure of strategies to engage with them, which was attributed to entrenched behaviour and observable detachment from significant adults throughout their lives. Reponses from CSC staff were pragmatic and practical but lacked a comprehensive understanding of domestic abuse strategies and practice, particularly when young people were involved. This was evidenced during IMR preparation, where awareness of training was apparent, but there was little knowledge

evident of research in the area of practice or access to the young people's domestic violence advisors role in Doncaster.

12.34 Children's Social Care staff did respond to incidents through appropriate procedures to look to protect the young people within a frame-work of child safeguarding, but not always in a timely manner or consistently. They may have been influenced by police decisions when it came to domestic abuse with a level of deference of perceived wider knowledge of what could be achieved. It is unclear what level of questioning or challenge CSC staff made about these decisions, but it is clear that staff lacked knowledge and experience of DASH risk-assessment and the Multi-agency Risk Assessment processes (MARAC); had they had the knowledge, it may have supported more active dialogue.

Comment: *The IMR author sought to determine whether the lack of a criminal prosecution influenced the intervention of social workers but was unable to form a definitive view either way.*

A MARAC is a victim focused information sharing and risk management meeting attended by all key agencies, where high risk cases are discussed. The role of the MARAC is to facilitate, monitor and evaluate effective information sharing to enable appropriate actions to be taken to increase public safety.

12.35 There was a reliance on staff to work together by choice rather than design, coupled with lack of a clear chronology, particularly around domestic abuse, which impacted on their capacity to reflect and to understand the risks and needs and to respond accordingly. Whether this would have made a difference in terms of the outcome is unknown because both Gerry and Susan had developed both physical and psychological avoidance skills and techniques and a co-dependency on each other.

12.36 The records appear to focus upon Gerry's needs for accommodation rather than to significantly highlight the risk of domestic abuse between the couple and it is not clear whether Gerry was moved solely for reasons of domestic abuse or whether it was also an attempt to tackle his criminality, drug taking and other disruptive behaviour.

12.37 Strategy Meeting notes indicate it was agreed that although Susan was in an unhealthy relationship with Gerry and everything was being done to discourage the match, they continued with it. CSC specifically detailed an action for the accommodation provider to ensure they knew where Susan was and not to report her missing until they have carried out all their checks. Additional actions included Gerry being moved to another city as a means of disruption, but with continuity of support by the same provider along with exploring the possibility of his attending a perpetrator course.

12.38 It is clear that the disruptive activity together with consideration of a perpetrator programme were appropriate and there is also evidence that Susan's social worker was progressing one-to-one work with her on relationships, as well as work on sexual health through the LAC Nurse. The social worker specifically expressed her wish to engage with Susan to challenge her thoughts about the domestic abuse she was experiencing in the hope she would recognise how unhealthy and damaging it was.

Comment: *There is no mention in Children's Social Care records of any consideration around Susan entering a perpetrator's programme.*

12.39 Staff who were interviewed during the preparation of the agency IMR said that the support they offered to Gerry and to Susan both around domestic abuse was declined no matter how hard they tried to work with them on a one-to-one basis. They were both teenagers and

reports indicate they considered the attempts to help them an interference in their lives rather than an attempt to support them.

12.40 It is noted that Gerry was offered perpetrator services, while Susan was offered victim services. This appears at odds with the original reports that Gerry was the victim or that both were seen by some staff as being 'as bad as each other' and equally violent. There is a question of whether unintentional gender bias played a part in the decision-making as well as a lack of understanding about typologies of abuse. It is known that DAN's, through Doncaster Children's Services Trust was developing specific responses to different typologies of abuse as part of the Innovations Programme. One of the social workers contacted the DAN service to ask for an allocated worker and was offered 'Information, Advice and Guidance' in the first instance to understand the nature of the concerns and potential action including mentoring. This was not taken forward, but instead it was decided to pursue the work with Susan using the Freedom Programme. It is not known whether contact with a DAN would have made a difference or a fuller assessment with emerging research would have helped.

12.41 LEAVING CARE

12.42 Arrangements and responsibility for young people, as care leavers when they became 18 change under legislation. The Section 20 arrangements for Gerry and the Care Order for Susan were automatically discharged. Instead the obligation rested on DCST to assess their needs through a Pathway Plan with young people becoming 'eligible' for services until they are twenty-five. Being adults, they were no longer required to access the services.

Comment: *The way that Doncaster Children's Services Trust delivers its services to care leavers has been reconfigured and children in care no longer transfer to the leaving care team (now known as Inspiring Futures) at 18. Instead they will transfer to the Inspiring Futures Team at 16 which enables them to build up closer relationships with the service and provides a better transition into adulthood. By the time that young people reach 18 and leave care, their needs, strengths and vulnerabilities are better understood and thus they can be supported more effectively by someone who they have already known for two years. In addition, workers in the Inspiring Futures team have developed expert knowledge around accommodation for young adults as well as accessing benefits, training and employment.*

12.43 Contact arrangements for young people when they reach 18 change from statutory visits (being not more than every six-weeks apart) when children are looked after, to having 'meaningful contact', with the minimum expected to be every twelve-weeks. The Doncaster 18+ Team had set this 'meaningful contact' at eight-weeks. Although this was difficult with Gerry and with Susan due to their disengagement, it was achieved by workers tenaciously pursuing the contact with them.

12.44 The formal transfer of Susan's case to the 18+ Team took place in October 2016, although she had already been attending regularly to collect her weekly living allowance and was therefore familiar with the staff. However, there were already a few failed planned appointments with her about matters relating to her Pathway Plan, one of which was an appointment to complete a St Leger Housing application form.

12.45 The day before, Susan reported that Gerry had 'kicked her in the ribs'. It was recorded that a Targeted Youth Support Worker had seen an incident in the street and had described it as *'contact made with clothing'.*

Comment: *The description 'contact made with clothing' indicated there had been no physical contact and that the incident had been a minor one.*

12.46 The social worker actively supported Susan to report the incident to the police and it was recorded in the case notes that the police arranged to see her at her friend's address. There are no further records about the incident despite the social worker asking her about it several times. The social worker said she had been unable to get any information about the incident from the police because of issues of confidentiality.

