TEWKESBURY BOROUGH COMMUNITY SAFETY PARTNERSHIP

DOMESTIC VIOLENCE HOMICIDE REVIEW

OVERVIEW REPORT

INTO THE DEATH OF ROSIE (PSEUDONYM) ON 18TH FEBRUARY 2014

DAVID WARREN QPM, LLB, BA, DIP. NEBSS
INDEPENDENT DOMESTIC HOMICIDE REVIEW CHAIR AND REPORT AUTHOR

REPORT COMPLETED: 27TH JANUARY 2015

Contents

Appendices

Tribute to Rosie (pseudonym) from her family

While Rosie was only 20 years old when her life was cruelly taken from her, she did more in that time than many others will do in their full lifetime. She was a wonderful daughter, sister, aunty and friend who lived life to the full. Style and fashion was her passion and we hope that her legacy will live on through the College students being sponsored.

She was a real treasure and will be sadly missed by her friends, family and many who did not know her. Her friend and manager said: "Rosie was the most vibrant, fun, vivacious, talented, warm, outgoing and beautiful young lady, a true inspiration for others to follow." This just about sums Rosie up.

We really appreciate the time and effort put in to this review by all concerned. We hope that the recommendations will be implemented and will result in the reduced suffering by others, the saving of lives and other families not having to endure the nightmare that we have been through.

1. **Preface**

1.1. Domestic Homicide Reviews (DHRs) came into force on the 13th 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) A person to whom she was related or with whom she was or had been in an intimate personal relationship or

(b) 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" as this term has been adopted by Tewkesbury Borough Community Safety Partnership.

1.3. The purpose of a DHR is to:

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

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

- Apply these lessons to service responses, including changes to policies and procedures as appropriate; 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 Rosie (pseudonym) in Gloucester on 18th February 2014 and was initiated by the Chair of the Tewkesbury Borough Community Safety Partnership in compliance with legislation. The Review process follows the Home Office Multi-Agency Statutory Guidance on the Conduct of Domestic Homicide Reviews (as amended 2011).

1.5. The Independent Chair and the DHR Panel members offer their deepest sympathy to Rosie's family and all who have been affected by her death and thank them, together with the others who have contributed to the deliberations of the Review, for their time, patience and co-operation. They also pay tribute to Rosie's family who has reacted so positively to such a tragic event by establishing a Charitable Trust to help others. In the first six months after Rosie's death the Charity raised over £45000.

1.6. The Chair of the Review thanks all of the members of the Review Panel for the professional manner in which they have conducted the Review and the Individual Management Review authors for their thoroughness, honesty and transparency in reviewing the conduct of their individual agencies.

1.7. The Chair is joined by the Review Panel, in thanking, Fiona Halsey for the efficient administration of the DHR.

2. Domestic Homicide Review Panel

David Warren QPM, Independent Chair

Kevin Dower, Bristol, Gloucestershire, Somerset and Wiltshire Community Rehabilitation Company Limited.

Claire Wilson, Gloucestershire Clinical Commissioning Group NHS Trust

Detective Chief Inspector Steve Bean, Gloucestershire Constabulary

Stella Potente, Gloucestershire County Council (Children and Young People Services)

Amanda Wilsdon, Info Buzz

Sally Morrissey, Gloucestershire Domestic Abuse Support Services

Ashley Bayliss Gloucestershire City Council Housing Services

Pat Dabbs, Gloucester Community Safety Partnership

Faye Kamara, Gloucestershire Public Protection Bureau

Jon Burford, Gloucestershire Hospitals NHS Foundation Trust

Valerie Garside, Tewkesbury Borough Council

Alison Curson, ^{2}gether NHS Foundation Trust (NHS)

Administrator

Fiona Halsey Tewkesbury Borough Council

3. Introduction

3.1. This Overview Report of the Domestic Homicide Review examines agencies' responses and support given to the victim, Rosie, an adult resident of Tewkesbury Borough, prior to the point of her death on 18th February 2014 their previous contacts with the perpetrator Paul (pseudonym)

3.2. Rosie lived with her parents and sister within an area of Tewkesbury Borough. While Tewkesbury itself is a town in the north of Gloucestershire, which has a population of only 10,704; the present borough of Tewkesbury, also contains a large portion of rural north Gloucestershire, extending as far as the edges of Gloucester and Cheltenham, and has a population of 81,943.

Gloucester, where the incident occurred, is situated midway between Bristol and Birmingham.

3.3. Incident Summary:

3.3.1. Rosie and Paul met in February 2013 and they began going out together. The relationship was at times volatile due to Paul's aggressive behaviour. On Friday 14th February 2014, Rosie ended the relationship. Over the next few days, Paul became increasingly irate and threatening in text messages and on the telephone to Rosie. On the afternoon of Tuesday 18th February 2014, Paul pawned a DVD player for £5.00. He then purchased an 8inch kitchen knife for £3.00 and walked around Gloucester City Centre before making his way to the hair dressers where Rosie worked. He entered the salon at 5.47p.m. and following a brief exchange of words, repeatedly stabbed Rosie (14 separate wounds), in front of terrified staff and customers. He then left the premises, discarding the knife in a nearby building site and caught a taxi to a relative's house. Attempts were made by police and paramedics to resuscitate Rosie, however these were unsuccessful and she was pronounced dead at Gloucester Royal Hospital a short time later.

3.3.2. Paul was arrested in the early hours of Wednesday 19th February 2014. He was interviewed and subsequently charged with Rosie's murder. Following assessments regarding his mental health, he pleaded guilty to the murder and was sentenced on 16th July 2014, receiving life imprisonment with a minimum tariff of 24 years. He later made an unsuccessful appeal against that tariff of 24 years' incarceration.

3.4. The key purpose for undertaking this Domestic Homicide Review (DHR) is to enable lessons to be learned from Rosie'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.

3.5. The Review considers all contacts/involvement agencies had with Rosie or Paul during the period from 1st January 2013 and the death of Rosie on 18th February 2014, as well as all events, prior to 1st January 2013, which are relevant to violence, harassment, stalking or domestic abuse.

3.6. The DHR panel consists 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 or any of the Independent Management Report (IMR) Authors have had any contact with Rosie or Paul prior to the homicide.

3.7. Expert advice regarding domestic abuse service delivery in Tewkesbury Borough has been provided to the Panel by Faye Kamara, the Gloucestershire County Strategic Domestic Abuse and Sexual Violence Coordinator, Amanda Wilsdon, Gloucestershire Domestic Vio-

lence Support and Sally Morrissey, Gloucestershire Domestic Abuse Support Service (GDASS), both of which provide a range of domestic abuse services across Gloucestershire.

3.8. The Chair of the Panel possesses the qualifications and experience required of an accredited independent DHR Chair, as set out in section 5.10 of the Home Office Multi-Agency Statutory Guidance. He is not associated with any of the agencies involved in the Review nor has he had any dealings with either Rosie or Paul and he is totally independent.

3.9. The agencies participating in this Domestic homicide Review are:

Bristol, Gloucestershire, Somerset and Wiltshire Community Rehabilitation Company Limited

Co-ordinated Action Against Domestic Abuse (CAADA)

Cheltenham Borough Homes

Crown Prosecution Service South West

Gloucestershire Clinical Commissioning Group

Gloucestershire Domestic Abuse and Sexual Violence Commissioning Steering Group

Gloucestershire Domestic Abuse Support Service

Gloucestershire Hospitals NHS Foundation Trust

Gloucester City Council Housing Service

Gloucestershire County Council (Children and Young People's Service)

Gloucestershire Multi-Agency Risk Assessment Conference

Gloucestershire Constabulary

HM Courts & Tribunals Service

Infobuzz

Independent Police Complaints Commission (IPCC)

Information Commissioners' Office (ICO)

Tewkesbury Borough Council

Tewkesbury Borough Community Safety Partnership

2gether NHS Foundation Trust (NHS)

3.10. During the preparation of this report the DHR Chair has consulted with Rosie's father, mother and sister. He has also consulted with Paul and his solicitor. Paul did not want any of his family to be approached by the Review; however his mother was contacted in her capacity of being a previous victim of Paul's violence. Notes of the subsequent conversations are set out in Appendix D of this report. Rosie's work colleagues were also contacted on behalf of the Review.

3.11. On completing this report the DHR Chair informed Rosie's family and Paul, of the outcomes of the Review. Rosie's mother, father and sister were shown the analysis, lessons

learnt, conclusions and recommendations sections of the Overview Report. Rosie's father commented on the detail and thoroughness of the Review and thanked the Panel for the clear recommendations, which he thought when implemented would make a significant difference for future victims of domestic abuse in Gloucestershire.

4. Parallel Reviews

4.1 The Coroner's Inquest has been opened but in view of there being a criminal trial relating to Rosie's murder, it was not continued.

4.2. There were criminal proceedings when Paul was tried for Rosie's murder, he pleaded guilty and was sentenced in July 2014, to life imprisonment with a minimum tariff of 24 years to be served in prison. He has since made an unsuccessful appeal against the 24 year tariff.

4.3. Consideration was given to holding a Mental Health Homicide Review however it was decided that the circumstances of this case did not meet the NHS England Guidance on implementing such an Independent Review.

4.4. The Independent Police Complaints Commission (IPCC) has conducted an investigation into the police contact with Rosie prior to her death. In its conclusion it asked the question:

Could Gloucestershire Constabulary have prevented xxxxxx's death? "Unfortunately it is impossible to determine whether a different response by officers would have prevented xxxxxx's death. Given the information available to officers about xxxxxx, the escalation of violence demonstrated by him was unpredictable."

The DHR Chair and Panel thank Commissioner Guido Liguori of the IPCC for sharing his final Report with the Review and permitting part of his recommendations to be included within appendix G of this Report.

5. **Timescales**

5.1. The decision to undertake a Domestic Homicide Review was taken by the Chair of the Tewkesbury Borough Community Safety Partnership on 12th March 2014 and the Home office informed on the 13th March 2014.

5.2. The Home Office Statutory Guidance advises that where practically possible the Domestic Homicide Review should be completed within 6 months of the decision made to proceed with the Review. In this case, due to the delay in waiting for the conclusion of the criminal proceedings, the DHR Chair was not appointed until 25th July 2014. Arrangements were made to promptly secure documents and to commence with the collation of the chronology. The first Panel meeting was organised for 29th August 2014 and participating agencies were advised to ensure that actions were taken to address lessons learnt as early as possible.

5.3. The Review was completed on 27th January 2015.

Confidentiality

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

6.2. As recommended within 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 Rosie is used for the deceased, who was aged 20 years at the time of her death. It was chosen by her parents. The name Paul is being used for the perpetrator after discussions with him and his solicitor.

6.4. The Executive Summary of this report has been carefully redacted. After this overview report has been through the Home Office quality assurance process, the report and attachments, excluding the chronologies, will be published in accordance with the Home Office Guidelines.

6.5. A redaction may simply replace a name with a pseudonym, or may be the removal of personal and sensitive details about an individual, i.e. medical information. Redactions will not be used to protect the identities of organisations participating in the Review.

6.6. The Review Panel has obtained the deceased's confidential information, (including police and medical records) after Rosie's father signed an authority for the DHR to access all such confidential documents. Paul signed a similar consent form to enable the Review to access his medical records although he declined to allow the Review to have access to two psychiatric reports which were completed on behalf of his Defence Team, during the course of the criminal proceedings.

7. Dissemination

7.1. Each of the Panel members (see list at beginning of report); the IMR authors, the Chair and members of the Tewkesbury Borough Community Safety Partnership have received copies of this report. The Report has also been discussed in full with Rosie's family who have had the opportunity to read sections of the Report in particular those relating to the analysis, lessons learnt, conclusions and recommendations.

8. The Terms of Reference

8.1. **The purpose of the statutory Domestic Homicide Review is to:**

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

- 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.

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

- Apply these lessons to service responses including changes to policies and procedures as appropriate.

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

8.2**. Overview and Accountability:**

8.2.1. The decision for Tewkesbury Borough Community Safety Partnership to undertake a Domestic Homicide Review (DHR) was taken by the Chair of the Tewkesbury Borough Community Safety Partnership on 12th March 2014 and the Home Office informed of that decision on 13th March 2014.

8.2.2. The Home Office "Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews" advises where practically possible the DHR should be completed within 6 months of the decision made to proceed with the Review. In this case a decision was made to delay the commencement of the Review until after the conclusion of the criminal trial.

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

8.3. **The Domestic Homicide Review will consider:**

8.3.1. Each agency's involvement with the following from 1st January 2013 (together with any other contact relevant to violence, harassment, stalking, domestic abuse or mental health issues prior to that date) and the death of Rosie (pseudonym) on 18th February 2014,

a. The victim, Rosie (pseudonym) 20 years of age at time of her death, lived in Tewkesbury Borough
b. The perpetrator, Paul (pseudonym) 22 years of age at date of incident, of Cheltenham

8.3.2. Whether there was any previous history of abusive behaviour towards the deceased or any previous partner of the perpetrator, and whether this was known to any agencies.

8.3.3. Whether family, friends or colleagues want to participate in the Review. If so, ascertain whether they were aware of any abusive behaviour to the victim, prior to the homicide.

8.3.4. Whether, in relation to the family members, were there any barriers experienced in reporting abuse?

8.3.5. Could improvement in any of the following have led to a different outcome for Rosie considering:

(a) Communication and information sharing between services.

(b) Information sharing between services with regard to the safeguarding of adults and children.

(c) Communication within services.

(d) Communication to the general public and non-specialist services about available specialist services.

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

(a) Professional standards.

(b) Domestic Abuse policy, procedures and protocols.

8.3.7. The response of the relevant agencies to any referrals relating to Rosie concerning domestic abuse or other significant harm from 1st January 2013 or to any referrals relating to the perpetrator prior to that date. 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:

(a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards with victim or perpetrator.

(b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.

(c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made.

(d) The quality of any risk assessments undertaken by each agency in respect of Rosie, or Paul**.**

8.3.8. Whether organisations' thresholds for levels of intervention were set appropriately and/or applied correctly, in this case.

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

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

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

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

9. Schedule of the Domestic Homicide Review Panel meetings

- 25th July 2014 Pre-meet Chair of Community Safety Partnership, Chair of DHR and the Senior Investigating Officer at Tewkesbury Borough Council Offices.

- 29th August 2014 Panel meeting at Tewkesbury Borough Council Offices.

- 11th November 2014 Panel meeting at Gloucestershire Constabulary Headquarters

- 27th January 2015 Panel meeting at Tewkesbury Borough Council Offices.

10. Methodology

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

- The Individual Management Reviews (IMRs) of participating agencies;
- The Senior Investigating Officer;
- The Criminal Trial and associated press articles;
- The victim's work-colleagues;
- Members of the victim's family;
- The Perpetrator;
- The Perpetrator's mother;
- The Independent Police Complaints Commission (IPCC)
- Discussions during Review Panel meetings;
- Consultations with the Home Office, the Information Commissioners Office (ICO) and
- Co-ordinated Action Against Domestic Abuse (CAADA)

11. Contributors to the Review

11.1. Whilst there is a statutory duty that bodies including, the police, local authority, probation and health bodies must participate in a DHR; in this case, nineteen organisations have voluntarily contributed to the review (listed in Para. 3.9). Twelve have completed Individual Management Reviews (IMRs) or reports. The perpetrator, the victim's family, work colleagues and friends have provided information to the DHR. Two agencies have provided advice to the Review relating to Data Protection and the training given to agencies regarding Data Protection and the Domestic Violence Disclosure Scheme. One body, the IPCC has shared the findings of its investigation into the police response to the incident relating to Paul and Rosie on 15th February 2014. The Gloucestershire Domestic Abuse and Sexual Violence Commissioning Steering Group has set a number of Gloucestershire wide recommendations to reflect the lessons learnt within this Review.

11.2. **Individual Management Review Authors:**

Antony Knight, Bristol National Probation Service

Paul Tuckey, Cheltenham Borough Homes

Dr. Richard Wharton, Gloucestershire Clinical Commissioning Group NHS Trust

Delia Amos, Gloucestershire County Council Children and Young People's Service

Rachael Scott, Crown Prosecution Service South West

Sally Morrissey, Gloucestershire Domestic Abuse Support Service

Jeanette Welsh, Gloucestershire Hospitals NHS Foundation Trust

Mary Hopper, Gloucester City Council Housing Service

Detective Inspector, Kevin McCloskey, Gloucestershire Multi-Agency Risk Assessment Conference

Detective Inspector Kevin McCloskey, Gloucestershire Constabulary

Sharon Graham, HM Courts Service

Gordon Benson, 2gether NHS Foundation Trust (NHS)

11.3. **Senior Investigating Officer**:

Detective Chief Inspector Steve Bean Gloucestershire Constabulary who briefed the Review Panel about the circumstances of the case.

12. The Facts

12.1. Paul was the eldest of two boys brought up by their mother who was separated from his father. In 1996, when he was four, he was referred to the East Gloucestershire NHS Trust Child and Family Services by his Health Visitor, following reports from his mother that she was struggling with his disruptive behaviour. This was in the context of his witnessing both long term physical violence and verbal abuse of his mother by his father and by her later partners. He was assessed by two mental health professionals who were of the opinion that he was emulating his father's behaviour. His mother endeavoured to provide boundaries and structure to his upbringing but this behavioural management was not supported by his father who still saw him irregularly.

12.2. In December 2001 Paul (aged 10 years) was once more referred to the Child & Family Services, via the family's Health Visitor, due to his increasingly angry behaviour at school and home. Again, this was considered to be related to contact with his father (who he had not seen for 3-4 months). The outcome of this referral was signposting Paul to an organisation which specialised in addressing issues of separation and divorce and their impact on children.

12.3. When Paul was 16 years of age, he was assessed by a Child & Adolescent Mental Health Services Clinical Nurse Specialist on the Children's Ward at Gloucester Royal Hospital, following an overdose of 16 paracetamol tablets. He described a "tumultuous" relationship with his mother and acknowledged both smoking and dealing in cannabis. He agreed to attend the Young Peoples Substance Misuse Services and engage in family therapy sessions with his mother. He successfully attended ten sessions, leading to greatly reduced cannabis use before deciding to cease with therapy and being discharged from the service in August 2008.

12.4. On 25th October 2009, the police were called to an address in Cheltenham where Paul was living with his girlfriend Kate (pseudonym), who alleged that Paul had damaged her flat. Paul was arrested for criminal damage, but Kate declined to make a formal complaint. Although efforts were made to obtain additional evidence, none was obtained and no further action was taken, The Police did identify this incident as domestic abuse but did not add it to the Domestic Abuse database.

12.5. In April 2010 Kate contacted the police reporting that her ex-partner, Paul, was refusing to leave her flat. Although she said she was fine and going to her mother's house, police officers attended twice to check on her welfare, Paul had left prior to the police attendance. A month later, the police again attended an incident between Paul and Kate. It was recorded as a verbal argument over cannabis and Kate refused to make a complaint or to provide any further information. While no further action was taken, the incident was recorded on the Gloucestershire Constabulary Domestic Abuse database.

12.6. Between July 2010 and July 2012 the police were called to a further nine incidents involving harassment, criminal damage or assault by Paul on Kate. On four of those occasions he was arrested and on two, he was charged (criminal damage and harassment). On a further two he was served with a Police Information Notice (PIN). Although Kate refused to support police prosecutions, in July 2012, the case was discussed at the Gloucestershire Multi Agency Risk Assessment Conference (MARAC). Kate was identified as a repeat victim, but the Independent Domestic Violence Adviser (IDVA) reported that Kate would no longer engage with her.

12.7. During the same period, Paul was arrested a further four times for violent offences in non-domestic situations. On most of those occasions, when in police custody Paul complained he was suffering from depression. In December 2010 he appeared at Magistrates Court, for offences of threatening behaviour and fear of provocation of violence (Public Order Act 1986) and was sentenced to twelve weeks in prison, suspended for 2 years, with re-

quirements of eighteen months supervision, unpaid work and low level drug treatment. His suspended sentence order was extended for a further three months in November 2011 when he was also fined for possession of cannabis.

12.8. In July 2012 Paul was sentenced to a community order with a single requirement of forty hours of unpaid work for an offence of harassment in relation to threatening texts he was sending to Kate. Gloucestershire Domestic Abuse Support Service (GDASS) contacted Kate, who confirmed that she had been receiving texts and telephone calls from Paul and wanted an injunction to stop him. She was given the contact details of a solicitor, but never contacted him. This was considered at the Gloucestershire MARAC.

12.9. In November 2012 Paul was in a relationship with Clare (pseudonym) who reported to the police that Paul had damaged her property following a "domestic incident". In custody he again stated he suffered from depression. He was seen by a nurse in relation to a head injury (two months old). He was charged with criminal damage, but was subsequently dismissed as Clare refused to give evidence.

12.10. Paul's mother contacted the police in December 2012 as a result of threats he had made to her, during an argument. While she did not want any police action, only the incident to be logged, an officer attended and warned Paul about his future behaviour.

12.11. Two weeks later on 26th December 2012 Paul called an ambulance, stating he had tried to hang himself. He was taken to hospital but left prior to formal examination. He was later arrested for breaching bail conditions after visiting Clare's house. As he again claimed he was suffering from depression he was referred for a medical assessment. It was confirmed that he was fit to be dealt with through the criminal justice system.

12.12. Rosie and Paul met in February 2013 and began going out together. On 10th March 2013 Rosie moved to Watford on a course to become a hairdresser on a cruise ship. While she was away, Paul told the Review, he partied and sold illegal drugs, but due to a "bad drug deal" he left Gloucester and joined Rosie in Watford; staying on in London after she left to work on a cruise ship. He claimed he did not work, but became involved in petty crime. During this period, on 30th March 2013, his mother contacted the police to complain that Paul had caused damage at her house. She stated she only wanted advice; nevertheless an entry was placed on the domestic abuse database.

12.13. Rosie left the cruise ship after a few weeks and rejoined Paul in London where she got a job as a hairdresser. Between June and August 2013 they lived together in a rented flat in Watford. Paul told the Review that at this time, he was drinking too much and using drugs. At the Notting Hill Carnival, while drunk, he pushed Rosie to the ground causing her bruises. She was upset and returned to her family home in Gloucestershire.

12.14. Paul followed Rosie back to Gloucestershire and they patched up their relationship. For a short time he stayed with her at her family's home but was asked to leave after getting drunk.

