Wiltshire Domestic Homicide Review

OVERVIEW REPORT

Into the death of Patricia (pseudonym)

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1 Preface

1.1 Domestic Homicide Reviews (DHRs) came into force on the13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom she was related or with whom she was or had been in an intimate personal relationship or a member of the same household as herself; held with a view to identifying the lessons to be learnt from the death.

1.2 Throughout the report the term “domestic abuse” is used in preference to “domestic violence” (other than when quoting from official documents), as this term has been adopted by Wiltshire Community Safety Partnership after widespread local consultation.

1.3 The purpose of a DHR is to:

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

1.3.2 Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

1.3.3 Apply these lessons to service responses, including changes to policies and procedures as appropriate; and identify what needs to change in order to reduce the risk of such tragedies happening in the future, to prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

1.4 This Domestic Homicide Review (DHR) examines the circumstances surrounding the death of Patricia (pseudonym) between 28th September 2015 and 1st October 2015 in Warminster. It was initiated by the Chair of the Wiltshire Community Safety Partnership, in compliance with legislation. The Review process follows the Home Office Statutory Guidance.

1.5 The Independent Chair, Report writer and the DHR Panel members offer their deepest sympathy to all who have been affected by the death of Patricia and thank them, together with the others who have contributed to the deliberations of the Review, for their time, patience and co-operation.

1.6 The Review Chair thanks the Panel for the professional manner in which they have conducted the Review and the Individual Management Review authors for their thoroughness and transparency in reviewing the conduct of their individual agencies. He is joined by the Review Panel, in thanking Emma Harrold for the efficient administration of this DHR.

2 Review Panel

- David Warren QPM, Home Office Accredited Independent Chair
- Jacqueline Beavington, Overview Report Author
- Petra Birkett, Wiltshire Substance Misuse Service (WSMS)
- Carol Bowes / Paul Bramley, Avon and Wiltshire Mental Health Partnership NHS Trust
- Andrea Brazier, Wiltshire Council Early Help
- Katie Currie, Wiltshire Council Public Health
- Debra Harrison, Royal United Hospital Bath
- Jennifer Holton, Wiltshire Police
- Tom Morgan, Kingdown School Warminster
- Amanda Murray, National Probation Service
- Jane Murray, Child and Adolescent Mental Health Service (CAMHS)
- Helen Osborn, Wiltshire Clinical Commissioning Group
- Nicole Smith, Wiltshire Council Housing
- Lucy Townsend, Wiltshire Council Children's Social Care
- Peter Twiggs, Wiltshire Council Adult Safeguarding
- Rachel Wetton. Splitz Support Service
- Ceri Williams, Wiltshire Multi Agency Risk Assessment Conference (MARAC)

Specialist Adviser to the Panel

Nikki Stevens – Splitz Support Services

Officer in the Case:

Martin Faulkner, Wiltshire Police

Review Administrator:

Emma Harrold, Wiltshire Council

3 Introduction

3.1 This Overview Report of the Wiltshire Domestic Homicide Review examines agency responses and support given to the deceased Patricia (pseudonym), an adult resident from Warminster, Wiltshire, and their contacts with Patricia's partner Alan (pseudonym), prior to Patricia's death.

3.2 Patricia, aged 20 at the time of her death, had been in a relationship with Alan, who was 27 years of age, for approximately four years. At the time of her death they were living together in a tent in the garden of Patricia's father's home in Warminster.

3.3 Warminster is a town and civil parish in western Wiltshire, England, by-passed by the A36 and the partly concurrent A350 between Westbury and Blandford Forum. It has a population of approximately 17,000.

3.4 Incident Summary:

3.4.1 Patricia was reported missing by her brother at 9.25pm on 29th September 2015. She had last been seen by Alan outside his mother's home in Warminster during the evening of the 28th September 2015. They had earlier been arguing in Warminster Town Centre and she had told him she would wait for him outside his mother's house whilst he had a shower. When he came out about twenty minutes later at approximately 7.10pm, she was gone but he found an earring, a necklace and his tobacco on a wall with the words "I love you forever" written on the wall. Concern grew as she was not contactable on her mobile and she had not returned home as she normally would. On 1st October 2015 Wiltshire Police teams commenced a search and at 1.06pm she was found hanging from a tree close to a small bridge not far from Alan's mother's home.

3.4.2 The post mortem report recorded that Patricia had a known history of anxiety and depression and had previously attempted to take her own life. On this occasion a scarf was use as a ligature. The ligature mark and fractures to the hyoid bone and thyroid cartilage were consistent with death due to hanging. A concentration of alcohol and cannabis were detected in her post mortem blood.

3.4.3 On 1st December 2015 Wiltshire Community Safety Partnership considered the circumstances of Patricia's death i.e. that she was believed to have taken her own life but had previously been known to have been a victim of domestic abuse from Alan and had been referred to the Wiltshire Multi Agency Risk Assessment (MARAC). The Wiltshire Community Safety Partnership Chair took the decision to undertake a Domestic Homicide Review and on 1st December 2015 the Home Office were informed.

3.4.4 The key purpose for undertaking this Domestic Homicide Review is to enable lessons to be learned from Patricia's death. In order for these lessons to be

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

3.4.5 The Review considers all contact/involvement agencies had with Patricia and/or Alan during the period from 1st January 2010 and 1st October 2015, as well as all events prior to that period which could be relevant to domestic abuse, violence, drugs or mental health issues.

3.4.6 The DHR Panel consisted of senior officers, from the statutory and non-statutory agencies, listed in section 2 of this report, who are able to identify lessons learnt and to commit their organisations to setting and implementing action plans to address those lessons. None of the members of the panel nor the Independent Management Report (IMR) Authors have had any previous contact with Patricia or Alan.

3.4.7 Expert advice regarding domestic abuse service delivery in Wiltshire has been provided to the Panel by Splitz Support Service, which provides the commissioned Independent Domestic Violence Adviser (IDVA) Service in Wiltshire. Specialist advice relating to substance abuse has been provided by Wiltshire Substance Misuse Service (WSMS) and for mental health by Avon and Wiltshire Partnership NHS Trust (AWP).

3.4.8 The Chair of the Panel is an accredited Independent Domestic Homicide Review Chair. He has passed the Home Office approved Domestic Homicide Review Chair's courses and possesses the qualifications and experience required in section 5.10 of the Home Office Multi-Agency Statutory Guidance. He is totally independent and has no association with any of the agencies involved in the Review nor has he had any dealings with either Patricia or Alan.

3.4.9 The Overview Report Author is also an accredited Independent Domestic Homicide Review Chair. She has passed the Home Office approved Domestic Homicide Review Chair's courses and possesses the qualifications and experience required in section 5.10 of the Home Office Multi-Agency Statutory Guidance. She is totally independent and has no association with any of the agencies involved in the Review nor has she had any dealings with either Patricia or Alan.

3.4.10 The agencies participating in this Domestic Homicide Review are:

- Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)
- Bristol Gloucester Swindon and Wiltshire Community Rehabilitation Company (BGSW CRC)
- Child and Adolescent Mental Health Services (CAMHS)
- Curo Housing
- Great Western Hospital

- Kingdown School
- National Probation Service
- Royal United Hospital (RUH)
- South Western Ambulance Service NHS Trust
- Splitz
- Victim Support
- Wiltshire Anti-Social Behaviour Risk Assessment Conference (**AS-BRAC**)
- Wiltshire Citizens Advice Bureau
- Wiltshire Clinical Commissioning Group
- Wiltshire Council Adult Services
- Wiltshire Council Children's Social Care (CSC)
- Wiltshire Council Early Help
- Wiltshire Council Education Welfare Service
- Wiltshire Council Revenue and Benefits
- Wiltshire Domestic Abuse Conference Call (DACC)
- Wiltshire Housing Options
- Wiltshire Multi Agency Risk Assessment Conference (MARAC)
- Wiltshire Police
- Wiltshire Substance Misuse Services

3.4.11 Patricia's father, mother and Alan were contacted at the commencement of the Review. Alan agreed to the pseudonym chosen by the Panel and signed a consent form for the Review to access his medical records; both he and Patricia's mother stated they wanted no further involvement with the Review.

3.4.12 Patricia's father was provided with details of Advocacy After Fatal Domestic Abuse (AAFDA) and it was explained to him what support the family could receive from the charity. Patricia's father chose the pseudonym for his daughter and signed the consent form for the Review to access her medical records. He asked to be kept informed of the progress of the Review but said he did not want any other engagement.

4 Parallel Reviews

4.1 A Coroner's Inquest was held in relation to the circumstances of Patricia's death and the Coroner concluded that Patricia took her own life and the cause of death was hanging. The Coroner provided the Domestic Homicide Review with copies of papers presented to him.

4.2 The police were satisfied that there were no suspicious circumstances relating to Patricia's death and there were therefore no criminal proceedings initiated.

5 Timescales

5.1 On 1st December 2015 the decision to undertake a Domestic Homicide Review was taken by the Wiltshire Community Safety Partnership and later the same day the Home Office were notified of this decision.

5.2 The Home Office Statutory Guidance advises, where practically possible, the DHR should be completed within 6 months of the decision made to proceed with the review. The Review was completed on 27th May 2016.

6 Confidentiality

6.1 The findings of this Review are restricted to participating officers/professionals, their line managers and the family of the deceased until after the Review has been approved for publication by the Home Office Quality Assurance Panel.

6.2 In accordance with the “Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews” to protect the identity of the deceased and her family, the following pseudonyms have been used throughout this report.

6.3 The name Patricia is used as a pseudonym for the deceased, it was chosen by her father. The Review Panel selected the pseudonym Alan for Patricia’s partner. He later agreed that this name could be used.

6.4 The Executive Summary of this report has been redacted. To enable the Home Office Quality Assurance Panel to have access to the detail of the Review, other than the use of pseudonyms and the exclusion of the names and addresses of involved individuals, the overview report and chronology have not been redacted. Both documents will be fully redacted prior to publication by the Wiltshire Community Safety Partnership.

7 Dissemination

7.1 Each of the Panel members (see list at beginning of report), the IMR authors, Chair and members of the Wiltshire Community Safety Partnership have received copies of this report.

7.2 A copy of the report will be sent to the Wiltshire Police and Crime Commissioner (PCC) prior to publication.

7.3 The Review Chair has notified Patricia's mother about the lessons learnt, recommendations and conclusions of the Review, she declined the opportunity to read the whole Overview Report or Executive Summary and after thanking the Chair and Panel for notifying her, she stated that she did not wish to have any further involvement. [1]

7.4 Alan was offered the opportunity to read the DHR Reports but declined.

7.5 Patricia's father did not respond to either telephone messages or a letter sent to his last known address offering him the opportunity to read the final reports or hear the outcomes.[2]

[1] **To be redacted prior to publication.** Patricia's mother is currently receiving treatment for drug problems in a residential drug rehabilitation centre.

[2] **To be redacted prior to publication:** Between the 17th May 2016 and the 20th July 2016, the DHR Chair wrote and telephoned eighteen times to Patricia's father to inform him about the Review findings and to arrange for him to read the Reports. Only on one occasion did he answer the telephone and then said, he was busy and would the Chair phone him during the evening. The Chair made a further five calls on different evenings but the telephone always went to voicemail. Patricia's father did not return any of the voice mail messages and made no further contact with the Chair. Previously during the course of the Review the DHR Chair spoke to Patricia's father on three occasions and he was helpful, however two issues may have interfered with his further involvement: a) after a contact, he was alleged to have made serious threats against Alan which resulted in police involvement and b) child protection action was initiated and is ongoing in relation to Patricia's younger siblings.

8 The Terms of Reference

8.1 Definition of a Domestic Homicide Review.

Section 9(3) of the Domestic Violence, Crime and Victims Act (2004). States: "Domestic Homicide Review" means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by;

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

(b) A member of the same household as himself,

Held with a view to identifying the lessons to be learnt from the death.

8.2 The purpose of the Domestic Homicide Review is to:

8.2.1 Ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case.

8.2.2 Establish what lessons are to be learned from the case about the way in which local professionals and organisations work, individually and together, to safeguard and support victims of domestic abuse, including their dependent children.

8.2.3 Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on and what is expected to change as a result.

8.2.4 Apply these lessons to service responses including changes to policies and procedures as appropriate; and

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

8.3 The focus of a Domestic Homicide Review is therefore about identifying and addressing lessons to be learnt from the death, it is not about blame.

8.4 Overview and Accountability:

8.4.1 The decision for Wiltshire Community Safety Partnership to undertake a Domestic Homicide Review (DHR) was taken by the Chair of the Wiltshire Community Safety Partnership on the 1st December 2015 and the Home Office informed the same day.

8.4.2 The Home Office Statutory Guidance advises where practically possible the DHR should be completed within six months of the decision made to proceed with the review.

8.4.3 This Review, which is committed, within the spirit of the Equality Act 2010, to an ethos of fairness, equality, openness, and transparency, will be conducted in a thorough, accurate and meticulous manner.

8.5 **The Review will consider:**

8.5.1 Each agency's involvement with Patricia (pseudonym), 20 years of age at time of her death which occurred 1st October 2015, and/or with her partner Alan (pseudonym), aged 27 years at the time of Patricia's death. Agencies involvement should include any contacts between 1st January 2010 and 1st October 2015 and any contacts relevant to domestic abuse or relevant health issues prior to that period.

8.5.2 Whether there was any previous history of abusive behaviour towards the deceased or to any previous partner of Alan and whether these incidents were known to any agencies or multi agency forum?

8.5.3 Whether family, friends, work colleagues or neighbours want to participate in the Review. If so, ascertain whether they were aware of any abusive behaviour to the deceased prior to her death?

8.5.4 Whether, in relation to the family members, friends, neighbours or work colleagues; were there any barriers experienced in reporting domestic abuse?

8.5.5 Could improvement in any of the following have led to a different outcome for Patricia:

- Communication and information sharing between services.
- Information sharing between services with regard to the safeguarding of adults and children.
- Communication within services.
- Communication to the general public and non-specialist services about available specialist services.

8.5.6 Whether the work undertaken by services in this case are consistent with each organisation's:

- Professional standards.
- Domestic Abuse policy, procedures and protocols.
- Drug abuse policy, procedures, protocols or treatment.

8.5.7 The response of the relevant agencies to any referrals relating to Patricia or Alan, concerning any form of domestic abuse. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:

- Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards with the deceased or her partner.
- Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.

- Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made.
- The quality of any risk assessments undertaken by each agency in respect of Patricia or Alan.

8.5.8 Whether organisational thresholds for levels of intervention were set appropriately and/or applied correctly in this case.

8.5.9 Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective family members and whether any specialist needs on the part of the subjects were explored, shared appropriately and recorded.

8.5.10 Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and completed in a timely manner.

8.5.11 Whether, any training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse processes and/or services.

8.5.12 The review will consider any other information that is found to be relevant.

9 Meeting Schedule

9.1 The schedule of the Domestic Homicide Review Panel meetings:

- 21st January 2016 0930 -1230 Wiltshire County Hall Trowbridge
- 15th April 2016 0930 -1500 Wiltshire County Hall Trowbridge
- 27th May 2016 13.00-16.30 Wiltshire County Hall Trowbridge

10 Methodology

10.1 This report is an anthology of information and facts gathered from:

- The Individual Management Reviews (IMRs) and Reports of participating agencies
- The Pathologist
- The Coroner
- The deceased father and friend
- Discussions during Review Panel meetings.

11 Contributors to the Review

11.1 Whilst there is a statutory duty that bodies including: the police, local authority, probation trusts and health bodies must participate in a DHR; in this case twenty-four organisations have contributed to the review (listed in Para. 3.13). Eighteen have completed Individual Management Reviews (IMRs) or reports.

11.2 Individual Management Review authors:

- Andrew Snee: Curo Housing
- Andy Fee: Wiltshire Multi Agency Risk Assessment Conference (MARAC) and the Wiltshire Domestic Abuse Conference Call (DACC).
- Anna Williams: Kingdown School
- Debra Harrison: Royal United Hospital (RUH)
- Dr Caroline Wingfield: Wiltshire County Clinical Commissioning Group
- Guy Turner: Wiltshire Police
- Heather Alleyne: Wiltshire Council Adult Services
- Jen Salter: Wiltshire Council Children's Social Care (CSC)
- Jo Naylor: Great Western Hospital
- Kate Wilson: Wiltshire Council Early Help
- Kirsten Harwood: Wiltshire Council Education Welfare Service
- Martin Lawrence: Wiltshire Substance Misuse Services
- Neil Blessitt: Avon and Wiltshire Mental Health Partnership NHS Trust
- Nicole Smith: Wiltshire Housing Options
- Stephanie Glasscoo: Bristol Gloucester Swindon and Wiltshire Community Rehabilitation Company (BGSW CRC)
- Emma Lewis: National Probation Service
- Samantha Shrubsole: Child and Adolescent Mental Health Services (CAMHS)

12 The Facts

12.1 The following facts are representative of the numerous contacts, which are detailed in the Chronology in Part Two of this Report, that Patricia and Alan had with agencies.