12.47 A chronology for Susan was not available to be shared with the police, nor was it possible to correlate notifiable information from the police about her because she was now an adult and not a vulnerable child in care.

12.48 Due to increasing concerns for Gerry, a Care Leavers at Risk Panel (CLAR) was convened with representation from the 18+ Team and a Youth Justice Officer to complete a Vulnerable Young Persons Checklist. This Checklist (risk-assessment) is not on Gerry's case file to review but is known to have been evaluated as high-risk. Part of the risk was that Susan's mother had reported that Gerry had been wielding a knife at her daughter, which had been reported to the police.

12.49 In terms of actions from the CLAR, it was agreed that the social worker would buy a mobile phone for Susan and would draw up a risk-plan. The social worker had doubts about how effective it might be though, stating *'The safety plan was initiated by me with [Susan] although I wasn't sure how far she accepted this'.* The mobile phone was collected by Susan's mother.

Comment: *The CLAR Panel was only attended by workers specific to Gerry. Given the history between him and Susan, it is recognised now that this did not contribute to a good exchange of information and it left only a list of actions for Susan's worker to deal with.*

12.50 ST LEGER HOMES OF DONCASTER LIMITED (SLHD)

12.51 St Leger Homes of Doncaster Limited (SLHD) is an 'arms-length' management company set up by Doncaster Council to manage all council housing in the Doncaster Borough. Some 21,300 homes are managed along with a portfolio that includes Housing Options services for Doncaster which offers an advice and information service for people who are homeless or threatened with homelessness or in some form of housing need.

12.52 St Leger Homes is a member of the Safer Doncaster Partnership, contributing both strategically and operationally to Doncaster's co-ordinated response to address the complexity and dynamics of domestic abuse. It is also a member of the Domestic Abuse and Sexual Abuse Theme Group, MARAC, MAPPA and various Task and Finish Groups.

12.53 Gerry and Susan contacted St Leger Homes separately as 'care leavers' requiring move-on accommodation during the period of this review.

12.54 GERRY

Gerry's first contact with St Leger Homes was when he approached Housing Options in October 2016 as a homeless person. It was established that Gerry was a care leaver, originally from Doncaster and that he had been living in a semi-independent placement in another city until funding had ceased on his 18th birthday. He was then placed in temporary accommodation by the 18+ Team at Doncaster but he had been evicted from there because of his drug use.

12.55 Housing Options contacted the 18+ Team who confirmed the eviction and said they had approached other supported accommodation providers but had been unable to secure accommodation for Gerry because of his drug use and his behaviour. Housing Options managed to secure accommodation for Gerry for one more night, pending investigations.

12.56 Gerry's next attendance at Housing Options was in late-October 2016. He presented as homeless stating he had stayed in temporary 'out-of-hour's' accommodation the previous night. Staff telephoned the 18+ Team to ask for advice on further placements and Gerry was referred to an emergency bed for the weekend. Further referrals were completed for accommodation providers for young people.

12.57 He attended again a few days later and said he had been on the streets all weekend after deciding not to access the emergency bed that had been allocated to him. Enquiries were made which revealed that Gerry had attended the emergency accommodation on Friday evening but had left after 30-minutes saying he was going to his girlfriends. A further referral for an emergency bed was completed.

12.58 The following day, Housing Options was told that Gerry had attended the accommodation the previous night but had left after five-minutes. Gerry came back to Housing Options and said he did not use the emergency bed because he did not want to stay around drug addicts. He gave details of family members who were contacted but they refused to accommodate him. The 18+ Team were also contacted but they were not in a position to offer any further housing because Gerry had failed to take up the accommodation previously.

12.59 In late-October 2016, Housing Options contacted various housing providers and identified a suitable vacancy for Gerry. Viewing and sign-up was completed the following day.

12.60 There was no further contact with Gerry until the end of January 2017, when he again presented at housing options accompanied by a member of the 18+ Team. He said he had been evicted from his shared accommodation. Housing Options telephoned the provider who confirmed that he had been asked to leave on three occasions for damaging property, allowing Susan to stay with him, providing her with a set of keys and abandoning his room. He said he had been living at Susan's flat, but he could not stay there any longer because he had been arrested for domestic abuse against her.

12.61 When he was asked about Susan, he became abusive and was told he would have to leave if it continued. He said he had slept-rough the previous night and that he believed he had mental health issues and that he wanted to be arrested again. He threatened the housing options staff member, telling her that she had *'better watch out'.* He threatened to burn the building down and he then tried to smash the windows. When he was taken out of the building by security staff, he kicked the windows and doors from outside.

12.62 SUSAN

Susan's initial contact with St Leger Homes was when she approached Housing Options at the end of September 2016, accompanied by her support worker. She said she was a care leaver who had received a notice to quit her current supported accommodation.

12.63 In late-October 2016, she telephoned housing options to say she was homeless but had made her own arrangements to stay with her family temporarily. She was told that she had been awarded 'Full Duty' homeless in November 2016, placing a duty on St Leger Homes to re-

house her. She was told about the allocation/bidding process and she confirmed she could continue staying with family and friends until she had secured the accommodation. She made a successful bid on a property tenancy and moved in during mid-January 2017. A post-tenancy visit was completed in March 2017 when she said she had settled in well and did not need any further support.

12.64 ANALYSIS OF THE SIGNIFICANT CONTACTS MENTIONED ABOVE

12.65 Established processes and procedures were correctly utilised in respect of Gerry and Susan and there was clear evidence of a desire to support them both. St Leger Homes has an up to date policy and procedure in respect of domestic abuse which is accessible electronically and training is offered as 'essential to role' for staff, with domestic abuse awareness being included in the safeguarding awareness training.

12.66 EMMA HOUSE

12.67 Emma House provides 24-hour, safe and progressive support in a nurturing residential setting to young people aged 16 and above who are in the process of making the transition from dependent to independent living. This is done through the delivery of a structured programme of support, consisting of an initial five-week assessment, a support plan developed in partnership with the young person, an individually tailor-made life skills programme and structured schedule of activities that promote being healthy, staying safe, enjoying and achieving, achieving economic wellbeing and making a positive contribution. Emma House prides itself on its multi-agency partnership working approach and has established excellent working relationships with a number of local and referring authorities.