12.15. In July 2013 Paul added Rosie as his fiancée, to his Cheltenham Borough Council "GlosHomeseeker" application for social housing, claiming they were homeless. The application was unsuccessful. Paul then applied to Gloucester City Council, for housing for him and Rosie (although she was never seen with him). He contacted the Housing Department, several times over a period of months, until January 2014 when as a single person he rented a flat in Gloucester.

12.16. In the early hours of the 20th July 2013, Paul and Rosie were seen, on a monitored Gloucester CCTV, having a verbal altercation near a night club. He was seen to put his hands around her neck and the police and members of the public quickly intervened. Paul was detained and at the police station claimed to have "non-medical depression," adding

that the previous Christmas he had tried to hang himself. Rosie stated in writing, that she wanted no further action to be taken against Paul, but he was kept in police custody overnight. Later that day officers again spoke to Rosie but she still declined to make a complaint against Paul. A standard Domestic Abuse, Stalking and Harassment risk assessment was completed (DASH), with a request for GDASS to be notified.

12.17. In October 2013 Paul self-presented to the Emergency Department at Gloucester Royal Hospital and was subsequently seen by the Mental Health Liaison Team. He was accompanied by Rosie when he attended an initial assessment. It is recorded that Paul was requesting professional help to manage his emotional instability as he was having thoughts of harm to self and others and auditory hallucinations. These were considered in the context of his significant historical illicit drug use, frequent use of alcohol and a lack of ability to regulate this once he started to drink. He was also prone to extremes of anger, which, after drinking resulted in angry and aggressive confrontations.

12.18. On completion of the initial assessment, Paul was offered additional assessment through the Crisis Resolution and Home Treatment Team (CRHTT). The aim was to further assess his mental state and determine the level of intervention required. His mother accompanied him for the first CRHTT assessment. Paul attended a number of further appointments and although he described "generalised symptoms of paranoia, no evidence of psychosis could be determined" by any of the practitioners. He did describe use of illicit substances and alcohol historically but denied recent usage.

12.19. Paul was referred to the Early Intervention Service, Gloucester Recovery In Psychosis (GRIP) but was discharged in November 2013 as it was assessed that there was no acute need for the service. He was signposted to the Lets Talk Service and encouraged to formally register with a GP to facilitate access to anger management resources. He never attended the Lets Talk Service.

12.20. On 17th November 2013 the police were informed that there had been violence involving Paul and other men in a public house. They attended and stopped Paul driving Rosie's car a short distance away. Rosie was in the car with him. Paul was arrested and later charged with three offences of common assault, possession of an offensive weapon (a wheel brace), drink driving and theft of Rosie's car. No risk assessment was conducted in respect of Rosie. Paul was bailed to court on a date in March 2014.

12.21. On 14th February 2014, whilst out together in Gloucester, Rosie ended their relationship and Paul, annoyed, threw a glass of water over her and stole her bank card, later withdrawing £300.00 cash from her bank account without her permission. Over the next few days Paul made several attempts to contact Rosie by way of mobile phone. Rosie contacted the police and informed them of the theft of her bank card and that Paul had made threats to beat her and to throw acid in her face. She also said he had made threats against her family. While initially Rosie was unsure about making a complaint about Paul, officers completed a Domestic Abuse Stalking and Harassment Risk assessment form (DASH) and assessed Rosie as being medium risk. On 16th February 2014 officers again contacted Rosie and she told them that she would make a written statement of complaint against Paul. In the statement she gave details of three previously unknown assaults on her by Paul. The Police officers, with the intention of arresting Paul, made two unsuccessful enquiries to trace him at his mother's address. However they did not circulate him as being wanted.

12.22. During the afternoon of. 18th February 2014 Paul sold a DVD player for £5.00 and used the money to purchase a large silver knife for £3.00. CCTV showed him wandering in and around the centre of Gloucester, until 5.47p.m., when he was seen to enter the hairdressing salon where Rosie was working.

12.23. Staff and customers in the salon, described how Rosie told Paul to leave, as she did not want to talk to him, Paul lunged forward and punched Rosie. Then when a male custom-

er shouted at him to stop; Paul threatened him with a knife. One of Rosie's colleagues telephoned the police and staff and customers ran to a secure room, leaving Rosie alone with Paul who was attacking her. When they came out, Paul had gone and Rosie was on the floor. Police officers and paramedics tried to revive her but she was declared dead on arrival at the hospital.

12.24. The Pathologist report recorded that Rosie died of multiple stab wounds having been stabbed 14 times to the front and back of her torso, of which 9 entered the chest cavities. One of the stab wounds was 6 inches deep. There were also several defence injuries to Rosie's left forearm, wrist and palm.

12.25. A full chronology of agencies' contacts with Rosie and Paul are set out in full in Volume Two of this report.

13. Overview

13.1. The Panel and Individual Management Review (IMR) Authors have been committed, within the spirit of the Equalities Act 2010, to an ethos of fairness, equality, openness, and transparency, and have ensured that their reviews have been conducted in line with the Terms of Reference. The Review has been cognisant of the vulnerability of Paul's earlier victims i.e. his mother and two earlier partners and arranged for checks on their welfare. This was done and whilst Paul's two previous partners refused any contact or support, Paul's mother appreciated the offer of help but said no one can help her shed the guilt she feels for what her son had done.

13.2 The practices of agencies were carefully considered to ascertain if they were sensitive to the nine protected characteristics of the Equality Act 2010, i.e. age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion and belief, sex or sexual orientation. In line with the Terms of Reference, the IMR authors detailed how these were considered. The fact that Paul was of mixed race, was not found to be a relevant factor either to the circumstances of the homicide or to the way he was treated by any of the agencies with whom he had any contact. The Review recognised that Paul displayed violent tendencies to women he was or had been in a relationship with and there was an element of this being learnt behaviour from his father's violence to his mother which he had witnessed from an early age; however the Panel also acknowledges that Paul has a significant history of violence towards men as well.

13.3 Agencies completing IMRs were asked to provide chronological accounts of their contact with Rosie and/or Paul prior to her death. Where there was no involvement or insignificant involvement, agencies advised accordingly. In line with the Terms of Reference the DHR has focused on agencies contacts from 1st January 2013 to 18th February 2014, but also includes all relevant information prior to that period. The recommendations of individual agencies to address lessons learnt are listed in section 17 of this report and their action plans to implement those recommendations are catalogued in Appendix C.

13.4 Nineteen agencies / multi-agency partnerships were contacted about this review.

13.5. Four agencies responded as having had no relevant contact with either Rosie or Paul. They are:

- Gloucestershire Domestic Violence Support and Advocacy Project
- Tewkesbury Borough Council
- Tewkesbury Community Safety Partnership
- National Probation Services

13.6. Two agencies have assisted the Review on the issue of the Data Protection Act and the Domestic Violence Disclosure Scheme (DVDS).

13.6.1. The DVDS or "Clare's Law" allows the police to disclose, to victims, information about a partner's previous history of domestic abuse or violent acts that may protect them from an abusive situation. Currently some specialist domestic abuse support services, providing IDVA support to victims, are advised that they will breach the Data Protection Act if they keep records of the names of perpetrators. This means they are not able to disclose to the police any information relating to perpetrators.

13.6.2. The Information Commissioner's Office (ICO) has provided specialist comment in relation to retention and disclosure relating to perpetrators and to explain the working requirements of the Data Protection Act in relation to the DVDS. (See Appendix F).

13.6.3. Co-ordinated Action Against Domestic Abuse (CAADA) notified the Review that it recognises that there can be confusion around the retention of information and although CAADA cannot advise on legal matters, they recommend that practitioners seek the appropriate legal advice and follow the relevant agency procedures. There is no 'blanket' advice as this needs to be considered on a case by case basis and each case reviewed on its merits. They recommend that practitioners have a discussion with the Information Officer responsible for data governance within their agency, as it is the decision of the individual organisation how sensitive information should be stored.

CAADA provides Home Office endorsed Independent Domestic Violence Advisor training across England and Wales. There is a regularly review of all provision to ensure that content is current and reflects any recent changes in policy or legislation. In light of the recommendations in this Review, CAADA will ensure that all training contains clear messages around the use and implementation of the Domestic Violence Disclosure Scheme (DVDS)and how that relates to the Data Protection Act.

CAADA has always recommended that practitioners should not disclose sensitive information to clients directly. The introduction of the DVDS has provided a defined pathway to facilitate decisions about disclosure by making an application to police under the scheme. The safety of victims of abuse and their children is paramount and any decision about sharing and storing information must ensure that their safety is maintained.

As CAADA is reviewing what national training should be provided to domestic abuse specialist support services and Independent Domestic Violence Advisers (IDVAs) on the issue of DVDS and Data Protection, this has been included within the DHR's recommendations and Action Plan.

13.6.4. The IPCC has provided the Review with a copy of its Report on its investigation into the police contact with Rosie prior to her death.

13.7. Twelve agencies provided IMRs or reports setting out their contacts with either Rosie or Paul.

13.7.1. **Bristol, Gloucestershire, Somerset and Wiltshire Community Rehabilitation Company Limited**

The then Gloucestershire Probation Trust's first involvement with Paul followed his sentencing on 3rd December 2010 to a Suspended Sentence Order (SSO) for offences of threatening behaviour, fear of provocation of violence (public order act 1986). The sentence was for twelve weeks imprisonment suspended for two years and included requirements of 18 months supervision, unpaid work and low level drug treatment.

He was assessed as posing a medium risk of serious harm to the public. At this time there was no evidence of previous behaviour relating to domestic abuse. The assessment recorded him as not being in a relationship at that time.

Paul engaged well and complied with work in supervision that focused on his substance misuse. The order included drug testing. Information was received from the MARAC in November 2011 indicating concerns about Paul abusing an ex-partner (Kate). Consequently Paul's supervising officer increased his reporting to twice weekly and commenced structured work on domestic abuse as part of his supervision plan. Paul continued to engage in work with his supervising officer throughout the order including the work on domestic abuse. He continued to comply with drug testing and work on reducing his cannabis use although there had been one instance of a positive test to cocaine.

In November 2011 he was fined £50 for possession of cannabis and the period of his SSO was extended by three months.

Overall Paul demonstrated good levels of compliance with the SSO, attending 82 appointments with 13 acceptable absences and one unacceptable absence. The period of supervision was completed on 2nd June 2012.

On 3rd July 2012 Paul was sentenced to a Community Order with a single requirement of 40 Hours unpaid work with no statutory supervision, for harassment of his ex-partner (Kate).

He was sentenced without a pre-sentence report as the District Judge had wanted to impose punishment only. Probation service policy in cases relating to domestic abuse is to ask the court to add a supervision requirement. The probation service does not have the authority to insist on this practice only to advise. However, it would appear in this case that a probation representative was not present in court at the time of sentence.

During the period of the order there were ongoing concerns with regard to his behaviour. It was noted on 11th October 2012 that he had been arrested for criminal damage and had been clearly under the influence of substances and or alcohol. Paul attended seven sessions with one unacceptable absence recorded and eleven acceptable when he had either provided medical or evidence of work. The order was therefore completed without breach.

On 8th February 2013 Paul was sentenced to one month imprisonment, having his suspended sentence order activated, for further offences of criminal damage and possession of cocaine. There was no further statutory supervision.

13.7.2. **Cheltenham Borough Homes (CBH)**

CBH had no contact with Rosie.

Paul's ex-partner, Kate, became a tenant of CBH in January 2003, but it was not until June 2010 that contact was made that indicated that she was the victim of domestic abuse.

Between June 2010 and July 2013 Kate had a series of contacts with staff members of CBH, to make them aware of on-going abuse from an ex-partner Paul.

The first indication that Kate was potentially a victim of domestic abuse was in June 2010. CBH was aware of a police visit, following a report of noise from Kate's address. The police carried out a welfare visit and reported that the situation was a domestic dispute. There was no recorded contact or attempt to contact with Kate made by CBH at this stage.

Following this, CBH personnel attended a MARAC meeting that provided details of Kate's situation. It was and continues to be normal practice for CBH to be involved in MARAC meetings and to follow up with contact to victims to offer advice and support although there is an absence of clear process and guidelines. Training was provided for three staff members around domestic abuse, but two of these subsequently left and CBH now have one solitary Domestic Abuse champion.

Advice was given to Kate regarding a non-molestation order and a referral made for a sanctuary assessment. Although sanctuary work was completed at the property, there is no record of what this work entailed or the reasons it was considered to be the best option. Kate was also in contact with an IDVA, and discussing her housing options with the Cheltenham Housing Options Team. This included the option of moving to another borough.

Three months later in November 2010 a further report was made by Kate to say that the windows to her property had been vandalised and that she was continuing to suffer harassment resulting in her living away from the property. She provided details of seven incidents registered with the police over a seven month period. On the back of this an emergency 'management move' to alternative accommodation was agreed.

At this time, these moves were often requested by members of the housing team and needed approval of the Service Manager and Housing Options Team Manager. In these cases it was normal that an applicant would be directly matched to a property rather than made to bid through the normal process. This practice has subsequently ended and housing applications are now assessed and prioritised by the Housing Options Team on the basis of information provided. The Housing Options Team also takes and provides advice on homelessness situations. This is in line with Gloucestershire “Homeseeker" policy.

The IMR author expressed concern that the move took two months to achieve and the property that Kate moved to, was only a few miles away from her old home consequently the risk of Paul locating the new home was high. The reasons for the delay in the move and the reason for moving to a property in close proximity are not recorded. Whilst the decision to move may have been appropriate the delay and location of the new address is a concern. Kate later voiced her worries over this move.

Although the next recorded report of domestic abuse to CBH was not until February 2012, there is a record of the sanctuary measures being completed in this property in November 2011 (on referral from an IDVA). In February 2012 Kate enquired about renting a garage as her car was being targeted by Paul. She was not allowed to register at this time due to a rechargeable repair debt relating to her occupation of her previous property, and damage carried out there by Paul. This was the first indication that housing debts were becoming a barrier to Kate receiving more appropriate support.

A further MARAC was held and this detailed that Paul had been arrested, charged and bailed until the following month. It was also recorded that Kate had an IDVA but was proving to be difficult to contact. As a result CBH sent a letter to Kate, referencing the MARAC and requesting contact to see whether they could assist. This was sent the same day as the MARAC but there is no recorded response. No follow-up attempts were made.

Another MARAC held on 11th September 2012 disclosed that although there was an IDVA in place Kate had failed to engage in the past and wanted an injunction against Paul.

The same month Kate informed CBH that Paul had been served with a harassment notice several months earlier in July 2012, but Kate was still receiving threatening text messages. Kate was trying to obtain a move, but rechargeable works and other debts were continuing to hamper her attempts to achieve this. Housing Revenues recorded that after consideration they were unwilling to waive the recharges and therefore blocked the application to “Homeswapper" which is a service that allows tenants to find properties to exchange.

*A*s part of this review, the Housing Revenues Manager confirmed that any application would normally be rejected and consideration only given if grounds to write off debt were provided. In cases similar to this there would be a request for police incident numbers and in this instance it would seem that these were not provided. There is an argument that where there is a recorded history of domestic abuse a more considered view should be taken. However there are no guidelines that cover this situation, although the Revenues Manager advised that each case would be considered on its merits. Kate was also seeking a move through “Gloucestershire “Homeseeker” who would have sought clarification on housing related debt. It would have been beneficial for Kate to have had an advocate within CBH liaising on her behalf although this may not have changed any decisions that were being made.

13.7.3. **Crown Prosecution Service South West (CPS)**

While the CPS had prosecuted Paul on the occasions he appeared before Gloucestershire Magistrates courts, they had no direct dealings with him and no lessons to learn or recommendations to make. Nevertheless the CPS has provided opinion to the DHR on the likelihood of Paul being detained in custody or being given bail, if he had been arrested by the police for the offences committed by him on 15th February 2014.

13.7.4. **Gloucestershire Clinical Commissioning Group**

Paul and Rosie were registered with GP practices in different towns. In this situation Primary Care Services would only be aware of any relationships if it had been declared or discussed by either Paul or Rosie and there is no evidence of this from their medical records. Rosie had opportunities to disclose as she had at least 15 contacts with medical services during 2013, but these were primarily for medical problems such as ear infections and migraine and she made no reference to her private life.

Paul was known to his GP practice to have a violent nature, as the practice had received a copy of MARAC report in October 2012. This followed an assault which involved his mother who was also a patient at the practice. The practice kept the report which included a number of other offences, filed separately from his medical record in an "admin folder".

On 27th December 2012 Paul was seen by his GP following an attempt to hang himself. In view of his admitted alcohol and drug use, Paul was advised to contact the Independence Trust. He did not make contact with that agency, although at his next GP appointment in January 2004 he claimed that he had. On that occasion he appeared much improved and no follow up was arranged.

.

13.7.5. **Gloucestershire County Council Children and Young Peoples Service**

There has been no involvement from Children and Young People's Services with Rosie.

Paul however had been known at various points in his life, although no significant interventions were detailed. Records indicate that he grew up, in the care of his mother, with a younger half-brother. His mother's relationships had been volatile at times, resulting in her contacting the police on a number of occasions.

In October 2010 Paul's mother made a suicide attempt and admitted to thoughts of taking her younger son with her. An assessment concluded that there was a supportive family and Paul's half-brother was sent to his grandmother.

During 2010 to 2012 the Children and Young Peoples Service became aware of reports of Paul's violent behaviour towards his partner Kate. An initial MARAC meeting in November 2011 recorded that Kate had moved from her previous address because of harassment from Paul. However he located her and damaged her then partner's car and threatened to burn her house down. In a further MARAC meeting, in June 2012, a social worker reported there was no current involvement from social care as a safety plan was in place.

In August 2012 the social worker reported that Kate did not engage with the initial assessment processes in November 2011, or in 2012. Kate was believed to have ended the relationship with Paul, who was then subject to a Harassment Order issued in November 2011. Service records indicate that there was insufficient concern identified for Kate's children to be subject to a child protection plan.

The Children and Young Peoples Service final record related to the MARAC meeting in October 2012 in respect of Paul being abusive to his mother and his grandmother, threatening

to “smash her caravan up”. Paul was recorded as a tier 1 medium risk of serious harm to the public and known adults with previous cannabis/ heroin /crack cocaine usage.

Throughout the spasmodic history there is no reference to any direct involvement by a worker from social care with Paul himself.

13.7.6. **Gloucestershire Domestic Abuse Support Service (GDASS)**

Gloucestershire Constabulary regularly refers victims of domestic abuse to GDASS, which provides a county wide service including an IDVA service in Gloucestershire. In July 2013 GDASS received a standard risk DASH from the police, in respect of Rosie, after Paul had been arrested for grabbing her around the neck. It took three attempts before Rosie was contacted. She told the GDASS help desk worker that she did not need support at that time, as she felt it was a one off incident and Paul had apologised. Nevertheless she was given the GDASS telephone number and said she would use it if she needed help in the future.

A second DASH referral for Rosie was made to GDASS in respect of the incident of the 14th February 2014 but this was only received after her death.

GDASS had in 2012 received referrals from the police, in respect of Kate, Paul’s previous partner and in respect of his mother. However GDASS policy is that only the details of referred victims can be retained as the Data Protection Act precludes the retention of perpetrators records. (This policy is the result of Data Protection advice). GDASS therefore had no records to identify Rosie’s assailant as having featured in the two previous separate referrals. GDASS with 22.5 members of staff average 3000 referrals a year, of which 2400 plus are provided with help.

13.7.7. **Gloucestershire Hospitals NHS Foundation Trust**

Rosie’s contact with the hospital trust was for routine ENT (ear, nose and throat) and dermatology (skin) outpatient clinics with three visits to the Emergency Department (ED) for minor complaints.

Paul’s contact included 29 episodes over 20 years. After the age of 12 these were at ED and were predominantly for injuries, but also for self- harm and hearing voices. The four contacts prior to the homicide were during his relationship with Rosie and include a visit on 30th October 2013 when Rosie accompanied Paul to ED. In her presence, he reported two years of depression and that he is hearing voices telling him to assault people and harm himself. He said they were getting worse and he was worried about having enemies and about stabbing. An emergency mental health assessment came out as high risk and he was referred to the mental health liaison team (2gether Trust). This was the only occasion where both Paul and Rosie were seen together at hospital.

The Trust also had a number of contacts with Paul’s previous partner Kate. The first such contact was in July 2010 when Kate had an arm injury after an assault by Paul. A DASH form was completed and escalated to a MARAC. This resulted in a safety plan for Kate and alerts were placed on her record. Kate attended ED twice more in 2010 with further arm injuries with three follow up visits to the fracture clinic.

13.7.8. **Gloucester City Council Housing Service**

Paul had previously made a sole housing application to Cheltenham Borough Council in January 2013 and in August 2013 he added Rosie’s name to his application for social housing as his fiancée. Later in October 2013 Paul went to Gloucester City Council for housing advice. He listed Rosie as his fiancée but was advised that they were unlikely to meet the criteria for homeless assistance as there was no evidence of a priority need (vulnerability). He continued to seek housing assistance for himself and Rosie; although Rosie was never

seen with him and Gloucester City Council Housing Services had no contact with her of any kind.

In January 2014 Paul was eventually helped, by the Council to access a suitable bedsit for himself in Gloucester.

13.7.9. **Gloucestershire Multi-Agency Risk Assessment Conference**

Paul's previous girlfriend Kate was the subject of three high risk DASH referrals to MARAC, all involving Paul as the perpetrator.

The first was after an incident on 7th November 2011 and the MARAC met on 22nd November 2011. The second referral was with regard to incidents on 7th May 2012 but was not considered by the MARAC until the 19th June 2012. On 30th July 2012 another incident occurred which, two days later, was referred to MARAC, it was not heard until September 2012. By the time each of these referrals were considered by the MARAC there had been such time delays that Kate had become reticent about taking action against Paul and about engaging with the IDVA. Nevertheless, a number of initiatives were actioned, including increased weekly reporting to his Probation Officer, extra police patrols in the vicinity of Kate's home, IDVA support, extra security measures at her address and help to re-house her.

On 9th August 2012 a referral was made to the MARAC, in respect of an incident involving Paul and his mother on 8th August 2012. While the incident was deemed to be of a standard risk, because of Paul being a high risk to Kate, this high risk was transferred to his mother. The incident was considered by a MARAC meeting on 9th October 2012.

Since the time of these MARACs, there have been comprehensive changes made to the MARAC meeting structure and timing. MARACs are now held as soon as possible after referral, which allows more timely intervention to be considered. One of the negatives of the previous meetings was that they were often held several weeks after the incident which did not tend to compliment the categorisation of high risk. A meeting is booked each day and cases dropped in as required. No more than 4 cases would be heard each day which allows for more focus on each case.