12.2 Patricia and her two elder brothers were first known to Children's Social Care (outside Wiltshire) in September 1997. Medical records indicate a documented history of domestic abuse between Patricia's parents. Patricia's mother has confirmed the abuse and said that Patricia often witnessed the violence from an early age. In 1998 Patricia and her two brothers were placed in foster care. (Her mother had been unable to look after them because of her drug and alcohol problems and her father was serving a prison sentence).[3] Her father later obtained a Residence Order that gave him parental rights in 1999.

12.3 From the age of eight, Patricia and her brothers lived mostly with her father and step-mother. The step-mother had four children of her own living with them. Patricia spent short periods during 2002 living with her mother, whilst her full siblings remained in their father's care. There were a number of recorded incidents of domestic abuse between Patricia's father and her stepmother and for a period in 2002, they separated, resulting in Patricia spent some time in foster care as her father was struggling as a single parent working full time.

12.4 During this period, Social Care received a number of notifications regarding the domestic violence between Patricia's father and stepmother and about concerns about neglect (not being collected from school) and physical abuse on Patricia. There was no record of a Strategy discussion being held and the physical harm to Patricia was classified as chastisement by the social worker. The effect on Patricia of witnessing domestic abuse apparently was not considered.

12.5 On 3rd July 2003 Alan first came to the attention of the Youth Offending Team as a result of two offences involving the theft of alcohol. It was noted during a core profile assessment that there were indication of recent solvents and alcohol use. Alan claimed he had first used alcohol when he was 12 and solvents from the age of 13 years of age. His mother confirmed that Alan had refused family therapy and medication for attention deficit hyperactivity disorder (ADHD).

12.6 On 11th November 2005 Patricia's stepmother was spoken to by a Social worker after a report that she "smacks the children around the head; swears at them and sometimes leaves them on their own unsupervised". She admitted that she was struggling as a single parent as she and Patricia's father had

[3] **To be redacted prior to publication.**

separated a couple of years earlier but she was still caring for his three children as well as the children they have together.[4] By March 2006 it appeared that Patricia's father had moved back with her step-mother, as the police attended an incident of domestic abuse between them in which Patricia's father was the perpetrator. In August 2006 Patricia's step-mother gave birth to another baby of which Patricia's father was the father. The midwife noted the chaotic state of the house and that she had scabs and head lice.[5] There were several further incident of domestic abuse the worst being on 23rd August 2006 when he assaulted his partner with a shoe whilst she was holding their two week old baby. The baby was hit and was taken to hospital with a bump on his head. A child protection medical examination was undertaken and there were no signs of injury to the baby.

12.7 There were repeated incidents of Patricia's poor behaviour at school. In May 2007 she began a six-week course of social skills interventions to address her behaviour and emotional issues. For the rest of her time at school she exhibited behaviour such as being increasingly rude to staff, reportedly pushing staff, spraying aerosol in the face of staff, bullying other pupils, not wearing school uniform and having poor attendance. She was repeatedly excluded and the school struggled with her increasingly difficult behaviour. In 2008 a Multi-Agency Meeting was held and Patricia was referred to the Young Person's Support Service that she attended from January 2009. Her parents did not attend meetings either arranged by school or the Education Welfare Service (EWS). They were issued with penalty notices, which were not paid and they were then invited to a Court Assessment Interview which they did not attend. The case was referred for prosecution.

12.8 On 7th February 2011 it was reported that Patricia had been staying at a friend's house for about three months, during that time her attendance at school improved. However after an argument over finances she moved back to the step-mother's home in March 2011, where she had to sleep on a sofa in her brother's bedroom.

12.9 Patricia was no longer of statutory school age from the last Friday in June 2011 but continued to have support from her NEET/Connexions worker. She left school not having taken any exams.

12.10 In September 2011 Patricia attended her GP practice, where it was recorded that she was sexually active. She was provided with the birth pill and given contraceptive advice. She advised her NEET worker she had moved in with her boyfriend Alan.

[4] **To be redacted prior to publication**
[5] **To be redacted prior to publication**

12.11 In November 2011 during a meeting with the NEET worker she explains she needed either a job or an apprenticeship because she was living with her boyfriend and needed money. Patricia was supported to register on an apprenticeship website and complete an application.

12.12 The first reported incident of domestic abuse between the couple was on 14th May 2012 - Alan telephoned the Police to report that he was having a dispute with Patricia and she was smashing the flat up and he wanted her removed. Police officers attended promptly and Patricia disclosed that Alan had pushed her to the floor and bitten her back. Alan was arrested for common assault. A domestic abuse report was completed with a DASH standard risk assessment. The Child Protection Referral Unit CPRU), Social Services Department (SSD) and the Safeguarding Nurse were notified. Alan was released without charge having stated in interview that he had been assaulted first and he denied assaulting Patricia. Patricia moved out of Alan's flat and on 16th May 2012 while staying with friends, contacted Wiltshire Housing Options, Job Centre First and met with NEET to discuss benefits and housing. Patricia received help with supported housing accommodation but on 3rd July 2012 she contacted Wiltshire Housing as she had been asked to leave supported housing. She confirmed she had been in local authority care when she was young. Options were explained to her and actions agreed. On the same day her social worker contacted Housing to enquire if Patricia was still homeless as he had been unable contact her. The referral was closed to social care with no further action being undertaken. Nevertheless Patricia's NEET worker attempted to sort out Patricia's housing problems but was unable to contact Patricia by phone.

12.13 On 21st July 2012 Police were called to an address in Westbury where Patricia and Alan were arguing. It was recorded that it was a verbal argument and no offences had been committed. Patricia went to stay with a friend and a DASH risk assessment was completed with a standard risk of harm assessment. Due to Patricia being homeless the Police placed her into emergency accommodation and Social Services were informed and efforts were made to try to find a host family for her.

12.14 On 2nd August 2012 Patricia saw her GP. She told her doctor that she had been in care as a child because her mother was an alcohol and drug user; she had lived with her father and stepmother for a time but she did not get on with her step-mother.[6] More recently she had been in a controlling relationship but that had ended. Patricia said, she stabbed herself in April 2012 as a cry for help. The GP prescribed antidepressants and referred her to a counsellor and the mental health team. In the early hours of the following day Patricia was taken by ambulance to the Royal United Hospital in Bath. She was

[6] **To be redacted prior to publication**

admitted after taking an overdose of the anti-depressants. A mental health assessment was carried out by CAMHS team in line their protocol. Patricia described having drunk alcohol and taken MDMA and cannabis at a friend's house earlier that evening, she said she had a verbal and physical fight with her boyfriend Alan, following which she impulsively took the tablets, partly as a result of being challenged to do so by Alan. Patricia did not describe this as a suicide attempt. She did however go on to disclose that she had taken an overdose of paracetamol in 2011 also following an argument with Alan, but that she did not seek help. She also reported stabbing herself in the leg 3 months previously and attended the Minor Injuries Unit. The assessment highlighted suicidal ideation and self-harming which Patricia related to her relationship with Alan and lack of a stable home.

12.15 Alan was arrested for common assault which he denied and as Patricia refused to provide a statement, Alan was released without charge. A DASH risk assessment of medium risk was recorded. Nevertheless the Police Child Protection Referral Unit requested a 'professional discussion' with Social Care due to this being the third incident within three months. This discussion was not held, however Patricia was seen by her Social worker on 14th August 2012, after an incident the previous day, when she had called at Alan's flat to collect some belongings. He would not let her in, and she had kicked the door causing damage. Patricia told the Social worker about her abusive and controlling relationship with Alan, she gave the impression that she accepted his behaviour because she had nowhere else to live at that time. However, Patricia was adamant that this relationship was over. The Social Worker described her as "vulnerable, homeless, has no income and is not in receipt of any benefits". A multi-agency meeting was called but later cancelled.

12.16 On 29th August 2012 Patricia and Alan were arguing in bed in Alan's flat. Alan became abusive and tried to stop her telephoning the police. He grabbed her around the throat and pushed her out of the flat. She went to her parents' house and the police were called. Alan was arrested but following Crown Prosecution Service (CPS) advice he was released without charge. The following day Alan telephoned police to report that he had run to his flat to get away from Patricia. She had followed and then punched him in the face and bitten his arm. Police attended promptly and arrested Patricia for assault.

12.17 Throughout August and September 2012 Patricia received a lot of help from NEET worker with housing, benefits and finding her way around other services. On 31st August 2012 Housing confirmed that they had referred Patricia to Social Services for a joint initial assessment but as she had temporarily stayed with her stepmother she was not considered to be homeless and not offered support for housing by Social Services or Housing. On 7th September 2012 Patricia reported to CAMHS she had received several missed calls and nasty texts from Alan. Patricia stated she was keeping the texts to show the

police. Patricia was advised by CAMHS not to have any further contact with Alan. She later told CAMHS that although she was aware the relationship would not go anywhere when she felt lonely she considered getting back with him; but on 5th October 2012 Patricia said Alan was still constantly phoning her, calling her a “whore” and “thick”. She was advised to change phone sim and not to respond to any calls or texts. Patricia said that she has had no contact from her social worker and felt let down by him as he stated he would help and she felt he had not done anything.

12.18 On 26th October 2012, Patricia reported to CAMHS that she had taken all of her benefits out of her account as Alan knew her bank details. She said she felt suicidal the previous night following contact with Alan. Three days later she disclosed to CAMHS that she had self-harmed by cutting her abdomen with scissors. Patricia reported that self-harming started when things started to go wrong with Alan.

12.19 On 29th November 2012 Patricia’s social worker contacted a Housing Options advisor and stated that he was aware Patricia had been ‘sofa surfing’ for a few weeks. He advised that assistance and support was being offered under Section 17 of the Children Act 1989 and that the three areas of need were being addressed through CAMHS, Connexions and Housing. Housing informed the social worker that Children's Services were the lead agency for finding Patricia accommodation as she was in foster care and therefore, a “section 20 child”. The social worker said he could not find any reference in Patricia's case notes that she was in foster care and he would make further enquiries and ring back. (She had been in care at an early age in another local authority area.)

12.20 On 12th December 2012, a Child in Need meeting was held. Patricia, her Social Worker, Housing, NEET and CAMHS attended. Patricia was still living with her father and stepmother. In the absence of host families, private rented accommodation was explored. CAMHS did not believe that Patricia has a mental health condition and that her difficulties were due to social concerns and difficulties. CAMHS would support Patricia until she was 18 years old and refer to Adult Services if necessary. Two days later a foster carer confirmed that Patricia had been in her care from January 1998 to November 1998 and from December 1998 she had shared custody of Patricia for eight weeks followed by one weekend a month until Patricia was seven years of age.

12.21 On 18th December 2012, the Outreach Service for Children and Adolescents (OSCA) Clinical Team Manager contacted Patricia’s social worker to share concerns about Patricia’s situation. The social worker stated he believed her needs were mainly mental health due to overdose and housing issues and that his role was peripheral. Two days later the social worker was contacted again as Patricia was staying with a friend and had not received her benefit payment and they had no food and very little electricity. It was requested her

social worker sorted something out that afternoon as it was stressed that Patricia was at risk of being asked her to leave if it was felt she was a financial burden.

12.22 On 21st December 2012 Alan telephoned the Police and reported that Patricia had smashed a window at his flat. Police Officers arrested Patricia for causing criminal damage. She was interviewed and denied the offence and was released without charge. On New Year's eve, Alan and Patricia were seen to be arguing about money outside a shop. Alan grabbed Patricia by the throat and the Police were called. Alan was arrested for assault and Patricia was arrested for obstruction after causing a disturbance. A DASH report was submitted Patricia as victim, Alan as perpetrator.

12.23 On 14th January 2013 Patricia told CAMHS that she was seeing Alan but that they were not back together. She added that she felt the relationship with Alan had been the cause of her low mood and stated that he was physically and emotionally abusive towards her and she knew she should not see him. Two weeks later she reported getting abusive texts from Alan's family via Facebook and on her phone.

12.24 On 25th January 2013 the police received several calls that a male was assaulting a female outside Warminster Railway station. Despite Alan's bail conditions not to contact Patricia they had met to have a drink together. Alan accused Patricia of looking at another male so she left, Alan chased and grabbed her, he took her phone after she tried calling the police. He continued to chase her, grabbed her by the hair and smashed her head into a fence. She fell to the floor where he kicked her in the side. Males who saw the incident chased Alan and the females took Patricia into their address to wait for the police.

12.25 On 2nd March 2013 Patricia was drunk and disorderly on the communal landing of the flat where she was living. Patricia was arrested and head-butted the police officer and was found in possession of a small amount of cocaine. She was charged and bailed to court. Consequently two days later she was issued with a first written warning in accordance with Curo Housing Association policy and procedure and the next day she was given a verbal warning after complaints from neighbours about the loud music coming from her property. This was followed on 6th March 2013 after further reports of noise nuisance, when another verbal warning was issued. On 7th March 2013 drug paraphernalia was found in her room and a warning was given but after being arrested on 31st March 2013 for an assault on another resident in the flats, a second warning was given by Curo Housing. Subsequently, following more damage to Patricia's flat a warning was given that a Notice of Seeking Possession could be served.

12.26 On 17th May 2013, Patricia disclosed that Alan was subject to a Restraining Order, precluding him from having any contact directly or indirectly with her, not to go to her address and not to go to her stepmother's address.

12.27 An Antisocial Behaviour Contract (ABC) was signed by Patricia on 22 May 2013 and a case conference took place. Patricia then missed numerous appointments with Curo Housing Association staff following this case conference.

12.28 On 10th June 2013, Alan attended a GP appointment. He said that he had been in prison for breach of bail conditions and he was prescribed antidepressants.

12.29 On 26th June 2013 Patricia was sentenced to 12-month community order, 12 months' supervision and 60 hours of unpaid work for an assault on Alan. Patricia was assessed by Court Assessment and Referral Service (CARS) practitioner and a core assessment and risk screen was completed with no evidence of severe or enduring mental illness. The abusive nature of Patricia's relationship with Alan was identified as ongoing but no action taken.

12.30 On 29th July 2013 Patricia was praised by her Offender Manager and key worker for completing 'Getting To Know You' programme. She set a personal goal to obtain employment and advised the Offender Manager she has got the restraining order in relation to Alan removed the previous week. She did not want to be reconciled with him however she did disclose she had made contact with him and wanted to stay in touch.

12.31 On 13th August 2013, Alan met with his Offender Manager who noted that the Court order to attend a Positive Relationships course had started 1st February but he still did not have a date to start the course. Alan had told his Offender Manager he had had no contact with Patricia but that was later found to be untrue as he had been seen out with her. No action was taken. Patricia's Offender Manager received information that the Restraining Order imposed on Alan had not been removed at Court as Patricia had previously stated. On 16th September 2013 Patricia had been seen with Alan, despite restraining order in place. Patricia dismissed these concerns stating they were "friends". Her Offender Manager pointed out the risks of domestic abuse but she did not appear concerned.

12.32 On 21st September 2013 the Police received a call that Patricia was kicking the door of a flat, as she believed that the occupant was having an affair with Alan. Police officers attended and Patricia was taken to hospital by ambulance as she had self-harmed and taken an overdose. A harassment notice was later served on her.

12.33 On 22nd September 2013 Patricia reported to the police that Alan had breached his restraining order by contacting her. Officers spoke to Patricia

however she refused to make a statement or to answer any questions. A PPD1 was completed and assessed as HIGH risk as Patricia refused to engage and answer questions for the risk assessment. The circumstances were referred to a MARAC meeting on 5th November 2013.

12.34 The following day, 23rd September 2013, Patricia admitted to her Offender Manager that she had been seeing Alan for several weeks and they had resumed their relationship. She also said that there had been constant arguments and physical violence (on both sides) during that time. She disclosed that Alan has physically assaulted her by grabbing her around her throat to strangle her on a few occasions, pushing her, as well as emotional abuse by flirted with others in front of her, pressurised her to pawn mobile phone for money and putting pressure on her to lift the Restraining Order. Patricia who had a good awareness of the impact this destructive relationship was having on her emotionally and physically felt that she required professional help and presented as frustrated and angry with herself for letting Alan back into her life. Patricia's Offender Manager discussed with her other support which she might access through an IDVA/Freedom Programme. The Offender Manager contacted IDVA requesting support for Patricia, however he received a response that at that time they could only accept referrals once they have been identified as high risk because of limited capacity. The Offender manager therefore completed a DASH risk assessment with a High risk harm assessment. He highlighted that Patricia would welcome intervention from an IDVA and considered that the freedom project would help keep her motivated to remain away from Alan. She was spending a lot of time with family which she stated remains supportive and had also changed phone number to reduce risk of contact from Alan

12.35 On 2 October 2013 Patricia surrendered her tenancy and during a support session on 21 October 2013 Patricia said she had viewed a shared house and was bidding on properties. She had been missing appointments with Probation and was due to be taken back to court.

12.36 On 6th November 2013 the police received a report that Patricia was being assaulted by Alan in the street. Police officers attended promptly and arrested Alan for common assault. Patricia would not provide a statement, however two independent witnesses did. Alan was charged with common assault and a breach of a restraining order. PPD 1 was completed with a medium risk of harm assessment,

12.37 On 7th November 2013 Alan attended the first session of the Positive Relationships course and the following day he reported that Patricia was sending him threatening text messages. Police officers attended and spoke to Alan. Public Protection Department form (PPD 1) submitted medium risk, Patricia arrested and charged and bailed with harassment. Alan was then of no fixed abode, and safeguarding advice was given to him. The same day a member

of the public reported that Patricia was behaving strangely, shouting and swearing in the street. Police officers attended and assisted in transporting Patricia to hospital by ambulance. She appeared to be under the influence of drink or drugs.