12.68 SUMMARY OF WHAT EMMA HOUSE KNEW ABOUT GERRY

12.69 Gerry arrived at Emma House in June 2016 and left in October 2016. He had contact with his mother about three-weeks before he left the residence, but Emma House was not aware of him having any other family contact although on rare occasions, he was visited by his girlfriend, Susan.

12.70 Gerry was a private person. He made no disclosures of abuse and kept himself to himself. He was pleasant and respectful and generally got on well with fellow residents and staff. There was one incident of threatening behaviour however, which was directed at another young person who had stolen Gerry's phone, but the matter was resolved with Gerry being recompensed.

12.71 He was a daily psychoactive substance user, for which he was offered and accepted support from the Corner Drug Support Service. It was a voluntary arrangement and Gerry stopped going there after about four-weeks.

Comment: *The Corner Drug Support Service no longer exists, and it has not been possible to access any of their records.*

12.72 Gerry engaged with key-work sessions, but he spent little time on them, despite staff encouraging him to do so. He rarely had use of a mobile phone through which the project could stay in daily contact with him. He was given mobile phones by his social worker, but he sold them. He was reported missing on a regular basis because of the inability of staff to contact him.

12.73 Gerry was a well-kempt young person, who usually took pride in his appearance, but there were periods when he would not care as much about how he looked; he would talk to staff about it and they offered to source therapeutic support for him, but he declined it.

12.74 PRIMARY CARE CONTACT WITH GERRY

12.75 SUMMARY OF GENERAL PRACTICE INVOLVEMENT

1.76 Gerry had been registered with 13-GP Practices over an 18-year period, so inevitably there was a lack of continuity in terms of provision of primary care and developing a relationship with a family doctor. There was evidence of several GP appointments that Gerry did not attend and on one occasion, an attempt was made to take him to an appointment, but he left the home before the nurse arrived, so the appointment had to be cancelled.

12.77 As far back as 2006, there were entries in his GP notes of behaviour and anger issues, which were said to be getting worse.

12.78 In 2013, there was an entry in the notes of Gerry being out all night taking MDMA and cocaine and in 2014, Gerry saw the GP about a nasal blockage due to cocaine use.

Comment: *MDMA, also known as ecstasy, is a psychoactive drug primarily used for recreational purposes.*

12.79 In August 2015, Gerry tested positive for chlamydia and gonorrhea. He subsequently attended the hospital for treatment.

12.80 Towards the beginning of January 2017, Gerry registered as a new patient with a GP practice. He said he had been living in a nearby city and he gave the name of his GP and the surgery. He also said he had been in care and was currently living in Doncaster in shared accommodation. He denied a history of alcohol or substance misuse at any point in the past and said his main problem was *'coping',* saying he got angry easily and struggled to control his mood. He said he had a girlfriend and he spoke very positively about the relationship, denying there was any verbal or physical aggression involved.

12.81 He also spoke positively about the future saying he wanted to train to become a plasterer; he wanted to work but said his mood and anger affected his ability to get work. He maintained good eye contact and expressed his feelings well. He added that he felt he had been low for many years, but he had future plans and goals. There were no delusional beliefs / hallucinations elicited. He said he had previously been involved with the crisis team, but they couldn't help him. The role of the crisis team in an emergency and their accessibility through the accident and emergency department was discussed. He admitted to having had thoughts of self-harm and suicide previously and said he had taken an overdose in past. He had no thoughts of overdose at present or self-harm and if he was to develop them, he was aware that help was available through the crisis team.

12.82 The role of talking therapies for coping strategies was also discussed. Gerry said he was keeping busy and had been going into town where he had been helping with a recent homeless event. It was agreed that Gerry would make contact again with talking therapies about coping mechanisms and a further appointment was made in two-weeks' time. He was prescribed Fluoxetine.

Comment: *Fluoxetine belongs to a group of drugs called selective serotonin re-uptake inhibitors. It works by increasing the amount of serotonin (a natural substance) in the brain. An increase in serotonin helps treat*

symptoms of depression, obsessive-compulsive disorder, bulimia nervosa, and panic attacks. Asking about domestic abuse was good practice and a safeguarding risk-assessment was completed because Gerry was a newly registered patient. The GP was unable to look at Gerry's past-records at the time, but the records were checked after surgery on the same day.

12.83 ANALYSIS OF THE SIGNIFICANT CONTACTS MENTIONED ABOVE

12.84 Good practice was demonstrated by the GP during Gerry's registration with the possibility of domestic abuse being explored and a risk-assessment being completed as well as exploration as to whether children were involved. Training was delivered to GPs in 2013 aimed at raising awareness of domestic abuse, routinely asking about it during consultations and then sharing information with other agencies. There was further training in 2014 highlighting the types of domestic abuse and the manner in which it can affect the lives of children.

12.85 The frequent movement of looked after children is an issue with primary care continuity. How to improve the care received by looked after children under 18 when there is evidence of non-attendance and who at times are not registered with a GP or/and dentist requires detailed exploration.

12.86 Another concern is the problems faced by Looked After Children regarding their access to services, for example, CAMHS referral and the continuity of care in primary care due to moving to placements in other areas. This complex issue cannot be addressed solely by NHS Doncaster and requires a wider discussion of the issues to see if solutions could be found.

12.87 DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS TRUST

12.88 The Trust has 720 in-patient beds across three sites, serving the population of Doncaster, Bassetlaw and surrounding areas. It provides a full range of acute and emergency care, as well as outpatient services across five sites.

12.89 WHAT THE DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS TRUST KNEW ABOUT GERRY

12.90 During the scope of this review the Doncaster and Bassetlaw Hospitals NHS Foundation Trust provided minimal health care services to Gerry, and what there was took place within the emergency department of the Doncaster Royal Infirmary.

12.91 Gerry's first attendance was in March 2015. He had been brought in by ambulance having told the ambulance crew that during the previous evening, he had smoked three-joints of cannabis and had drunk a large bottle of spirits. By the time he was due to be treated, he had left the department without being seen and without telling staff he was leaving. Emergency Department staff made a referral to the Children's Social Care in view of his age, the nature of the attendance, and the fact that he left without being seen.