13.7.10. **Gloucestershire Constabulary**

Between 2008 and February 2014 Paul was arrested 23 times for a variety of offences. These included domestic abuse related offences, criminal damage, failing to surrender to custody, possession of Class 'A' drugs, theft from motor vehicle and drunk and disorderly.

He was involved in 24 violent incidents known to the police; 3 involving 'Rosie', 12 involving his ex-partner (Kate), 2 involving his ex-partner (Clare), 3 involving Paul's mother, and 4 incidents of violence involving unconnected persons. Paul was subject to arrest on 13 of these occasions with disposal using the following sanctions:

2008	Cautioned
2009	No Further Action (NFA
2010	charged with Criminal Damage, 2 x Section 4 Public Order Act offences
2011	2 x NFA
2014	charged with Harassment, Criminal Damage, Breach of Bail
2013	NFA, and charged with Drink Drive, Assault x 3, Possession of weapon, Theft of Motor vehicle.
2014	Murder

Whilst the incidents are summarised in section 12 of this Report, the IMR author has provided substantially more detail in respect of the domestic abuse related incidents:

On 22nd July 2010 Paul damaged property belonging to his ex-partner, Kate. On his arrest, 6 days later, he claimed to be suffering from depression. A "DV1" (Risk Assessment form) was completed and submitted. The incident was identified as high risk and a police warning marker was placed on Kate's home address. (This meant that any call relating to that address was treated as requiring an urgent response). Paul was charged and pleaded guilty to criminal damage. The Crown Prosecution Service indicated that: "This is a case where a restraining order may be appropriate, perhaps with conditions not to enter the block of flats where Kate lives and not to contact Kate and her current partner", there is no record of this being granted.

On 12th August 2010, Kate reported to the police that Paul had sent her a text message of a sinister nature. Several attempts were made by the police to contact her, initially through appointments, but she failed to keep any of them, then by an officer going to her house. The incident was identified as 'Domestic Abuse' but no risk assessment was completed, due to the inability to engage with Kate.

On 1st November 2010 Kate contacted the police that she was having problems with Paul again. She said he turned up at her house on 20th October and on being refused entry, he poured white spirits through the letter box but made no attempt to light it. Two days later she discovered a bedroom window smashed. A police officer attended and Kate told the officer that Paul repeatedly texted her and turned up at her address, however she refused to pursue a complaint at the time. The incident was identified as domestic abuse and details were placed on the domestic abuse database. While the IMR author could find no evidence that a risk assessment was completed, the officer stated he visited Paul at his mother's address and served him with a PIN with warnings as to his future conduct. The IMR author, who was unable to find any record of the PIN being served, believed this incident had been an opportunity to deal with Paul for offences under Section 4 Protection from Harassment Act 1997, given that the information from Kate suggested a prolonged campaign of incidents and harassment in which she has been in fear. A Police Information Notice (PIN) was not appropriate in these circumstances.

On 1st May 2011 Paul was arrested for having allegedly pushed Kate over in the street. There was no complaint by Kate and he was subsequently released with no further action. While in custody Paul again said he was suffering from depression and had made an overdose attempt in 2008. He was seen by 2 nurses whilst in custody regarding jaw injury. Although a high risk DASH was completed which detailed Kate's fear of Paul, further contact by the Domestic Abuse Unit team stated; "She (Kate) does not feel she is being stalked or harassed" but also stated that she is very frightened and that is why she will not support any prosecution. The case was passed to the Central Allocation Referral Project (CARP), the forerunner of GDASS, but Kate did not want support.

On 4th November 2011 Kate reported that three tyres on her partner's car had been slashed. She believed it was Paul who was responsible, as a neighbour had seen him in the area. Kate also reported text and telephone threats to kill and damage. The officer who attended took a detailed statement, however Paul was never arrested although an Inspector had instructed that an arrest should be made. The officer confirmed that a PIN had been served on 1st November 2011, (this may have been the one referred to as being served on 1st November 2010). The IMR author is of the opinion that the crime investigation was probably concluded as a consequence of Kate failing to engage with the investigating officer. It was considered by the MARAC on 22nd November 2011.

On 7th May 2012 Kate reported that her car has been damaged (wing mirror knocked off) followed threats by Paul. These involved repeated threats via text to burn her house and damage her car. Kate stated that later Paul admitted doing the damage, on this occasion she made a complaint. The next day Paul was arrested and subsequently charged with harassment. Whilst in custody Paul was seen by a nurse as he stated he was feeling mentally

unwell. The incident had been identified as domestic abuse and a high risk DASH was completed. Paul was bailed to Court on 3rd July 2012. However no conditions were applied despite a request from the CPS. Paul subsequently pleaded guilty. The case was discussed in MARAC on 19th June. Kate was categorised as a repeat victim, however Kate refused to engage with the IDVA service. Probation explained to the MARAC the work they had been doing to control his anger.

On 30th July 2012 Kate made a 999 call stating that Paul had grabbed her around the throat and has gone for her eyes. Kate told the officers that Paul continued to harass her, but she refused to provide any other information. Paul was subsequently arrested on 18th August, but the custody officer decided there should be no further action. Paul again declared historical depression when he was detained. This was the last report of any incident involving Kate.

Paul's mother contacted the police, about threats by Paul toward her and her property following an argument at her home on 8th August 2012. No offences were disclosed but the Central Referral Unit (CRU) raised the standard DASH to high risk, having transferred the risk from Kate. It was referred to the MARAC which, after a significant delay, was held on 9th October 2012. Paul's mother was spoken to about this and the other incidents she was involved in. She indicated that she was content with the police response and stated that: 'they left me with a feeling that they would be there, if I needed them'.

On 30th November 2012 Paul, who was then in a relationship with Clare, was reported to the police for having damaged property belong to her, following a domestic incident at her home. Paul was arrested and while in custody stated he suffered from depression. He was seen by a nurse in relation to historic head injury (2 months previously). He was charged with criminal damage and bailed to court where he was found not guilty as Clare refused to give evidence against him. The incident was reported as a standard DASH, it was not raised to high risk on this occasion. *(The IMR author spoke to Clare who stated she was never the victim of domestic abuse from Paul. She said their relationship only lasted about three months*).

On 12th December 2012 Paul's mother reported threats by him toward her property following argument at her home address. She stated she did not want any police action but merely wanted it logged. Nevertheless in view of his previous domestic abuse history, the Police control room upgraded the incident to require a response. Police officers attend but no offences were disclosed. A message was left on Paul's mobile phone by an officer warning him about his future behaviour. It was not recorded as a crime, no DASH and no domestic abuse database entry was made, although it had been identified as a domestic abuse incident by the control room.

On 26th December 2012 Paul had called the Ambulance Service to say he was trying to hang himself. He was conveyed to Hospital but left prior to any formal examination. He was reported missing by the hospital. Enquiries were made and it was found that he had been to his ex-partner, Clare's home, thereby breaching his bail conditions for the matter on 30th November 2012. He was arrested and after again declaring he suffered from depression, he was seen twice by medical professionals whilst detained. Once he was medically assessed, he was declared fit to be dealt with by the criminal justice system and he went to court the next day.

On 30th March 2013 Paul's mother reported damage by him at her home address. The police attended but no offences are disclosed. The incident records state that Paul's mother was 'looking for advice'. An entry was made on the domestic abuse database and although the officer stated that a standard DASH was completed the IMR author could not locate it.

In the early hours of 20th June 2013, a CCTV operator saw Paul and Rosie arguing near a nightclub in Gloucester, Paul was seen to place his hands around Rosie's neck. The police are called and Paul was detained. Paul was kept in custody overnight then released with no

further action as Rosie had signed the police officer's notebook that she did not wish to make a complaint. A standard DASH was completed and a domestic abuse database entry was made. Officers asked Rosie later that day if she had changed her mind about making a complaint about Paul but she again declined to do so. The IMR author viewed the CCTV evidence and whilst it can be argued that the action did not amount to strangulation, the whole circumstances of the interaction, the behaviour of Paul immediately prior to and as a result of the intervention by the member of the public, lead him to conclude that this was an assault which justified Paul's arrest and prosecution.

On the 17th November 2013 the Police received a call that Paul had assaulted three men in a Public House. Paul was stopped driving Rosie's car a short distance away, Rosie was in the car with him. He was arrested for offences of assault, drink & drive, possession of an offensive weapon and unauthorised taking of Rosie's car. He was later charged with a number of offences, including three common assaults, possession of an offensive weapon, drink drive and theft of Rosie's car. No DASH was submitted as the theft of the car was not identified as a domestic related matter.

On 15th February 2014 Rosie contacted the police, informing them that Paul has stolen her bank card and withdrawn £300. She explained that she has been trying to end their relationship for some time but he has not accepted it, he had threatened to beat her and to throw acid in her face, he had also made threats about her family. She said she was unaware of Paul's address, saying he's 'here there and everywhere', While she said she only wanted advice, police officers were sent. They confirmed that a medium risk DASH would be completed. Later Rosie made a statement of complaint and the officers made enquiries to locate Paul at his mother's address. Although Paul was not circulated as being wanted, instructions were left for other colleagues to retrieve possible CCTV of card usage, they were not informed of the full extent of the harassment that Rosie had experienced, thereby alerting them to further offences under the Protection from Harassment Act 1997. There has been an Independent Police Complaints Commission inquiry into the actions of the officers.

13.7.11. **Her Majesty's Court Service (Gloucestershire)**

Paul appeared before Gloucestershire Magistrates Courts on nine occasions prior to the homicide, for a variety of offences including harassment of Kate and criminal damage relating to Clare. He was subject to a range of sentences from fines, community orders, suspended sentences, through to prison. With regard to the offence of criminal damage against Clare in 2013, the case was dismissed due to lack of evidence as Clare refused to give evidence against him.

13.7.12. **[2]gether NHS foundation Trust (NHS**)

Paul was first referred to East Gloucestershire NHS Trust Child & Family in January 1996 (aged 4 years) by his Health Visitor following reports from his mother that she was struggling with his disruptive behaviour. This was considered in the context of his having witnessed both long term physical violence and verbal abuse of his mother by his father. His parents had separated. He was assessed as emulating his father's behaviour. His mother endeavoured to provide boundaries and structure to his upbringing but this behavioural management was under constant sabotage from his father. The intervention of choice was Family Therapy which would need to include his father, as his father did not wish to engage follow up was not indicated.

In December 2001 when Paul was 10 years of age, a further referral to the Child & Family Services was made via the Health Visitor as he was becoming increasingly angry at school and home. Again, this appeared to be related to contact with his father (who he had not seen for 3-4 months). The outcome of this referral was signposting to an organisation that specialised in addressing issues of separation and divorce and their impact on children.

The next contact with trust services came in March 2008 when Paul was 16. He was assessed following an overdose of 16 paracetamol tablets. He described a “tumultuous” relationship with his mother and acknowledged both smoking and dealing in cannabis. He had accumulated a considerable debt which was causing additional stress and had run away from home. When he returned home, he “pushed the boundaries” regarding coming home late which lead him into conflict with his mother, this in turn upset him and led to the overdose. He agreed to attend Young Peoples Substance Misuse Services and engage in family therapy sessions with his mother

He successfully attended 10 sessions leading to greatly reduced cannabis use before deciding to cease with therapy and being discharged from the service in August 2008. In June 2008 he was involved in a fight whilst intoxicated and arrested and charged with causing Actual Bodily Harm. The outcome of this arrest was not known to Trust services as he was discharged prior to the proceedings.

Paul next came into contact with ^{2}gether Mental Health Services in October 2013 when he self-presented to an Emergency Department and was seen by the Mental Health Liaison Team. He attended the initial assessment with Rosie. It is recorded that Paul was requesting professional help to manage his emotional instability, thoughts of harm to self and others and reported auditory hallucinations. These were in the context of significant historical illicit drug use, frequent use of alcohol and lack of ability to regulate this once he started to drink. He was also prone to extremes of anger, which, after drinking, resulted in angry and aggressive confrontations. On completion of the initial assessment Paul was offered additional assessment through the Crisis Resolution and Home Treatment Team (CRHTT).

Paul attended his first assessment with CRHTT accompanied by his mother. Further appointments were facilitated by the CRHTT, including an assessment to determine whether a pharmacological intervention would be required. No pharmacological was indicated, and whilst Paul described generalised symptoms of paranoia no evidence of psychosis could be determined by any of the medical practitioners he saw. He did describe use of illicit substances and alcohol historically but denied recent usage.

Paul was referred to the Early Intervention Service - Gloucester Recovery In Psychosis (GRIP) as a mechanism to assess further the exact nature of the experiences being referenced in the assessment with Mental Health Liaison and CRHTT. He was discharged from the CRHTT caseload in November 2013 as there was no acute need for the service at the time and their assessment period had concluded.

Paul had several appointments with GRIP and in December 2013 the details of his assessment was explained to him. The outcome of the assessment determined that he did not require the intervention of the GRIP service. The clinical record concluded that he experienced problems with anger management and impulsivity associated with anxiety, poor stress coping strategies and back ground substance misuse. It was noted that the described auditory hallucinations were of a pseudo nature and the generalised paranoia was in the context of stress, past trauma and social circumstances. There did not appear to be any evidence of functional psychosis or mental illness at the point the assessment was completed.

At this meeting, Paul advised the GRIP service that he was currently on bail for driving under the influence of alcohol and for assaulting an acquaintance with a wheel brace. It was recorded that he demonstrated the capacity to understand the nature and severity of this event. There was evidence that capacity was formally considered during the appointment which indicated that this was not impaired.

He was signposted to the Lets Talk Service and encouraged to formally register with a GP to facilitate access to anger management resources. A letter was sent to him confirming the outcome of the assessment process and concluding:

“Finally we spoke about what we thought was going on and I explained to you that we did not believe that you had a serious mental illness, specifically psychosis, requiring treatment with medication. We believe that the difficulties you expressed could be managed through Talking Therapies, and we gave you information leaflets for “Let’s Talk”, which can provide talking therapy in relation to anxiety and stress management. We also advised you to register as soon as possible with a local GP Practice, who could provide you with support and facilitate access to anger management services.

In the interim we discussed practical ways of managing your anger, as you are responsible for any actions you take and the associated consequences.”

14. Analysis

14.1. The Panel has considered the individual management reports, through the view point of Rosie, to ascertain if each of the agencies' contacts 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 the lessons have been identified and properly actioned.

14.2. The authors of the IMRs have followed the Review's Terms of Reference and addressed the points within it. They have each been honest, thorough and transparent in completing their reviews and reports. The following is the Review Panel's opinion on the appropriateness of each of the agencies interventions.

14.3. **Bristol, Gloucestershire, Somerset and Wiltshire Community Rehabilitation Company Limited**

14.3.1. In the opinion of the IMR author, during the period when Paul was subject to supervision by the then Gloucester Probation Trust, he was treated fairly and professionally in accordance with statutory policies and agency practices.

14.3.2. The risk assessments were made using established accredited tools and the conclusions were proportionate in relation to the evidence on which they were based. Paul's supervising officer acted promptly and appropriately in revising Paul's supervision plan and increasing the frequency of supervision once the information relating to domestic abuse came to light. He was also satisfied that the order was supervised and reviewed in accordance with accepted agency policies and practice.

14.3.3. **The Review Panel agrees with the findings of the IMR author regarding the quality of the supervision of Paul and accepts that while it is unfortunate that a probation officer was not in court when the District Judge gave a community order without supervision, a probation officer can only request that a Judge or Magistrate adds a supervision order to any other sentence. The Gloucestershire Probation Trust had a policy that where possible a probation officer should attend court hearings relating to domestic abuse cases, on this occasion the probation officer was in the building but was not called into court to provide advice.**

14.4. **Cheltenham Borough Homes (CBH)**

14.4.1. The IMR Author found that CBH had not had any direct contact with Rosie and only limited contact directly with Paul, when he registered for social housing. He has therefore focused his report on CBH contacts with Paul's ex-partner Kate. She was a CBH tenant and had been the subject of several incidents of domestic abuse from Paul. Those contacts are considered in depth in section 13.8.2 of this report. The IMR author, in addition to identifying a number of lessons specifically for CBH, has also drawn attention to previous inconsistencies between differing local authorities and how they applied the "Homeseeker" policy with regard to suspending or activating applications where there is a housing related debt. The Gloucestershire "Homeseeker" policy was updated in November 2013 and adds clarity to this area of the policy.

14.4.2. The Review Panel thanks the IMR author for the thoroughness of his report and agrees with the identified lessons learnt and the recommendations for actions to address them.

14.5. **Gloucestershire Clinical Commissioning Group NHS Trust**

14.5.1. The IMR author, having reviewed the medical records of both Rosie and Paul, drew attention to the fact that they were registered with practices in different cities and that neither practice were aware of the relationship between the two. Paul's GP practice did know of his violent nature and that he had been the subject of a MARAC in October 2012. A copy of the MARAC report had been received and filed separately from his medical record. The practice was also aware that Paul had tried to hang himself in 2012 and had consequently received counselling in respect of his drugs and alcohol use.

14.5.2. During the time Rosie was with Paul, she visited her GP practice on 15 occasions, for minor medical problems including ear infections and migraines. There was no record that she ever disclosed her relationship with Paul during these consultations nor was there any reason for either her GP or nurse to ask her about her private life.

14.5.3. The Panel is satisfied that the IMR has considered all of the issues set out in the terms of reference and that both GP practices treated Paul and Rosie in accordance with good practice. There are therefore no lessons learnt from this case or recommendations from the Gloucestershire CCG.

14.6. **Gloucestershire County Council Children and Young People's Social Care**

14.6.1**.** The IMR Author found the Service had no contacts relating to Rosie but that Paul was known through his abusive behaviour towards his mother and his first partner Kate. A number of lessons were identified although it was acknowledged that the limited involvement of social care services were in accordance with practice and policy at that time.

14.6.2. The Review Panel accepts that the lessons identified in the IMR have already been addressed by the introduction of current practice which promotes a more proactive approach to the provision of advice, support and guidance to families.

14.7. **Gloucestershire Domestic Abuse Support Service (GDASS)**

14.7.1. The IMR highlights that the first DASH relating to Rosie that GDASS received, had assessed Rosie as a standard risk, so there had been no prior referral to MARAC. The referral was dealt with in accordance with standard procedures but by the time contact was made Rosie declined the offer of help, while accepting GDASS contact details. GDASS had previously dealt with referrals relating to Paul's previous partner Kate and his mother, but as they did not retain records of perpetrators (as per advice relating to Data Protection) Paul was not recognised as a previous perpetrator. GDASS with 22.5 staff averaged 3000 victim referrals a year of which an average of 2400 receive help.

14.7.2. The Review Panel accepts that GDASS had taken care to research what information they could retain and what they could not hold or share under the Data Protection Act.

14.8. **Gloucestershire Hospitals NHS Foundation Trust**

14.8.1. The IMR Author has reviewed all contacts with Paul, Rosie and with Paul's previous partner Kate from 2004. The contacts with all three were initiated by the need for acute healthcare; Rosie's contacts were for minor complaints including routine visits to ENT and Dermatology clinics. Paul's contacts with the Hospital Trust were predominantly for injuries but also for self-harm and hearing voices. Kate's contacts were largely for injuries caused by Paul. The IMR Author has carefully considered what lessons can be learnt and has made suitable recommendations.

14.8.2. **The Review Panel is satisfied that the IMR has been thorough and has identified both good practice and lessons to be learnt. The recommendations made are considered to be appropriate.** 14.9. **Gloucester City Council Housing Service**

14.9.1. The IMR reveals that although Paul made a "Homeseekers" application in his and Rosie's name, all direct contact with Housing Services involved Paul only. It is not known what level of involvement Rosie had, if any. The assessment of Paul's applications were appropriate in terms of the Local authority's statutory homeless duties, but inadequate when considering whether he/they had a connection with the City and could have accessed the "non priority assistance" for Gloucester households scheme. This is not a breach of the City Council's statutory duties, but does not comply with discretionary policies to non-priority households.

14.9.2. **The Review Panel is satisfied that the IMR has been searching and thorough and agrees with the lessons identified and the recommendations to address them.**

14.10. Gloucestershire Multi-Agency Risk Assessment Conference

14.10.1. The MARAC Chair has provided the Review with a report detailing MARAC meetings that involved victims of Paul, but has highlighted changes to the MARAC meeting structure since those meetings. MARAC meetings are now held much sooner after referral, normally within 48 hours, which allows for more timely interventions to be considered, with less time for victims to change their minds about accessing support.

14.10.2. **The Panel thanks the MARAC Chair for the comprehensive report and acknowledges the changes that have already been introduced.**

14.11. **Gloucestershire Constabulary**

14.11.1. The IMR Author has been conscientious and open in preparing his report. Whilst there has been an Independent Police Complaints Commission inquiry into the actions of the officers who dealt with Rosie on 15th /16th February 2014; the IMR author has carefully reviewed all of the police contacts relating to Paul, which include those regarding Rosie, Kate, Clare and Paul's mother. Whilst acknowledging good practice when appropriate, he has highlighted a significant number of lessons to be learnt and recommended actions to address them, many of which had already been implemented.

14.11.2. In December 2013 Her Majesty's Inspector of Constabulary (HMIC) conducted a review of the handling of domestic abuse incidents by all police forces. Subsequently HMIC wrote to Gloucestershire Constabulary expressing concerns about the ability of the Constabulary to deal consistently and appropriately with victims of domestic abuse and to reduce the risk of harm to them and that given the scale and extent of the areas of improvement identified… "Remedial action is required to address the key risks identified." The Constabulary was asked to respond with an Action Plan by 21st February 2014.

14.11.3. HMIC re-inspected the Gloucestershire Constabulary in June 2014 and commended the Constabulary for the strong progress made to date. They have commented that "Gloucestershire Constabulary have understood the risk areas and are putting measures in place to deal with them".

14.11.4. **The Review Panel is cognisant of the recommendations of both the IPCC and HMIC and is satisfied that those recommendations together with the action plan set out by the IMR author in this case, if fully implemented, should properly address the lessons learnt.**

1

4.12. Her Majesty's Courts and Tribunals Service

14.12.1. Although Paul appeared before the Gloucestershire Courts on a number of occasions and for a variety of offences, it is not appropriate for HMCTS to comment on any individual judicial decision, nevertheless the IMR author has identified lessons to be learnt from the Review.

.