12.38 On 22nd November 2013 Alan's Offender Manager contacted him following concerns raised by the positive relationships facilitator. He admitted he was drunk at the session and he was reminded that he had signed to say he was not to turn up drunk, which he acknowledged.

12.39 On 25th November 2013 Alan reported to the police to report that Patricia was being abusive to him. Patricia was gone prior to police arrival but was later arrested and interviewed. She denied any offence and was later released without charge. PPD1 submitted, medium risk. Three days later, Patricia was arrested for two threats to kill by text, she was granted bail.

12.40 On 3rd December 2013 a MARAC Meeting acknowledged that the case has been previously subject to a MARAC on 5th November 2013. This was the fourth incident in a rolling 12 month period. Agencies shared information: Splitz confirmed that Patricia was not known to the service. IDVA has attempted to make contact with Patricia without success. Probation confirmed that both Patricia and Alan are known to the service. Alan had made threats on Facebook to Patricia. Alan has pleaded not guilty with a view to trial on 6th January 2014. Alan engaged well and had started a positive relationship course. Patricia engagement was not as good and there had been three violent offences since March. Council Housing had no update. Alan had presented to Housing stating that he was a victim of domestic abuse against his ex-partner Patricia. The following risks were determined: alcohol; breach of injunction; physical harm; non engagement; suicidal mental health issues; escalating violence; (strangle). The actions were for the Police DAIT to check that Standard Operating Procedure was in place, and make Probation team aware. The Investigating Police Officer to feedback to Patricia.

12.41 On 24th December 2013 the Police received a call reporting that Patricia and Alan were fighting in the street. When officers arrived at the scene Patricia was clearly unset but would not speak to them. Alan was also there, they both had marks on their faces and were both arrested for assaulting one another. Patricia also in breach of a supervision order and Alan had breached bail conditions not to contact Patricia. No complaints made re the assaults. Alan charged with breaching bail conditions and charged to court. A PPD 1 was completed with a medium risk assessment.

12.42 On 14th January 2014 Alan was incorrectly referred to the MARAC as the risk had been assessed as Medium. It was withdrawn from the meeting by the Chair. Alan had already been contacted by the IDVA who said there was no chance of resuming his relationship with Patricia. He was homeless and

would like help with housing. He had asked for IDVA to make contact with Turnaround Programme (a perpetrator course.) The case was closed.

12.43 On 15th January 2014 Patricia saw her GP. She was more positive having completed a self-esteem course. She was given a prescription for anti-depressants and it was noted that she had not had anti-depressants between August 2013 and January 2014.

12.44 On 30th January 2014 Alan appeared at Magistrates Court for sentencing for the offence of Assault (domestic abuse) and new unpaid work order was imposed. On 5th February 2014 Alan met with his Offender Manager as his order was ending the following week. His new order was discussed but as Alan began to make excuses why he could not attend his Offender Manager firmly explained that he had to complete the course or return to Court. Two weeks later Alan told his Offender Manager that he was working and staying with a friend who he refused to name.

12.45 On 20th February 2014 Patricia reported to her Offender Manager that she had moved and was renting a room through a friend of family and that she had obtained employment as a waitress. A week later her father told the Offender Manager she was living with Alan.

12.46 On 15th March 2014 the police received a call that Patricia and Alan were arguing in the street. Patricia told the police that Alan was drunk and they had taken a taxi. He had grabbed her by the throat because she would not kiss him. She ran from the taxi with Alan chasing her, and jumped into a lake, (telling the police, that she would rather kill herself than have Alan assault her again). Alan was arrested for common assault, a PPD1 submitted with a medium risk assessment. The MARAC was informed and the IDVA updated. Patricia refused to make a statement, and as there were no independent witnesses CPS decision was that no further action should be taken.

12.47 On 16th April 2014 Patricia visited her GP and reported that she had been subjected to more recent domestic violence, consequently she felt low and was not able to concentrate. She was prescribed an increased dose of medication and referred for counselling.

12.48 On 3rd May 2014, the police were called to a train station after reports that Alan had assaulted Patricia. He was arrested for common assault and possession of drugs. Both were extremely drunk and Patricia was treated by paramedics and taken to hospital. Patricia disclosed she had been drinking alcohol and had had a line of cocaine. Whilst on the train, she had an argument with Alan. Passengers on the train witnessed Alan grabbing Patricia by the throat and slapping her. Patricia disclosed to the emergency room doctor that she had taken an overdose one week previously. Neither Patricia nor Alan would cooperate with police. Nevertheless a PPD 1 was completed with a DASH High risk assessment.

12.49 On 24th September 2014 Patricia was taken to hospital by ambulance after taking an overdose after an argument with Alan when she found out that he had been unfaithful to her with the next door neighbour. It was noted that Patricia became very aggressive and abusive towards staff, using very "foul" language. The abuse continued and she was asked to leave the ward.

12.50 On 7th October 2014, Alan attended Probation offices where Patricia had an appointment. After he left with her in breach of his conditions he was arrested and placed before the court the same day.

12.51 On 16th November 2014, Patricia's father reported to Police that she was arguing with Alan in a field. Alan was in breach of bail conditions by being there. Police officers attended but Patricia refused to make a complaint statement. She did have injuries but would not say how they occurred nor would she co-operate with the DASH risk assessment process which was completed by the officers. DASH risk was assessed as medium. This was reassessed by a supervisor as HIGH then reassessed as medium by DAIT. Patricia would not engage with DAIT officers and in fact put the phone down. YOTS informed, MASH and MARAC. Alan was arrested and released without charge after a CPS charging decision.

12.52 On 20th January 2015 a member of the public reported a dispute between Patricia and her step-mother. Police officers attended and arrested Patricia's step-mother for assaulting her. Patricia provided a statement stating that she did not want her step-mother to be prosecuted and she was released without charge. The next day Patricia saw her GP. She was tearful and low due to her housing situation as a result of the fight with her step-mother. Anti-depressants were prescribed and the Social Services telephone number was given to her.

12.53 On 27th January 2015, Alan attended an assessment with Wiltshire Substance Misuse Service (WSMS). He disclosed difficulties in his relationship with Patricia and that he had been arrested for domestic violence over 20 times in four years. He said he drank daily and wanted to learn how to control his use of alcohol. His risk assessment highlighted that he had been both a victim and perpetrator of domestic abuse. Other risks identified were around Alan being homeless and having a poor diet, along with outstanding debts.

12.54 On 2nd April 2015 when Alan attended an appointment at WSMS he was under the influence of cannabis and was therefore advised that no drugs were to be brought onto premises. He stated he would stop use when he started work.

12.55 On 11th April 2015 Alan telephoned the Police reporting that on the 8th April 2014, Patricia had broken into his flat and stolen some of his clothes. Alan stated that he was extremely frightened of her as he believed she was capable of killing him. She was using class A drugs and drinking heavily which

triggered her violent episodes. A decision was taken not to arrest Patricia as there were no witnesses.

12.56 On 2nd July 2015 due to multiple missed appointments and lack of contact, Alan was discharged from WSMS and the file closed. Probation and his GP were notified of the discharge. Five days later Alan went to prison and whilst he was in prison Patricia re-ignited their relationship and wrote letters to him.

12.57 Alan was released from prison on the 24th August 2015 and was met by Patricia. They spent the next three or four nights in hotels locally, but when they ran out of money, they lived in a tent in the back garden of Patricia's family home. The relationship was noted by the police after sightings of the couple together on 22nd September 2015. Alan described this period of their relationship as fine. He said that Patricia was optimistic about the future; she had a job as a cleaner and would get up early to go to work. She was looking forward to having a home of her own and children with Alan.

12.58 On the evening of Monday 28th September 2015, Patricia and Alan were seen arguing in Warminster town centre. They continued arguing as they walked to Alan's parent's home. Patricia waited outside while Alan went in for a shower. When Alan came out Patricia had gone. She had left an earring, a necklace and Alan's tobacco on the wall, with the words 'I LOVE YOU FOREVER' written on a wall. Alan phoned Patricia and she answered, stating she had decided not to wait for him and was on her way home, a journey of about 1km. Alan told her he would phone her in half an hour to check she was safely home but when he did phone she did not answer. After trying to contact her several more times, Alan called Patricia's brother and asked him to report her missing, which he did at 9.25pm the next day. Police missing person enquiries were carried out and at 1.6pm on 1st October 2015 Patricia's body was found hanging from a tree.

12.59 A full chronology of agency contacts with Patricia and Alan is included in Part Two of this Report.

13 Key issues arising from the Review

13.1 The Review Panel, having had the opportunity to analyse the information obtained from agencies, from one of Patricia's friends and from the Coroner's Inquest, considered the key issues in this Review to be:

13.2 **Significant family history of domestic abuse being the norm, where Patricia was not only witnessing domestic abuse but was the victim of domestic abuse.**

13.2.1 This review has revealed evidence that Patricia had been exposed to domestic abuse throughout her childhood, with her father being the perpetrator of significant violence towards her step-mother and prior to this, to her mother. There is at least one report of Patricia also suffering childhood physical abuse at the hands of her father. (Her father told the Review that he had grown up in a household where domestic abuse regularly occurred.)

13.2.2 From records, Patricia's step-mother suffered visible symptoms of abuse on more than one occasion. Although the couple lived separately for long periods, the abuse continued with the police being called on many occasions however the step-mother repeatedly failed to press charges for the violence she suffered.

13.2.3 Individual Management Review (IMR) authors noted that in her childhood, Patricia did not have anyone who was a role model on how to be in a relationship and that this impacted on how Patricia was able to have a relationship with others. There were no records of her parents or step-mother attending any of the many school meetings or subsequent court proceedings in respect of Patricia's poor attendance and behaviour. The school had no contact details for her father for a number of years.

13.2.4 In February 2015, the Police were called to Patricia's step-mother's address after she attacked Patricia. The Police arrested the step-mother due to the injuries Patricia sustained to her face, but Patricia refused to press charges. In May 2015 Patricia reported physical abuse from her brother and father that resulted in bruising and her being offered a Refuge space, which she refused.

13.2.5 Children's Social Care were aware of the abuse and neglect that Patricia and her siblings suffered during childhood. However, the review has revealed that the impact of this domestic abuse was not well assessed and led to poor management of the clear on-going risks of domestic abuse, with incidents continuing to occur. The only intervention recorded to have been provided was anger management for the father, during his involvement with Probation. There is no evidence that work was undertaken with Patricia's step-mother, or Patricia herself in relation to domestic abuse.

13.2.6 There is a wealth of evidence about the negative effects of children witnessing domestic abuse. The effects are significant with children displaying symptoms

similar to abused children. They tend to be fearful and show more anxiety and depression than other children, which affects their behaviour at school. (See for example, Meta-analysis by Evans S et al 2008).

13.2.7 McFarlane et al. (2003) found that girls, 12–18 years, of abused mothers showed behaviour problems such as aggression and delinquency. Cummings et al. (1994) reported that female adolescents tend to feel anger. This may help to explain Patricia's behaviour and admitted short fuse.

13.2.8 Patricia talked about the domestic violence, abuse and control that Alan exerted over her to agencies. Often she said that the relationship had ended and that she did not want to be with him. She loved him but recognised that the relationship was abusive and not good for her physical or mental health and emotional wellbeing. In spite of this she also maintained that he understood her and that he was the only person to whom she could talk.

13.2.9 Like her step-mother before her, Patricia was unwilling to make a complaint or talk to police about any of the incidents of domestic abuse that she experienced. This made it difficult for the police to take any action against Alan except in the limited number of times when independent witnesses were present and provided statements. Crown Prosecution Service (CPS) on occasions declined to prosecute due to lack of victim statements.

13.2.10 Patricia was also identified as being a perpetrator of violence against Alan. However, as some of the IMR authors noted, this needs to be taken in the context of the aggression and control that Alan exerted over her, what some academics have referred to as violent resistance. (See for example, Johnson M (2008) and Hester M (2012).) Patricia recounted how Alan wound her up and she would explode and take action, break his windows or fight back. According to the Police Patricia was recorded as the perpetrator on more occasions than Alan.

13.2.11 Patricia often witnessed violence in the family home. Her father was reported to take a door off its hinges in anger. When this is perceived as normal behaviour it is not so surprising that Patricia retaliated against Alan by breaking his windows.

13.2.12 Her father suggested that she had an anger problem similar to the one that he had when he was younger and got involved in the criminal justice system. Her friend said that any violence that she saw was instigated by Patricia in response to Alan "winding her up". It is evident that this happened on many occasions as demonstrated by the chronology of events and may explain why in the reporting period, the Police recorded twenty-three incidents of domestic violence between them; on eleven occasions Alan was the perpetrator and on twelve occasions it was Patricia. Agencies recorded that: 'They were as bad as one another'.

13.2.13 The findings in this review would suggest because Patricia was seen as a perpetrator as well as a victim this may have masked her vulnerability.

13.3. Patricia's vulnerability and fragile mental state feeling belittled and unloved

13.3.1. The review has found many examples where Patricia felt let down by the people around her. She talked about her biological mother, "My mother has never been there for me … I used to miss her but now I don't care".

13.3.2. She felt let down by her father, who she said did not want her living with him. Patricia reported that she had been raped/abused by one of her brother's friends and that her father had done nothing about this. She wanted her father to acknowledge that he should not have ignored it and that he should have done something about it.

13.3.3. Patricia disclosed many instances of domestic abuse with Alan, reported feelings of being controlled, isolated from others and becoming introverted, losing what she described as her "lively sociable personality". However, when she discussed her relationship with Alan in a psychiatric assessment, she said that she felt that she had no one else in the world apart from Alan and when they quarreled she felt that she might as well end it.

13.4. History of self-harm

13.4.1. There were many instances of Patricia taking overdoses and harming herself, including superficial cutting her stomach and stabbing herself with scissors. Patricia reported taking an overdose of paracetamol in 2011 but did not seek help, she reports that this followed an argument with Alan; she also attended Minor Injuries Unit (MIU) with Alan, with lacerations where she had stabbed herself in the leg in April 2012.

13.4.2. In September 2013 she took an overdose and self-harmed. In May 2014, when she attended the Emergency Department following injuries she sustained from Alan, she disclosed that she had taken an overdose the previous week. She also disclosed this to her GP.

13.4.3. All of the self-harming and suicide attempts followed 'arguments' with Alan.

13.5. Alcohol and drugs

13.5.1. Both Patricia and Alan regularly used drugs and alcohol.

13.5.2. At other times, notably to her Offender Manager, GP and mental health worker, she said that she rarely used alcohol and was trying to cut down on her cannabis use. In early 2015 she reported sleeping problems when she was trying to go without cannabis. She did however have traces of both in her body when she died.

13.5.3. Alan drank heavily and when attending Offender Manager appointments he often turned up drunk. This was challenged, but he did not see his alcohol

or drug use as problematic. He reported that he drank sociably three or four nights per week at home or with girlfriends at their accommodation. He said it was usual "to drink 8-12 cans of Stella or a bottle of vodka or brandy and get drunk".

13.5.4. Patricia's Offender Manager offered her an assessment with the local drug and alcohol agency to assess her suitability for a Drug Rehabilitation Requirement as part of her sentencing proposal. Unfortunately, she failed to attend two appointments so this was not taken forward.

13.5.5. The police recounted that either drugs or alcohol or both, fuelled most of the incidents of reported domestic abuse between Patricia and Alan.

13.6. Lack of any agency taking ownership/lead role

13.6.1. When Patricia was first in a relationship with Alan and suffered domestic abuse, she was still a juvenile.

13.6.2. The Children's Social Care IMR author noted that a number of the professionals who were involved with Patricia during 2012/2013, including CAMHS, NEET, Housing and the Police, did not raise the on-going risks of domestic abuse to Patricia or challenge that Children's Social Care, as the responsible lead agency, were not considering this risk sufficiently.

13.7. Transition between child and adult services

13.7.1. In the absence of support from her social worker, Patricia received a great deal of support for the eight months prior to her eighteenth birthday from the CAMHS team. The worker went beyond her normal role to support Patricia with her housing, education and training. She accompanied her to the doctor and helped with her benefit claims and secured emergency payments and food parcels. At this time she was also receiving support from the Youth Offending Team, now part of Early Help, which also contains the NEET Service. There was demonstrated good joint working between these services and the Housing Key Worker from the supported accommodation where Patricia lived.

13.7.2. CAMHS made no referral to adult mental health services as it was always considered that Patricia did not have any real mental health needs and that her problems were as a result of her difficult social circumstances. It was not believed that she would meet the criteria for adult mental health services. There were however handover meetings between CAMHS, YOT and Probation who took over her offender management once Patricia was sentenced as an adult.