12.92 His next attendance at ED was 7-months later, in October 2015. He had bruises and contusions to his ankle which he said had happened two-weeks earlier when he had jumped from a second-floor window. He was X-rayed and found to have no bony injuries. He was given analgesia and discharged from the department.

12.93 There was no further contact until April 2016, when he arrived with his Youth Offender support worker, who stayed with him throughout; he was found to have a fracture of a small

bone in his wrist. He was referred to the fracture clinic, as per protocol, for a follow up appointment but he did not attend it or a second appointment that he was given.

12.94 Six months later, he attended the emergency department again. He said he was suicidal and had felt that way for about two-weeks. He was referred to the Crisis Team, who saw him while he was in the emergency department.

12.95 The next time Gerry was in the department was when he was brought there by ambulance after the fatal attack. He had a stab-wound to his chest-wall and he was pronounced dead a short time later.

Comment: *Gerry had other contacts with the hospital before the period covered by this review. Many were unremarkable and were consistent with normal childhood activities and gave no cause for concern. In June 2013, he attended with a nose-bleed which he said had been the result of a fight and the following month, he had taken amphetamine based 'legal-highs'. A further referral was made to Social Care, and he was discharged with a Social Care plan in place. Care home staff were present throughout his attendance.*

12.96 ANALYSIS OF THE SIGNIFICANT CONTACTS MENTIONED ABOVE

12.97 The contacts with Gerry and with Susan happened as would be expected. There was no indication of domestic abuse in respect of either of them and there were no identifiable links between the two with neither being noted in each-others care records.

12.98 Referrals to support services were appropriate, for example, the Crisis Team, the Fracture Clinic, and Out-Patient services. There were no referrals required to other services, so the only communication was in the form of internal referral pathways.

12.99 The Trust has an up to date policy in respect of domestic abuse, with all staff being able to access it electronically. Training is offered as 'essential to role' for all grades of staff and includes e-learning packages and basic safeguarding training at level two.

12.100 SOUTH YORKSHIRE POLICE

12.101 The contact that South Yorkshire Police had with Gerry and with Susan were mirror-images of one another. Both were frequently absent from their respective care settings, with them invariably being found together. The contacts frequently involved the misuse of substances, criminality, anti-social behaviour and domestic abuse.

12.102 SUMMARY OF WHAT SOUTH YORKSHIRE POLICE KNEW ABOUT GERRY

12.103 Gerry first came to the attention of the police in 2013, following issues at home and disputes with other family members. He was placed into the care of the local authority and came into contact with the police again as a result of repeated periods of absence from care settings. He was engaging in criminal activity and the misuse of substances, in particular legal-highs.

12.104 Between May and December 2015, when both Susan and Gerry were residents at Local Authority supported accommodation for 16-18-year-olds, staff called the police on several occasions to deal with complaints of anti-social behaviour in relation to Gerry and those visiting him, in respect of their use and sale of 'legal-highs'. Gerry had also been in disputes with other residents. Despite investigations by the police, no criminal offences were identified, and the police were able only to give warnings about their future behaviour.

Comment: *At this time Gerry and Susan were in a period of transition from Children's Social Care to Adult Services.*

12.105 From October 2015, police contact with Gerry was often more to do with his relationship with Susan. Gerry appeared to find it increasingly difficult to control his temper and following a verbal argument between him and Susan, he was charged with an offence of criminal damage, for which he was given a Conditional Discharge for 12-months.

Comment: *All of these incidents were recorded as domestic abuse incidents and DASH risk-assessments were carried out.*

12.106 During 2015 and leading up to his death in 2017, agencies were involved with Gerry in respect of his aggressive behaviour with reports of domestic assaults, arguments with his mother and reports from local authority care residences of Gerry arguing with residents and of damaging property. Those of particular relevance to this review were:

- May 2015, Staff at a care home reported a smell of cannabis coming from the flat of one of their residents and that Susan, Gerry and another resident were present. No drugs were found
- January 2016 – Report of a heated argument between Gerry and Susan. Advice was given by the police, but no crime had been committed
- January 2016 – Allegation of assault by Gerry on Susan by ramming her head against a wall. Susan subsequently withdrew her complaint and no further action was taken
- January 2016 – Gerry was questioned by the police about an assault on a tram driver. No further action was taken
- February 2016 – Report from Gerry's mother of a heated argument outside her home in which Gerry threatened to damage her vehicle and tell everyone that she was a bad mother.

Comment: *This incident was DASH risk-assessed as standard due to Gerry's mother not taking the treats seriously and because Gerry was living in another city at the time.*

- April 2016 – Two reports from a care home of Gerry being abusive to staff, threatening them and kicking furniture. No criminal offences were evident, and no further action was taken
- May 2016 – Report from the same care home of the theft of money. Gerry was interviewed, denied the offence and no further action was taken
- August 2016 – Another report from the same care home that Gerry had caused damage to a staircase. Gerry was interviewed, denied the offence and no further action was taken
- September 2016 - The relationship between Susan and Gerry continued to be volatile with reports of damage and disturbances, including a third-party report of a young-man, believed to be Gerry, kicking and banging at the door of Susan's home address
- October 2016, Gerry was arrested for assaulting Susan, allegedly after they had met by chance in Doncaster town centre. He was charged with common assault and bailed to attend court. (He was still on bail when he died in March 2017)

- December 2016 – Report of Gerry committing a robbery with a knife, but subsequently the witnesses were unable to identify him

- January 2017 – Susan reported that Gerry had pushed her against a wall and had taken her phone following an argument. Susan subsequently refused to make a formal complaint.

12.107 SUMMARY OF WHAT SOUTH YORKSHIRE POLICE KNEW ABOUT SUSAN

12.108 Susan was under the care of Local Authority from 2009 and she was reported missing from home on several occasions from 2012 onwards. The police submitted numerous referrals to Children's social care and were involved in several meetings with local authority professionals about her welfare.

12.109 The police were concerned that Susan could have been at risk of child sexual exploitation; she was often found out of the area and overall, she showed a lack of engagement with agencies or any acknowledgement of concerns in relation to her own safety.