14.12.2 **The Review Panel thanks HMCTs for contributing to the DHR and is satisfied with the lessons learnt and recommendations made.**

14.13. [2]gether NHS Foundation Trust

14.13.1. On the basis of information available, the IMR Author did not determine any care delivery factors that had a direct causal relationship or significantly contributed to Rosie's murder. Paul was offered and completed a full assessment based on his presenting problems and an appropriate intervention was identified that met his needs. There were no areas of concern regarding the contact that Paul had with [2]gether mental health services and good practice between the teams and clear channels for communicating changes that occurred out of hours was highlighted in the IMR.

14.13.2. There was no evidence of acute symptoms that required secondary or tertiary levels interventions. Paul was assessed by three separate teams and the transition between teams was within the expected specifications of each of those services.

14.13.3. On his final contact it was fully and clearly explained to him that services did not think that he had a severe mental illness and practical ways of managing his anger were discussed. It was also made clear to him that he was responsible for any actions he might take and their consequences. This information, as well as being discussed face to face was followed up in writing. (See appendix E).

14.13.4. The Review Panel is satisfied that Paul was dealt with by the [2]gether NHS Foundation Trust in accordance with accepted policy and practice and that therefore there are no lessons to be learnt or recommendations to be made. The Panel acknowledges the good practice of writing Paul a letter setting out in a clear fashion everything he had been told at his final meeting with the GRIP team.

15. Effective Practice / Lessons to be learnt

15.1. Only the following agencies that had contacts with Rosie or Paul have identified effective practice or lessons they have learnt during the Review.

15.2. **Bristol, Gloucestershire, Somerset and Wiltshire Community Rehabilitation Company Limited**

15.2.2. Proportionate actions were taken with regard to the case management of Paul. In particular, the revision of the supervision and risk management plan in the light of new information regarding domestic abuse. There had clearly been good engagement with Paul on the part of the supervising officer as evidenced by the high levels of compliance during the supervision element of his Suspended Sentence Order. However, an opportunity for further supervision was missed when he was sentenced to unpaid work only on 3rd July 2012. It is the policy of this service to recommend to courts considering unpaid work only, that when there is a background of domestic abuse a period of supervision should be added.

15.3. **Cheltenham Borough Homes (CBH)**

15.3.1. Paul's ex-partner Kate was subject to formal risk assessment through MARAC, and CBH involvement with the knowledge, understanding and engagement with this was prompt and responsive.

15.3.2. Nevertheless there are signs that those involved in the case did not always recognise that they were faced with a complex domestic abuse situation or appreciate that there may be many reasons why Kate was still in contact with her ex-partner, or act in a way that may not have followed a normal pattern, or be what the officer might have expected. There is also evidence to show that other factors, such as anti-social behaviour at her property drove decisions or opinions on Kate's situation.

15.3.3. There was not a single point of contact for Kate, who was involved with a number of sections across the organisation. A single point of contact would help support a victim centered approach.

15.3.4. The CBH Domestic Abuse Champion has a wealth of knowledge and experience, but whilst there were initially three Champions only one is still employed by CBH.

15.3.5. Whilst most actions in this case were prompt and were well intentioned, the decision to move Kate within the same area was, with hindsight, inappropriate. As a result moves of this type no longer happen the same way.

15.3.6. From the review, it is acknowledged that clear guidelines, for when CBH manages victims of domestic abuse who owe a housing debt, need to be implemented. Kate was denied access to several services when it is clear that the rechargeable debt was related to a domestic abuse situation.

15.3.7. The CBH policy on domestic abuse is presently incorporated within the Anti-Social Behaviour policy statement however; this review identifies the need for there to be a stand-alone policy.

15.4. **Gloucestershire County Council Children and Young People's Service**

15.4.1. The series of incidents and threats reported by Paul's mother may have been given insufficient attention. Another vulnerable child was supported to stay in the household for a period, as a looked after child, although the arrangement was temporary and no concerns were reported about that child at the time.

15.4.2. The more direct concern about Paul's violent behaviour to Kate may be an indicator for subsequent events. However the limited involvement of social care services was consistent with practice at that time. The threshold for child protection procedures was not met, and Kate's children were reported to not present any concern. Current practice and knowledge would suggest a more proactive approach be taken to offering support and guidance to Kate.

15.4.3. There has been a significant shift to a wider understanding of the impact of domestic abuse on children and families. Increased alertness to the needs and experiences of the children in the household would be expected. The introduction of the Gloucestershire MASH also increases the likelihood of more effective information sharing and risk management.

Note Re Gloucestershire MASH: This is a multi-agency safeguarding hub consisting of police, education, health, social care, adult and children's services, all co-located currently in Cheltenham. Information is shared across all agencies according to the information sharing protocols in place which have to be "Haringey Compliant" to meet OFSTED requirements. Whilst MASH is still in its infancy in Gloucestershire early indications are good in terms of ensuring our response is appropriate taking into account all historical knowledge and any previous history. This is particularly beneficial where domestic abuse is a feature as any police information will inform our risk assessment.

15.5. **Gloucestershire Domestic Abuse Support Service**

15.5.1**.** Had GDASS been able to link Paul with previous clients this would have shown that he had a history of abusing women, also that his previous victims had been assessed as high risk victims. Although Rosie would not engage with GDASS services, the knowledge that Paul had that history of abusing women, added to the fact that during the incident he had put his hands round Rosie's neck would have resulted in the DASH being re-evaluated to a high risk case with a referral to MARAC.

15.6. **Gloucester City Council Housing Service**

15.6.1. It is evident that there was no statutory homeless duty to accommodate Paul either as a single person or as part of a couple with Rosie. Individually or together they had no vulnerability under the Housing Act 1996.

15.6.2. There was no indication that there was a problematic relationship between the couple which required referral or liaison with any other agency.

15.6.3. The process of screening those in housing need by Customer Services staff rather than Homeless Officers led to confusion in this case. Customer Services staff routinely telephoned "Homeless" colleagues for advice, but may not have given all the relevant information needed to give appropriate advice.

15.6.4. It is not appropriate to consider an absent partner part of an enquiry without written consent from the individual concerned.

15.7. **Gloucestershire Multi-Agency Risk Assessment Conference**

15.7.1. Actions should be bespoke to each case rather than simply generic.

15.7.2. MARAC meetings need to be limited around cases to ensure that appropriate focus can be placed on each case. A day going through a large number de-values the process and impacts on effectiveness.

15.8. **Gloucestershire Constabulary**

15.8.1. There was a need identified that there should be a system of auditable action to ensure that, subject to risk assessment, officers should establish detail of a relevant incident by way of face to face meetings with victims.

15.8.2. There was evidence of a lack of an effective exit plans / signposting for all mental health affected prisoners and sharing of information with other agencies (where appropriate).

15.8.3. The need for effective use of the Stalking & Harassment tool kit within the DASH was highlighted.

15.8.4. The need for supervisors to take time to enact positive action / agreeing safety plans was identified.

15.8.5. Unclear records show the importance of officers making timely and accurate pocket notebook entries.

15.8.6. The Review identified the need to raise the level of risk when a standard matter is committed by high risk offender.

15.8.7. The need for appropriate consideration of the use of the Domestic Violence Disclosure Scheme was identified. (DVDS had not been introduced until March 2014)

15.8.8. Control Room personnel missed opportunities to pass relevant information on to operational officers attending incidents.

15.8.9. The submission of relevant intelligence was not constantly in accordance with Gloucestershire Constabulary policy.

15.8.10. The handover of information and actions where offender is wanted (in Domestic Abuse cases) was not in line with Constabulary practice procedures.

15.8.11. In relation to detainees in custody, new risk assessment procedures were introduced on 6th October 2014. These include prompts to ask more questions; additional questions are also being asked on the paper based system; Custody Officers are being reminded of the need for risk assessment on entry and release from custody. Detainees are being provided with literature regarding specialist support agencies upon release.

15.8.12. Gloucestershire Constabulary has opened a new custody facility which will be employing a medical professional 24/7 within the custody block. Detainees will now be assessed according to their vulnerability.

15.8.13. In this case the DASH was not correctly completed at the relevant time.

15.9. **HM Courts & Tribunals Service**

15.9.1. This Review has provided HM Courts & Tribunals Service with the opportunity to identify a general lesson to be learnt - that with the advent of new legislation and guidance on domestic abuse, (e.g.: Domestic Violence Protection Orders and Domestic Violence Disclosure Scheme - Clare's Law), training for magistrates and other court personnel needs to be reviewed and updated.

15.9.2. The service will also take heed of the Probation Service's recommendation that a supervision requirement is considered on any community orders imposed following domestic abuse charges.

15.10. **²gether NHS Foundation Trust**

15.10.1. Although Paul has persistently complained of depression and mental health problems, the IMR has shown that he was carefully assessed and there was no evidence of acute symptoms that required secondary or tertiary levels intervention.

15.10.2. It was fully explained to him that services did not think that he had a severe mental illness and practical ways of managing his anger were discussed. It was also made clear to him that he was responsible for any actions he might take and their consequences. This information, as well as being discussed face to face, was further supported by a letter to him.

15.11 **Gloucestershire Hospitals NHS Foundation Trust**

15.11.1 those accompanying patients assessed as "high risk" on the Emergency Mental Health Risk Assessment should be advised separately about their personal safety.

16 **Conclusions**

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

- Have the agencies involved in the DHR used the opportunity to review their contacts with Rosie or Paul 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 domestic abuse victims in Gloucestershire in the future?

- Was Rosie's death predictable?

- Could Rosie's death have been prevented?

16.2. The Review Panel is satisfied that the IMRs have been open, thorough and questioning from the view point of the victim. The organisations have used their participation in the Review to identify and address lessons learnt from their contacts with Rosie and Paul in line with the Terms of Reference (ToR).

16.3. The Panel is of the opinion that the agreed recommendations appropriately address the needs identified in the lessons learnt. The Panel also recognises that the individual agencies represented on the review, now have or are in the process of, completing comprehensive domestic abuse strategies and putting policies in place. Provided those recommendations, strategies and policies are fully and promptly implemented, they will improve the safety of future domestic abuse victims in Tewkesbury Borough in particular and Gloucestershire in general. The Review also notes that as a result of Her Majesty's Inspectorate of Constabulary (HMIC) inspection, Gloucestershire Constabulary has already initiated key changes to the way the Constabulary deals with victims of domestic abuse.

16.3.1 The Panel is clear that the thorough review undertaken highlights the importance of effective risk assessments to identify the likelihood of harm for all those at risk from the perpetrator.

16.4. Was Rosie's death predictable?

16.4.1. Paul had a long history of violence towards women, and whilst not all of the incidents were known to any one agency, he was known to the MARAC members and to the police to pose a number of risks, including a high risk of domestic abuse against his mother and previous partners. He had "put his hands around" the necks of two women, Kate once and Rosie twice. He had seriously assaulted Kate to the extent of her needing hospital treatment and had made threats of violence against them both and against his mother. In 2008 he had been arrested for public order offences and possession of an offensive weapon, in 2010 he had threatened nightclub door staff with a metal pole and on two other occasions, one in 2010 and one in 2013 had been arrested for attacking two and three men respectively on his own. On the later occasion he was also charged for possessing an offensive weapon.

16.4.3. The Review Panel therefore concludes that if all of this evidence had been known to any one agency, it would have been predictable that Paul would at some stage critically injure or kill someone. It was not considered to be predictable that it would be Rosie that he killed.

16.5. Could Rosie's death have been prevented? The Panel considered the following is-

sues to be particularly relevant:

16.5.1. While Paul was known to the MARAC to be a high risk perpetrator towards more than one victim, it would appear that there was never any consideration by any agency, that he might meet the threshold for a referral to a Multi-Agency Public Protection Arrangements (MAPPA). The DHR Panel recognises that that his victims routinely refused to support action against him and this may have masked the number and the seriousness of his harassment, threats and violence towards them.

16.5.2. If Paul had been arrested for the offences of the 15th February 2014, would he still have murdered Rosie? It would have been open to a custody officer to either bail or detain Paul to await an appearance in court for these offences, but that even if he had been kept in police custody to attend court, it was probable he would still have been given bail at court. The Panel accepts that even if he had been remanded in custody, he may still have killed Rosie at a later date.

16.5.3. After the incident of the 20th July 2013, a standard DASH was completed, with a request for GDASS to be notified. GDASS, on receipt of the standard DASH, and with no knowledge of Paul's history of violence, contacted Rosie. She declined their assistance. The Panel considered if the police had raised the standard risk DASH to high risk, by virtue of the transfer of risk through Paul being a known high risk perpetrator, (as they had previously done in relation to abuse committed against Paul's mother); would GDASS's contact with Rosie have been different? This event occurred before the introduction on 8th March 2014 of the Domestic Violence Disclosure Scheme, so it is unlikely that GDASS could have done more to engage with Rosie.

16.5.4. The Review Panel therefore concluded Rosie's death could not, at that time, have been prevented.

Recommendations

17.1. National

17.1.1. That the Information Commissioner provides clarification/guidance re the legality of domestic abuse specialist support services being able to retain information relating to perpetrators of domestic abuse, to enable them to provide information, via the police, to safeguard vulnerable new partners of the perpetrators, under Domestic Violence Disclosure Scheme (Clare's law).

Completed (see Appendix F)

17.1.2. That CAADA reviews the national training given to IDVAs and to domestic abuse support services relating to the Data Protection Act and the Domestic Violence Disclosure Scheme (Clare's law)**.**

17.2. Gloucestershire Domestic Abuse and Sexual Violence Commissioning Steering Group

7.2.1. A public awareness campaign should be rolled out encouraging third parties including friends and family aware of domestic abuse to contact the police and/or independent local specialist support services.

17.2.2. Encourage companies and organisations to implement HR workplace policies in relation to domestic abuse.

17.2.3. Encourage companies and organisations to appoint key members of staff as Domestic Abuse Champions.

17.3 **Bristol, Gloucestershire, Somerset and Wiltshire Community Rehabilitation Company Limited**

17.3.1. A reminder should be given to probation staff to continue to advise the courts that the probation service provides a comprehensive service to the courts including written reports as well as oral advice in regard to sentencing options. Probation staff are on hand to provide this. The courts are not bound to act on this advice. However, the probation service recognises the need to remind courts of the advisability of including a supervision requirement in cases where there is evidence of domestic abuse.

17.3.2. A senior National Probation Service (NPS) manager will write to HM Courts and Tribunal service in Gloucestershire to advise Magistrates and Judges of the benefits to risk management, of always adding a supervision requirement for offenders with a background of domestic abuse where a stand-alone unpaid work requirement is being considered.

(For offences committed post 1st February 2015 the supervision requirement becomes a Rehabilitation Activity Requirement as per the Offender Rehabilitation Act 2014).

17.4. **Cheltenham Borough Homes**

17.4.1. Domestic Abuse Awareness training is arranged for front line staff. This will enable staff to recognise and respond appropriately to victims of domestic abuse.

17.4.2. Identify key staff to act as "domestic abuse champions," to become a single point of contact for identifying victims and provide the necessary training to enable them to facilitate the role.

17.4.3. Review existing processes and guidelines where “housing debt” may be a barrier to a victim receiving appropriate support of obtaining a move to a safe environment and to ensure each case is given appropriate consideration.

17.4.4. Ensure victims records include full information and records of contact, including confirmation that the victim’s situation has been assessed and that the records are maintained that provide the rationale behind the decision.

17.4.5. To adopt a stand-alone Domestic Abuse Policy to include appropriate processes and guidelines.

17.5. **Gloucestershire County Council Children and Young People’s Social Care.**

17.5.1. Gloucestershire County Council, where they are the lead professional, will speak to all children in a domestic abuse household following a domestic abuse incident.

17.5.2 Agencies need to consider the safeguarding needs of all children in a domestic abuse household following a domestic abuse incident and take the appropriate action according to the agreed Gloucestershire Safeguarding Children’s Board Levels of Need document and complete a DASH form as appropriate.

17.6. **Gloucestershire Domestic Abuse Support Service**

17.6.1. That DASHs are sent through to GDASS as quickly as possible to enable contact with the victim to be made promptly at the time when they are most vulnerable.

17.7. **Gloucester City Council Housing Service**

17.7.1. There is a need to ensure that written consent from every adult, listed as an applicant on any approach for homeless assistance, is obtained. This is currently the case for all households approaching for statutory homeless assistance, but not for those who do not meet the vulnerability homeless criteria (as outlined in the Housing Act 1996 as amended). In future the Gloucester City Council Housing Service will require written consent before proceeding with any non-statutory assistance to non-priority households.

17.7.2. There should be in depth housing and homelessness expertise available to clients at the point of first contact. This is necessary to extract relevant information from clients, and offer the most appropriate advice for a range of situations. Customer Services Officers have a generalised knowledge of council services and cannot offer sufficient expertise in this area. The two tier system of customer service screen, with reference to Homeless Officers for advice on difficult cases, fails homeless customers as it inevitably relies on a précis of the customer’s situation by telephone which may not include relevant factors. Homeless officers should therefore be the first contact for anyone facing homeless crisis.

17.7.3. The initial enquiry pro-forma should be amended to include a prompt to consider local connections to the Gloucester area to ensure appropriate details are considered.

17.7.4. Implement a local Domestic Abuse policy linked to Countywide Policy, at CHIG (countywide housing implementation group) to formulate consistent local policies across the county

17.7.5. Implement regular refresher training on Domestic Abuse for all front line housing staff.

17.8. **Gloucestershire Multi-Agency Risk Assessment Conference**

17.8.1 That MARAC meetings are held within 48 hours of any incident where possible to ensure early intervention. (This is now the agreed protocol)

17.8.2. A system of action tracking will be introduced to ensure that allocated actions are carried out and reviewed.

17.9. **Gloucestershire Constabulary**

17.9.1. Analysis of intelligence is required regularly, in order to feed into the Constabulary's intelligence (NIM) processes so as to identify those most at risk of causing harm.

17.9.2. Force Control Room Managers should ensure that all relevant information pertaining to the threat and risk of harm to and from the perpetrator is captured through careful management of the initial call and the record of that information is made available to the attending officers at the time.

17.9.3. Incidents of Domestic Abuse must not be closed without the attending officers confirming (within the incident itself) that a Risk Assessment has been completed and submitted to a supervising officer.

17.9.4. In consultation with the Crown Prosecution Service, officers in the case are expected to ensure that applications for Restraining Orders are made in appropriate cases.

17.9.5. Supervisors to ensure that any incident identified as Domestic Abuse is fully updated detailing the fact that a DASH has been completed.

17.9.6. The Constabulary Training Department to re-enforce the understanding by officers of the definition of Domestic Abuse and to ensure that where an alleged crime is reported, it is appropriately recorded as a crime.

17.9.7. Gloucestershire Constabulary considers using Body Worn Video devices in an operational capacity.

17.9.8. Evidence-led prosecutions must be a consideration for all Domestic Abuse allegations.

17.10. HM Courts & Tribunals Service

17.10.1. HM Courts & Tribunals Service will conduct a review of our service to victims and witnesses, in conjunction with Gloucestershire Constabulary Witness Care Unit and Victim Support – to be concluded by 31st January 2015.

17.10.2. HM Courts & Tribunals Service will meet with Probation managers to discuss the consideration of supervision requirements on any community orders imposed following domestic abuse charges, by 31st January 2015.

17.10.3. HM Courts & Tribunals Service will conduct a review of domestic abuse training for magistrates and staff, and implement any changes or refresher training required by 31st March 2015.

18. Postscript

Actions to be taken after presentation of the Overview Report to the Tewkesbury Borough Community Safety Partnership.

- On receiving the Overview Report and supporting documents, the Partnership should:

- Agree the content of the Overview Report and Executive Summary for publication, ensuring that they are fully anonymised, apart from including the names of the Review Panel Chair and members.Sign off the Overview Report and supporting documents.

- Provide a copy of the Overview Report and supporting documents to the Home Office Quality Assurance Group. This should be via email to DHRENQUIRIES@ homeoffice.gsi.gov.uk.

- The document should not be published until clearance has been received from the Home Office Quality Assurance Group.

On receiving clearance from the Home Office Quality Assurance Group, the CSP should:

- Provide a copy of the Overview Report and supporting documents to the senior manager of each participating agency.

- Contact IPCC to inform them prior to publishing the redacted report

- Provide an electronic copy of the Overview Report (this must first be carefully redacted) and the Executive Summary on the Tewkesbury Borough Community Safety Partnership web page.

- Monitor the implementation of the specific, measurable, achievable, realistic and timely (SMART) Action Plan.

- Formally conclude the review when the Action Plan has been implemented and include an audit process.

- Make arrangements to provide feedback and debriefing to staff, family members and the media as appropriate.

The Victim's family has requested that they be notified when all of the recommendations have been implemented.
They would also appreciate an invitation to a future Tewkesbury Borough Community Safety Partnership meeting when the recommendations are audited.