13.8. Risk of age gap

13.8.1. Patricia started a relationship with Alan about the time she left school aged sixteen. He was twenty four years old. The first police report of domestic abuse came seven months later when she was still a child and he was an

adult. The police did refer to Children's Social Care, but no further action was taken by them on the basis Patricia and Alan were reported to have separated. This should not have been taken at face value and a full risk assessment should have been undertaken.

13.8.2. Recent child sexual exploitation case reviews have highlighted the difficulties inherent in adolescent sexual relationships and in services responses to them. One important message of relevance to this review is to always call anyone under the age of eighteen a child so that their status is never overlooked (Brooke 2016).

13.8.3. The significant age gap was not picked up on by any of the agencies. Today such an age difference would have rung alarm bells, and is a risk factor for child sexual exploitation. Child safeguarding procedures would be implemented by Children's Social Care. The police, following the first report of domestic abuse would have referred Patricia to the Police Child Sexual Exploitation Team (CSE). Significant work would be carried out with her in order to try and support her to leave the inappropriate relationship. There also would have been a large focus from the CSE team to deter the older male from seeking out the younger female.

13.9. Lack of Stable Housing

13.9.1. After leaving school, Patricia moved in with Alan, as her father disapproved of the relationship and told her to leave the family home. When she ended this relationship following the first reported incident of domestic abuse she became homeless.

13.9.2. Patricia went to stay with friends, her aunt or her step-mother on a temporary basis. Throughout the IMRs there is evidence to suggest that Patricia felt unwanted by her father and step-mother and even though her step-mother's house was her family home, she had no room of her own, had to sleep on her brother's bedroom floor and was never allowed to stay for long.

13.9.3. During 2012 there was confusion about who was responsible for Patricia's housing and whether or not Children's Social Care had a responsibility to house her. Whilst there was some involvement by Social Care to find alternative accommodation for Patricia there was minimal link up with the Wiltshire Housing Options and no joint assessment of her needs. Patricia's CAMHS and NEET workers spent a lot of time helping her to find housing and to access benefits. There is evidence of good joint working between them and Wiltshire Housing Options. For CAMHS this was outside of their normal role but was justified because of the belief that Patricia's lack of a stable place to live had a significant impact on her mood throughout their involvement with her.

13.9.4. Patricia did not have any secure accommodation until she moved into a supported flat in February 2013. However, due to poor behaviour this did not

last. She received her first written warning on the 4th March and the second on the 4th April.

13.9.5. Patricia failed to engage with support workers and had serious breaches of her tenancy agreement including for non–engagement with support, noise, damage to her flat, letting visitors use her flat when she was not there, assault towards another resident and possessing drug paraphernalia. She had a total of fourteen warnings whilst the agency struggled to help her sustain her tenancy.

13.9.6. The non-engagement with her tenancy key worker meant that she did not get the support she would have with, for example, budgeting, benefit issues and registering with a GP. Despite signing an acceptable behaviour contract agreement on 22nd May, Patricia continued to miss appointments and breached her agreement. She finally left the scheme voluntarily on 29th October 2013, so that she did not have to pay for damage to her flat. This meant that she was termed intentionally homeless which impacted on her ability to secure future accommodation. She started to look for privately rented accommodation.

13.9.7. Wiltshire Housing Options made a number of appropriate referrals at the right times in attempting to house Patricia. Sometimes she would engage and placements were offered and other times she would not turn up and decide to stay with friends or family ("sofa surfing"). There is evidence to suggest that at times Patricia went back to live with Alan even when this was not what she wanted because of the abuse.

13.9.8. The lack of somewhere to live impacted on Patricia in a number of ways. She reported to CAMHS that she would like for example, to address her issues relating to anger but felt unsure about how she could make changes, as she was not staying anywhere regularly. She also wanted to engage with other activities, for example, on 21st September 2012 Patricia talked to CAMHS about needing more structure to her day and that having too much time to think was impacting on her mood and gave her too much time to think about Alan. She wanted to go to college and get qualifications, do some voluntary work, but could not commit to any of this due to issues relating to her accommodation and her mood.

13.9.9. Housing remained a problem for Patricia. At the time of her death she was living with Alan in a tent in the garden of the family home.

14 Analysis

14.1 The Review Panel has checked that the key agencies taking part in this Review have domestic abuse policies and is satisfied that those of the statutory and specialist domestic abuse organisations are fit for purpose. The need for other organisations to introduce domestic abuse policies is addressed in the recommendations

14.2 The Panel and Individual Management Review (IMR) Authors have been committed, within the spirit of the Equalities Act 2010, to an ethos of eliminating discrimination, fairness, equality, openness, and transparency, and have ensured that the Review has been conducted in line with the Terms of Reference.

14.3 Twenty-four agencies/multi-agency partnerships were contacted about this review. Six agencies, namely, Wiltshire Council Revenue and Benefits, Splitz, South Western Ambulance NHS Trust, Wiltshire ASBRAC, Citizens Advice Bureau had no relevant contact with either Patricia or Alan. (Victim Support had limited non-relevant contact with Alan but no contact with Patricia).

14.4 Eighteen organisations/Multi-agency partnerships have provided Individual Management Reviews and Reports. The Review Panel has considered them carefully from the view point of Patricia and Alan to ascertain if each of the agencies' interventions were appropriate and whether they acted in accordance with their set procedures and guidelines. Where they have not done so, the Panel has deliberated if all of the lessons have been identified and are being properly addressed.

14.5 The Panel is satisfied that the authors of the IMRs and Reports have followed the Review's Terms of Reference carefully and addressed the points within it where relevant to their organisations. The Panel is also satisfied that each author has been honest, thorough and transparent in completing their reviews and reports. The following are the analysis of each report together with the Review Panel's opinion on the appropriateness of the agency's interventions.

14.6 **Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)**

14.6.1 AWP received a referral related to domestic abuse from the Police in 2012 but as they do not provide a CAMHS service in Wiltshire, they then made no contact with Patricia who was under eighteen years of age.

14.6.2 Later Patricia had four face to face contacts with AWP services. Two were with Court Assessment and Referral Service (CARS), on 26 June 2013 and 13 November 2014. She was also seen by the Royal United Hospital Acute Hospital Liaison Team on 24 September 2014, following an overdose and by the Early Intervention Team on 27 November 2014 in response to a referral from CARS.

14.6.3 Patricia was described as having a vulnerable personality and poor coping strategies but she was not diagnosed with a specific mental illness at any point during her contacts with Avon and Wiltshire Mental Health Services. She was described as presenting no symptoms of a severe and enduring mental illness, the presence of which is a defining characteristic for admission to mental health services.

14.6.4 AWP has a well-established and fit for purpose Domestic Abuse Procedure which supports all staff in managing domestic abuse. It is to be used in conjunction with the Safeguarding Policy where the person has a need for care and support and as a consequence is unable to protect themselves against abuse. In addition there is a National Operating Model for CARS. Patricia's care was consistent with this model.

14.6.5 There was however evidence of current risk in relation to domestic abuse and an opportunity was missed to check if it was being dealt with, and if not, to consider either sharing the information with another agency who was best placed to manage the risk (often Police) or in some circumstances make a MARAC referral in line with the AWP policy.

14.6.6 The risk summary completed by the CARS practitioner referred to the risk of abuse from others but the summary confusingly referred to the "ex-boyfriend".

14.6.7 There was no evidence that a DASH document was completed or of any action being taken regarding domestic abuse at this time.

14.6.8 At no point was Patricia a formal AWP service user; in other words she was never felt to meet the admission criteria for acceptance onto a secondary care caseload. She had no diagnosed mental illness, was therefore deemed not to be in need of care or support and therefore would not have been formally viewed as being a "vulnerable service user" or to be eligible for a Rapid Access process, or subject to dual diagnosis processes.

14.6.9 She was discharged to her GP and the letter contained a reference to relationship counselling; but not to any actions to protect Patricia from the possibility of domestic abuse such as sign-posting Patricia towards Wiltshire domestic abuse services. Again there is no evidence of the completion of a DASH tool. This was another missed opportunity to potentially reduce the harm caused to Patricia by her relationship with Alan. In addition, the letter did not contain any advice about what to do in the event of a deterioration in her mental health.

14.6.10 The Panel thanked the IMR author for an honest and open review. It is in agreement with the recommendations identified within the review

14.7 **Bristol Gloucester Swindon and Wiltshire Community Rehabilitation Company (BGSW CRC)**

14.7.1 BGSW CRC was formed on 1st June 2014 as part of the Government's reform of Probation services. Now operated by Working Links in partnership with Innovation Wessex, it is responsible for the management of low and medium risk offenders who have been sentenced to serve their Order in the community or on Licence, having served a custodial sentence.

14.7.2 Two reports were produced due to the agency having had involvement with both parties.

14.7.3 **Patricia**

14.7.3.1 A supportive working relationship was established between Patricia and her Offender Manager (OM1). However, her case was re-allocated to a new Offender Manager, due to OM1 moving roles within the Organisation. The timing of this may not have been good for Patricia and could have contributed to her feeling she did not have anyone to whom she could talk.

14.7.3.2 A number of domestic abuse incidents were reported from the start of Patricia's relationship with Alan, resulting in her reporting feelings of being controlled, isolated from others and becoming introverted, losing what she described as her "lively sociable personality".

14.7.3.3 Patricia disclosed self harm on several occasions and made attempts to take her life following arguments with Alan, which left her feeling worthless (the last occasion was in September 2014). Following this incident, when she was hospitalised, the follow-on plan and what was to be provided in the community to prevent a similar incident was not clear.

14.7.3.4 The effective and supportive relationship that was established between Offender Manager 1 and Patricia, enabled issues to be discussed and challenged. However, structured work was not undertaken, due to inconsistent compliance and the issues Patricia invariably attended with, for example, housing/homelessness.

14.7.3.5 At times, information was being shared with BGSW CRC, which was key to the overall management of the Court Orders and presenting risk issues. In November 2014, OM2 successfully followed up with CARS and obtained a copy of their report and in February 2015, pro-active contact was made with the Witness Care Unit, which was clearly recorded on Delius. It was not always clear how consistently these issues were being followed up with the relevant agencies, which may be because of a recording issue.

14.7.4 **Alan**

14.7.4.1 Since being supervised by BGSW CRC, Alan was consistently assessed as presenting a medium risk of serious harm to a known adult, namely Patricia. The IMR author believed this was an accurate and appropriate assessment.

14.7.4.2 This assessment took into account a number of factors, including the fact their relationship appeared to be on/off in nature and also his motivation and commitment to address his alcohol and drug issues would fluctuate.

14.7.4.3 The Offender Manager (OM2) appeared to have established an effective working relationship with Alan and did not give up on him, despite evidence of his non-compliance at particular point.

14.7.4.4 OM2 was committed to working with him to address the assessed needs, for example, OM2 was keen for him to address his alcohol use, partly evidenced by him attending some WSMS appointments with him, to ensure he attended. However, it took approximately six weeks for Alan to attend his first alcohol treatment requirement appointment, which the IMR author considered to be too long and this could have impacted on his motivation to attend/engage and the overall outcome from this requirement. Although the above areas were, in the main, monitored during planned office visits with Alan, structured work particularly around relationships and his attitude towards Patricia was not undertaken. Furthermore, as detailed above, as Alan's Order was revoked, there was insufficient time for him to complete BBR.

14.7.5. The Panel thanks the IMR author for her detailed reports. Important lessons were identified and the Panel is satisfied with the recommendations made to address them. The Panel was however concerned about the number of times Alan attended meetings whilst drunk or with alcohol in his possession and the reluctance to deal with this positively.

14.8. Child and Adolescent Mental Health Services (CAMHS)

14.8.1. In the initial CAMHS assessment Patricia was described as having been in a physically and verbally abusive relationship with Alan. His behaviour towards her was recorded as being controlling and manipulative with Patricia attributing overdoses to arguments with Alan.

14.8.2. The IMR author was able to see throughout the clinical notes some very good communication and information sharing between the services working with Patricia. In particular the joint working between CAMHS, Housing and Connexions to support Patricia to access both housing and benefits. There was also evidence of Housing, Connexions and CAMHS working closely with Patricia to find appropriate housing for her.

14.8.3. The CAMHS worker undertook many actions that are not traditional CAMHS roles. The IMR author questions whether this was to over-compensated for the lack of support for Patricia, that the worker reported she was getting from other services. In particular she did not feel that Patricia was receiving coordinated support around housing, benefit and educational help and she was concerned about the impact of this on Patricia's mental health. It was the IMR

author's opinion that this should have been discussed with Oxford Healthcare NHS Trust Named Nurse Safeguarding Children with a view to escalating these concerns. Opportunities may have been missed to support Patricia with her domestic abuse because of the focus on her immediate housing needs.

14.8.4. The Panel thanks the IMR author for the detailed and open review. The Panel is satisfied key recommendations were identified. The Panel would like to commend the support worker for the care she showed to Patricia.

14.9 Curo Housing Association

14.9.1 The IMR author highlighted that after Patricia was given the supported tenancy she did not engage with the support team. There was a substantial history of non-engagement and a failure to show up to appointments but he was satisfied that every effort has made to engage with her to sustain her tenancy and work with her on her support needs.

14.9.2 Whilst she was given two written warnings quite soon after taking the flat, she received a total of fourteen warnings, so the emphasis clearly was on sustainment. Curo Housing Association policy and procedure was clearly followed at all times.

14.9.3 The Panel accepts that Curo Housing Association followed their established procedures in endeavouring to engage with Patricia and are satisfied that the lesson learnt will be addressed by the recommendation made. The Panel however noted that Patricia by agreeing to voluntarily give up her accommodation, when Curo Housing starting action to evict her, she was recorded as being intentionally homeless and this adversely affected the housing support she could receive from Housing options.

14.10 Great Western Hospital (GWH)

14.10.1 GWH NHS Foundation Trust Acute Services did not have any contact with Patricia or her partner. There were no child health records available for Patricia although she would have been known to the children's health services within Wiltshire when she was resident in the county. It is known that Patricia was in foster care from January 1998, but no Looked After Child records were located. There are no records held in Wiltshire as she was not resident in the County until 1999.

14.10.2 The family records from other areas were located and identified issues around children services and alcohol services prior to Patricia's 3rd birthday.

14.10.3 It was confirmed that there had been no contact with School Health Nurse team.

14.10.4 The Panel noted that information and records were missing due to historic records on children not being kept. Therefore Panel accepts that, from the limited contacts with Patricia's mother, GWH has no lessons to learn.

14.11 **Kingdown School**

14.11.1 Patricia's behaviour towards staff and other students was often described as abusive, rude and generally defiant. The appropriate sanctions were applied according to behaviour policies. Consequently there were numerous internal and external exclusions.

14.11.2 External exclusions would not now happen for such vulnerable and challenging students. Sending students back to the family home for five days does not help improve their behaviour.

14.11.3 Patricia was defiant and resistant to wearing the correct uniform. This was only sporadically documented. This could have been considered a welfare issue but no documents are available. The IMR author was unable to find any file recording of any safeguarding or welfare concerns.

14.11.4 Patricia's attendance was poor and although some documentation was in place indicating that some meetings were held and other agencies were involved, information was not consistently recorded. This was due to a lack of clarity of process and procedures not being as thorough as they are now.

14.11.5 The Panel, while satisfied and in agreement that the lessons identified, by the IMR author, will be addressed by the new procedure at the school together with the recommendations, also added a recommendation that domestic abuse training should be identified as a training requirement by the school.

14.11.6 The Panel also included that there should be a multi-agency recommendation for domestic abuse training to be included in the safeguarding training within all schools in Wiltshire.

14.11.7 The Panel noted that the school is currently involved in statutory child protection procedures with regard to other children within the family.

14.12 **National Probation Service (Wiltshire and Gloucestershire LDU)**

14.12.1 The IMR author presented two reports as the then Wiltshire probation Trust (WPT) had contact with both Patricia and Alan.

14.12.2 **Patricia**

14.12.2.1 Involvement of the then WPT with Patricia began at the Pre-Sentence Report interview. Patricia identified a number of pertinent factors, including: her use of alcohol, poor emotional well-being, drug misuse and her experience of being in an abusive relationship.

14.12.2.2 The recommendation to address Patricia's cognitive deficits, substance misuse and propensity to use violence within supervision was both appropriate and proportionate.

14.12.2.3 She was assessed as posing a medium risk of serious harm to the public, staff and herself at this stage, which was an appropriate risk assessment.

14.12.2.4 The IMR author noted that the Initial Sentence Plan (ISP) was not completed in a timely manner until some 7 weeks following sentence.

14.12.2.5 Following disclosure of violence perpetrated against Patricia by Alan and Patricia self-harming, the Offender Manager (OM3) undertook appropriate liaison with other agencies. There was good co-working of this case from the start with a three way meeting with Patricia's housing key-worker and good use of home visits at the beginning of the order. However, when there were further disclosures of more incidents with Alan, there does not seem to be any follow up with other agencies, in terms of the abuse perpetrated against Patricia by Alan, by OM3. OM3 did follow up the arrest of Patricia with the Police to establish bail dates, although there did not appear to be any evidence to suggest any liaison with Alan's Offender Manager.

14.12.2.6 Whilst there is evidence to suggest referrals to both Keeping Calm and Conflict Resolution were considered and discussed, there was no evidence of such work being undertaken with Patricia in order to reduce her own risk of serious harm and risk of re-offending.