Comment: *There was no actual evidence of Susan being victim of child sexual exploitation, but the fact that it was considered serves as an indication that the police were concerned about her safety.*

12.110 In May 2015, the police were alerted to an incident where staff at the accommodation provider had reported a smell of cannabis coming from the flat of one of their residents and that Susan, Gerry and another resident were present. No drugs were found, and no offences were disclosed. This was the first of several contacts the police had involving Gerry and Susan together.

12.111 At the end of August 2015, Susan reported an incident to the police in relation to an assault by her boyfriend (not Gerry), When the police got there, she said there had only been a verbal altercation. The police risk-assessed the non-crime domestic incident as medium-risk and a referral to social care was submitted. The boyfriend was the father of Susan's child (the child was not in Susan's care).

Comment: *A 'non-crime' domestic incident is one where the circumstances indicate that an incident, or series of incidents, has taken place which may fall within the definition of domestic abuse and requires to be recorded as such, but where no substantive criminal offence is disclosed.*

12.112 Susan was known to be using 'legal-highs' and the police received reports that she was struggling to fund her drug use and that she was having problems with local youths about money she owed to them.

Comment: *In September 2015, both Susan and Gerry were taken to Doncaster Royal Infirmary, suffering adverse reactions to substances they had taken.*

12.113 Susan went to live with her grandmother in January 2016, although only briefly. She was struggling to come to terms with not having contact with her baby and her grandmother was unable to cope with her granddaughter's continued unruly behaviour and inability to adhere to any boundaries.

12.114 In February 2016, a strategy meeting was held because of the concerns raised about the domestic abuse between Gerry and Susan. A plan was made to move Gerry to West Yorkshire in an effort to widen the geographical gap between him and Susan. South Yorkshire Police

notified West Yorkshire Police at the point of him moving of their concerns in relation to domestic abuse between the couple, in addition to the likelihood of Susan finding Gerry wherever he lived. New accommodation was being sought at the same time for Susan.

Comment: *The decision to move Gerry to a placement in a different county was taken because nothing else had worked. The potential for either of them to abscond from their respective placements and to find one another was well known, but in an attempt to reduce the likelihood of it happening and therefore to reduce the chances of the domestic abuse continuing, it was felt the strategy was worth attempting.*

12.115 In late February 2016, the accommodation provider reported that Susan was making threats to stab staff, after she had been given an eviction notice earlier in the day. The police discovered that she did not have a knife. She was taken to an alternative address in Doncaster and was advised about her behaviour.

12.116 Susan continued being reported absent or missing between March and early August 2016, and the indications were that she was finding it difficult to settle in her new placement; she was often found at the home of her grandmother.

12.117 The relationship between Susan and Gerry continued to be volatile with reports of damage and disturbances, including a third-party report in September 2016 of a young man, believed to be Gerry, kicking and banging at the door of Susan's home address.

12.118 The following month, Susan's mother contacted the police following an argument with her daughter in the presence of her younger children. She did not wish to make a complaint, but she did say she was concerned about Susan's need to have support. A referral to social care was made.

12.119 In October 2016, Susan reported that Gerry had assaulted her following a chance meeting in Doncaster. A risk-assessment of 'Standard' was made by both the officer attending and the DARA team following a secondary risk-assessment. The tag on Susan's address was updated with the focus being given to investigating the complaint and the prompt arrest of Gerry. Gerry was arrested and was then bailed to appear at Doncaster Police Station in November 2016; he failed to answer his bail and was re-arrested in January 2017. He was charged with assault and with failing to surrender to custody and was then bailed again with a condition that he did not contact Susan. He had been due to appear at court on in May 2017.

Comment: *All domestic abuse incidents reported to South Yorkshire Police are subject to a secondary risk-assessment conducted by the DARA team. They conduct checks across all police systems in relation to both the victim and the perpetrator and will then complete a risk-assessment based on all the information available, including incidents where the victim may have been identified as a perpetrator. System alerts are generated as required, based on the vulnerabilities of victim(s) and perpetrators(s). DARA will then complete referrals as necessary and send them to partner agencies. All high-risk domestic abuse incidents are referred to MARAC.*

12.120 In early 2017, Susan reported that she and Gerry had had an argument about her ending her relationship with him. He had pushed her against a wall and had taken her phone. When the police arrived, she refused to make a formal complaint and said she would not support a prosecution. Gerry was reported for common assault.

12.121 In late January 2017, Susan reported hearing noises outside her property, which she thought could have been Gerry. When the police got there, they couldn't find anyone in the vicinity. Susan referred to Gerry as being her ex-partner. That was the last occasion the police had contact with Susan before Gerry's death in March 2017.

12.122 ANALYSIS OF THE SIGNIFICANT CONTACTS MENTIONED ABOVE

12.123 South Yorkshire Police have clear and defined procedures in relation to domestic abuse risk-assessments and officers are trained from induction onwards about them for both crime and non-crime domestic incidents. The only occasion a domestic abuse risk-assessment was not completed for either Gerry or Susan was in respect of the non-crime incident in October 2015 when Susan refused to answer any of the assessment questions.

12.124 However, the secondary risk-assessment team (DARA), was able to complete a risk-assessment from other sources of information, including previous domestic abuse incidents and data held across all police systems as well as from other agencies. The DARA team is fully resourced and afforded the necessary time to scrutinise information and to determine whether there appears to be an escalation of risk.

12.125 While none of the domestic abuse incidents were risk-assessed as high and therefore did not result in referrals into MARAC, there were referrals into social care and both Gerry and Susan were subject to meetings by multi agency professionals who could have referred into MARAC should they have felt this was necessary based on the risk level.

12.126 Since the incident in March 2017 involving Gerry and Susan, further guidance and policy amendments have taken place to ensure officers capture dynamic information following incidents to ensure all elements of risk are considered including where victims refuse to answer DASH questions. Observations and any comments of children at the property are included, with a focus on including sufficient information to ensure the assessment is valuable. Supervisors must quality assure all assessments, adding necessary commentary where required. DASH risk-assessments are subject of ongoing audits to ensure compliance, with learning being addressed through briefings and further training.