Appendix A

Glossary of terms

Glossary of terms

Acro-nym/term	Definition
A	
A&E	Accident and Emergency
Albion Chambers	Team base for GRIP
B	
Bipolar Af-fective Dis-order (BAD)	Bipolar affective disorder is a mental health condition that causes severe mood swings. The mood swings vary from excitement and elation, known as mania, to depression and despair.
C	
CAADA	Co-ordinated Action Against Domestic Abuse
CAMHS	Child and Adolescent Mental Health Services
CARP	Central Allocation Referral Project
CBC	Cheltenham Borough Council
CBH	Cheltenham Borough Homes
CCP	County Community Projects
CCTV	Closed Circuit Television
COCP	Combined Oral Contraceptive Pill
CPS	Crown Prosecution Service
Criminal Justice Liai-son Service (CJLS)	The Criminal Justice Liaison Service (CJLS) provides interventions to adults over the age of 18 who are suspected of having a mental illness or learning disability, who find themselves within the criminal justice system. The CJLS provides a triage and screening service which is available for those who have been arrested and in Police Custody, charged with an offence and appearing in front of the courts, or serving sen-tences in the community under the supervision of the Probation service.
CRU	Central Referral Unit
D	
DA	Domestic Abuse
DARP	Domestic Abuse Response Process.
DASH	Domestic Abuse Stalking & Harassment - Risk Assessment Form.
DAST	Domestic Abuse Safeguarding Team
DAU	Domestic Abuse Unit
Delius	Offender case record
Denmark Road	Team base for CRHTT
DNA	Did not attend
DRR	drug rehabilitation requirement
DVDS	Domestic Violence Disclosure Scheme (Clare's Law)
DVPN / O	Domestic Violence Protection Notice / Order
E	
ENT	Ear, Nose and Throat

Essex Medical	Essex Medical and Forensic Services provide forensic and medical services to Police forces in England, including direct access to a senior Forensic Medical Examiner (FME) 24 hours a day to assess and process detainees.
F	
Family Therapy	Family therapy is a type of psychological counselling (psychotherapy) done to help family members improve communication and resolve conflicts.
FCR	Force Control Room
FDR	fast delivery report
G	
GCIS	Gloucestershire Constabulary Information Systems
GDASS	Gloucestershire Domestic Abuse Support Service
GRIP	Gloucester Recovery In Psychosis - Early Intervention in psychosis is an innovative approach using evidence-based practices to promote positive mental health care for those experiencing a first or possible first episode of psychosis. It focuses on early detection, treatment and preventative measures that assist service users and families, as early as possible in treatment. This is to enable service users and their families to have an understanding of psychosis, in relation to their experiences, thereby reducing stress and distress and developing skills for recovery.
H	
I	
IAU	Incident Assessment Unit
IDVA	Independent Domestic Violence Advisor
IMR	IMR – Individual Management Review
J	
K	
L	
Let's Talk Service	Let's Talk is an Improving Access to Psychological Therapy service. It offers information, guidance and therapy for people during times of stress, anxiety or depression.
LPA	LPA – Local Policing Area
M	
MASH	Multi-agency safeguarding hub consisting of police, education, health, social care, adult and children's services.
MALRAP	Multi-agency lifer risk assessment panel
MARAC	Multi Agency Risk Assessment Conference
Mental Health Liaison Team (MHLT)	The Mental Health Nurse Liaison Service offers a comprehensive mental health assessment service to adults aged 16 years and over, who have self-harmed and present to the Emergency Department, and/or are admitted to either the Cheltenham General Hospital or Gloucestershire Royal Hospital.
Mental State Examination (MSE)	MSE is a systematic appraisal of the appearance, behaviour, mental functioning and overall demeanour of a person. In some ways it reflects a "snapshot" of a person's psychological functioning at a given point in time. A MSE is an important component of the assessment of a patient.
MH	MH – Mental Health
MIS	MIS – Management Information System
N	
NFA	NFA – No Further Action
NHT	Neighbourhood Housing Team

Non-Medical Prescriber (NMP)	Non-Medical Prescribing is the prescribing of medicines, dressings and appliances by health professionals who are not doctors but have been specifically trained in prescription of a defined group of medicines, dressings and appliances.
NPS	National Probation Service
O	
OASys	Offender assessment system
OOH	Out of Hours
P	
PANNS	Positive and Negative Symptoms Scale (PANSS) is used in conjunction with a professional judgment to determine the extent of the presenting symptoms of psychosis.
Paranoia	A severe but relatively rare mental disorder characterized by the presence of systematized delusions, often of a persecutory character involving being followed, poisoned, or harmed by other means, in an otherwise intact personality.
PCSO	PCSO – Police Community Support Officer
PIN	PIN – Police Information Notice
PNB	PNB – Pocket Note Book
PNC	PNC – Police National Computer
PND	PND – Police National Database
POP	Progesterone Only Pill
Psychosis	A mental and behavioural disorder causing gross distortion or disorganization of a person's mental capacity, affective response, and capacity to recognize reality, communicate, and relate to others to the degree of interfering with that person's capacity to cope with the ordinary demands of everyday life.
Q	
Quetiapine	Quetiapine is a medication used to relieve the symptoms of schizophrenia, bipolar disorder, and other similar mental health problems.
R	
RiO	Electronic Patient Record – Mental Health Services
ROSH	risk of serious harm
RT	Revenues Team
S	
SET	Safer Estates Team
SMI	Severe Mental Illness
SSO	Suspended Sentence Order
STORM	STORM – Command and Control recording system for all incidents.
T	
Treatment Outcomes Profile (TOP)	The Treatment Outcomes Profile (TOP) measures change and progress in key areas of the lives of people being treated in drug and alcohol services. TOP consists of 20 simple questions focusing on the areas that can make a real difference to clients' lives - substance use, injecting risk behaviour, crime and health and quality of life.
U	
UNIFI	Intelligence System.
UPW	Unpaid work
V	
W	
X	
Y	

Z	

Appendix B - Bibliography

Access to Health records Act 1990

CAADA Responding to Domestic Abuse: Guidance for General Practice.

Data Protection Act Schedule 1 - 8 Data Protection Principles.

Delivering a Standard Operating Model for Investigating Mental Health Homicides for NHS Services in England. (NHS England 2014)

Department of Health Guidance on “Independent Investigation in Mental Health Services”.

Domestic Homicide Review Toolkit.

Domestic Violence, Crime and Victims Act 2004.

Equalities Act 2010

Guidance to doctors & GPs on the release of medical records into a Domestic Homicide Review. Sheffield Safer & Sustainable Community Partnership.

HM Government Information Sharing: Guidance for practitioners and managers.

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

Policing Domestic Abuse: How to? Gloucestershire Constabulary Guidance

The Protection from Harassment Act 1997

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

Appendix C Action Plan

Recommendation	Scope of recommendation i.e. local/ regional/national	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
That the Information Commissioner provides clarification/guidance re: the legality of domestic abuse specialist support services being able to retain information relating to perpetrators of domestic abuse, to enable them to provide information, to the police, to safeguard vulnerable new partners of the perpetrators, under Domestic Violence Disclosure Scheme (Clare's law).	National	ICO to review the Data Protection Act and the Domestic Violence Disclosure Scheme. Paper sent to review from the ICO and now appendix F ICO paper sets out that agencies can consider on a case by case basis to retain information relating to domestic abuse perpetrators for the safety of individual victims. Information about domestic abuse perpetrators can be passed to the police on the grounds of safeguarding victims of domestic abuse ICO paper to be shared with relevant agencies in Gloucestershire who support victims of domestic abuse- with particular regards to retention of perpetrator information. All agencies across the partnership to be reminded of the Domestic Violence Disclosure Scheme- particularly 'Right to know'(Clare's law)	Gloucestershire Domestic Abuse and Sexual Violence Commissioning Steering Group.	ICO paper has been forwarded to Home office for circulation and information. The same paper has been shared with CAADA to influence future training programmes	December 2015	27/01/2016
That the Home Office and	National	CAADA to review advice	Gloucestershire Do-	National training pro-	Completed	27/01/2015

Recommendation	Scope of recommendation i.e. local/ regional/national	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
Co-ordinated Action Against Domestic Abuse (CAADA) considers the current advice given to many domestic abuse support services that they would be breaching the Data Protection Act if they retain details of perpetrators on their data bases and how this affects the implementation of the Domestic Violence Disclosure Scheme (Clare's law).		and training provided to specialist domestic abuse services and IDVAs	mestic Abuse and Sexual Violence Commissioning Steering Group	gramme has been rewritten and will be provided to agencies from beginning of February 2015		
A public awareness rolling programme should be undertaken to encourage 3rd parties including friends and family aware of domestic abuse to contact the police and / or independent local specialist support services.	Gloucestershire Wide Cross Agency	A multi-agency communications plan to be developed and agreed by the partnership for campaign activity over the next 4 years in line with the commissioning strategy	Gloucestershire Domestic Abuse and Sexual Violence Commissioning Steering Group	Plan to be agreed June 2015	Delivery of new campaign June 2015	On going
Encourage companies and organisations to implement HR workplace policies in relation to domestic abuse.	Gloucestershire Wide	Two conferences to be held inviting employers from across the county to learn more about their responsibility to safeguard their employees from domestic abuse, sexual violence stalking and harassment	Gloucestershire Domestic Abuse and Sexual Violence Commissioning Steering Group and partners supported by Office of Police and Crime Commissioner for Gloucestershire	Funding has been granted by the Office of the Police and Crime Commissioner for Gloucestershire to support this action.	September 2015	271/2016
That all agencies are encouraged by the Gloucestershire Domestic Abuse and Sexual Violence Commissioning Steering	Gloucestershire Wide	Gloucestershire Domestic Abuse and Sexual Violence Commissioning Steering Group to provide the agencies with a skeleton tem-	Gloucestershire Domestic Abuse and Sexual Violence Commissioning Steering Group		September 2015	27/01/2016

Recommendation	Scope of recommendation i.e. local/ regional/national	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
Group to have a Domestic Abuse policy for their employees to adhere to when either they receive a disclosure or are a victim themselves. The Partnership also encourages agencies to identify domestic abuse champions in their organisation to support a coordinated response		plate making clear references to the Commissioning Strategy 2014-2018				
Agencies need to consider the safeguarding needs of all children in a domestic abuse household following a domestic abuse incident and take the appropriate action according to the agreed Gloucestershire Safeguarding Children's Board Levels of Need document and complete a DASH form as appropriate.	Gloucestershire Wide	Gloucestershire Domestic Abuse and Sexual Violence Commissioning Steering Group to ensure all relevant partnership agencies are aware of the need to implement this recommendation.	Gloucestershire Domestic Abuse and Sexual Violence Commissioning Steering Group	Policy to be adopted by all relevant agencies.	1st September 2015	26/01/2016
A reminder should be given to probation staff to continue to advise the courts that the probation service provides a comprehensive service to the courts including written reports as well as oral advice in regard to sentencing options. Proba-	Local – Gloucester wide - National Probation Service	A training update will be worded and circulated to all staff	National Probation Service			31/03/2015

Recommendation	Scope of recommendation i.e. local/ regional/national	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
tion staff are on hand to provide this. The court are not bound to act on this advice. However, the probation service recognises the need to remind courts of the advisability of including a supervision requirement in cases where there is evidence of domestic abuse.						
A senior National Probation Service (NPS) manager will write to HM Courts and Tribunal service in Gloucestershire to advise Magistrates and Judges of the benefits to risk management, of always adding a supervision requirement for offenders with a background of domestic abuse where a standalone unpaid work requirement is being considered.	Local – Gloucester wide	Senior Probation manger to write letter.	National Probation Service			28/02/2015
Domestic Abuse Awareness training to be arranged for front line staff. This will enable staff to recognise and respond appropriately to victims of domestic abuse.	Local - Cheltenham Borough Homes	Develop training program. Hold DA awareness sessions for all staff. Develop promotional material. Identify colleague/ roles for additional training. Set up training strategy	Cheltenham Borough Homes		31/12/2015	26/01/2016

Recommendation	Scope of recommendation i.e. local/ regional/national	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
Identify key staff to act as "domestic abuse champions," to become a single point of contact for identifying victims and provide the necessary training to enable them to facilitate the role.	Local - Cheltenham Borough Homes. Also multi agency.	Links to other CBH recommendation. Identify key staff. Provide training. Raise awareness within CBH of these main contact points.	Cheltenham Borough Homes.		1/4/2015 – identify staff 31/12/2015 – provide training	31/12/2015
Review existing processes and guidelines where "housing debt" may be a barrier to a victim receiving appropriate support of obtaining a move to a safe environment and to ensure each case is given appropriate consideration.	Local - Cheltenham Borough Homes.	Identify policies affected. Consult relevant teams on changes. Encapsulate within DA policy. Provide guidance to teams affected by any change to policy/process	Cheltenham Borough Homes		31/12/2015	26/01/2016
Ensure victims records include full information and records of contact, including confirmation that the victim's situation has been assessed and that the record are maintained that provide the rationale behind the decision.	Local - Cheltenham Borough Homes	Identify systems currently used to record information. Develop one reporting system. Ensure staff aware of how to correctly record information. Ensure systems in place to handle information appropriately. Build in audit process	Cheltenham Borough Homes		01/07/2015	01/07/2015
To adopt a stand-alone Domestic Abuse Policy to include appropriate processes and guidelines.	Local - Cheltenham Borough Homes	Review ASB policy. Identify best practice. Consult with tenants. Write policy Share outcome with neighbouring RSL's.	Cheltenham Borough Homes			01/04/2015
All Children should be spoken to alone, by a So-	Local - Gloucestershire County Council	Ensure that this forms part of Practice Standards	Gloucestershire County Council Children and	Summary of Learning points from this DHR	04/03/15.	04/03/15

Recommendation	Scope of recommendation i.e. local/ regional/national	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
cial Care professional following volatile incidents in the family home. Also ensure that the child is referred to the appropriate therapeutic support to address any unmet need.	Children and Young People's Social Care	across all Social Care Teams.	Young People's Social Care	taken to the Operational Leadership Team with the recommendation for sign off to ensure this forms part of Social Care Practice Standards. Information shared at the Getting To Good Managers Meetings. Team Managers to share with their staff at team meetings and supervision	W/C 09/03/15 W/C 16/03/15	13/03/15. 31/03/15 Integral Part of Practice Standards
That DASHs are sent through to GDASS as quickly as possible to enable contact with the victim to be made quickly after the event when they are most vulnerable.	Local - Gloucestershire wide		Gloucestershire Domestic Abuse Support Service and Gloucestershire Constabulary			01/04/2015
There is a need to ensure that written consent from every adult, listed as an applicant on any approach for homeless assistance, is obtained. This is currently the case for all households approaching for statutory homeless assistance, but not for those who do not meet the vulnerability	Local - Gloucester City	Staff briefing to emphasise the importance of consent. Amend policies on non-priority advice and assistance	Gloucester City Council Housing Services	Staff briefing Policy amendment	30/11/2014	Completed

Recommendation	Scope of recommendation i.e. local/ regional/national	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
homeless criteria (as outlined in the Housing Act 1996 as amended). In future the Gloucester City Council Housing Service will require written consent before proceeding with any non-statutory assistance to non-priority households.						
There should be in depth housing and homelessness expertise available to clients at the point of first contact. This is necessary to extract relevant information from clients, and offer the most appropriate advice for a range of situations. Customer Services Officers have a generalised knowledge of council services and cannot offer sufficient expertise in this area. The two tier system of customer service screen, with reference to Homeless Officers for advice on difficult cases, fails homeless customers as it inevitably relies on a précis of the customer's situation by telephone which may not include relevant factors. Homeless officers should	Local - Gloucester City	Arrange for service to be provided by Homeless staff	Gloucester City Council Housing Services	Meet with Customer Services and senior management to discuss weakness of assessments by staff without specific working knowledge of homelessness. Determine date to cover service	30/09/2014	completed

Recommendation	Scope of recommendation i.e. local/ regional/national	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
therefore be the first contact for anyone facing homeless crisis.						
The initial enquiry proforma should be amended to include a prompt to consider local connections to the Gloucester area to ensure appropriate details are considered.	Local - Gloucester City	Re-draft proforma	Gloucester City Council Housing Services	Re-draft proforma and brief staff	30/11/2014	completed
Implement local DA policy linked to Countywide Policy	Local - Gloucester city and Gloucester wide via link to countywide policy	Raise at CHIG (countywide housing implementation group) to formulate consistent local policies across the county	Gloucester City Council	Secure agreement from districts Work with Countywide DA Coordinator	Early 2015	30/03/2015
Implement regular refresher training on Domestic Abuse for all front line housing staff	Local - Gloucester City	Arrange training – and reschedule on a regular basis	Gloucester City Council	Arrange training	Early 2015	30/03/2015
Introduction of a process to address repeat offenders with repeat victims in cases where support for prosecution is limited.	Gloucestershire Constabulary- Gloucestershire wide	The Constabulary will consider and scope a process whereby offenders who have come to notice on multiple occasions with multiple partners in circumstances which reveal a repeated unwillingness to prosecute are subject to an investigative review in order to maximise evidence-led prosecutions.	Gloucestershire Constabulary	Public Protection Bureau (Safeguarding) will commence a scoping process to determine the feasibility of a single department reviewing cases of multiple discontinued prosecutions involving the same offender.	Sept 2015	01/09/2015
Analysis of intelligence is required regularly, in order to feed into the Constabulary's intelligence (NIM) processes so as to	Gloucestershire Constabulary - Gloucestershire wide	The police IMR identified a significant number of issues, relating to how officers and call handlers have dealt with domestic abuse	Gloucestershire Constabulary	A weekly internal Public Protection Bureau intelligence meeting has taken place since January 2013. The	01/04/2015	Completed but regular analysis is ongoing.

Recommendation	Scope of recommendation i.e. local/ regional/national	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
identify those most at risk of causing harm.		incidents, which have been detailed as lessons learnt. Gloucestershire Constabulary has introduced a new policy "Policing Domestic Abuse - How To?" This guidance document compliments an ongoing comprehensive training programme introduced in 2014 aimed at improving the quality of service delivered to victims of domestic abuse. Tackling Domestic Abuse as a force priority is clear to all staff, re-enforced through force intranet messages, bulletins by Chief Officer Group members, Professional Development Review supervision, rolling screen messages and master-class academic presentations. It is anticipated that training will be completed by mid-2015.		meeting is chaired by DCI (Safeguarding-Public Protection), and is supported by a strategic analyst and an intelligence officer from the Public Protection Bureau. This information informs fortnightly tasking.		
Force Control Room Managers should ensure that all relevant information pertaining to the threat and risk of harm to and from the perpetrator is captured through careful management of the initial call and the record of that information is	Gloucestershire Constabulary - Gloucestershire wide		Gloucestershire Constabulary	Call handling training now includes specific training on all intelligence systems to enable the call taker to assess risk and harm to determine the grading of the incident. There is regular assessment of the opera-		Completed

Recommendation	Scope of recommendation i.e. local/ regional/national	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
made available to the attending officers at the time.				tors' performance through a QA process which includes whether the operator has utilised these systems correctly. If not then feedback is given immediately and if there is no improvement then operators are placed on a development plan and have supportive mentoring. Force Control Management have confirmed that all call handlers and Control Room operators, including Supervisors have been trained in how to respond to domestic abuse incidents. The learning programme is built into the training schedules for new staff to the department.		
Incidents of Domestic Abuse must not be closed without the attending officers confirming (within the incident itself) that a Risk Assessment has been completed and submitted to a supervising officer.	Gloucestershire Constabulary- Gloucestershire wide		Gloucestershire Constabulary	The Constabulary control room will create the incident on STORM and can only be closed down by a supervisor within the Constabulary control room. DASHs must be signed off by a Sergeant or Inspector depending on the level of risk. Officers are		Completed

Recommendation	Scope of recommendation i.e. local/ regional/national	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
				expected to highlight on the DASH what actions have been taken to address the risks. Policing Domestic Abuse; How-to? Guidance Page 10 sets out the requirements of supervisors. The guidance also provides a helpful non-exhaustive list of safety measures available to officers		
In consultation with the Crown Prosecution Service, officers in the case are expected to ensure that applications for Restraining Orders are made in appropriate cases.	Gloucestershire Constabulary- Gloucestershire wide	Police bulletin to be drafted advising officers of this issue. Furthermore, Staff training to ensure it is captured in force training.	Gloucestershire Constabulary	Staff Development Unit confirms that current Domestic Abuse training, now underway since October 2014, are being well received. The Case Studies session includes a reference to the use of Restraining Orders. Bulletin is being prepared for publication.	On going	01/04/2015
Supervisors to ensure that any incident identified as Domestic Abuse is fully updated detailing the fact that a DASH has been completed.	Gloucestershire Constabulary- Gloucestershire wide		Gloucestershire Constabulary	Force Control Supervisors who close Domestic Incidents are fully aware of what is expected from officers prior to the closure. This forms part of FCR training. The How-To Guide makes it clear. Officers have undertaken DA		Completed

Recommendation	Scope of recommendation i.e. local/ regional/national	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
				training provided by our Staff Development Unit which informs them of their role and responsibilities in responding to domestic abuse and how to complete the DASH risk assessment from which is focused on victim's safety and associated risks. The last page of the DASH also allows for staff to outline what safety measures have been put in place to protect the victim. All DASHs are signed off by a supervisor.		
The Constabulary Training Department to reenforce the understanding by officers of the definition of Domestic Abuse and to ensure that where an alleged crime is reported, it is appropriately recorded as a crime.	Gloucestershire Constabulary - Gloucestershire		Gloucestershire Constabulary	Our Staff Development Unit has delivered and continues to deliver a range of training across the Constabulary about domestic abuse which includes specific inputs to Special Constables, PCSOs, Force Control Room staff and response officers. This has been delivered through face to face classrooms sessions, NCALT packages and Master-classes.		Completed

Recommendation	Scope of recommendation i.e. local/ regional/national	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
				The How To Guide makes is clear on Page 14, the importance of recording a crime, once sufficient information is made known and regardless of whether the victim wishes to pursue the matter or not. The training currently being delivered also explores issues in relation to Honour Based Violence, and Forced Marriage. Furthermore, Initial training (Student Officers, Specials and PCSOs) – are introduced to safeguarding topics including HBV, FM & FGM.Quarterly Operational Learning days have been used for reminding and reinforcing messages on HBV, FM & FGM to frontline officers. NCALT packages have been mandated with completion rates in the 90% region for all. ICIDP programme has 2 full sessions on these topics. Regular law and policy updates		

Recommendation	Scope of recommendation i.e. local/ regional/national	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
				on the Constabulary intranet.		
Gloucestershire Constabulary consider using Body Worn Video devices in an operational capacity	Local - Gloucestershire Constabulary	In consultation with Chief Supt, agreement given that the Constabulary intend to scope its uses and may consider a piloting of its use in the future.	Gloucestershire Constabulary	Await outcome of scoping exercise.	Ongoing	
Evidence-led prosecutions must be a consideration for all Domestic Abuse allegations.	Local - Gloucestershire Constabulary	Focus to be given to all operational officers of the benefits of seeking an evidence-led prosecution where appropriate – this is to address those cases, where through a lack of formal complaint, have often traditionally resulted in No Further Action	Gloucestershire Constabulary	Through our Staff Development Unit, the importance of enhanced investigative practice is to be re-enforced. This will be demonstrated through improved sanctions.	Ongoing	
HM Courts & Tribunals Service will conduct a review of our service to victims and witnesses, in conjunction with Gloucestershire Constabulary Witness Care Unit and Victim Support – to be concluded by 31st January 2015.	Regional - HM Courts and Tribunal service in Gloucestershire and Gloucestershire Constabulary	HM Courts and Tribunal service in Gloucestershire to contact Gloucestershire Constabulary Witness Care Unit and Victim Support	HM Courts & Tribunals Service		31/01/2015	31/01/2015
HM Courts & Tribunals Service will meet with Probation managers to discuss the consideration of supervision requirements on any community orders imposed following domestic abuse charges, by 31st January 2015.	Regional - Gloucestershire wide. HM Courts & Tribunals Service and Bristol Gloucestershire, Somerset and Wiltshire Probation	HM Courts and Tribunal service in Gloucestershire to contact National Probation Service	HM Courts & Tribunals Service		31/01/2015	31/01/2015

Recommendation	Scope of recommendation i.e. local/ regional/national	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
HM Courts & Tribunals Service will conduct a review of domestic abuse training for magistrates and staff, and implement any changes or refresher training required by 31st March 2015.	Regional - Gloucestershire wide. HM Courts & Tribunals Service	HM Courts and Tribunal service in Gloucestershire	HM Courts & Tribunals Service		31/03/2015	31/01/2015

Appendix D

Family of Victim

31st July 2014, telephone call made by DHR Chair to victim's father, followed by an email giving information about the DHR and the AAFDA leaflet.