14.12.2.7 The effective practice that has been identified in the management of this case includes:

- Consistent and effective communication with other agencies involved with Patricia throughout the course of the period of supervision, including her housing key-worker, IDVA, MARAC and the Domestic Abuse Investigation Team.
- Identification of Patricia being a victim of domestic abuse and utilising other agencies for a joined up approach - Email to IDVA following disclosures of violence and prompt MARAC referral.
- Appropriate assessment of risk of harm levels and appropriate sentencing proposal.
- Both Offender Managers utilised supervision with Patricia to encourage her to consider the risks of her relationship with Alan and assist her to make plans to ensure her safety.
- Good use of home visits to both Patricia's own property and her parent's property.

14.12.3 **Alan**

14.12.3.1 The Positive Relationships group work programme was started, some nine months after the commencement of the Community Order. During the period of the group work programme, all of the entries that relate to this intervention are limited. There is positive use of the facilitators of the group work programme and the Offender Manager utilised a 3-way with Alan and

the group facilitator after he attended a group session under the influence of alcohol.

14.12.3.2 The effective practice identified in the management of this case includes:

- The proposal detailed in the Pre-Sentence Report was clearly linked to risk of serious harm and re offending. It was an appropriate proposal given the information made accessible.
- There is evidence of the Offender Manager following up information with both Alan and the Domestic Abuse Investigation Team.
- There is evidence that the Offender Manager sourced information from other sources prior to the Pre-Sentence Report interview.
- An appropriate referral was made to the Education, Training and Employment provision to assist Alan in improving his employability.

14.12.3.3 However, good practice was not always followed and recording could have been improved. Where interventions were undertaken there were delays in starting, a lack of focus on offence work and no work to address Alan's alcohol use. This led to missed opportunities for Alan to start addressing issues to reduce his risk of serious harm and manage his own behaviour in relationships.

14.12.3.4 Following conviction of a new offence against Patricia the recommendation for a conditional discharge was not entirely appropriate in this case. There is no evidence that communication took place with either a line manager or the programmes team to discuss the proposal.

14.12.3.5 The Panel thanked the IMR author for the detailed and open reports. They accept she has included the key lessons learnt and appropriate recommendations to address them.

14.13 **Royal United Hospital (RUH)**

14.13.1 During the periods of admissions to the Emergency Department medical and nursing staff and the Mental Health Liaison Team saw both Patricia and Alan, although there were no occasions when both presented at the Emergency Department at the same time.

14.13.2 The IMR author was satisfied that the involvements at each contact by the Royal United Hospital with both Patricia and Alan were appropriate. The staff made referrals to the Mental Health Liaison Team, CAMHS and General Practitioners to follow up with their care and treatment.

14.13.3 The IMR author found that the clinical practice was appropriate for each episode. Nevertheless, there were missed opportunities to offer Patricia advice and support with the domestic abuse and the difficult relationship that she had disclosed on some of her attendances.

14.13.4 The Panel are satisfied the IMR author has identified lessons learnt and provided appropriate recommendations to address them.

14.14 Wiltshire Clinical Commissioning Group (CCG)

14.14.1 Patricia and Alan were both seen by GP Practices in Wiltshire.

14.14.2 Patricia had frequent interactions with the primary health care team including where she disclosed domestic abuse and discussed her self-harm and overdoses following arguments with Alan. She was prescribed anti-depressants, referred to mental health services and received appropriate clinical help. She did not always turn up for appointments, but did gain access often, and when needed. It was not clear from the records where she was living at the time of her death.

14.14.3 The IMR author noted that the practice could have been more proactive in contacting her when they received information from other agencies.

14.14.4 The Panel thanks IMR author for the thorough review and agreed with the recommendations she made.

14.15 Wiltshire Council Adult Services

14.15.1 The Department had only limited contact with Patricia and the IMR author was satisfied that it was in line with the Council's / department's policies and procedures.

14.15.2 The Panel is satisfied and agrees that the contacts were conducted in accordance with accepted policy. Adult Social Care have no lessons to be learnt from this Review**.**

14.16 Wiltshire Council Children's Social Care (CSC)

14.16.1 Patricia first became known to Children's Social Care in 2002 when she was seven years old. There was clear evidence that Patricia and her siblings had been exposed to domestic abuse throughout their childhoods, with their father being the perpetrator of significant violence towards their step-mother and prior to this their mother.

14.16.2 The IMR author acknowledged that the assessments, planning and interventions throughout Children's Social Care's involvement with Patricia were of poor quality and a number of opportunities were missed to improve outcomes for Patricia.

14.16.3 Social care records indicate that Patricia started a relationship with Alan in 2012 when she was sixteen years of age and he was twenty four years old. Patricia was clearly the victim of domestic abuse and was not offered any specific support in relation to domestic abuse. There were a number of professionals involved with Patricia during Children's Social Care involvement in 2012/2013, including CAMHS, Connexions, Housing and the Police none of whom appeared to raise the on-going risks of domestic abuse to Patricia nor

challenged that the Children's Social Care social worker was not considering this risk sufficiently.

14.16.4 When Children's Social Care become involved with Patricia again in 2012/2013, the extent of the domestic abuse was known and commented upon but there is no record that Patricia was offered any support in relation to this or that this was considered as a child protection matter that she needed to be protected from, given that she was still a child.

14.16.5 Children's Social Care did not take any further action on the basis that the couple had separated. Given that Patricia was a child who had been assaulted, the CSC social worker should have called for a strategy discussion.

14.16.6 The case was closed prematurely despite further reports of domestic abuse against Patricia.

14.16.7 Children's Social Care are considering what action is required regarding the continued practice of the social worker in charge of the case who has been found to be negligent but who is no longer in their employment.

14.16.8 The Panel thanked the IMR author for her detailed, open and honest review. Although it is acknowledged that Patricia was at times difficult to work with, there were a number of missed opportunities from CSC, which should have been the organisation that took ownership of Patricia's overall care. Nevertheless the IMR author has identified the key lessons learnt and the appropriate recommendations will address these.

14.17 **Wiltshire Council Early Help**

14.17.1 Patricia was known to the NEET (Not in Education Employment or Training) Service between 2010 and 2014 with contact beginning whilst Patricia was still at school. She first came to the notice of the Youth Offending Team in September 2013 following Police intervention during a domestic incident with her partner Alan.

14.17.2 Records indicated that the NEET service were aware that Patricia had difficulties in her relationship with her boyfriend. There was little evidence that these issues were explored in any detail and there was no evidence of discussion around support for Patricia in her relationship with Alan. This was despite evidence of incidents and arguments that ended with violence and aggression from either Patricia or Alan.

14.17.3 The IMR author acknowledged that there was a lack of real understanding about Patricia's complex family history and the impact of this on her relationship with Alan, her reliance upon alcohol and her ability to maintain engagement with support services.

14.17.4 There were a number of professionals involved in supporting Patricia and significant amounts of information shared but there was no evidence of an as-

sessment by NEET or an overarching plan of support which may have held professionals to account and monitored progress more closely.

14.17.5 There is very limited information relating to Alan. This was due in part to a change of recording system and issues with transfer of information between systems. In an assessment dated 3rd July 2003 it was identified that Alan's offences were linked to alcohol although Alan did not consider alcohol as problematic. There was no record of any referrals or work carried out in relation to alcohol use.

14.17.6 The IMR author noted that it was not clear from case recordings what actions were taken regarding management of the domestic abuse between Patricia and Alan. This issue did not seem to have been explored through NEET or YOT involvement in this case.

14.17.7 The Panel is satisfied and agreed the lessons learnt have been identified and that the recommendations are appropriate to address them.

14.18 **Wiltshire Council Education Welfare Service (EWS)**

14.18.1 The IMR author reviewed and analysed the case recordings in relation to the Education Welfare Officer contacts with Patricia. At the time of involvement EWS Case management protocol centred on the engagement of the parent, but this was not evident in this instance.

14.18.2 The EWS practice in this case was robust in the approach of holding meetings regularly and of providing actions as far as possible. The school based actions were as a result of good communication between the EWO and the school in an attempt to create windows of opportunity for Patricia to be supported academically and to access an adult to whom she could share concerns should she wish to do so.

14.18.3 Due to the manner in which information was recorded, it was difficult to identify or ascertain any underlying factors which may have contributed to Patricia's non attendance, and parental non engagement. Practice now would dictate that these are crucial areas to be explored and understood.

14.18.4 Parental non-engagement regarding the concerns of poor school attendance contributed to the decisions taken regarding Penalty Notices and prosecution.

14.18.5 The EWO's involved acted in accordance with their role to uphold the legislation regarding school attendance (Education Act 1996). It is possible that this largely sanction based approach alienated the adults which had a cumulative effect on Patricia not engaging with the support offered.

14.18.6 The Review Panel is satisfied that the IMR author has identified the key lessons and made appropriate recommendations to address them.

14.19 **Wiltshire Council Housing Options**

14.19.1 The Housing team provided Patricia with appropriate housing advice that was in line with Government legislation and internal policies and procedures at the time. The IMR author, however, noted that since 2012 many changes have been made to improve support for young people who approach Wiltshire Council as well as better partnership working with children services to offer a more joined up and child centric approach to providing accommodation.

14.19.2 It was recognised that Patricia had very unstable housing since 2012 when she left supported housing. During the latter part of 2012 a significant degree of confusion was noted in regard to Patricia's status.

14.19.3 The Housing advisor who worked with Patricia informed CAMHS that the adviser was going to challenge Children's Social Care in regard to their duties, but there is no record of this being done. This should have been followed up more formally and a request made to a senior manager for the case to be reviewed to ensure the needs of Patricia were being met. Housing could have also called a multi agency meeting when it was recognised that she was struggling to cope even in supported accommodation which would have ensured that all agencies were clear about what was being offered to Patricia and to identify how her needs were being met and any risks mitigated.

14.19.4 Appropriate referrals were made at the right times to both Refuge placements and supported accommodation. Sometimes Patricia would engage and placements were offered and other times she would not turn up having decided to stay with friends and family ("sofa surfing"). A multi-agency meeting would have been helpful.

14.19.5 Poor behaviour contributed to Patricia losing her supported housing placements, although efforts were made to work with Patricia to try and maintain those placements. When Patricia approached Housing, accommodation options were always discussed and appropriate referrals made. However, the IMR author highlighted that it would be helpful to conduct a review of the placement to determine how poor behaviour from young people is managed, rather than the young person being asked to leave/evicted, which would then have long-term impacts on their ability to secure future accommodation.

14.19.6 The Panel is satisfied with the lessons learnt which have been identified and with the recommendations to address them.

14.20 Wiltshire Domestic Abuse Conference Call (DACC)

14.20.1 Wiltshire Police and partners utilise a Domestic Abuse Conference Call which is carried out on week days. This process is only carried out in the Wiltshire local authority area and does not include Swindon.

14.20.2 All domestic abuse crime and incidents are collated on a daily basis (apart from weekends). They are compiled on a spreadsheet and added to the SharePoint link as soon as possible to allow agencies to read and collate information prior to the conference call. The report contains all domestic abuse

reports from the previous twenty fours hours (0700-0700). The Monday DACC's contain all reports from 0700 Friday morning until 0700 Monday morning. Due to the number of cases contained within a Monday report only high and medium risks are discussed. Any standard risk cases which cause concern to any agency can be raised and discussed at the end of the conference call. This is also the case on Wednesdays following a MARAC meeting on the Tuesday.

14.20.3 The DACC started in July 2014 as a trial but did not take place every weekday until 10th November 2014. The DACC did not start including weekend domestic abuse reports until the 24th November 2014.

14.20.4 There was a domestic abuse incident between Patricia and Alan on the 16th November 2014. This incident was not discussed at the DACC as this incident fell on the weekend which was prior to the date when the DACC included weekend incidents.

14.20.5 On the 15th April 2015 a 'medium risk' domestic abuse case was discussed at the DACC involving Patricia and Alan for an incident that occurred on the 9th April 2015. The delay in discussing this case was due to a PPD1 not being completed until the 14th April 2015. At this DACC, Patricia was identified as the perpetrator and Alan as the victim. The agencies that were involved in this conference call were Police, IDVA, and Wiltshire Children Services. DACC records indicate that Splitz emailed the DACC to advise that there were no cases known to their agency and Probation received the case list. Wilshire Council Housing Department did not call into the DACC. There were no actions recorded for this particular case or any further information recorded on the DACC list regarding this case.

14.20.6 The DHR Panel thanks the DACC Chair for his report.

14.21 **Wiltshire Multi Agency Risk Assessment Conference (MARAC)**

14.21.1 Patricia was first discussed at the MARAC as a victim of domestic abuse on 27 November 2013. Key risks were identified and actions to reduce the risk assigned.

14.21.2 These actions were reviewed at the North & West MARAC on the 3rd December 2013. The minutes indicated that the above actions were reviewed and completed. However, the IMR author notes that it is clear from these minutes that the IDVA was having difficulty getting in contact with Patricia and the action was recorded as complete despite the IDVA not having made contact.

14.21.3 Actions were agreed and recorded in the minutes and reviewed at a meeting on the 14th January 2014. The minutes indicate that the actions were reviewed and completed.

14.21.4 Following a domestic incident reported on the 24th December 2013 where Patricia was listed as the perpetrator and Alan as the victim, the minutes indicate that the Chair made the decision not to hear this case as the domestic incident was marked as medium risk and had therefore been referred incorrectly to MARAC. However, in relation to this case, it is recorded that Alan saw an IDVA and reported that there was no chance of resuming his relationship with Patricia. He was homeless and wanted help with housing. He requested the IDVA make contact with Splitz regarding the Turnaround Programme (a perpetrator programme) but later changed his mind. He also presented at housing options and was given advice.

14.21.5 Risks identified in the MARAC included mental health and alcohol issues. The IMR author stressed the importance of agencies, representing these areas, to regularly attend MARACs.

14.21.6 The Panel accepted the points made by the MARAC Chair.

14.22 **Wiltshire Police**

14.22.1 In the reporting period Police recorded twenty three incidents of domestic abuse between Patricia and Alan; on eleven occasions Alan was the perpetrator and on twelve occasions Patricia was.

14.22.2 The Officers that attended the various incidents took positive action in arresting Patricia and Alan. This was in line with the Wiltshire Police positive action policy and the training that officers receive in dealing with Domestic Abuse.

14.22.3 Officers completed a DASH risk assessment for every Domestic Abuse incident that they attended. The risk was generally interpreted correctly, which at times was not easy to assess due to Patricia's often drunken behaviour and her not being willing to co-operate with the process. The risk assessment forms attracted the correct level of supervision and intervention from the Domestic Abuse Investigation Team where necessary. Where the risk was identified as high, a referral to the MARAC was made. There was also one occasion where a referral to MARAC was made under the repeat criteria

14.22.4 The police officers attending to the reported incidents were invariably at a disadvantage due to the lack of co-operation from Patricia in pursuing a complaint. They were then faced with the difficulty of how to achieve a positive outcome when there was little or no evidence to support a charge. On two occasions statements were obtained from independent witnesses to support charges against Alan.

14.22.5 With an age gap such as the one which presented at the start of the relationship in this case, today Patricia would have been referred to the Child Sexual Exploitation team.

14.22.6 The IMR author is confident that all policies and procedures in place at the time were followed correctly.

14.22.7 The Panel is satisfied that the Wiltshire Police has introduced a number of policy improvements which will improve the safety of young victims of domestic abuse.

14.23 Wiltshire Substance Misuse Services (WSMS)

14.23.1 WSMS had no direct contact or dealings with Patricia. Her boyfriend Alan was a client of WSMS from the 27th January 2015, until the 2nd July 2015. During this time he was in treatment due to an Alcohol Treatment Requirement (ATR) as directed by the Courts.

14.23.2 During his time in treatment Alan's contact and engagement was inconsistent, with several missed appointments that ultimately resulted in his Court Order ATR (Alcohol Treatment Requirement) being revoked and he was discharged from the service.

14.23.3 Normal policy was not followed as he should have been referred back to the courts following two consecutive missed appointments. However a joint decision was made between the Offender Manager and the Key Worker to give him a final opportunity to engage.

14.23.4 There was some reference in Alan's initial assessment to inform of previous arrests for domestic abuse issues and there was indication from Alan that he was at times the victim. These issues were not explored.

14.23.5 The Panel is satisfied the IMR author has identified the recommendation appropriately.

14.24 Pathologist's Report

14.24.1 The pathologist recorded that Patricia was a twenty year old female with a known history of anxiety and depression, who had previously attempted suicide. She was found hanging from a tree with a scarf used as a ligature. The ligature mark and fractures to the hyoid bone and thyroid cartilage were consistent with death due to hanging. The Pathologist stated that in his opinion the cause of death was unnatural and due to hanging.

14.24.2 The toxicology report indicated consumption of alcohol at some point prior to death. The effect of the concentration on the deceased would have been dependent upon her tolerance to alcohol. It was explained that in a normal social drinker a similar blood alcohol level would not be associated with notable intoxication.