12.127 Information was shared appropriately with other agencies about domestic related incidents and the police participated effectively at strategy meetings in relation to Gerry and Susan. In addition, South Yorkshire Police made their colleagues in West Yorkshire aware of the domestic abuse between Susan and Gerry and the likelihood of them finding one-another following Gerry's move to a city in their area.

12.128 Generally speaking, Gerry was identified as the perpetrator within the relationship, but it is of note that the referrals submitted to social care reflected his vulnerability also.

12.129 ANALYSIS OF MISSING PERSON INCIDENTS

12.130 Between May 2015 and September 2016 (when Gerry was last recorded on police systems as being absent), he was reported absent from his local authority placement on over 20-occasions, with a further three reports of him being a medium-risk missing person. He was only 14 when he was first reported missing. In a similar pattern of behaviour, the first report of Susan going missing was when she was 13. During the timeframe of the review, she was recorded absent three-times and medium-risk missing from home on 17-occasions.

12.131 For the purposes of this review, the missing from home reports have been analysed which has identified the following key-themes:

- Contact was regularly made with staff in the care settings by both Gerry and Susan. saying they would soon return of their own accord

- On several occasions, Gerry and Susan were together when they were found
- When reporting Gerry missing and on occasions Susan, local authority staff would frequently state that they had no concerns about them
- An agreed plan was made between police and the care settings that staff would make enquiries to trace Gerry themselves before reporting him missing. Some of the reports were made prior to enquiries/checks being conducted to locate them. (The multi-agency protocol across South Yorkshire in relation to missing from homes includes an agreement that there would be attempts to locate the child prior to reporting the matter to the police
- Gerry and Susan frequently refused to answer any questions about their being missing
- In line with the multi-agency protocol in relation to Missing from home or Care and runaways, strategy meetings were convened in relation to both of them when they had been missing for more than 72-hours
- Attempts to keep them apart by moving their placements failed.
- Neither appeared to want to be separated or to be outside the Doncaster area
- There was a pattern of Gerry returning to the local authority care setting in another city between 12am and 1am.
- In May 2015, Susan had gone missing having been upset at missing a contact meeting with her son. In August 2015, she went missing after a meeting with social care to discuss future care plans for her son.

Comment: *In line with missing person risk-assessment guided by the College of policing risk principles, the national decision-making model and Police Code of ethics, children and young people would rarely be recorded as absent given that absent is described as there being "no apparent risk of harm to either the subject or the public". Guidance in relation to Missing person risk-assessment was reissued to all South Yorkshire Police officers in June 2017. At the time of the repeat missing episodes for both Susan and Gerry, a record of absent would be created where there was deemed to be no apparent risk to the subject or the public. The risk management in these instances centred on actions to locate the subject and gather further information from the informant with reviews in line to reassess the risk.*

12.132 WEST YORKSHIRE POLICE

12.133 West Yorkshire Police had four missing person records on their systems for Gerry when he was living in their area during February and March 2016 and references to his involvement in criminal damage and a hate-crime in March 2016.

12.134 Susan has 16-missing person records on West Yorkshire Police systems between August and December 2013 and custody records for a breach of the peace in September 2013, and a racially aggravated assault in December 2013.

12.135 There were two domestic incident reports recorded by the West Yorkshire Police involving Gerry and Susan; they took place at the same address in within two-days of one another.

12.136 The first was in February 2016. A neighbour reported a disturbance taking place and when the police arrived, they found everything to be quiet. Gerry and Susan admitted they had been arguing but said there had not been any physical violence involved. The officers recorded it as a 'non-crime domestic incident'. The officers also recorded that Gerry had recently moved to another city under care of 'Next Step' supported living. Susan was recorded as living at a flat in Doncaster.

12.137 A DASH risk-assessment was completed which was adjudged to have been standard (the risk of harm level was increased to medium upon review by the Domestic Abuse Coordinator). The

following day, the incident was referred to the Partners Vulnerability Unit (PVU), which was a multi-agency Hub which is now known as the Multi agency sharing hub (MASH).

12.138 Two-days later, the police were again called to the address by a neighbour who had heard a disturbance taking place. Susan had picked up a knife during an argument and had run outside with it. Gerry had gone to 'calm her down' and then Susan had hit him in the face before running off before the police arrived. Gerry refused to make a statement, nor would he allow the police to take a photograph of his slightly reddened face. A DASH risk-assessment was completed, and an assessment of medium-risk was made.

12.139 Susan could not be found, and the police report stated that she had 'missing from home issues', that she was rehabilitating from drugs and that she was three-months pregnant. The case was allocated to an officer to trace and interview Susan and a referral was made to Children's Social care in West Yorkshire citing both incidents.

12.140 In February 2016, South Yorkshire Housing reported to West Yorkshire Police that they were concerned about Susan. They said she was in a volatile relationship with Gerry and that they had left Doncaster train station together 30-minutes previously. The Emergency Duty Team had been contacted and had asked that a welfare check be carried out because of previous domestic incidents between the pair.

12.141 A week later, the South Yorkshire Police sent their West Yorkshire colleagues an email to say that they were aware that Gerry, who was a looked after child, had moved to a city in their area. It said he was in a relationship with Susan who regularly goes missing and turns up wherever Gerry is living. It added that there were concerns from Social Care about Gerry inflicting domestic violence upon Susan.

12.142 Susan was interviewed and she said that Gerry had been violent towards her in the past and that he had a problem with drugs. She said they had split-up two-days previously and that she no longer wanted anything to do with him, although she still loved him. She added that she was not pregnant. With Gerry declining to support a prosecution, the officer considered an evidence-led prosecution that would not require his cooperation. There was however, insufficient evidence available to present a realistic prospect of securing a conviction.

12.143 The officer has told this review that both parties were well supported by Social Services who stated that no further referrals or safeguarding measures were required.

12.144 ANALYSIS OF THE SIGNIFICANT CONTACTS MENTIONED ABOVE

12.145 The West Yorkshire Police response to the two domestic abuse incidents was compliant with their established procedures, including the completion of the DASH risk-assessments.