18th August 2014 Chair visit to parents and sister of victim.

The Chair provided the family with the DHR terms of reference and asked for their authorisation to allow the DHR to access Rosie's medical records. (Consent form signed by Rosie's father). The issues they would like the Review to consider were their concerns regarding the actions/lack of action by the Police Officers who attended their home, after perpetrator stole Rosie's debit card on14th February 2014 and also the perpetrator's mental health issues.

On 1st November 2014 Rosie's father asked that stalking be included in part of the Terms of Reference.

On 16th January 2015 the family were shown the draft Overview Report and considered the sections on analysis, lessons learnt, conclusions and recommendations in detail. Although the family understood that this was a draft report and may be amended by the Panel on 27th January 2015, Rosie's father asked the Chair to thank the Panel and IMR authors for the thoroughness of the Review and for the opportunity to write a Tribute to Rosie in the Report.

Victim's Work Colleague/friend

Rosie had confided in a friend and work colleague that she had recently broken up with Paul and that there had been some incidents of abuse and violence. Rosie asked her that if Paul turned up at the hairdressing salon where they worked, that she telephones the police. On 18th February 2014 when Paul came into the salon, she went out to a back room and telephoned the police on her mobile phone.

Perpetrator & his solicitor

Telephone call to solicitor & letter sent on 3rd August 2014 informing him and his client about the DHR and requesting Paul to sign a consent form for the DHR to access his medical records. The solicitor agreed in principle and agreed the pseudonym Paul for his client.

Chair visited Paul in prison on 22nd August 2014. After the purpose of the DHR was explained to Paul he agreed to sign a consent form to allow the DHR to access his medical records. He agreed to the name Paul being used as a pseudonym.

When asked if he had any issues he would want the DHR to include. He replied at length about his family back ground:

His mother and father constantly arguing, his mother taking him to hospital (he thought, regarding his mental health) when he was about 5 years old because of his bad behaviour.

Later he regularly took cannabis and when he was about 14 his mother took him back to “Social Services” as she was worried “weed” (cannabis) was going to ruin his life. He said he pretended to give up and they said his behaviour improved.

When he was 18, his mother was diagnosed as Bi-Polar and with depression. He claimed he had always been blamed for his bad behaviour “but it was my mother who had something wrong with her”.

He said he sold drugs cannabis, cocaine, and crack regularly from the age of 16.

He went into detail about his relationships and said he tried to hang himself at Christmas 2012. He went to a Gloucester hospital and later to his GP. (Gave address). He said he believed they did not provide the support he needed. He claimed he did not have an assessment or any medication. He was arrested for “smashing” his then girlfriend’s window after he left hospital.

During 2013 he lived in London for a while and took too many drugs and drunk too much. He found himself talking to himself and at the August 2013 Notting Hill Carnival he pushed Rosie over and hurt her, he could not remember doing it because he was “out of his mind” on drugs. His mother collected him and took him back to Gloucester. She contacted Mental Health Services and he had his first appointment in September 2013. He was having “anger outbursts” and told them he did not feel safe with himself or for other people. He claims he told his counsellors that if he had a knife he would use it. He said they did not give him any medication so he asked to be locked up.

Later he was arrested again by the police for “grabbing Rosie by the throat” in Gloucester.

He claimed that on 14th February 2014 he had taken Rosie’s bank card because she owed him money.

He said that on 18th February he bought the knife to protect himself because he had arranged to meet Rosie’s sister’s boyfriend, who he was “out to get,” at the hair dressers where Rosie worked.

On 5th November 2014 the Review were contacted by Paul’s solicitor to be informed that Paul had appealed against the length of his sentencing tariff and that he no longer wanted the Review to have access to two psychiatric reports which had been completed during the criminal proceedings.

Family of Perpetrator

The perpetrator stated through his solicitor that he did not want the DHR to contact his parents or half-brother. He confirmed this when he was seen in prison on 22nd August 2014. Nevertheless Paul's mother was contacted in her capacity as a victim. She confirmed that she had already received a welfare check from the Police and appreciated that, but stated she cannot stop blaming herself for what her son had done. She refused the offer of any further help. She also confirmed that she had always been happy with the responses she had had from the police whenever she would telephone them about Paul, until the night the officers had come to her house looking for Paul after he had threatened Rosie and stolen her bank card. She told them to go to Paul's grandmother's as she may know where he was, but they did not do that.

Previous partners of Perpetrator

The DHR made contact with the perpetrator's previous partners, Kate and Clare but both declined the opportunity to assist or engage with the Review. They were both asked if they would like any welfare support, but declined the offer.

Appendix F Expert opinion from the Information Commissioners' Office (ICO)
I am now able to provide you with a response to your query.

I understand that in your capacity as Chair of a homicide review you would like our views on whether there would be any data protection issues arising if a charity providing support services to victims of domestic violence were to routinely record the name of alleged offenders, and then subsequently disclose these to third parties upon request in a manner akin to "Clare's Law".

We recognise there is need to adequately safeguard the public from incidents of domestic violence, and that a failure to do so may have very real and tragic consequences for victims. The Data Protection Act 1998 (DPA) does not prevent the recording and sharing of data where it is necessary and appropriate to do so, and the Information Commissioner has published extensive guidance designed to help organisations understand their obligations. These include The Guide to Data Protection[1] and the Data Sharing Code of Practice[2].

As I am sure you are aware, "Clare's Law" is an initiative that provides for the police to disclose in certain circumstances whether a particular individual has a record of committing domestic violence offences. There are strict controls in place to ensure disclosures made are appropriate in the circumstances, and limitations may be imposed on what information is disclosed and to whom. Even in such controlled conditions there remains the very real concern that a person to whom data is disclosed might then make that information publicly available, for example by posting details on social media.

In the scenario you describe there are a number of public policy issues that need to be considered, not least whether the recording of offenders' details, and their subsequent disclosure to individuals, would provide any additional, meaningful safeguards to the public. We are mindful that a number of charities provide support services to victims of domestic violence and these will vary in terms of size, the types of issue they deal with and geographic coverage. It might be questioned how practicable it would be for a victim, or potential victim, to approach all such services in order to undertake checks on their partner and obtain a reasonably accurate picture of their propensity to commit violent acts in a domestic context. Given the fragmentary nature of support services it might be argued that a false sense of security could be obtained from conducting such checks which, in reality, present an incomplete picture. In addition, there may be public policy concerns that the effectiveness of services could be undermined if users thought that details of their partner were being recorded and might subsequently be made known to a third party.

From a legal perspective, charities are likely to be data controllers for the purposes of the DPA. Data controllers are required to comply with the principles of good information handling set out in the data protection principles. These principles provide that personal data must be:

- processed fairly and lawfully
- processed in accordance with a condition under Schedule 2 and, in the case of sensitive personal data, a Schedule 3 condition also
- obtained only for one or more specified and lawful purpose, and not further processed in a manner incompatible with that purpose or those purposes
- adequate, relevant and not excessive in relation to the purpose or purposes for which the data is processed
- accurate and, where necessary, kept up to date

- kept for no longer than is necessary
- kept secure from unauthorised or unlawful processing, theft, loss or damage.

In this instance there are several acts of 'processing' to be considered, namely the recording and subsequent storage of the data in question, and then the subsequent act of disclosing that data to the third party.

Information about the commission, or alleged commission, of an offence is 'sensitive personal data'. This being the case a Schedule 2 and Schedule 3 condition would need to be met by the data controller when processing the data. As regards a Schedule 3 condition, in the case of counselling and support services there is provision for the processing of this data if it is in the *substantial public interest*, it is *necessary* for providing that service, and the processing is carried out without the consent of the data subject (the offender) because, for example, it would not be reasonable to obtain their consent, or it would prejudice the provision of the counselling or support service. There may be circumstances in which it would be *necessary* to record an abusive partner's name in case notes, for example, in order to provide a counselling or support service to the victim. Recording it for the purpose of creating a database of alleged offenders to potentially be disclosed to third parties at a later date is, however, another matter.

No doubt there will also be an expectation of confidentiality between the service provider concerned and the victim which results in legal obligations under the law of confidence. Charities would need to consider whether disclosure of information to a third party which was provided in confidence would itself amount to an unlawful act. Consideration would also need to be given as to whether any disclosure is, in the circumstances, fair.

Accuracy of the data is another relevant consideration; charities would need to ensure that the data is accurate, relevant and not excessive. There are particular risks in recording details of third parties as the data may be subjective and unsubstantiated - especially where the information is supplied by a victim without opportunity for verification such as through investigation by the police. There would also have to be an identified and justifiable purpose for requiring the information in order to be able to record it in the first place. In this case it would seem only to be needed in order to subsequently disclose it to a third party.

There are other risks for charities to consider, such as the potential for an improper disclosure of data (or indeed, a loss of data or similar security incident) to cause significant damage and distress to those to whom it relates, and their families, especially if the data is not accurate.

The DPA provides an exemption from compliance with certain data protection principles where the data is processed for the prevention or detection of crime. This exemption applies only to the extent that compliance would prejudice the purpose, and it should be noted that it does not remove the requirement for there to be a Schedule 2 and Schedule 3 condition under which to process the data. In addition, data controllers would still need to ensure that the data is kept securely in accordance with the seventh principle.

In conclusion, and for these reasons detailed above, the recording of alleged offender details and subsequent disclosure by domestic violence charities is potentially problematic from both legal and policy perspectives. I would reiterate that the existing "Clare's Law" scheme operates under controlled conditions and appears to be a more appropriate route for individuals to uncover information about suspected abusive partners. Chari-

ties may wish to promote this scheme to their clients in order that they may obtain the desired information from the police.

I trust this satisfactorily explains our position, but please do not hesitate to contact me if you require further clarification on any of the points raised.

In addition to this advice The ICO responded to the following two questions as follows:

Question A
Would it be appropriate to advise Specialist Domestic Abuse Support Services and Independent Domestic Violence Adviser (IDVA) who receive referrals directly by victims themselves or by third parties;
that if they retain details of victims referred to them, they may on a case by case basis consider recording and storing details of the perpetrator, if it is primarily to assist them in providing appropriate support to that individual victim?

ICO Response:
It would be a matter for the charity, as the data controller, to determine whether the recording of the perpetrator's details is necessary for the provision of the services they provide to the client. In accordance with the third data protection principle the personal data recorded should be adequate, relevant and not excessive in relation to the purpose or purposes for which it is processed.

(Question B) If a new victim presents to a charity or IDVA and the perpetrator is identified as one whose details are stored in connection with an assault on an earlier victim, can the charity/IDVA consider sharing that information with the police on the basis of detecting a crime or preventing a serious assault? It would be strongly recommended that the Charity /IDVA do not share information about a perpetrator with a victim as the DVDS is clear that it is the police who may consider disclosure under the scheme.

ICO Response: An organisation may consider a disclosure to the police on a one-off basis in appropriate circumstances. Organisations who are considering making such a disclosure may find it helpful to consider the checklist on page 47 of The Data Sharing Code of Practice.

Appendix G Recommendations **of the IPCC Investigation into the police contact with Rosie prior to her death.**

Recommendations Learning

In 2010 the IPCC made a recommendation that Gloucestershire Constabulary should reconsider their intelligence systems to ensure that they were more accessible to police officers and staff. It is clear that the detailed information in the Domestic Abuse Database is not readily accessible to call handlers and officers responding to calls and as such, further work should be considered in relation to this matter. It is recognised that currently this database is not auditable, nor is it read-only, and so universal access to the database in its entirety would not be appropriate. Sometime after this incident, the Incident Assessment Unit was introduced in order to provide intelligence in relation to domestic abuse calls. In theory, this should contribute to making the information from the domestic violence database more accessible, however, as a newly established unit, it is vital that its effectiveness is monitored. It is necessary that protocols are put into place so that all staff and officers know how they can access the information held on the domestic abuse database, and that this information is circulated to all response officers and control room staff.

In December 2013 Her Majesty's Inspectorate of Constabulary (HMIC) conducted a review of the handling of domestic abuse incidents by all police forces. HMIC wrote to Gloucestershire Constabulary on 5 February 2014 to inform them of their findings, and Gloucestershire Constabulary was asked to respond with an action plan by 21 February 2014.

HMIC expressed "significant concerns about the ability of Gloucestershire Constabulary to deal consistently and appropriately with victims of domestic abuse and to reduce the risk of harm to them" and that "given the scale and extent of the areas for improvement identified...remedial action is required by the Constabulary to address the key risks identified". The IPCC acknowledge that given the timing of this report, it is unlikely that changes in working practices would have been implemented in time to impact on the manner in which Rosie was dealt with.

HMIC reported that there was "no accepted or consistent practice to risk assess domestic abuse victims at the first point of contact" and that the "storm aide memoire (was) not mandatory". It was established through this investigation that the call handler had not received sufficient training in handling domestic abuse calls, despite having worked for Gloucestershire Constabulary since 2006. The IPCC has concluded that further training in this area is vital. Gloucestershire Constabulary appears to have made a positive start in rolling out training, but it is recommended that a plan is implemented to provide for ongoing training. The IPCC also note that since this incident, a mandatory set of 10 questions has been implemented, to be asked during any call identified as a domestic incident.

HMIC identified a significant gap around victim care in domestic abuse cases assessed as medium or standard risk, and concluded the ownership of these cases was not clear. Feedback obtained from survivors indicated that they felt the service they had received had been disjointed. Frontline police officers are often expected to maintain ownership of any standard or medium risk domestic abuse cases, due to the resources available to the PPB. It is vital that should this working practice continue, attending officers understand that aside from dealing with the perpetrator, they must also address the safety of the victim. There are a number of measures available to Gloucestershire Constabulary officers when dealing with domestic abuse. In this case, the officers stated that they considered the arrest attempts to be sufficient in terms of a safety plan. It is recommended that when an officer submits a DASH form, s/he should also clearly detail the safety plan they have implemented, and a rationale as to why the proposed measures have been chosen as opposed to other available methods. The PPB should then endeavour to provide feedback where they have cause for concern around the propriety of any safety plan, in order to maintain an awareness of the options available to officers

in such circumstances.

It is important to note however, that HMIC re-inspected Gloucestershire Constabulary on 8 – 9 June 2014 and have commended them for the strong progress they have made to date. They have commented that Gloucestershire Constabulary have understood the risk areas, and are putting measures in place to deal with them.

It is apparent that there needs to be a consistent understanding of DASH completion amongst response officers. Gloucestershire Constabulary take the approach that best practice is to complete the DASH form in the presence of the victim, however, this practice does not appear to be acted upon by all officers. It is vital that Gloucestershire Constabulary provide fuller guidance on the expectations surrounding the practicalities of risk assessments to all officers, and that these expectations are incorporated into policy.

The Domestic Abuse policy should be reviewed as soon as possible; prior to the stated end date, so that officers receive adequate guidance on how to meet these aims. For example, it should cover how, when and where a DASH form should be completed, e.g. each question to be put to the victim; details of things seen and heard should be taken into account in identifying a risk level; forms to be completed at the scene and submitted before the end of that tour of duty. The guidance should also explain the safety planning process that should be followed once risks have been identified.

The CRU reviews conducted by sergeants into repeat domestic incidents appears to be a positive approach to ensuring that patterns of domestic abuse are assessed and acted upon. There does, however, need to be clearer remit in regards to situations such as this, where the report of one incident also includes details of previous, unreported incidents. Officers should make it clear to the CRU when this is the case, by indicating it on the referral, and a sergeant review should take place as it would if the incidents had been referred separately.

The information elicited from the PPB, the control room and the training team illustrate that a great deal of learning has already taken place, and changes are in the process of being implemented. These changes were reflected in the accounts of SD PCH and PCC, who each commented that Gloucestershire Constabulary appeared to be putting a lot more focus on domestic abuse.

Appendix H. Policing Domestic Abuse: How to? Gloucestershire Constabulary Guidance

Gloucestershire Constabulary
Policing Domestic Abuse How to?

1. Introduction

Gloucestershire Constabulary is committed to protecting the lives of both adult and child victims of domestic abuse. The Constabulary recognises its obligation under Article 2 of the Human Rights Act to take positive steps to minimise the risk of harm to individuals. In this context it is clear that the investigation of crimes relating to domestic abuse and honour based violence is at least as important as any other serious investigation. **The Constabulary's governance arrangements in respect of domestic abuse are described at Appendix A.**

Whole lifetimes can be blighted by a single act of domestic abuse or honour based violence by one person against another. Entire families can be affected for generations by the harm perpetrated by or against even a single member. Domestic abuse is very rarely a single act but a pattern of abusive behaviour, therefore the impact can be devastating for victims, children, families and the communities in which they live. Working in partnership with other agencies we aim to:

- Protect the lives of both adults and children who are at risk of domestic violence
- Adopt a proactive multi-agency approach in preventing domestic abuse

- Fully investigate criminal offences and hold offenders accountable through the criminal justice system
- Reduce repeat victimisation
- Offer support, reassurance and facilitate access to other agencies

Every member of the Constabulary needs to demonstrate that protecting victims is central to our core business of tackling domestic abuse. It is the responsibility of us all.

Gloucestershire Constabulary is committed to giving victims of domestic abuse a level of service that gives them the confidence to report incidents and keeps them safe from further risk of harm. If the Police are perceived to have dealt with domestic abuse incidents issues poorly then this will impact on public confidence in reporting the issues.

Victims of domestic abuse may appear reluctant to give officers attending an incident details but officers must take cognisance of the reasons why victims may often appear uncooperative and should endeavour to support victims by explaining police processes and support that is available to them. There are many reasons for example fear of further incidents, fear of losing their children, fear of losing financially stability that the offender provides to them which may impact on the decision of a victim to report an incident.

Gloucestershire Constabulary is committed to protecting victims of domestic abuse. The Human Rights Act 1998 includes positive obligations on police officers to take reasonable action, which is within their powers, to safeguard the rights of **victims and children**. The requirement for positive action in domestic abuse cases incurs obligations at every stage of the police response. These obligations extend from initial deployment to the response of the first officer on the scene, through the whole process of investigation and the protection and care of victims and children.

The purpose of this guidance is to ensure that by dealing with victims of domestic abuse effectively and by conducting thorough risk assessment processes with victims that we endeavour to reduce the likelihood of future harm, including homicide, serious injury and acts of violence by providing guidance to all officers and police staff in the identification of cases and the level of risk they present.

2. Definitions

DOMESTIC ABUSE

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

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

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. This definition includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

Family members are defined as mother, father, son, daughter, brother, sister and grandparents, whether directly related, in-laws or step-family.

Not every incident reported involving people who are/were in an intimate relationship or are family members will involve an element of controlling, coercive or threatening behaviour, or violence or abuse. Officers are encouraged to use their professional judgment as to whether a reported incident is in fact a domestic incident as above.

TYPES OF DOMESTIC ABUSE

Domestic abuse takes many different forms, which must always be considered when dealing with a victim of domestic abuse. Domestic abuse can manifest in any one of or all of the ways listed below:

Physical Abuse: Any offence of violence, including common assault, grievous bodily harm or actual bodily harm.

Sexual abuse: Rape, sexual assault and other sexual offences.

Emotional or psychological abuse: Any harm deliberately or recklessly inflicted on another person's well-being. This may amount to an offence under the Offences against the Person Act 1861 and could, for example also, fall under the Protection from Harassment Act 1997.

Financial abuse: The abuse of power in a relationship where one partner maintains control over the other's money or financial circumstances. Again, this may amount to an offence under the Protection from Harassment Act 1997.

REPEAT VICTIM

A common feature in most domestic abuse cases is repeat victimisation. This is where a victim has been involved in more than one incident in a given period of a rolling 12 months. If several incidents are reported to the police at once that would qualify the individual as a repeat victim.

SERIAL PERPETRATORS

These are perpetrators that are alleged to have used or threatened violence against two or more victims who are unconnected to each other and who are or were intimate partners of the perpetrator.

HONOUR BASED VIOLENCE (HBV)

Honour Based Violence is defined as any crime or incident, which has or may have been committed to protect or defend the perceived honour of the family and / or community. Forced marriage and female genital mutilation are types of this harmful practice.

When dealing with incidents of so-called 'Honour' Based Violence it is important to keep in mind that it cuts across all cultures, nationalities, faith groups and communities and such violence transcends national and international boundaries.

Honour Based Violence is a form of domestic abuse and when dealing with such cases officers must refer to the Honour Based Violence & Forced Marriage Policy.

The policy outlines the different forms of HBV and guidelines of what action should be taken when dealing with cases. Officers must ensure that a thorough risk assessment is carried out with victims of Honour Based Violence.

VULNERABLE AND INTIMIDATED VICTIMS

In accordance with the Victims Code of Practice 2013, a victim of crime is considered vulnerable and thus eligible for an enhanced service under the Code if they are:

(a) Under the age of 18 at the time of the offence; or

(b) If the service provider considers that the quality of evidence given by the victim is likely to be diminished by reason of any circumstances falling below

The circumstances falling within this are:

(a) That the victim:

(i) suffers from mental disorder within the meaning of the Mental Health Act 1983,

(ii) otherwise has a significant impairment of intelligence and social functioning;

(b) that the victim has a physical disability or is suffering from a physical disorder.

In determining whether a victim falls within the definition above any views expressed by the victim must be considered. This is very relevant in a domestic abuse setting where a fear of court attendance is prevalent.

VULNERABLE ADULTS

The term 'vulnerable adult' has a specific meaning and should not be confused with the term 'vulnerable victim'. Vulnerable adults are those aged 18 or over:

- Who is, or may be, in need of community services due to age, illness or a mental or physical disability, and
- Who is, or may be, unable to take care of himself/herself, or unable to protect himself/herself against significant harm or exploitation

Such adults may be particularly susceptible to the negative effects of residing in a household where abuse is prevalent and so their details should be recorded on the DASH form.