14.24.3 The post mortem also demonstrated that the Patricia had used cannabis some time prior to death. However, from the analytical findings it was not possible to say when Patricia had last used cannabis. The pathologist concluded that it was not possible to determine the exact effect of cannabis on Patricia's state of mind at the relevant time.

14.25 Patricia's Friend, Megan (pseudonym)

14.25.1 Megan, a close friend of Patricia talked to the Chair of the Panel and disclosed that although they were friends and they worked together, she was not aware of any long term violence from Alan.

14.25.2 Megan described Patricia as being strong willed. She would not do anything she did not want to do. She tried to be in control of what was going on. The only violence Megan saw between Patricia and Alan was started by Patricia, as a result of too much alcohol. She said Alan would goad her and Patricia would react. She described how one night Alan was at her house waiting for Patricia. He was excited when she came in but she was drunk. He started "winding her up" and she left, with him following, they had some sort of fight outside, because they came back in with mud on their clothes as if they had been rolling around. They then did not speak to each other for the rest of the evening.

14.25.3 Megan did however recall taking Patricia to hospital with bruises a week or so before she died, but Patricia had been drunk and she was not clear what had happened.

14.25.4 Megan did not know about any domestic abuse support services in the area. Although she did not know if Patricia knew about them, Megan was certain that Patricia would not have gone to speak to anyone about Alan.

15 Effective Practice and Lessons Learnt

15.1 Avon and Wiltshire Mental Health Partnership NHS Trust

15.1.1 The IMR author noted that Patricia was charged and convicted of assault on her partner and housemates so may have been viewed as less vulnerable than perhaps she was.

15.1.2 AWP communicated the idea of “referrals” to other services (LIFT, WSMS) to the GP. This was potentially misleading language implying an action delivered, whereas these contacts could only be actioned by Patricia herself. Communication around the idea of “referral” to services that require the service user to be pro-active in making contact, should be clearer.

15.1.3 Patricia did not have clear advice about how to re-access mental health service in the event of her mental health deteriorating.

15.1.4 Domestic abuse risk management and Safeguarding needs to be specifically and explicitly addressed whenever a vulnerability to abuse is identified during risk assessment.

15.1.5 Need to update Standard Operating Procedures and remind staff of the resources available to support them.

15.1.6 Service users who have had contact with any part of AWP services should be copied in to letters to their GP and these letters should contain advice about clear, realistic and deliverable actions to be taken in the event of deterioration in, or recurrence of, mental health needs.

15.2 Bristol Gloucester Swindon and Wiltshire Community Rehabilitation Company (BGSW CRC)

15.2.1 Patricia may have benefited from targeted alcohol work, which could have been delivered internally or a referral to a specialist agency.

15.2.2 It’s not clear how consistently issues were being followed up with the relevant agencies, which may be a recording issue.

15.2.3 In terms of specialist support for Patricia, there was a referral to a specialist support service for women, but at the time provision was not consistently being provided in Trowbridge. Had this support been available, Patricia could have engaged with this service whilst subject to an Order and this support could have continued even when the Order had terminated. Furthermore, Patricia may have benefited from a volunteer mentor, who could have provided additional support.

15.2.4 It’s evident from the Delius records that Alan did not consistently comply with the requirements of the Court Orders, enforcement action should have been taken sooner to clearly demonstrate that this was not acceptable and would not be tolerated.

15.2.5 The IMR author noted that reflective supervision should be prioritised, so Offender Managers are encouraged to explore how these cases are being managed and to ensure that key risk issues are not being missed. It's also imperative that the CRC continues to work in close liaison with other agencies to improve outcomes for victims, perpetrators and communities.

15.3 Child and Adolescent Mental Health Services (CAMHS)

15.3.1 CAMHS should have raised concerns, along with other agencies about the lack of effective multi-agency working to support Patricia. They should not have relied on another agency raising these concerns, but should have escalated their concerns. The voice of Patricia was very clear in the clinical notes and should have been escalated through the agency managers.

15.3.2 Domestic abuse risk management and Safeguarding needs to be addressed whenever a vulnerability to abuse is identified. Opportunities were missed to address the domestic abuse because workers concentrated on Patricia's immediate housing and financial situation. Safeguarding needs should have been discussed with the safeguarding lead when Patricia's needs were unmet and she was at continued risk of harm.

15.4 Curo Housing Association

15.4.1 Patricia left her Curo Housing accommodation very soon after the disclosure of domestic abuse was made, but it would have been beneficial if there was one lead agency in such cases to ensure all agencies were aware of the situation and the possible effects of decisions made by individual agencies.

15.5 Kingdown School

15.5.1 Since 2010 in particular, the Head and senior pastoral leaders reviewed, amended and implemented policies and procedures to support the most challenging students and their families. Attendance issues are monitored and support offered.

15.5.2 The IMR author was confident that child protection and welfare practices have improved considerably since 2010. Child protection is very high profile, staff are not afraid to report incidents and do so quickly. There is better alternative provision and more resources available to help deal with the most vulnerable and challenging students.

15.5.3 Awareness of domestic abuse requires improvement and will be included as part of future child protection training.

15.6 National Probation Service

15.6.1 Patricia

15.6.1.1 There was a lack of focus on Patricia's own offending and limited work to address her behaviour in terms of her propensity to utilise violence towards others. A referral to Keeping Calm and Conflict Resolution was con-

sidered in the original order but not proceeded with. This would have targeted the offending behaviour.

15.6.1.2 There is no evidence to suggest, through the contact entries, that the line manager of the Offender Managers was active in the management of this case.

15.6.1.3 As identified in the Pre-Sentence Report, Patricia had a history of misusing both alcohol and cannabis and whilst this was monitored throughout the period of supervision, with disclosures of minimal use, no work appears to have been completed to address this.

15.6.1.4 Contact with Patricia's GP would have ensured a better understanding of her emotional well-being and closer monitoring of the risk of harm that she posed to herself.

15.6.1.5 Following disclosure of a self-harm incident, a risk review was not completed. This would have allowed appropriate exploration of the incident to be contained in the assessment.

15.6.1.6 Following the revocation of Patricia's original order and subsequent resentencing, there is no evidence, from the contact logs, that a referral to Positive Relationships was prioritised in order for the intervention to start promptly.

15.6.1.7 Initial Sentence Plan should have been completed in a timely manner.

15.6.2 Alan

15.6.2.1 An Initial Sentence Plan was started and logged as completed, however the document in OASys was locked incomplete, with no completed sentence plan objectives.

15.6.2.2 Home visits should have been undertaken in order for the Offender Manager to assess the suitability of the accommodation and for an investigative approach to be taken.

15.6.2.3 All interventions should have started promptly after the commencement of the Community Order to avoid a delay in offence focused work being undertaken.

15.6.2.4 There appears to have been a lack of focus to undertake offence focused work with Alan whilst waiting for the start of the Positive Relationships group work programme. This was a missed opportunity for Alan to start reducing his risk of serious harm and managing his own behaviour in relationships.

15.6.2.5 Work to address alcohol misuse was not undertaken, despite evidence to suggest that Alan was utilising alcohol on a frequent basis and to excessive quantities.

15.6.2.6 Initial Sentence Plan to evidence the objectives to be achieved during the course of supervision.

15.6.2.7 Reviews should have been prioritised following significant events.

15.6.2.8 The level of contact with Alan was reduced without defensible rationales. The initial reduction of contact took place before any offence focused work had been undertaken.

15.6.2.9 There was no evidence through the contact entries that the line manager of OM1 had any active involvement in the management of this case.

15.6.2.10 A MARAC referral was prioritised by the Offender Manager of Patricia, there is no evidence to document that OM1 had considered such a referral and if OM1 had discussed with Patricia's OM the referral that they made.

15.7 **Royal United Hospital (RUH**)

15.7.1 There are no clinical practice issues that have been identified when reviewing the details of the contacts documented in the medical records, however improvement was needed in the assessment of the risks to Patricia associated with Domestic abuse and her chaotic lifestyle.

15.7.2 There would be an expectation by the safeguarding team that any staff would be able to question further when a patient discloses that they have been a victim of domestic abuse. The Trust now delivers a domestic abuse awareness training programme.

15.8 **Wiltshire Clinical Commissioning Group**

15.8.1 The Primary Care Practice requires improved policies and procedures to manage patients following disclosure of domestic abuse.

15.8.2 Better recording of information about where vulnerable patients are actually living and who is living with them is required.

15.8.3 Whilst the main District General Hospitals have easy access to Mental Health services, Community hospitals do not. Patricia was not offered direct support during her attendance at Trowbridge Minor Injuries Unit and the Practice should have made a documented effort to contact her after they received this letter in May 2015. In future it has been agreed that a new policy will be developed to ensure some contact is made with patients who are subject to domestic violence. This could be attempts at direct telephone contact or letters suggesting GP review. However, being mindful of the situation, this could alternatively be in terms of medication review or general health check so that perpetrators are not alerted. Outside support with this will be sought from Splitz and other specialist organisations.

15.8.4 Better recording of other agencies involved with patients need to be developed. Records of specific named social workers or other external agencies

should be recorded under the administration tab in the patient record. Communication with these agencies need to be improved and GPs encouraged to make direct contact with other agencies, if relevant, after direct patient contact or letters are received.

15.8.5 The Practice has developed a standing item at the weekly business meeting to discuss child and adult safeguarding issues so that all GPs and managers are aware of current issues with patients and their families. The practice has always run a personal list system so that a named GP has responsibility for a patient and usually their family but this ensures other team members are also aware in case of contact through other systems such as the Duty Doctor.

15.8.6 Wiltshire Clinical Commissioning Group recognises that the learning from this domestic homicide review needs to be disseminated to other practices at local GP events to improve practice around domestic abuse throughout the area.

15.9 Wiltshire Council Children's Social Care (CSC)

15.9.1 The history and chronology of involvement should always be considered within assessments as a predictor of capacity to change and parenting capacity in general.

15.9.2 Joint assessments with housing should be undertaken whenever a child/young person is at risk of homelessness. During such assessments, the wider needs of the child/young person should be considered and the homeless issue should not overshadow any other concerns highlighted. The single assessment that is completed covers all aspects of a child's needs, providing a holistic picture of them, which ensures all of the assessment framework domains are considered.

15.9.3 Young people who are in domestically abusive relationships and are subject to physical harm should be considered under our child protection procedures. This should include the use of the Child Sexual Exploitation Screening Tool and liaison with the Emerald Team (Wiltshire Council and Police Child Sexual Exploitation Team).

15.10 Wiltshire Council Early Help

15.10.1 Case recordings needed to be analytical and not just descriptive. If there are gaps in recording these should be explained.

15.10.2 There should always be management oversight and this should be recorded.

15.10.3 An evidence based assessment of what is contributing to being NEET should be undertaken.

15.10.4 A clear chronology of events between Patricia and Alan would have been beneficial to understanding the issues in their relationship and also Patricia's mental health.

15.10.5 Specific actions regarding safeguarding issues should be present in NEET recordings. There was liaison with Social Care following Patricia being assaulted, having moved in with her boyfriend and a joint approach to dealing with Patricia's housing issues was attempted but no follow up was documented.

15.11 **Wiltshire Education Welfare**

15.11.1 In instances of poor engagement a home visit prior to making decisions of significance could provide additional information.

15.11.2 At the time of this case EWS practice was not supported by a wider inter-agency approach the same way that it would be now, through the Common Assessment Framework.

15.11.3 A sanction-based approach must be carefully assessed alongside the supportive working. Where there are also siblings of concern a family/sibling involvement could be considered with one lead professional.

15.11.4 It does not appear that historic concerns and concerns regarding Patricia's siblings were taken into consideration, regarding the longevity of concern or the complexity of the family dynamic. If this had been evident it could be considered that a parenting assessment could have been undertaken to highlight needs within the family home.

15.11.5 There was no individual record of a discussion with Patricia which may have informed of her wishes and feelings. From current practice this would be obtained through the Common Assessment Framework document.

15.12 **Wiltshire Council Housing Options**

15.12.1 Staff should follow up advice provided to clients on support agencies with appropriate referrals to those specialist services and escalate concerns appropriately.

15.12.2 Housing staff need to better understand safeguarding triggers and how issues / concerns should be reported.

15.12.3 A requirement for housing staff to better understand the importance of safeguarding and domestic abuse issues and attend regular annual training.

15.12.4 Improved understanding of what agencies are available to assist those fleeing domestic abuse.

15.12.5 To improve working relations between Housing and social care to ensure that young people are not pushed between services leading to no service/officer taking real ownership of the case.

15.12.6 Review and consider the support being offered to young people in supported accommodation who exhibit poor behaviour and how it is effectively managed.

15.13 **Wiltshire Domestic Abuse Conference Call (DACC)**

1.1.1. Participation in the DACC has been limited and sporadic. A common area of feedback from agencies is that they find it hard to find time for staff in their respective agencies to research cases listed and then take part in a conference call.

1.1.2. The DACC faces similar challenges to a MARAC in that it is only as good as the participation of agencies who call in/or, in the MARAC case who turn up, to share relevant information and take on actions to reduce risk, support victims and children and look at ways to tackle offenders.

15.14 **Wiltshire Multi Agency Risk Assessment Conference (MARAC)**

15.14.1 One of the risks identified from the minutes from the MARAC dated 3rd December 2013 is alcohol. The minutes indicate Alan was intoxicated during the domestic incident. It is important that Alcohol/Drug agencies attend MARAC.

15.14.2 One of the risks identified was mental health. Mental Health attendance is crucial for MARAC as mental health issues are frequently identified. A real difficulty MARACs face is that they are not on a statutory footing like MAPPA and therefore securing attendance of key agencies can be difficult. Making it statutory and identifying key statutory agencies who should take part in MARAC would be beneficial.

15.14.3 The IDVA had difficulty in contacting Patricia. It is important for the Chair to consider who/what agency has engagement with victim and look to signpost IDVA through that agency to try and see a victim who may have engagement issues.

15.15 **Wiltshire Police**

15.15.1 Wiltshire Police have carried out extensive training of all front line officers around domestic abuse and to take positive action. Officers have also received training on the new coercive and controlling behaviour law that came into effect on the 31st December 2015.

15.15.2 Where there is a large age gap such as the one that presented at the start of the relationship in this case, there will be a referral to the Child Sexual Exploitation (CSE) team where significant work would be carried out in order to try and support her to leave the potentially inappropriate relationship. There also would have been a large focus from the CSE team to deter the older male from seeking out the younger female. This ensures a strong focus is kept upon the subject and that victims are protected whilst suspects are deterred or prosecuted. It also allows a much stronger link between Social Services and police when presented with challenging young females in potentially harmful relationships.

15.15.3 A system of informing officers of the number of domestic incidents involving both victims and perpetrators has been developed, which will soon be availa-

ble on the NICHE crime recording system. This will allow officers to easily identify serial abusers and victims rather than having to refer to each individual incident.

15.16 Wiltshire Substance Misuse Services

15.16.1 In viewing the notes surrounding Alan's treatment order with us the IMR author suggests that the order should have been taken back to Court sooner as an unworkable order due to the ambivalence to the Court order and lack of commitment shown to treatment by Alan.

15.16.2 Clarity of Alan's relationship status should have been discussed with Alan's Offender Manager following the Police report, that he gave permission for his ex partner to enter his accommodation demonstrated a relationship of sort was evident, however the WSMS priority and focus is around substance misuse treatment.

16 Conclusions

16.1 In reaching their conclusions the Review Panel has focused on the questions:

- Have the agencies involved in the Review used the opportunity to review their contacts with Patricia and Alan in line with the Terms of Reference (ToR) of the Review and to openly identify and address lessons learnt?
- Will the actions they take improve the safety of vulnerable domestic abuse victims in Wiltshire in the future?
- Was Patricia's death predictable?
- Could Patricia's death have been prevented?

16.2 **Have the agencies involved in the Review used the opportunity to review their contacts with Patricia and Alan in line with the Terms of Reference (ToR) of the Review and to openly identify and address lessons learnt?**

16.2.1 The Review Panel acknowledges that the Individual Management Reviews and other reports have been thorough, open and questioning from the view point of Patricia. The Panel is satisfied with the evidence provided by those organisations that have shown that their contacts with Patricia and Alan were in accordance with their established policies and practice have no lessons to learn. Other organisations have used their participation in the Review to properly identify and address lessons learnt from their contacts with Patricia and Alan in line with the Terms of Reference.

16.3 **Will the actions they take improve the safety of vulnerable domestic abuse victims in Wiltshire in the future?**

16.3.1 The Panel, while satisfied that the implementation of the recommendations made within the Review will address the needs identified from the lessons learnt and make life safer for young people who are victims of domestic abuse, emphasises the need for all agencies to make referrals to specialist domestic abuse services and when the abuse is with a child, to remember that it is a safeguarding concern and to take appropriate action to protect the child from further abuse.