12.146 There was an issue around an officer not completing Police National Database (PND) checks on Gerry and Susan. Had they been completed the officer would have had access to a myriad of information about both of them. The issue has been identified during previous safeguarding reviews in West Yorkshire. Briefing items have been circulated to all officers and staff within the force and the completion of PND checks are subject to regular compliance audit.

13

ADDRESSING THE TERMS OF REFERENCE FOR THE REVIEW

13.1 ➢ *Whether the incident in which Gerry died was an isolated incident or whether there were any warning signs and whether more could be done to raise awareness of services available to victims of domestic abuse?*

13.2 The incident from which Gerry died was not an isolated one. Domestic abuse was very much recognised between Gerry and Susan by agencies, with each being perpetrator and victim at different times. The Looked After Children services were aware of the domestic abuse and they did all they could to move them to different areas to keep them apart and to refer them to specialist domestic abuse services.

13.3 Oher agencies, such as the hospital trust were not aware of any warning signs because the contacts they had with Gerry and Susan were unconnected. There were never any indications of domestic abuse.

13.4 There were several strategy meetings between interested agencies because the recognition of the obvious risks in relation to both of them, with appropriate referrals being made to support services.

13.5 The review panel acknowledges there can never be enough awareness raising of services available to victims of domestic abuse, but this review has not highlighted any areas where it was of particular significance in the lives of Gerry or of Susan.

13.6 ➢ *Whether there were any barriers experienced by Gerry or his family/friends/colleagues in reporting any abuse in Doncaster or elsewhere, including whether they knew how to report domestic abuse, should they have wanted to?*

13.7 There were no obvious barriers to the reporting of abuse by Gerry (or by Susan), in fact they both made allegations against each other frequently. There may have been odd occasions though when Gerry may not have been able to make an immediate report, because he did not have his own phone.

13.8 With both of them being in the care of the local authority, decision-making about disclosure of abuse was often a matter for placement providers or local authority staff to make, rather than for Gerry or Susan.

13.9 ➢ *Whether Gerry had experienced abuse in previous relationships in Doncaster or elsewhere and whether this experience impacted on his likelihood of seeking support in the months before he died?*

13.10 Nothing has come to light during the review to suggest that Gerry had experienced abuse in previous relationships in Doncaster or elsewhere.

13.11 ➢ *Were there opportunities for professionals to 'routinely enquire' as to any domestic abuse experienced by Gerry that were missed?*

13.12 With the exception of the GP Practice(s), the nature of the presentation of both Gerry and Susan to agencies was such that routine enquiry was unnecessary; in the case of the police and social care for example, the issues were often about domestic abuse from the outset.

13.13 Routine enquiry about domestic abuse took place during the last GP consultation for Gerry, which was evidence of good practice and was accompanied by a risk-assessment and exploration as to whether children were involved.

13.14 ➢ *Did Susan have any previous history of abusive behaviour to an intimate partner and whether this was known to any agencies?*

13.15 In August 2015, Susan reported to the police that she had been assaulted by her boyfriend. The boyfriend was not Gerry but was the father of Susan's child. When the police got there Susan said there had only been a verbal altercation. The police risk-assessed the non-crime domestic incident as medium-risk and a referral to social care was submitted. (In October 2015, the accommodation provider reported that Susan was in another relationship and that she had said he was verbally abusive towards her and that she hit him when he refused to stop).

13.16 ➢ *Were there opportunities for agency intervention in relation to domestic abuse regarding Gerry or Susan or to any dependent children that were missed?*

13.17 There was evidence that managers were involved in key decisions at specific points in the cases of both Gerry and Susan and that key decisions were made at appropriate times, with intervention very much at the forefront of their minds. No missed opportunities were identified during the review, with several strategy meetings having been convened to discuss ways to facilitate agency intervention.

13.18 ➢ *Have any training or awareness raising requirements been identified that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and/or services in the region?*

13.19 Learning and development for practitioners working with young people who are in abusive intimate relationships is acknowledged and specifically how to respond to complexity in their case work. This should be extended to commissioned placements for young people through contracting and monitoring delivery.

13.20 Continuous professional development in domestic abuse is required for CSC workers and specifically in understanding typologies of abuse to inform and tailor their practice. This case raised issues of domestic abuse in young people's intimate relationships and disclosed mutual coercive behaviours which could be seen as mutual couple violence. However, this was not fully explored or assessed in context.

13.21 St Leger Homes with Doncaster Council and the Children's Trust has jointly developed and delivered domestic abuse training across all partner organisations. Frontline staff have completed it and in-house training on procedures, DASH risk-assessments, identifying issues and offering support is ongoing.

13.22 There is a rolling schedule of training in operation within Doncaster Council consisting of Domestic abuse levels 1,2 and 3, supporting male victims of domestic abuse, honour abuse, forced marriage and female genital mutilation, supporting children living with domestic abuse

(primary age), coercive and controlling behaviour, stalking and harassment and young people experiencing intimate partner abuse.

14

CONCLUSIONS

14.1 Gerry and Susan had significant trauma in their lives and much work was undertaken over several years to address their underlying stress and neglect through poor family functioning and relationships. Their refusal to engage with support services and the chaotic nature of their lifestyles, including regularly separating and then reconciling was indicative of the way they led their lives.

14.2 There was evidence available to agencies that Gerry and Susan were engaged in an unhealthy and damaging relationship where domestic abuse was a feature and that both were the perpetrators and victims at different times. Although domestic abuse was considered on several occasions, there was not a single shared view about the level of risk posed by either of them.

14.3 Many practitioners were tenacious in their efforts to provide better outcomes for Gerry and for Susan and they displayed genuine care for their wellbeing. Prioritisation of needs was uppermost in workers minds within the context of their roles and domestic abuse was identified as an issue, even if it wasn't always the main priority.

14.4 Services for domestic abuse were offered, but there is evidence that Gerry and Susan had different views to that of practitioners about their relationship, with aggressive and abusive behaviours being the norm. There is no doubt that Gerry and Susan construed the services that were offered to them to have been unwanted interference and that they actively avoided it.