3. Taking Reports of Domestic Abuse

ROLE AND RESPONSIBILITY

CALL TAKERS AND CONTROL ROOM STAFF

The first priority when a domestic abuse incident is reported is to protect the victim and any other persons at risk, including children or police officers. To this end call takers should:

- prioritise the safety of those at risk by giving immediate safety advice and reassurance
- establish how frightened the caller is
- establishing if anyone else such as children may be at risk
- keep the caller informed of the deployment of officers

All reports of domestic violence and abuse will be recorded as an incident on Storm and tagged as a domestic incident.

In order to standardise the default priority of each Domestic Abuse incident a default priority of 2.1 HR Upset / Vulnerable has been added to the Domestic Abuse opening code. This requires the incident to be attended within 1 hour.

Operators will still have the flexibility to 'up' the priority to a grade 1 when the circumstances meet the grade 1 criteria (based on the current Incident grading policy).

However operators will not be allowed to downgrade the Domestic Abuse incident without agreement from the FCR Sergeant or Supervisor.

The incident must be endorsed on these occasions indicating who authorised the change to a lower priority and why.

A person making a report should be calmed, reassured and dealt with in a supportive manner. Immediate safety planning advice should be given. When a member of the public reports an incident of domestic violence abuse, members of staff will establish and commence an immediate investigation.

In addition to general considerations such as the caller's details and location, the following information should be collected wherever possible in respect of reported domestic abuse:

- Alternative contact details for the informant and safe times to contact.
- Details of a third party who could safely pass information to the caller
- Any previous history of domestic violence/abuse or harassment
- If any weapon/implement was used and what type

- Is there access to firearms, including those lawfully held
- Any other aggravating factors, e.g. alcohol misuse
- If there are/were any children in the house and present whereabouts and safety
- Any other occupants in the house or persons present (potential witnesses)
- Any communication problems or special needs and whether an interpreter may be required
- Any Court orders in existence and powers associated with them
- Demeanour of victim
- Any vulnerable adults within the household

The above list is not exhaustive and staff should ascertain the facts in order to protect the public; detect offences; and bring offenders to justice. **The call taking process and question set is at Appendix B.**

If the report is made at the front office the person making the report will be interviewed sensitively and in private wherever possible.

ABANDONED CALLS

When an emergency call is abandoned after speech or sound that gives cause for concern, and that call is either traced to an address where a previous domestic incident has taken place, or it is suspected a domestic Incident is taking place, then a resource will be dispatched to that address.

The officers attending will satisfy themselves all is in order with regard to the safety and well-being of all persons involved before leaving.

Where a call is received notifying police of an ongoing domestic incident and prior to dispatch or arrival of officer/s a further call is received from any person, (including the initial caller) stating police attendance is no longer required, the officer/s will still attend and will satisfy themselves all is in order with regard to the safety and well-being of all persons involved.

Staff should be alert to the possibility that victims are often forced or intimidated into terminating calls or cancelling police attendance. Abusers sometimes attempt to cancel police attendance. Consideration should be given to other indicators, i.e. background noise, screams, etc. If there is background noise or any other significant factor it should be recorded on the incident log and notified to the attending officers.

If such calls are received from mobile phones all effort must be made through intelligence databases to identify the source of the call.

PROVISION OF INFORMATION TO ATTENDING OFFICERS

Officers who attend incidents of domestic abuse should be in receipt of information that allows them to best assess and reduce the risk to the parties involved. At the same time control room operators must retain the capacity to protect the public by effectively managing police resources.

In every domestic incident the parties involved should be checked using the Force Intelligence System (Unifi) and PNC to establish if any high risk markers are in place. Where children are present at the address checks should also be made to establish if they are subject to child protection plans.

Control room operators must also check GCIS in order to provide the attending officers with a summary of the reported domestic abuse history between the parties involved.

An aide memoir to assist with the effective deployment of officers can be found at Appendix C

4. Responding to domestic abuse

ROLE AND RESPONSIBILITY

POLICE OFFICERS AT DOMESTIC ABUSE INCIDENTS

Police officers will attend all calls and reports relating to domestic violence or abuse, and check the welfare of all parties.

Officers will engage positively with victims upon first contact to ensure the needs of the victim are met. Negative and indifferent attitudes may prevent victims from seeking assistance and therefore put people at risk.

Officers should ensure that they speak to each party separately. The victim should be spoken to in a place where the alleged offender cannot overhear, so that they may talk freely.

Research indicates that victims are likely to have suffered over 30 previous instances of domestic abuse before reporting to the police. At the same time victims are likely to have competing emotions concerning their own safety; the safety and security of their children; and feelings for their partner, ex-partner, or family member. Because of this context officers should not simply take the apparent wishes of victims at face value.

The attending officers will secure and preserve evidence **(See chapter 6 for evidential opportunities)** and will identify all available witnesses to facilitate a quality investigation. The victim should be treated as the primary crime scene and advised not to undertake actions which may affect the preservation of evidence.

Children should always be considered as primary victims and as suitable witnesses – care should be taken to ensure that their evidence is recorded and assessed appropriately.

Officers will endeavour to establish as many methods and safe times of contacting the victim as possible. They will provide information on support agencies and safety planning advice.

ARREST

Failure to reasonably exercise powers of arrest may leave officers and the Constabulary vulnerable to legal challenge under the Human Rights Act. More importantly, it may leave victims of abuse at risk of ongoing serious harm.

Where grounds for arrest exist, the suspect will be arrested as soon as practicable in all but exceptional circumstances. **Such circumstances must be provided to the Duty Inspector and both must be prepared to justify a decision not to arrest and ensure that this rationale is recorded on Storm.**

The decision to arrest a suspect lies with the police on the basis of the allegations made and the supporting evidence. Victims should not be asked whether they require an arrest to be made.

All actions taken must be justified and proportionate in the circumstances. The arrest of an alleged offender may act as a powerful deterrent against re-offending, and might provide the window of "freedom" needed by a victim to assist investigators and seek support and advice.

All decisions will be made in accordance with the National Decision Model (NDM) **(See Appendix D)** and recorded.

The risk to the victim increases if a perpetrator absconds prior to police arrival. Every effort will be made to locate the suspect and circulation of outstanding suspects on the Police National Computer should be considered with a supervisory officer.

The circumstances surrounding an outstanding perpetrator should be considered and discussed with a supervisor following which, depending on the determination of threat posed, responsibility remains with the officer and their supervisor to promote positive activity to locate the individual through either local or force tasking.

DASH (DOMESTIC ABUSE, STALKING, HARASSMENT AND HONOUR BASED VIOLENCE) RISK ASSESSMENT

Officers attending domestic incidents must assess the risk and respond positively to ensure the safety of all vulnerable parties, particularly children. **The responsibility for assessing the risk presented and taking initial steps to reduce that risk lies with the attending officer.**

Officers must complete the DASH Risk Assessment in all cases falling within the domestic abuse definition (it will also be considered in cases of stalking, harassment and honour based violence). Officers are still encouraged to use their judgment to determine if the incident they are attending is a matter of domestic abuse.

There will be incidents that have been tagged as domestic incidents by the Control Room that do not meet this definition. For example, subsequent calls relating to the collection of property, or incidents that occur between partners or family members that have no element of coercion, controlling behaviour or abuse.

Wherever the officer considers that a fuller understanding of the relationship, based on established risk factors, would be useful in preventing further harm a DASH is clearly beneficial and should be completed.

Where officers consider that a DASH is not required because the matter they have been assigned to is not a domestic abuse incident then they must ensure the Storm log is fully updated to this effect with their reasons.

Victims may minimize the risk that they are facing. Officers should be objective and should value the victim's perception of ongoing risk as being accurate.

As far as practicable, officers must ensure that their decisions have included consideration of the previous domestic history between the parties and this should be proactively sought from the Control Room where needed.

There are three categories of risk which are defined as follows:

- **Standard -** Current evidence does not indicate likelihood of causing serious harm.
- **Medium –** There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, and drug or alcohol misuse.
- **High –** There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious.

Risk of serious harm is defined as 'risk which is life threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible'.

Officers are able to use their professional judgement and experience to categorise the risk level based on the information provided.

SAFETY PLANNING AND REDUCING THE RISK FACED BY VICTIMS

It is the responsibility of the attending officer(s) to take steps to reduce the risk faced by the victim. Officers must never assume that someone else will do it.

Officers will actively respond to the domestic abuse risk assessment model and then take action to meet the identified risk.

Officers must consider each potential measure that would protect the victim and then take steps to minimise the risk and create a safety plan bespoke to the victim's needs. (Appendix E is an example of a safety plan). The initial responsibility for this in all cases lies with the attending officer.

ROLE AND RESPONSIBILITY SUPERVISORS

Where the victim has been identified as **Standard Risk** then the DASH should be emailed to the Central Referral Unit within one working day having been examined by an officer of at least sergeant rank.

Where the victim has been identified as **Medium Risk** then the DASH should be emailed to the Central Referral Unit prior to the conclusion of duty having been examined by an officer of at least sergeant rank.

Where the victim has been identified as **High Risk** then the DASH should be examined by an officer of at least the rank of inspector prior to the completing officer concluding duty.

It is the responsibility of the sergeant examining the DASH to consider the risk level applied and to verify that suitable steps have been taken to reduce the risk presented through appropriate safety planning.

FIREARMS

Where an offender/suspect has access to firearms, consideration should be given to seizure/revocation of licence etc. A supervisor will be notified and a decision made and recorded on whether seizure took place or not.

ROLE AND RESPONSIBILITY PUBLIC PROTECTION BUREAU (PPB)

The PPB, Neighbourhood Policing and Incident Policing will jointly hold the responsibility for the investigation of Domestic Abuse. PPB will hold the strategic lead for the force.

PPB investigation officers are specialist domestic abuse investigators including offences of stalking and harassment, honour based violence and female genital mutilation. **The unit will be responsible for investigating domestic offences involving serious crime or that have caused serious harm to the victim.**

The Central Referral Unit (CRU) will coordinate the risk management, information sharing and MARAC processes.

The PPB will take ownership, through the MARAC, for the risk management of cases that have been identified as high risk. Medium and standard risk is managed by the Local Policing Domestic abuse teams.

Investigation of **domestic abuse offences** by the PPB will include those offences involving;

- Serious violence.

- Rape and Serious sexual offences (where no RASSO team available).
- Arson with intent to endanger life.
- Kidnapping and false imprisonment.
- Blackmail.
- Honour Based Violence.
- Female Genital Mutilation.
- Forced Marriage.
- Stalking and harassment with fear of violence.

ROLE AND RESPONSIBILITY LOCAL POLICING DOMESTIC ABUSE UNIT

The unit will support front line staff in dealing with domestic abuse cases with primary focus on victim care. This is an interim solution prior to any consolidated organisational operating model to support identification and mitigation of risk and safety planning.

5. Potential linked considerations to DA

There is a background of domestic abuse in 46% of child homicides. About 50% of children living with domestic abuse have been badly hit or beaten and are more likely to experience sexual and emotional abuse. Many of Gloucestershire's children who are on child protection plans are at risk because of their exposure to domestic abuse. Officers should be consistently alert to the welfare of children when dealing with domestic abuse incidents.

Where children are present as observers or involved either directly or indirectly, or a member of the household is pregnant this will be recorded in the relevant sections of a on the DASH assessment. The appropriate child abuse and domestic abuse tags should be added to ensure that the case is sent automatically through to the Central Referral Unit (CRU). Only if the incident is tagged as CP will a child protection referral form not be needed.

Officers will be mindful of the links between child abuse and domestic abuse and flag this appropriately within the risk assessment. Where there are serious concerns regarding child abuse the Duty Inspector should be notified immediately to ensure that any risk is identified and escalate the situation if necessary.

MINORITY GROUPS

There are a number of reasons why domestic abuse may be under reported amongst minority groups. These include lack of confidence in the police; concern over insecure immigrations status; increased fear of children being removed; and cultural considerations regarding the role of women.

Any individual, be they from a minority ethnic background or gay or transgender, is entitled to protection from harm by the police as public servants. That said, every person has individual needs that should be considered and this is particularly pertinent with those where there may be additional barriers to reporting. Officers responding to domestic abuse in such circumstances should be alert to this and seek additional advice accordingly.

Officers should avoid making judgments based on their own perception or experience. Do not assume that because a victim might appear unhelpful they are lying or not frightened.

MISSING PERSONS

When dealing with missing person reports where the individual may be the victim of domestic abuse officers should maintain their confidentiality as much as possible. If they are traced officers should seek their consent before informing others of their location. Abusers may seek to manipulate situations to use the police as a means of locating domestic abuse victims. Officers should carry out background checks wherever there is a suspicion of domestic abuse in a missing person case to inform further actions.

STALKING & HARASSMENT

Harassment is frequently linked with domestic abuse and is in itself a significant risk indicator of escalating harm in abusive relationships. Where harassment is occurring officers should complete the additional relevant questions of the DASH form to allow better-informed risk assessment and risk reduction.

Stalking is a term used to describe a form of harassment. It can be described as a series of acts that intend to, or do in fact, cause harassment to another person. DASH forms can and should be used to assess the risk posed in stalking situations but positive action to mitigate risk is still required.

FORCED MARRIAGE

A forced marriage is conducted without the full and free consent of the parties involved. It is not the same as an arranged marriage, which has the consent of both individuals. Forced marriages in themselves represent abusive behaviour and may be indicative of further abuse.

Officers attending domestic abuse incidents where there are suspected links to forced marriage should take steps to reduce the immediate threat of harm and seek advice from the Domestic Abuse and Vulnerable Adults Unit.

SEXUAL VIOLENCE

The potential for domestic violence cases to include sexual abuse needs to be considered at the earliest stages of an investigation. Sexual abuse is often part of domestic violence but is rarely disclosed; particularly when other forms of abuse are the primary reasons for police involvement. Most victims find it difficult to disclose details of sexual abuse, even at crisis point. Information from partner agencies, particularly voluntary sector support services may well indicate the presence of sexual abuse and this should be identified and acted upon as appropriate.

The skills and expertise of specialist domestic violence staff and staff who are trained to investigate sexual offences should be used to ensure that domestic violence victims are provided with the opportunity to disclose sexual abuse where it is present. Victims of domestic sexual abuse should be offered the benefits of emotional and medical support through the SARC in the same manner as the other sexual abuse victims.

6. Investigating domestic abuse

EVIDENCE GATHERING

All available evidence and witnesses will be identified and efforts made to secure best evidence. In the case of domestic violence/abuse investigations the most likely sources of evidential material will be gathered by:

- House to house enquiries; neighbours can be a very useful source of information and even if they did not witness the specific incident under investigation they may have vital information about previous incidents or about the relationship of the people involved which will be vital to informing the risk assessment process.
- Forensic evidence, (including in some cases forensic telephony)
- Photographic evidence (digital photos, video evidence of the victim/scene and follow-up SOCO photographs). Also note injuries to all parties and any damage/disruption at the scene.
- Medical evidence where available, victims must be asked to sign a medical consent form as soon as possible.
- Information held by other agencies such as Gloucestershire County Council
- 999 call recording
- CCTV footage
- Significant comments by the suspect

The investigating officer will explore all lines of enquiry and approach the investigation of a domestic abuse incident seeking to secure evidence from all available sources, rather than being reliant on victim testimony. Statements should be taken from any available witnesses.

Officers should be alert to the possibility of an early admission to a minor offence by the suspect in order to hasten the process instead of where a more detailed investigation may reveal evidence of serious offending.

Officers should seek to use early photographic evidence and the 999 call in their initial interview with the perpetrator. A significant statement by the offender (capable of being used as evidence) must be included as part of the suspect interview plan. The full details of the significant statement and circumstances must be recorded in the Pocket Notebook and offer to the suspect to sign.

A joint checklist to assist officers has been compiled by ACPO and the CPS and it is available here.

CRIME RECORDING

For all incidents where the victim has confirmed the circumstances that amount to a criminal offence a crime record must be created on UNIFI, regardless of whether or not the victim wishes police to pursue the matter.

Whilst responding to a domestic incident or carrying out the DASH risk assessment further disclosure may be made about previous offences that may or may not have been reported to the police. Where offences have not previously been reported to the police the most serious offence disclosed at the time must be the one recorded.

All domestic abuse offences should be recorded in compliance with the National Crime Recording Standards (NCRS).

STATEMENTS & VICTIM INTERVIEWS

An early decision should be made regarding the best means of capturing the victim's testimony. Officers should bear in mind the victim's need and wishes but also that a victim may be discouraged from following up a complaint in the time taken to arrange a video interview. A full account from the victim should include:

- details of family composition
- the history of the relationship and any other previous incidents
- the actual incident
- the victim's injuries (physical and emotional)
- whether a weapon has been used and the type and source of this
- any threats made since the attack
- whether children were present and the effects on them
- damage at the location
- if either party has a history of drug or alcohol misuse, or mental health issues
- the victim's view of the relationship

The account should include details of any identified risks. This may reveal factors that are difficult for the victim to discuss and consideration should be given to a preferred gender of officer or officers with specialist skills.

Victims should also be afforded the opportunity to make a victim personal statement.

Statements should be taken from any available witnesses. Consider interviewing any children present in compliance with Guidance for Vulnerable or Intimidated witnesses and Achieving Best Evidence.

The first officer(s) at the scene should provide a full statement including the officers' initial appraisal of injuries and demeanour of all parties, observations of scene, risk factors, allegations made by the victim, and comments made by the suspect.

COUNTER ALLEGATIONS & DUAL ARRESTS

Police responding to domestic abuse calls may be confronted with conflicting accounts of what has taken place, with each party claiming to be the victim. Officers should use their investigative knowledge to make a judgment on where the coercion and control lies within the relationship. The suspect may make a false counter allegation and or both parties may exhibit some injury and distress.

Counter allegations necessitate that police officers conduct immediate further investigation at the scene (or as soon as practicable) to attempt to establish the primary aggressor. Officers should be aware that the primary aggressor is not necessarily the person who was first to use force or threatening behaviour.

Officers should evaluate each party's complaint separately to determine the primary aggressor. Officers should avoid making dual arrests without conducting meaningful enquiries to establish what has happened. When counter allegations or dual arrests have occurred, this should be recorded and the information included in the prosecution file.

Depending on the severity of the offence, arrests should not be made for acts which officers have reasonable cause to believe were committed in self-defence.

ONGOING CONTACT, SAFETY PLANNING AND SUPPORT SERVICES

All victims of crime should be treated according to their individual needs. Investigating officers should avoid making assumptions regarding the nature of those needs.

The investigating officer must maintain contact with the victim where a crime has occurred, keeping them informed of the developments of the case. Efforts should always be made to obtain details such as a safe contact number/time to call/alternative address/third party to aid future contact with a victim.

In all cases officers should provide contact details for the Gloucestershire Domestic Abuse Support Service. Officers should also be proactive in seeking the consent of victims for their details to be passed to GDASS for the provision of specialist support and advice. GDASS provide advice, support and information to victims of domestic abuse throughout the county by offering outreach support, group work survivor programmes, telephone advice, access to accommodation/'places of safety' and an IDVA (Independent Domestic Violence Adviser) Service which specifically works with high risk victims of domestic abuse.

Safety planning advice must be provided and discussed with the victim to create a tailored plan for their circumstances. The following are examples of what should be considered:

- Cocoon watch – request the help of friends, neighbours and relevant agencies to contact the police immediately if another incident occurs.
- Improving home security and consideration of sanctuary scheme
- Civil Orders- Non molestation Order, Occupation Order
- Specialist Support for victims via GDASS

- Arrest / charge / remand / bail conditions (that are checked)
- Victim Code - keeping victim updated, especially outcome of remand hearing
- DVDS - at very least security briefing for home, route to work, at work (involve boss to agree risk reduction at work place)
- DVPN - with follow up during 28 day period - referral to appropriate services.
- OPI - Alert on the address setting out risk / Intelligence submission
- Local Police intervention - Responsible for managing risk through proactivity (neighbours), PCSO's / briefings / targeted policing of perp
- Specialist Police Investigation involvement - does it need DA team / Organised Serious Crime to conduct surveillance to prove stalking?
- Local bulletin / Force bulletin - taskings and responding to intelligence
- Dedicated Source Handling Unit - to determine whether there is any relevant risk / threats
- PINS marker - to highlight risk when released from prison - advance warning will allow pre-planning
- Briefing of Probation to link Offender manager of perp seeking intel when imprisoned
- Welfare visits in the area (local police / PCSO's)
- Targeted patrol in area
- Child Protection referral
- Vulnerable Adult referral
- Alarm at address, including GPS tag to allow mobility
- Safeguarding alert
- Register victims on BT ‘999’.com
- ANPR - flags on vehicles where appropriate

- Specialist Support service (IDVA, Drugs & Alcohol)- contact victim within 48 hours
- Contact relevant housing authority - target hardening / sanctuary scheme
- A&E tag
- Social Care assessment
- MARAC
- Alert to Firearms Enquiry Team - view to having licence and firearms withdrawn

An example safety plan can be found at Appendix E.

Officers should always seek the consent of the victim regarding the sharing of information with support agencies via the DASH. Only high risk DASH forms are shared with partner agencies without the consent of the victim. It is therefore incumbent on the attending officer to obtain the victim's consent for their details and those of the risk assessment to be shared with the Gloucestershire Domestic Abuse Support Service.

CUSTODY CONSIDERATIONS

Custody staff should be alert to the possibility of those arrested for domestic abuse matters seeking to influence victims whilst in custody. Particular attention should be paid to requests for telephone calls.

Custody officers should also consider the following:

- sharing any threats of self-harm with the investigating officer as an indicator of heightened risk
- record any injuries to the suspect
- record any significant statements made by the suspect

Custody officers should require officers to provide them sight of the DASH risk assessment prior to granting bail. Suspects should be reminded that it is their responsibility to comply with any conditions imposed.

If a suspect is to be released on police bail then the officer in the case must inform the victim of what is to happen. Early engagement will allow the victim to consider options and prepare.

CHARGING AND DISPOSAL DECISIONS

Charging decisions relating to all domestic abuse cases will be taken by a Crown Prosecution Service lawyer. The Custody Officer may refuse the charge and no further action cases when all avenues of investigation are completed and there is insufficient evidence to warrant charge. The joint CPS and Police charging standards will be applied for all assaults and public order offences.

CAUTIONING

Cautions are rarely appropriate in domestic violence cases. This position is in accordance with the *ACPO Guidance on Investigating Domestic Abuse*. This is because such cases involve a breach of trust and are unlikely to be the first offence. Generally, the public interest will require the prosecution of the suspect where there is sufficient evidence for charges to be brought.