16.4 **Consider any gaps/actions needing to be addressed**

16.4.1 The Chair asked the Report Author to include within the overview report that it has come to the attention of the Panel that Alan is now in a new relationship with Patricia's cousin. This has been passed through for a DVDS disclosure and is being progressed. It was noted that an IDVA should be in attendance

at the disclosure meeting and a DASH Risk Assessment completed and referral to the MARAC considered. [7]

16.5 **Was Patricia's death predictable?**

16.5.1 The Chair asked the Panel to consider if the death was predictable bearing in mind the history of self-harm.

16.5.2 The Panel discussed Patricia's history of self-harm and attempts to take her own life, at length. She was recorded as deliberately having taken four overdoses between 2011 and 2014 and an 'accidental' one in August 2012 when Patricia reported that Alan had challenged her to take the tablets. Some of these attempts were accompanied with self-harm. In March 2014 following an assault by Alan she ran away from him and jumped into a lake which she later said was because she would rather kill herself than have Alan assault her. It is not known if this was a serious attempt or not but she did take another overdose in May of that year. In September 2014, after another failed attempt, Patricia was recorded as ambivalent about the overdose, felt stupid as it had not worked and that she might do it again if pushed. All of the suicide attempts were following 'arguments' with Alan.

16.5.3 The Review Panel nevertheless noted that there were many other reported incidents of arguing and abuse between them when she did not take an overdose. Her life was described as difficult and complex and there was no way that any individual or organisation could have anticipated what particular set of circumstances would 'push' Patricia into making such an attempt. Furthermore, when Patricia did successfully take her own life she did not take an overdose but killed herself by hanging.

16.5.4 There was a divergence of opinion in the Panel as to whether or not it was predictable, given her upbringing, repeated attempts at suicide and the trajectory she was on, that Patricia would end her life at some time. However the Panel was in agreement that there was no indication that it was inevitable.

16.5.5 The Review Panel finally came to the conclusion that they were satisfied that there was no single reason that could be identified to predict her death at that time.

16.6 **Could Patricia's death have been prevented?**

16.6.1 The Chair asked the Panel to consider if the death was preventable.

16.6.2 The Review Panel discussed this in detail. Patricia was brought up in a family environment that lacked positive role models on forming good relationships. Domestic abuse and non-engagement with the police was the norm in both her childhood and adult life. She was never given any specialist help when

[7] This paragraph must be redacted prior to publication.

she witnessed abuse as a child that would make her more resilient and able to walk away and stay away from Alan when he was abusive to her.

16.6.3 At the time of her death, Patricia and Alan had resumed their relationship after his release from prison and they were living together in a tent in her father's garden. Alan described this period of their relationship as fine; he said that Patricia was optimistic about the future; she had a job as a cleaner and would get up early to go to work. There was no pattern of escalating risk and no single factor that could be identified as the trigger. There was no one agency that she was involved with that could have intervened and prevented her taking her own life on that day.

16.6.4 The Panel has therefore concluded that whilst there are many lessons to be learnt there was nothing any agency could have done that would have prevented Patricia's death at that time.

17 Recommendations and Action Plans

Recommendations	Scope of recommendation i.e. local/regional	Action to take	Lead Agency	Key Milestones	Target Date	Outcome
CAMHS						
All CAMHS staff will recognise that domestic abuse experienced by young people is a Safeguarding issue. This includes the effect of perpetrators using power and control after a relationship has allegedly ended.	Local - Swindon Wiltshire and BANES	• Domestic Abuse will always be discussed with the Named Nurse Safeguarding Children within CAMHS • Domestic Abuse will continue to form part of safeguarding training and supervision which all CAMHS staff are required to attend as part of their mandatory training	Oxford Health NHS Foundation Trust			December 2016
CAMHS clinicians should routinely use the assessment triangle to aid the understanding of the needs of young people with complex is-	Local - Swindon Wiltshire and BANES	• The use of the assessment triangle will be actively promoted as part of Safeguarding Children case discussion, training and	Oxford Health NHS Foundation Trust			December 2016

sues.		supervision by CAMHS staff.				
The NNSC in CAMHS will explore training for all CAMHS clinicians about domestic abuse in young people can be delivered.	Local - Swindon Wiltshire and BANES	• This will form part of the Safeguarding Children work plan for the 2016/17 financial year.	Oxford Health NHS Foundation Trust			December 2016
The NNSC for CAMHS in Wiltshire will explore with the Service Managers and Team Managers the use of timescales in supervision to determine when an issue needs to be escalated to avoid drift	Local - Swindon Wiltshire and BANES	This will form part of the Safeguarding Children work plan for the 2016/17 financial year.	Oxford Health NHS Foundation Trust			December 2016
Education Welfare						
Cases of this nature should evidence actual or attempted visits to the family home.	local	• EWO's are to be encouraged to undertake home visits in instances of poor or non engagement of family or young person	EWS	Evidenced through case management oversight	May 2017	Home visits made where appropriate
EWO's are required to utilise the Common Assessment Framework approach to all cases where	local	• EWO's to build into their practice on a routine basis completion and involvement in CAF	Early Help	Evidenced through case management oversight	December 2016	CAF in place for each open case where there is more

there is evidence of poor engagement and vulnerabilities in families.		process and TAC reviews.				than one concern. Evidence of multi agency working
EWO's to use a variety of methods to engage young people and their families, including working with/alongside schools	local	• Ensure that EWO's are aware that all avenues of information gathering are considered and evidenced	EWS	• Monitoring through case supervision	December 2016	Evidence of clear , accurate and reflective case recording
EWO's to ensure appropriate consideration and discussion with schools regarding referral to MASH	Local	• Ensure that EWO's are adequately informed of safeguarding practice and referral routes	Early Help	• Monitoring through case supervision	On going	Policy and practice is robust and consistent
Cases to remain within the legal system where this has commenced	Local	• Ensure additional oversight of case progression	Early Help	• Monitoring through case supervision	On going	All cases brought to a formal conclusion
Wiltshire Council – Housing Options						
All housing staff should attend annual safeguarding training – already actioned and in place.	Local	This is also now a Wiltshire council corporate requirement and annual training is being rolled out for all staff in the next month.	Wiltshire Council	Annually	May 2016	On going
All staff to attend Domestic Abuse training and made	Local	All staff have attended Domestic Abuse training	Wiltshire Council - Housing		December 2015	Completed

aware of the agencies that they can refer families too as well as an understanding of the MARAC process						
All Housing Options staff should ensure that any client who discloses Domestic Abuse should ensure a DASH Risk Assessment is completed to assess the risk.	Local	All Housing Options staff since April 2014 now complete DASH risk assessment forms when any form of domestic abuse has been mentioned. A team meeting is due to be held w/c 11th April 16 where all housing staff will be reminded of this requirement	Wiltshire Council – Housing		All Ready completed Team meeting w/c 11th April	Completed
Wiltshire Council – Early Help						
Clear management oversight in NEET PA cases	Local	• Early Help Team Leaders to ensure that supervision procedure is implemented and cases are discussed regularly including risk and vulnerability factors. • Records to be made on IYSS re: supervision discussion	Early Help	Evidence of case discussion in supervision. Recording on IYSS with clear management oversight Evidence within NEET PA case work of understanding re: risk and vulnerability	June 2016	
NEET PA cases to	Local	• Implement NEET	Early Help	All YP being worked with to	June 2016	

have an assessment and action plan		assessment and planning tool. • Ensure tool includes identification of DV issues		have assessment and action plan		
Case recording are accurate, and analytical rather than descriptive	Local	• Guidance to go out to staff on case recording – rather than describe what has happened need to identify what this means • Quality of case recording to be reviewed and scrutinized regularly through supervision	Early Help YOT	Case recordings for all early help professionals consistent and analytical Case recordings regularly discussed in supervision	July 2016	
Pathway for homeless young people needs to be clear	Local	• YP homelessness protocol to be reviewed and rewritten to ensure that there are clear pathways for homeless young people. • Document to ensure that agencies are clear about roles and responsibilities	Early Help YOT Housing Social Care	Staff and service users are clear about the Pathway for homeless young people Staff provide an outcome focused intervention for young people presenting as homeless	Sept 2016	
CAF / TAC approach to all young people being supported (whether through CAF/ My	Local	• Services to young people needs to be more joined up with a single lead to en-	Early Help YOT	All Early Help / YOT cases to have a TAC approach to assessing, planning and reviewing intervention.	Sept 2016	

support plan / ASSET) so that information be better shared and understood between agencies		sure that actions are followed through and monitored. Information needs to be appropriately shared but in complex cases with many professionals we need to ensure that information is acted up and appropriate referrals are made to move things forward.		Lead professions take responsibility for coordinating the plan to ensure that it is outcome focused and moves on.		
There should be Better coordination at the point of turning 18. This would enable a smoother transition to adulthood and ensure that things to do get missed.	Local	• YOT to improve transition arrangements with Probation • Professionals to consider what services can step up when young person reaches 18 but does not meet threshold for adult mental health services	YOT Early Help CAMHS	• Clear processes in place for young people who reach 18 but continue to offend • Identification of a service to provide support for emotional wellbeing for young adults who do not meet threshold for adult mental health services.	Sept 2016	
Improve professionals understanding of complex per-	Local	• All staff to receive training on healthy	Early Help YOT	All Early staff to complete domestic abuse training Multi-Agency Risk Assessment	Dec 2016	

sonal relationships and the impact of this on individuals.		relationships including co dependence, violent and manipulative relationships. An understanding of the complexities of working with young people within their relationships		Conference MARAC Referral and DASH Risk Assessment Additional training provided by MARAC team on relationship issues		
Swindon and Wiltshire Domestic abuse reduction strategy to be disseminated and implemented within Early Help Service.	Local	Disseminate How do work in Early Help to implement this	Early Help YOT	• Raised awareness in Early Help about domestic abuse and impact on young people • Staff are confident in carrying out assessments and making appropriate referrals for support regarding domestic abuse	Dec 2016	
Kingdown School						
There there is a known CP case, there should be a 'flag' of some sort on a child's electronic file so that staff are aware not to contact home.	In the notes page, wording such as 'do not ring home' or 'please see Head of House before making	• Child protection leads to add the note	Kingdown School		Immediately	To protect child from further possible harm at home.

	contact with parents would suffice.					
NPS – National Probation Service						
All Offender Managers should complete an Initial Sentence Plan in a timely manner and in accordance with National Policy- within 10 working days of sentence and ensure the document is locked and marked as completed.	Local	• Staff development hours to be used to remind staff to complete ISPs within 10 days Offender Managers to familiarise themselves with NPS South West & South Central: New Service Level Performance Measures. • Line managers to manage performance of staff and take appropriate action in cases of poor performance	• National Probation Service-Middle Managers- Gloucestershire and Wiltshire LDU	All Offender Managers to have attend SDH on ISPs All Offender Managers to have read NPS South West & South Central: New Service Level Performance Measures Line Managers to be familiar with PI 2014-39	September 2016	
All Offender Managers should undertake an OASys review following a significant event to review the risk of serious harm	Local	• Staff development hours to be used to discuss what a 'significant event' is and be familiar with OASys guidelines	• **National Probation Service-Middle Man-**	• All Offender Mangers to have attended SDH	September 2016	

			agers-Gloucestershire and Wiltshire LDU			
All facilitators of programmes should ensure that every programme session attended by an offender should be documented via Ndelius.	Local	• Middle Managers to liaise with Community Rehabilitation Company Middle Managers (CRC) where intervention is provided by CRC • Where intervention is provided by NPS-Middle Managers to liaise with NPS Treatment Managers	• National Probation Service-Middle Managers-Gloucestershire and Wiltshire LDU	• Ongoing liaison with CRC managers • Liaison with NPS Treatment Managers	September 2016	
All interventions following sentence should be started promptly in order for offence focused work to be undertaken to start reducing the risk of serious harm and risk of re-offending	Local	• Middle Managers to liaise with Community Rehabilitation Company Middle Managers (CRC) where intervention is provided by CRC to monitor intervention start dates. • Where intervention is provided by NPS-Middle Managers to liaise with NPS Treat-	• National Probation Service-Middle Managers-Gloucestershire and Wiltshire LDU	• Ongoing liaison with CRC Managers • Liaison with NPS Treatment Managers	September 2016	

		ment Managers				
Any areas that have been identified as linked to risk of serious harm or re-offending for an offender should be prioritized within supervision sessions.	Local	• Staff development hours to be utilised to remind Offender Managers • **Staff to utilise the Practice Framework National Standards for the Management of Offenders For England and Wales 2014** • Staff training where relevant	• National Probation Service-Middle Managers-Gloucestershire and Wiltshire LDU	• All Offender Managers attend SDH • Re-issue of Practice Framework • Staff to have attended training where applicable	September 2016	
The National Probation Service will remind Offender Managers of the importance of undertaking home visits, especially when there are concerns about domestic abuse.	Local	• Staff Development hours to be used to remind Offender Managers of importance of undertaking home visits	• Nation Probation Service-Middle Managers-Gloucestershire and Wiltshire LDU	• All Offender Managers attend SDH on home visits • All Offender Managers to read PI15/2015 to ensure safe management of home visits	September 2016	
Line managers should be actively involved in the management of cases, particularly when there are	Local	• Individual supervision to be utilised on a frequent basis • Offender Managers to ensure Line Man-	• National Probation Service-Middle Managers-Gloucester-	• Individual Supervision on regular basis •	September 2016	

concerns in regards to domestic abuse and this should be clearly recorded via Ndelius.		ager is aware of concerns in domestic abuse cases	shire and Wiltshire LDU			
The National Probation Service will ensure that Offender Managers have a clear understanding of the MARAC referral process via team meetings, staff development hours and individual supervision.	Local	• Local training to be undertaken to train staff on completion of MARAC referrals.	• National Probation Service-MARAC Lead	• Training to be delivered to all relevant staff members	September 2016	
The National Probation Service will continue to promote the importance of building strong working relationships with external agencies through individual supervision, staff development hours, team meetings and any relevant training events.	Local	• Staff Development hours to be used to invite staff from other agencies to discuss their role , to continue to build strong working relationships	• National Probation Services-Middle Managers-Gloucestershire and Wiltshire LDU	• All Offender Managers to have attended SDH	September 2016	
The National Probation Service will work closely with the Community Re-	Local	• Staff development hours/Supervision to be used to ensure staff	• National Probation Services-Middle	• All Offender Managers to have attended SDH • SPO's to utilise supervi-	September 2016	

habilitation Company to discuss report proposals where relevant and necessary.		are aware of the need to liaise with CRC staff	Managers- Gloucestershire and Wiltshire LDU	sion		
All interventions following sentence should be started promptly in order for offence focused work to be undertaken to start reducing the risk of serious harm and risk of re-offending	Local	• Middle Managers to liaise with Community Rehabilitation Company Middle Managers (CRC) where intervention is provided by CRC to monitor intervention start dates. • Where intervention is provided by NPS- Middle Managers to liaise with NPS Treatment Managers	• National Probation Service- Middle Managers- Gloucestershire and Wiltshire LDU	• Ongoing liaison with CRC Managers • **Liaison with NPS Treatment Managers**	September 2016	
All Offender Managers should complete an Initial Sentence Plan in a timely manner and in accordance with National Policy- within 10 working days of sentence.	Local	• Staff development hours to be used to remind staff to complete ISPs within 10 days Offender Managers to familiarise themselves with NPS South West & South Central: New Service Level Performance Measures.	• National Probation Service- Middle Managers- Gloucestershire and Wiltshire LDU	All Offender Managers to have attend SDH on ISPs All Offender Managers to have read NPS South West & South Central: New Service Level Performance Measures • Line Managers to be familiar with PI 2014-39	September 2016	

		• Line managers to manage performance of staff and take appropriate action in cases of poor performance				
Any areas that have been identified as linked to risk of serious harm or reoffending for an offender should be prioritised within supervision sessions.	Local	• Staff development hours to be utilised to remind Offender Managers • Staff to utilise the Practice Framework National Standards for the Management of Offenders For England and Wales 2014 • Staff training where relevant	• National Probation Service-Middle Managers-Gloucestershire and Wiltshire LDU	• All Offender Managers attend SDH • • Re-issue of Practice Framework • • Staff to have attended training where applicable	September 2016	
The National Probation Service will continue to promote the importance of building strong working relationships with external agencies through individual supervision, staff development hours, team meetings and any relevant training events.	Local	• Staff Development hours to be used to invite staff from other agencies to discuss their role , to continue to build strong working relationships	• National Probation Service-Middle Managers-Gloucestershire and Wiltshire LDU	• All Offender Managers to have attended SDH	September 2016	