14.5 Although children's practitioners identified abuse in the relationship between Gerry and Susan, they described them as victims who were abusive towards each other. Agency case records also provided conflicting presentations of them in the relationship. This identifies that assessment should take account of the typology of abuse in context of maturity of young people, depending on their life experience, with responses/services being tailored accordingly.

14.6 Gerry and Susan were assessed as being vulnerable and troubled by their history, with Susan particularly affected by severe neglect. They were also separated from their families; Susan had lost her child through care proceedings and both young people were assessed as lacking secure attachment with significant adults in their lives. In addition, they used illicit drugs which are known to produce side effects such as anxiety; mood change and depression.

14.7 Primary care access was affected by frequent changes of surgery and lack of continuity of General Practitioner. Gerry failed to keep several appointments, or he arrived late and wasn't seen. It is not possible for any sort of meaningful relationship to be developed between a GP and someone like Gerry when there are 13 changes of practice in 18 years.

15

KEY AGENCY LESSONS LEARNED

15.1 DONCASTER CHILDREN'S SERVICES TRUST

15.2 Services available for domestic abuse are designed for perpetrators or victims but do not acknowledge that in this case, the two young people involved were foremost vulnerable adolescents. The options available to practitioners meant that they were left with making choices about who was perpetrating the abuse and who was the victim, which could lead to unintentional gender-bias in assessment and response. For example, Gerry was offered Foundations for Change while Susan was offered Woman's Aid.

15.3 Although children's practitioners identified abuse in Gerry and Susan's relationship and named it domestic abuse, they described the young people in interviews as victims who were both abusive towards each other. Case records (CSC and from partners) also provide conflicting presentations of Gerry and Susan in their relationship. This identifies that assessment should take account of the typology of abuse in context of the maturity of young people, depending on their life experience, with the responses/services being tailored accordingly.

Comment: *As mentioned previously, It is now expected that in cases involving domestic abuse (regardless of the ages of the perpetrator or victim) that a DASH risk-assessment will be completed by the Social Worker alongside the statutory assessment of need. The expectation is that the level of analysis within the statutory assessment of need (which for children in care is updated every six-months) would be greater than that contained within a DASH risk-assessment.*

15.4 The young people in this case were assessed as vulnerable and troubled by their history, with Susan particularly affected by severe neglect. Gerry and Susan were also separated from their families by being in local authority care. Susan had the loss of her child through care proceedings and both young people were assessed as lacking secure attachment with significant adults in their lives. In addition, they were both users of 'Spice' which had specific side effects such as anxiety; mood change and depression. There were some observable traits of coercive control, for example Gerry demanding money for drugs and Susan and Gerry sleeping with other young people. However, this was described by CSC as co-dependency of each other and mutual controlling behaviour.

Comment: *The presence of the DANs team now provides a body of expertise in relation to domestic abuse.*

15.5 It is acknowledged that there is more work to be done with consideration being given to psychological and therapeutic work at an earlier stage in a child or young person's care journey to understand deficiency in parental child attachment, support to understand and manage intimate relationships and build resilience and skills to make healthier life choices. It is agreed that joint chronologies and joint working with supervision of cases as a matter of routine would have helped in this case rather than responding to incidents through isolated practice. Learning and development for practitioners working with young people who are in abusive intimate relationships is acknowledged and specifically how to respond to complexity in their case work. It is agreed this should be extended to commissioned placements for young people through contracting and monitoring delivery.

15.6 It is also acknowledged that there is much to be done with regard to information sharing when young people turn 18 and the gathering of intelligence to support their needs becomes

more difficult due to confidentiality issues. Inevitably, many will remain vulnerable young people, but under the adult definition the criteria for information sharing changes significantly.

15.7 ST LEGER HOMES OF DONCASTER LIMITED

15.8 There were no key learning points identified for St Leger Homes.

15.9 EMMA HOUSE

15.10 There were no key learning points identified for Emma House.

15.11 NHS DONCASTER AND PRIMARY CARE

15.12 NHS Doncaster acknowledged the value of the training it has received in respect of awareness of domestic abuse which includes lessons learned from previous domestic homicide reviews locally. In addition, they hold the view that the training previously delivered to GP's about raising awareness of domestic abuse and routinely asking questions during consultations could be delivered to other agencies.

15.13 The main learning was that services were affected by frequent changes in Gerry's placement. For example, Gerry did not receive timely support for his mental health issues because he was moved so frequently. A consultation with a Children's Mental Health Professional may have helped determine a more accurate assessment rather than being seen by Adult Mental Health Services when he reached the age of 18.

15.14 There was evidence that primary care access was affected by frequent changes of surgery and the lack of continuity of a General Practitioner. There was also evidence of several appointments where Gerry failed to attend or arrived late and therefore wasn't seen.

15.15 DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS TRUST

15.16 There were no key learning points identified for the Doncaster and Bassetlaw Teaching Hospitals NHS Trust.

15.17 SOUTH YORKSHIRE POLICE

15.18 The key lesson learned for the South Yorkshire Police was the value of a coordinated (and consistent) approach by partnership agencies in supporting and working with young people like Gerry and Susan to understand their needs and to create appropriate actions to address them.

16

RECOMMENDATIONS

16.1 GENERIC

- The partnership should explore ways of improving the care received by looked after children under 18 when there is evidence of non-attendance and who at times are not registered with a GP or/and dentist.

- The partnership should explore the complex issue faced by looked after children regarding their access to services, for example, CAMHS referral and the continuity of care in primary care due to moving to placements in other areas.

- Knowledge of domestic abuse issues should become a contractual obligation for care providers.

- Domestic abuse training should be delivered to all care providers.

- A domestic abuse toolkit should be developed to assist practitioners when the service user refuses to engage with specialist agencies.

- Training should be delivered in respect of DASH risk-assessments to all frontline practitioners dealing with vulnerable young people aged 16 or over.

16.2 ST LEGER HOMES OF DONCASTER LIMITED

16.3 There are no recommendations identified for St Leger Homes.

16.4 EMMA HOUSE

16.5 There are no recommendations identified for Emma House.

16.6 NHS DONCASTER

16.7

- To continue to raise awareness of domestic abuse and share good practice and lessons learnt from recent reviews.

- There should be improved record-keeping to identify the risk of domestic abuse in primary care records.