A custody officer may determine that a caution is appropriate in a domestic violence case if they are satisfied that the Full Code Test evidential standard is met. Additionally, the custody officer must be satisfied that the public interest can be adequately met by the administration of a caution and the written decision with rational endorsed by an Inspector.

As stated clearly in the Director's Guidance on Charging, domestic violence cases may not be considered for conditional cautioning

UPDATING THE VICTIM

It is the responsibility of the identified officer in the case (OIC) to update any victim. This will include any temporary OIC investigating in the event of case passed to another officer at shift handover.

A new code for Victims came into effect on the 10th December 2013. It defines a **'victim'** is a person who has;

- suffered harm, including physical, mental or emotional harm or;
- economic loss which was directly caused by criminal conduct or;
- a close relative of a person whose death was directly caused by criminal conduct.

The obligations are **statutory** not discretionary – meaning they are legally binding in the same way as PACE.

The Victims Code sets out standard and enhanced entitlements for **victims** of crime

Enhanced entitlements are available for **priority categories** which are:

- Victims of the most serious crime,
- Persistently targeted victims; and

- Vulnerable and intimidated victims

You must conduct a **'needs assessment'** to determine if the victim is in a **priority category** or requires any support as prescribed by the Victims Code.

You must agree how often updates or information will be given with regards to the status of the case taking the victims' views into consideration.

Explain details will be passed to victims' services unless the victim does not wish this to happen. They can self-refer at a later date

Seek explicit consent from victims of sexual or domestic violence or bereaved close relatives before sending details to victims' services.

Victims in a **priority category** receive 'enhanced service'

If a victim is not in a priority category but you feel they need 'enhanced service' you can do this on discretionary basis

It is ultimately the service provider's decision as to whether a victim is in a priority category

Victims receiving the enhanced service must be updated within **1 working day** rather than the usual 5 working days.

Within **5 working days** for **standard service** and **1 working day** for **priority victim categories** you must notify victim if a suspect is:

- Arrested;
- Interviewed under caution;
- Released without charge;
- Released on police bail;
- Changes or cancellation of bail conditions
- Or if a decision is made to file a report.

If an out of court disposal is being considered, you must, if practicable, ask the victim for their views and take these into account.

You must inform victims of police decisions not to prosecute and give the reasons for this

Where CPS decide not to prosecute you must:

- inform the victim and give a reason for decision e.g. insufficient evidence.
- tell the victim how they can access further information from CPS and seek a review of their decision where dissatisfied
- This is called the **CPS Right to Review Scheme**. The prosecutor should give you the necessary information on the returned MG3.

Where victim reports a breach of bail and a decision is made not to place suspect before the court, the police should notify the victim and explain reasons why.

NFA DISPOSALS

A case will only normally be disposed of by means of no further police action when it has been thoroughly investigated and there is insufficient evidence to justify charge.

If the decision to NFA a case prior to the completion of an investigation or the arrest of a suspect is made, then this will only be with the agreement of an Inspector with a recorded rational on the crime report.

VOLUNTARY ATTENDANCE

Officers should consider whether it is appropriate for an alleged perpetrator of domestic abuse to attend voluntarily for interview rather than being arrested. A full consideration of all the attendant circumstances is required in reaching this decision. Section 24 of PACE determines that an arrest is lawful if a person is suspected to be involved in the commission of an offence and there are reasonable grounds for believing that an arrest is necessary. The nature of the offence, the protection of victims and witnesses, and the need for searching are crucial considerations.

RESTORATIVE JUSTICE

It is the position of Gloucestershire Constabulary that restorative justice will not be used for domestic abuse cases involving partners or ex-partners. This is in line with the current ACPO lead position.

Where restorative justice is being considered for incidents between family members the proposed course of action should first be discussed with a supervisor within the Domestic Abuse and Vulnerable Adult Unit. Officers should avoid making promises regarding RJ resolutions prior to this discussion.

WITHDRAWAL OF COMPLAINTS

There are numerous reasons why victims may seek to withdraw a complaint of domestic abuse

In cases where a victim has made a statement and criminal proceedings have commenced, a further statement of retraction should only be taken ***when all other options have been exhausted.***

The OIC should discuss the matter fully with the victim to ensure it is the right decision for them, prior to any statement being obtained. The OIC should also consider involving an Independent Domestic Violence Advisor to speak with the victim at this stage. If, following these discussions, the victim still wishes to retract their complaint, the OIC will take this statement.

Pro-forma statements will not be used. Statements should establish:

- Details of the alleged crime
- The reason for wishing to withdraw the complaint
- Whether they are saying the offence did not occur or whether they are saying that they do not wish the investigation or prosecution to continue
- Whether any pressure, directly or otherwise, has been placed on the victim
- Who they have discussed the case with
- Whether any civil proceedings have been instigated
- The impact on the victim's life and that on any children
-

When submitting the retraction statement the police officer will also submit a report to CPS containing the officer's view of the following:

- The veracity of the reasons given
- How the case should be dealt with
- How the victim might react if compelled to attend
- How the decision would be likely to be impact on the safety of the victim or the safety of the children of the family

- The officer will be prepared to attend Court to give such evidence orally, in the case of an application being made under Section 116 of the Criminal Justice Act 2003.

The officer will explain to the victim that making a withdrawal statement does not necessarily mean they will not have to attend Court and give evidence if necessary. In such cases the victim may be invited to make a Victim Personal Statement or add to a previous statement, to express their views as to why they do not support a prosecution and their views on the incident/relationship/defendant. The officer taking the statement will encourage the victim to call the police again should they need to.

If there is any suggestion that there has been interference or intimidation of the victim, the police should consider arresting the suspect under Section 51 of The Criminal Justice and Public Order Act 1994 (intimidating a witness, and harming or threatening to harm a witness).

At the time of taking the retraction statement, the OIC should also consider if an updated risk assessment is required.

PROVISION OF INFORMATION TO THE CPS

In order that the Crown Prosecutors can make informed decisions the police must provide them with as much information as possible. This enables the CPS to make an informed decision regarding the evidential and public interest tests. It will also assist them to prosecute the case effectively and maximise the protection of the victim and any children, particularly when opposing bail applications, applying for a remand in custody and applying for special measures.

Officers should think beyond the basic components of the file of evidence to ensure that the prosecutor is as well informed as possible. The offence charged may not fully reflect the seriousness of the risk faced by the victim and so the DASH risk assessment should be shared with the prosecuting lawyer along with other material or officer opinion that would contribute to the protection of the victim.

In some circumstances this information will not be readily available but it should be passed to the CPS as soon as possible. It is important to keep the CPS updated of any change in circumstances.

File preparation for CPS must be diligently completed and should include;

- All relevant victim, witness and agency statements
- Details of the background of the relationship
- Medical or photographic evidence where applicable
- Intelligence and previous convictions in respect of all parties
- Current status of the relationship
- Requirements for special measures

- DASH Risk assessment
- Details of bail conditions
- Details of counter allegations if applicable
- If there is a need for an early meeting with CPS

SPECIALIST DOMESTIC VIOLENCE COURTS

Victims and witnesses should be further assured that the Gloucestershire Local Criminal Justice Board has established a Specialist Domestic Violence Court. This is held every Tuesday at Cheltenham Magistrates Court.

Cases of domestic violence/abuse should be bailed to this court for first hearing where possible.

SPECIAL MEASURES

Eligibility for Special measures is dependent on the victim or witness being identified as vulnerable/intimidated and the court agreeing to the use of such measures. Officers must provide an MG2 for the charging prosecutor. Victims/witnesses should be advised that if required to give evidence to a court they might be entitled to the use of special measures. It is important that officers/staff do not promise that special measures will be available. Such promises can cause serious problems later in the process, and undermine the victim's confidence and faith in the system.

Further advice can be obtained either from the Domestic Abuse and Vulnerable Adult Unit, or from the Witness Care Unit, where there are members of staff who specialise in handling domestic abuse cases.

CIVIL REDRESS

Where a criminal case has been unsuccessful at any stage in the proceedings, the OIC should advise the victim that there are civil remedies available to them (injunctions, prevention orders etc.). Further advice is available from the Gloucestershire Domestic Abuse Support Service or, for officers, from the DAVA Unit.

7. Management of ongoing risk

CENTRAL REFERRAL UNIT

The Central Referral Unit within the Public Protection Bureau will identify all incidents that have been tagged as domestic abuse by the Control Room. Those that meet the definition of a domestic abuse incident will be added to the Constabulary's domestic abuse database.

Safeguarding officers within the CRU will receive DASH forms completed by attending officers and will ensure that the prescribed risk rating adequately reflects the history of the individuals contained within the domestic abuse database. Where three or more incidents involving a particular individual occur within a rolling six month period then this will automatically trigger a review by a CRU sergeant.

MULTI AGENCY RISK ASSESSMENT CONFERENCE (MARAC)

The Constabulary is committed to the MARAC process. High risk cases will be referred into the MARAC so that information can be shared with other agencies and the best decisions made to keep victims and their families safe from further harm. This will happen every day Monday to Friday.

Immediate actions that can be taken to prevent further harm must not be delayed because a case is going to be considered by the MARAC.

The Constabulary will share relevant information that is held in respect of victims, offenders, and others within an abusive household.

INDEPENDENT DOMESTIC VIOLENCE ADVISORS (IDVA)

Independent Domestic Violence Advisors, working alongside the police and other relevant agencies, have been shown to produce positive outcomes in domestic abuse cases.

The Constabulary shall refer all high risk domestic abuse cases for IDVA intervention. IDVA are based within the GDASS (Gloucestershire Domestic Abuse Support Service) team.

DOMESTIC VIOLENCE PREVENTION NOTICES/ORDERS

Domestic Violence Protection Notices and Orders are aimed at perpetrators who present an on-going risk of violence to the victim primarily where no criminal complaint is being pursued through the criminal justice system. The aim is to give the victim a degree of additional protection coupled with the time and space to help them break any cycle of abuse

It is imperative that early consideration is given to the potential use of a DVPN especially if an individual is in custody.

A DVPN is the initial notice of immediate emergency protection to the victim or victims that is issued by the police. This is issued by a Supt and initiates a hearing in a Magistrates Court within 48 hours. A number of controls can be put in place such as removing the perpetrator from the address.

A DVPO is an order made by the magistrates' court after a DVPN has been issued. If agreed by the Magistrates the police conditions can be endorsed or additional measures put in place. It will run for between 14-28 days, beginning on the date it is made by the magistrates' court.

The DVPNs and DVPNs affect the victims of violence and the perpetrators. Offenders are often free to return to the scene of abuse sometimes within hours of arrest. Research shows us that this is a time of increased risk to a victim. Victims have "traditionally" had to make the decision to leave the address (often with children) and/or an injunction taken out to prevent further abuse or harassment by the alleged perpetrator. A DVPN/PO could allow the victim to stay and for the alleged perpetrator:

to leave the address

be prohibited from entering the address

to be prohibited from going within a specific distance of the address

to not prohibit the victim from the address

Gloucestershire Constabulary will use the legislation from the 2nd June 2014 within a custody setting. Use of this tactic can be considered outside of custody through discussion and dialogue with the local policing domestic teams and the PPB.

OPERATIONAL POLICE INFORMATION (OPI) AND ALARMS

Management of on-going risk is critical in Domestic Abuse cases. There are a suite of options that attending officers need to consider as part of the process of managing on-going risk to victims. These may include;

- the creation of OPI alerts on the victim or offender's address to inform attending officers of previous domestic violence incidents. These should include any specific warnings about the address or individuals that are pertinent for officers.

- Submission of intelligence is also critical regarding incidents of domestic abuse and informs the creation of appropriate markers on the Unifi intelligence system to highlight risks faced or posed by individuals that have been involved in domestic abuse incidents which assists in the risk management and information available to officers attending future incidents.

- The installation of alarms at the addresses of victims and the provision of a mobile panic button by National Monitoring On-line should also be considered as part of this suite of options http://www.monitoring.pnn.police.uk/

8. Domestic abuse involving officers and staff

As an employer of a large number of people there will be both victims and perpetrators of domestic abuse within the organisation. Police officers, special constables and police staff who commit domestic abuse related offences should not be seen or treated differently from any other perpetrator and should be investigated and held accountable through the Criminal Justice System.

Domestic abuse perpetrated by any member of the Constabulary's workforce will not be tolerated. If you are found guilty of any domestic related criminal offence, misconduct or disciplinary procedures, your job may be at risk.

Victims are e**ncouraged to report the matter to a supervisor or confidante within the organisation**. Disclosing such information may be difficult; however it is important that victims receive the relevant support both at work and also in your home environment in order to protect you from further incidents of harm.

The Constabulary's policy in respect of domestic abuse involving employees can be found at: Police Officers and Staff Who Commit Domestic Abuse

Appendix A: Domestic Violence Governance

The Assistant Chief Constable, Operations is the ACPO Officer responsible for the oversight of domestic abuse policing in Gloucestershire.

The Detective Chief Inspector, Safeguarding is the strategic owner for all elements of the Constabulary's response to domestic abuse. That individual will maintain an improvement plan to capture best practice, the outcome from inspections, Domestic Homicide Review recommendations etc.

The Detective Inspector, Safeguarding is the Constabulary's operational lead for domestic abuse policing.

Strategic direction and internal governance will be by the Public Protection Board chaired by the ACC Operations.

Operationally domestic abuse performance will form part of the monitoring and challenge programme of the Constabulary's Performance and Operations Meeting.

The Constabulary will also provide updates to the MARAC Steering Group and the Gloucestershire Domestic Abuse and Sexual Violence Board.

Appendix B: Aide Memoir for Call Takers

The opening code C40 has been amended to read Domestic Abuse incidents. Once the opening code is used it will trigger a question set – a ten question front end Risk Assessment process that is mandatory for all call taking. The incident will default to a 2.1 Grading.

1. **What exactly is happening? - Record verbatim**
2. **Are you in immediate danger? - Check whether weapons are being used**
3. **Are you in a safe place to continue to talk to me? If NO advise caller to find a safe place and take the phone with them**
4. **Is anybody injured? Check severity of injury and whether medical assistance is required**
5. **Are any children present and are they safe?**
6. **Are you frightened? What is frightening you?**
7. **Has this happened before? If YES record - how often and or who was this reported to NB If happened before even if not recorded on our systems specify that this person is a repeat victim**
8. **Obtain the location and identity of person making the report, children and or suspect(s)**
9. **Identify the details of the people involved including victim, caller, children or suspects (names, address, dob, tel no)**
10. **Conduct and record result**

If the incident is urgent and is a grade 1 then the call taker will need to exit the question set in order to prioritise the incident creation and transfer to dispatch. If this occurs then the call taker will note on the incident a rationale for exiting the question set. They will also conduct checks on relevant systems to ensure that the officer attending is updated with relevant information and intelligence. **A C40 opening code will automate a Domestic Abuse tag.**

If the call has been concluded prior to the incident being recognised / tagged as a Domestic Abuse incident then it is the responsibility of the operator to inform the attending officer that it is their responsibility to risk assess the incident through the completion of a DASH.

Incidents that have been opened or subsequently tagged as Domestic Abuse will remain on the relevant dispatch desk however they will also appear on a duplicate “Domestic Abuse” queue. This is in order that the FCR supervisors can maintain an over view of Domestic Abuse incidents. With immediate effect operators will not be authorised to close Domestic Abuse incidents as this function will now be performed by FCR supervisors **once the incident has been quality assured by that supervisor.**

- Full update on the incident or crime number if appropriate
- DASH has been completed
- Indication on the incident of whether the victim is of high, medium or low risk
- An update on who has been contacted to support the victim to include partner agencies

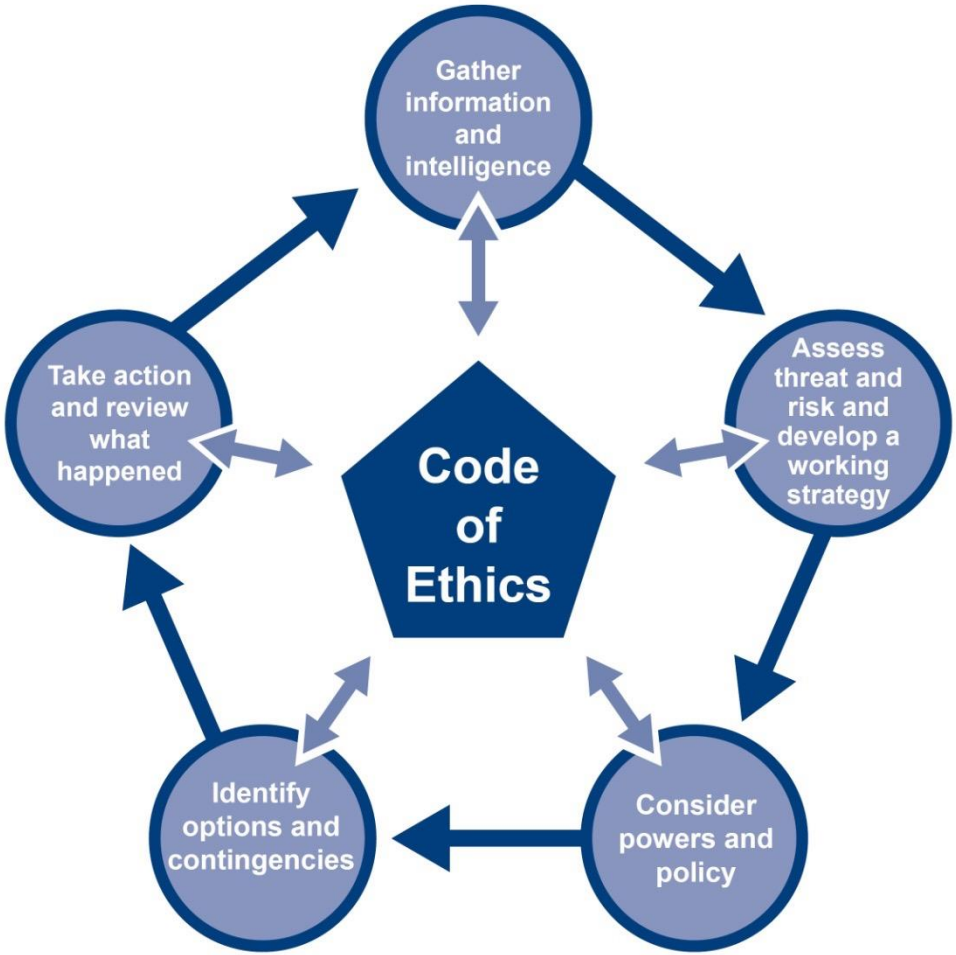
Once the Incident Assessment Unit is established Domestic Abuse incidents that do not require an emergency response will be screened by IAU supervisors in order that they can review the incident and complete all relevant systems checks. IAU supervisors form a part of the FCR team and as such will be available to assist in the overall quality assurance of Domestic Abuse Incidents

Appendix C: Aide Memoir for Deployment

- Prioritise the safety of officers and others;
- Ensure that medical assistance is on route, where appropriate;
- Make sure that support (backup) is available for the officer(s) attending the incident, where appropriate;
- Inform the caller that an officer(s) has been dispatched;
- Make appropriate checks of IT and/or paper-based systems for previous reported domestic violence history, PNC checks, bail conditions, civil injunctions, court orders relating to child contact, child protection intelligence systems, child protection register, VISOR;

- Inform the officer attending of the following:
  - Details of any children present,
  - Any relevant history, injunctions and child protection issues,
  - Any communication difficulties (language, hearing, speech),
  - Any other factors that may affect the police response, e.g. those relating to culture, same sex, male victim, disability, mental health,
  - A description of the suspect, where necessary,
  - Whether supervisors are aware of the incident, in accordance with local policy;
  - Inform the caller when a police officer(s) has arrived at the scene so that the officer(s) can be safely admitted to the premises.

Appendix D: The National Decision Model



Appendix E: Example Safety Plan

If you are staying with the abuser:

- Seek professional advice and support from local support and outreach organisations. GDASS can be contacted on 0845 602 9035.
- Consider how agencies could make contact with you safely if needed, e.g., through a work number or at a friend's address.
- Consider where you can quickly and easily use a telephone if yours is not available. Memorise a list of numbers for use in an emergency, like friends, police, and support organisations.
- Consider a signal with children, family, neighbours, friends or colleagues, which will alert them to call the police when help is needed.
- Think through escape routes in advance; if possible avoid rooms with no exit or with weapons in (e.g., bathroom or kitchen).
- Try to save some money for fares and other expenses.
- Receive medical help for any injuries ensuring that they are recorded and if possible photographed. These may be used at a later date to support court cases or re-housing applications.

If you are planning to leave:

- Take care over whom to trust with any plans that you are making to leave.
- Consider whether or not an injunction is a viable option - seek legal advice.
- Make an extra set of keys for home and/or car and store them somewhere safe.
- Have spare clothes, phone numbers, keys, money etc. handy so that you can take them quickly or keep them in a bag with a trusted friend.
- Have the following available in case you have to leave quickly:
    - Important papers such as birth certificates, social security cards, driver's licence, divorce papers, lease or mortgage papers, pass-ports, insurance information, school and medical records, welfare and immigration documents, court documents.
    - Credit cards, bank account number
    - Some money
    - Extra sets of keys - for car, house and work
    - Medications and prescriptions, including those for children
    - Phone numbers and addresses for family, friends, doctors, lawyers and community agencies
    - Clothing and comfort items for you and the children
    - Photographs and other items of sentimental value such as jewellery
- Take identification that might help others to protect you from the abuser, such as a recent photo of the abuser and their car details.
- Talk to children about the possibility of leaving and try to take all children, whatever long-term arrangements might be.

If you are living without your abuser after separation (in your own home or after moving):

- Seek expert legal advice on child contact and residence applications, and about options for injunctions
- Change phone numbers and screen calls; pre-programme emergency numbers into the phone

- Change the locks and install a security system, smoke alarms and an outside lighting system
- Notify neighbours, employers and schools about any injunction, and ask them to call the police immediately if they see the abuser nearby
- Make sure that schools and those who care for any children know who has authorisation to collect them
- Employ safety measures before, during and after contact visits, if appropriate
- Consider changing daily patterns - hours and routes taken - and the route taken to transport children to school
- Avoid other places frequented when living with the abuser
- Make up a code word for family, colleagues, teachers, or friends, so they know when to call the police for help
- Keep copies of all relevant paperwork (including civil injunctions) and make written records of any further incidents.