The National Probation Service will work closely with the Community Rehabilitation Company to discuss report proposals where relevant and necessary.	Local	• Staff development hours/Supervision to be used to ensure staff are aware of the need to liaise with CRC staff	• National Probation Services-Middle Managers-Gloucestershire and Wiltshire LDU	• All Offender Managers to have attended SDH • SPO's to utilise supervision	September 2016	
AWP – Mental health						
• Ensure all SOPs within AWP contain explicit reference to Domestic Abuse and Safeguarding and the actions required. By AWP Safeguarding Team by 31 July 2016	Trust-wide	• Review all current Standard Operating Policies • Agree a form of words for inclusion in SOPS • Achieve ratification via the appropriate Trust committee.	AWP Safeguarding team		31 July 2016	
• For the team managing the RiO template documents to formally consider producing a new standard "Discharge to GP" editable letter in RiO that references a "Crisis and Contingency-type" plan. By AWP Clini-	Trust-wide	• Wiltshire Quality Director to liaise with the Clinical Systems Manager on updating discharge letter templates. • If agreed, for the change to be added to the RiO update workplan.	Wiltshire Quality Director and Clinical Systems Manager.		30 June 2016	

cal Systems Manager by 30 June 2016						
• For staff to be advised to use the term “signposted” rather than “referred” when discussing the outcome of discussions about Turning Point and LIFT /IAPT which require the service user to be proactive to access such services. By Service Managers by 31 May 2016.	Trust-wide	• Wiltshire Quality Director to discuss this Trust-wide Integrated Governance Group to agree a communication for all services.	Wiltshire Quality Director	•	31 May 2016	
• For AWP staff to be reminded that Ourspace contains a Domestic Abuse Library containing resources for identifying and managing the risk of domestic abuse. By Service Managers by 31 May 2016	Trust-wide	• Wiltshire Quality Director to discuss this Trust-wide Integrated Governance Group to agree a communication for all services.	Wiltshire Quality Director		31 May 2016	
CCG						
Closer working with Social Services	Practice	• Meet with Social Services local lead Paul Hunter	The Avenue Surgery	Meeting date	June 2016	
Develop robust train-	Practice	• Instigate recently	The Avenue Surgery	System up and	June 2016	

ing log		purchased Training Tracker software		running		
Closer working with Support services	Practice	• Meet with representatives of Splitz to develop appropriate policies	The Avenue Surgery	• Meeting date	July 2016	
Add domestic violence to agenda for Local Education Group meeting	Locality	• Discuss with Dr Beale who is arranging the Mental Health orientated meeting and invite outside agencies for input	White Horse Surgery	• June 2016	Sept. 2016	
Review safeguarding adults policy with respect to domestic violence	Wilts	• Discuss with Adult Safeguarding lead • Develop model adult safeguarding policy with clear reference to domestic violence which practices can adopt	Wilts CCG		June 2016	
Raise profile of domestic violence/abuse and Share the learning from this domestic homicide review across practices	Wilts	• Share learning at GP forum /GP learning events • Consider implementation of IRIS programme	Wilts CCG		May 2017	
Develop systematic way of flagging sus-	Wilts	• Discuss development of icon specif-	Wits CCG		April 2017	

pected victims of domestic violence/abuse in clinical GP systems		ic to domestic violence/abuse to alert practice staff to presence of real/suspected domestic violence				
Children's Social Care						
Social Care practice improvements	Local	• Improvement Plan Developed	Children's Social Care	Improvement Plan Implemented	Introduced in 2013 - completed	Recommendations from this DHR had already been identified and progressed as part of the improvement plan introduced in 2013.
The history and chronology of involvement should always be considered within assessments as a predictor of capacity to change and parenting capacity in general.	Local	• A training session for social worker's to be scheduled that includes examples of where the use of chronologies has assisted in building a picture of a child's life and progressing a case accordingly. • Staff to be reminded of the chronology Guidance as part of the above. • Social Care Teams have targets in relation to the completion of chronologies – these will	Children's Social Care	*Chronology Guidance issued (completed July 2015) *Training session t social work conference on guidance and use of chronologies (complete September 2015) *Training sessions delivered to all social workers (June 2016) *Chronology Audit (completed in January 2016 & booked for June 2016)	June 2016	Social worker awareness of the importance of this will be raised and future assessments will fully consider the history.

		continue to be monitored. • Chronology Audit to be completed in June 2016.		*Chronology targets have been set (completed March 2016)		
Joint assessments with housing should be undertaken whenever a child/young person is at risk of homelessness. During such assessments, the wider needs of the child/young person should be considered and the homeless issue should not overshadow any other concerns highlighted.	Local	• A sample of assessments where housing is the presenting issue will be audited to assess current practice in this area. • Joint housing/social care service development meetings to continue. • Implement action plan from positive Pathways session with housing relating to housing needs of 16 and 17 year olds.	Children's Social Care		June 2016	A Joint Housing, Early Help/Social Care Positive Pathway will be in place for 16/17 year olds in Wiltshire linked to housing needs.
Young people who are in domestically abusive relationships and are subject to physical harm should be considered under our child protection procedures.	Local	• Multi Agency Safeguarding Hub and Safeguarding Staff to receive a briefing on this learning in order to ensure staff are considering this from the outset.	Children's Social Care		May 2016	Young people are appropriately safeguarded from future abuse.
Children's Social Care should refer vulnerable young	Local	• A briefing to be given to Social Workers by their Team	Children's Social Care		June 2016	Ensure young people continue to receive support through adult

people moving into adulthood to adult safeguarding/social care as routine practice		Managers through team meetings.				services.
Action is taken in relation to the individual social workers practice.	Local	• Refer to relevant professional body.	Children's Social Care		May 2016 - Complete	Ensure practice issues are addressed.
The Child Sexual Exploitation (CSE) Tool to be considered when working with vulnerable young people particularly where this is an age gap in a relationship. This identifies risk factors, protective factors and level of risk.	Local	• CSE Handbook	Children's Social Care	*CSE Handbook introduced *CSE Screening Tool Re-Launched *Emerald Team set up	Complete	Ensure child at risk of CSE are identified and supported to reduce/eradicate risk.
Wiltshire Police						
1	Local	From the 01/01/2016 Horizon, the witness care unit at Wiltshire Police telephone victims of domestic abuse that have been identified as standard risk of harm, and signpost them to appropriate support agencies as required.	Wiltshire Police		01/01/2016	Implemented
2	Local	Training of front line offic-	Wiltshire police		30/04/2016	Implemented

		ers on the new coercive and controlling behaviour law				
3.	Local	DAIT/MASH to identify potential victims of child sexual exploitation in domestic abuse cases and make a referral to the CSE team.	Wiltshire police		01/01/2016	Implemented
4.	Local	Develop a system in order that front line officers can easily identify serial victims and perpetrators when they attend domestic abuse incidents.	Wiltshire Police		31/08/2016	Ongoing
Royal United Hospital, Bath						
Training programme for all relevant clinical staff	Local	• Complete training needs analysis • Work with the Learning and Development team to design training packages	RUH	Prioritise; Emergency Dept staff Sexual Health Staff Midwives All other staff	March 2017 March 2018	
Continue funding for IDVA project at the RUH	Local	• Project report and activity data has been submitted to the CCG's to support their decision making processes	CCG	Funding secured; one of the post holders priorities would be to deliver training Funding not secured; safeguarding team to	April 2016	

				scope how to deliver training		
Risk assessment process		• Ensure staff are trained and then using Safer Lives Risk Assessment in priority areas as above	RUH	IDVA or safe-guarding team to audit use of forms in priority areas	January 2017	
Great Western Ambulance Service						
Safeguarding		• To review internal process for sharing safeguarding information with external agencies other than Social Care.	Ambulance Service	Implementation of an internal safeguarding referral triage and information sharing process	Completed 2014	
MARAC						
Improve attendance from Drug and Alcohol Services and Mental Health Services	Local	• MARAC to continue to encourage participation in the MARAC from Substance Misuse and Mental Health Services	MARAC		Ongoing	
Support for MARAC to be placed on a statutory footing	National	• Support for MARAC to be placed on a statutory footing	MARAC		Ongoing	
Wiltshire Substance Misuse Service						
	Local	• Identify a lead person in the service to attend regular probation meetings to discuss the clients placed on orders with their respective probation case man-			Immediate	

		ager/offender manager				
	Local	• Meeting with probation Service to review treatment options and policy of faltering engagement with a view of managing non-compliant clients and revoking court orders.			Completed March 2015	
	Local	• Domestic Abuse Training for Recovery Worker arranged for 01/06/15			To be completed 01/06/16	
Wiltshire Domestic Abuse Conference Call (DACC)						
	Local	• Recommendation for an independent review to be undertaken for the DACC.			?	
Probation - CRC						
BGSW CRC staff will ensure all requirements are started in a timely manner (or sequenced as appropriate). In addition, staff will continue to monitor key issues and undertake structured work to address the areas identified in the Risk	Local – across BGSW CRC	• Offender Manager's to consistently deliver the Risk Management and Sentence Plan • Dip samples by Middle Managers and findings to be shared with Offender Manager's • Reflective case discussions during	BGSW CRC	No specific milestones identified	Ongoing	To ensure all service users are provided with timely and the best interventions to address the presenting needs and areas assessed as linked to risk of harm and/or re-offending.

Management and Sentence Plan.		individual and group supervision – by Middle Managers and identified actions to be prioritised by Offender Manager's				
All BGSW CRC staff to continue to build and develop effective working relationships with other agencies. What's agreed and put in place to clearly be recorded on the case recording system. Offender Manager's to inform their Line Manager's if they are dissatisfied with the response/involvement from a specific agency.	Local – across BGSW CRC and involving liaison with local specialist agencies	• Dip samples by Middle Managers and findings to be shared with Offender Manager's • Reflective case discussions during individual and group supervision – by Middle Managers and identified actions to be prioritised by Offender Manager's • Middle Managers to look into and discuss any issues raised with specific agencies as appropriate.	BGSW CRC	No specific milestones identified	Ongoing	Service users to be supported and all areas of need addressed as required, to achieve effective risk management.
Appropriate enforcement action to be undertaken and use of behaviour contracts to be con-	Local – across BGSW	• Dip samples by Middle Managers and findings to be shared with Of-	BGSW CRC and NPS	No specific milestones identified	Ongoing	To ensure the correct balance is achieved be-

sidered by all Offender Manager's within BGSW CRC.	CRC	fender Manager's • Reflective case discussions during individual and group supervision – by Middle Managers and identified actions to be prioritised by Offender Manager's • Offender Manager's to respond to feedback if received by the NPS				tween delivering the Order of the Court and the individual's needs/circumstances being taken into consideration. This will help to maximise overall gagement/compliance and outcomes for individual's.
BGSW CRC to consistently provide intervention and support for female service users.	Local – across BGSW CRC	• Action to be taken by the lead Middle Manager dependant on the feedback from Offender Manager's re: their views on the services being provided to female service users • Lead Middle Manager to review the feedback and quarterly performance reports from the providers of the	BGSW CRC	01.04.16 – implementation of the new contract; 01.07.16 – first quarterly Review	Ongoing	Offender Manager's to have a better understanding of the needs of female service users. Female service users to be provided with interventions and support to help them address the issues that impact on their emotional well-

		female provision				being, their behaviour and offending.
BGSW CRC to consider the timing of cases being re-allocated. A 3-way to be prioritised if a re-allocation can not be avoided.	Local – across BGSW CRC	• Middle Manager's to consider the issues in consultation with individual Offender Manager's and balance with wider organisational developments	BGSW CRC	No specific milestones identified	Ongoing	To reduce the potential negative impact of cases being re-allocated and service users being managed by a new Offender Manager.
All BGSW CRC staff (when Court appearances are known) to continue to discuss cases with the NPS at the pre-sentence stage. NPS to also be pro-active in discussing current cases.	Local – across BGSW CRC	• Offender Manager's to prioritise and be pro-active in these discussions • Middle Manager's to promote during individual and group supervision, plus during Team Meetings (as appropriate) • Middle Manager's to discuss and promote during inter-face meetings with the NPS and discuss specific cases if this is not happening	BGSW CRC and NPS	No specific milestones identified	Ongoing	To ensure views are expressed on the most appropriate sentencing options to help ensure robust risk management.

BGSW CRC to continue to effectively manage domestic abuse cases through adhering to the Operating Model guidelines; reflective supervision being prioritised and continuing to work in close liaison with other agencies.	Local – across BGSW CRC	• Offender Manager's to adhere to the Operating Model and prioritise liaison with other agencies as appropriate • Middle Manager's to monitor during reflective case discussions in individual and group supervision – Offender Manager's to follow up with any agreed actions	BGSW CRC	No specific milestones identified	Ongoing	To achieve the best outcomes and ensure all risks are being effectively managed, for the benefit of victims, perpetrators and communities.
Curo Housing Association						
In circumstances where a tenant is identified as a victim of domestic abuse, and is already known to be in receipt of DA Specialist Support a discussion will be had with that specialise DA agency to determine who is the lead professional coordinating support to the individual/family	Local	Curo Housing will amend its policy accordingly			31st July 2013	

Appendix 1

Glossary

Abbreviation	Explanation
AEP	Alcohol Education Programme
AHL	Acute Hospital Liaison Service
Appt	Appointment
AWP	Avon and Wiltshire Partnership Mental Health NHS Trust
CAB	Citizen's Advice Bureau
CAMHS	Child and Adolescent Mental Health Services
CARS	Court Assessment and Referral Service
CMHT	Community Mental Health Team
CO	Community Order
CPA	Care Planning Approach
CPRU	Child Protection Referral Unit
CPS	Crown Prosecution Service
DA	Domestic Abuse
DAIT	Domestic Abuse Investigation Team
DASH	Domestic Abuse Stalking Harassment Risk Assessment tool
Delius	Offender case record
DNA	Did Not Attend (an Appointment)

DRR	Drug Rehabilitation Requirement
DV	Domestic Violence
DVU	Domestic Violence Unit
ED	Emergency Unit
EDT	Emergency Duty Team
EI	Early Intervention team
ETE	Education, Training and Employment
EWO	Educational Welfare Officer
EWS	Educational Welfare Service
GP	Family Doctor
GTKY	Getting to Know You (Group Work Programme)
HV	Home Visit
IDVA	Independent Domestic Abuse Advisor
ISP	Initial Sentence Plan
LIFT (Or IATP)	Primary Care Psychological Therapy Service
MARAC	Multi-Agency Risk Assessment Conference
MHLT	Mental Health Liaison Team, based in an Acute Hospital

NEET	A young person aged 16-18 who is not in education, employment or training. In Wiltshire, there are around 1000 young people who fall into this category and this is due to a number of reasons from changing educational circumstances to teenage pregnancy.
NICE	National Institute for Clinical Excellence
NICHE	Crime recording system
NPS	National Probation Service
OASys	Offender Assessment System
OM	Offender Manager
OS	Offender Supervisor
OSCA	Outreach Service for Children and Adolescents
PCLMS	Primary Care Liaison and Memory Service
PPD1	Public Protection Department form
PSR	Pre-Sentencing Report
Resolve	Resolve is a 13 week flexible learning programme aimed at 16-18 year olds who are classified as NEETs. The programme focuses on work experience, job skills, improving CVs, and confidence building
RiO	Mental health electronic health records system
RO	Restraining Order
ROSH	Risk Of Serious Harm

RUH	Royal United Hospital, Bath
SBAR	Situation, Background, Action, Response tool
SMHP	Senior Mental Health Professional
SOP	Standard Operating Procedure
SSD	Social Services Department
UPW	Unpaid Work
WPT	Wiltshire Probation Trust
YOTS	Youth Offending Team

Appendix 2

Bibliography

Cummings, E., Davies, P. & Simpson, K. (1994) Journal of Family Psychology, 8, 141– 149. Marital conflict, gender and children's appraisals and coping efficacy as mediators of child adjustment:

Domestic Homicide Review Toolkit.

Equality Act 2010

Evans S, Davies C, DiLillo D, (2008) Exposure to domestic violence: A meta-analysis of child and adolescent outcomes. University of Nebraska—Lincoln, United States

Government Equalities Office (2015) Equality Act 2010 Guidance

Hester M. (2013) "Who Does What to Whom? Gender and Domestic violence Perpetrators in English Police Records" *European Journal of Criminology* Sage publications 10: 623 originally published online 16 April 2013 *European Journal of Criminology* http://euc.sagepub.com/content/10/5/623

Hester M. (2012) in "Portrayal of Women as Intimate Partner Domestic Violence Perpetrators" in Violence Against Women Sage publications, http://vaw.sagepub.com/content/early/2012/09/19/1077801212461428

Home Office (2013). The Revised Multi-Agency Guidance on the Conduct of Domestic Homicide Reviews.

Home Office (2015) Controlling or Coercive Behaviour in an Intimate or Family Relationship Statutory Guidance

Johnson M., Leone and Yill XU (2014) Intimate Terrorism and Situational Couple Violence in General Surveys

Johnson, M. P. (2008). *A typology of domestic violence: Intimate terrorism, violent resistance, and situational couple violence*. Boston, MA: Northeastern University Press

Johnson, M. P. Leone Janel L M. (2005), "The Differential Effects of Intimate Terrorism and Situational Couple Violence, Findings From the National Violence Against Women Survey" Pennsylvania State University

McFarlane, J., Groff, J., O'Brien, A. & Watson, K. (2003) Paediatrics, 112, e202–e207. Behaviours of children who are exposed and not exposed to intimate partner violence: an analysis of 330 black, white and Hispanic Children.

Michael P. Johnson1, Janel M. Leone2, and Yili Xu3, (2014) " Intimate Terrorism and

Situational Couple Violence in General Surveys: Ex-Spouses Required” in Violence Against Women 2014, Vol. 20(2) 186–207, Sage

Myers J, Carmi E (2016) The Brooke Serious Case Review into Child Sexual Exploitation Identifying the strengths and gaps in the multi-agency responses to child sexual exploitation in order to learn and improve. Final Report

Nice Guidance on “Domestic Violence and Abuse: How Health Services Social Care and the Organisations they work with can respond effectively”. (February 2014)