Wakefield and District Community Safety Partnership

Domestic Homicide Overview Report regarding the death of Rosie who died in August 2019

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1. Introduction

1. This Domestic Homicide Review (DHR) Overview Report examines agency responses and support given to Rosie, a resident of Wakefield District, prior to her death by manslaughter in August 2019.

2. Rosie's death was notified to Wakefield and District Community Safety Partnership (CSP) on 30th August 2019. Rosie died as a result of severe head trauma.

3. The DHR panel wishes to offer its condolences to Rosie's family and friends.

4. Wakefield and District Safety Partnership (CSP) determined that this case met the criteria for a DHR, based on information provided through an initial scoping exercise. 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 inform national and local policies and procedures as appropriate.

    - Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

    - Contribute to a better understanding of the nature of domestic violence and abuse; and highlight good practice.

5. In addition to agency involvement the DHR has examined the past to identify any relevant background or incidences of domestic abuse or violence before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach this DHR has sought to identify key issues for learning and to make appropriate recommendations for action.

6. The subjects of the review are Rosie and Robert. For completeness, the family composition is outlined in the table below.

Name used for the DHR in the published report	**Age**	**Relationship**
Rosie	Aged 30	Victim
Robert	Aged 32	Perpetrator
Child A	Aged 6	Child of the victim
Child B	Aged 8	Eldest child of the perpetrator
Child C	Aged 4	Youngest child of the perpetrator

2. Timescales

7. In October 2019 a tendering process was completed to appoint an independent chair and author and the formal contract was agreed in December 2019. The DHR formally commenced at that stage. A first panel meeting was held in March 2020, following a period of scoping. There then followed a process of IMR completion and submission, with a further panel meeting to review the IMRs and a third to review the first draft of the Overview Report. The process was concluded in August 2020. The DHR panel met once in person, with the second and third meetings being held virtually. There were a number of additional discussions by telephone. The Chair also held discussions by phone with the DHR lead within Wakefield and District CSP.

8. The DHR was affected by the COVID19 outbreak, which saw some key colleagues diverted to other work roles to address the impact of the pandemic. It also necessitated the use of 'virtual' meetings of the panel and email exchange of comments and feedback on the report in its draft stages. This included contact using video and telephone conferencing to engage with panel members.

9. Despite this, the panel has concluded the process thoroughly, albeit with some delay to the six-month recommended timescale set out in the national guidance.

3. Confidentiality

10. The DHR was conducted in private. All documents and information used to inform the review are confidential. A suitably anonymised version of the Overview Report and Executive Summary for this review will be made available on the CSP website once the Home Office Quality Assurance Panel has cleared the reports.

11. Pseudonyms have been used in this Overview Report to ensure confidentiality. The victim is represented in the report by the name Rosie. The perpetrator is represented by the name Robert. Both pseudonyms were chosen at random.

4. Terms of Reference and principles of the review

12. Terms of Reference were developed and agreed jointly. Panel members and the independent chair discussed these. The Terms of Reference were as follows:

- Examine the events leading up to the incident, including a chronology of the events in question.

- Review the interventions, care and treatment and or support provided. Consider whether the work undertaken by services in this case was consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols including Safeguarding Adults and Safeguarding Children and education services.

- Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment and management and the care and service delivery of all the agencies involved. This should include the application, or otherwise of the relevant legislative requirements and safeguards pertaining to information exchange.

- Identify any care or service delivery issues, alongside factors that might have contributed to the incident.

- Examine how organisations adhered to their own local policies and procedures and ensure adherence to national good practice.

- Review documentation and recording of key information, including assessments, risk assessments, care plans and management plans.

- Examine whether services and agencies ensured the welfare of any adults at risk, whether services took account of the wishes and views of members of the family in decision making and how this was done and if thresholds for intervention were appropriately set and correctly applied in this case.

- Whether practices by all agencies were sensitive to the gender, age, disability, ethnic, cultural, linguistic and religious identity of both the individuals who are subjects of the review and whether any additional needs on the part of either were explored, shared appropriately and recorded.

- Whether organisations were subject to organisational change and if so, did it have any impact over the period covered by the DHR. Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

- That where organisations identify broader learning that might lead to a need for awareness raising of domestic abuse issues during their IMR processes, this should be highlighted and acted upon locally as part of the system response to the DHR.

Overview and Accountability:

- The Chair and members of the Wakefield and District Community Safety Partnership took the decision to undertake a Domestic Homicide Review (DHR) in September 2019 and the independent chair and author was appointed on 11th December 2019.

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

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

Principles of the Review

13. The DHR was undertaken in accordance with the current national DHR Guidance, most recently updated in December 2016. It was guided by seven principles:

    - The DHR will be objective, independent & evidence-based.
    - The DHR will be guided by humanity, compassion, and empathy, with the subjects of the review at the heart of the process.
    - The DHR will ask questions, identify issues, and make recommendations that seek to reduce or prevent future harm, and learn lessons.
    - The DHR will not blame individuals or organisations, but if the evidence supports it, will seek to ensure that organisations are held to account for actions or the lack of.
    - The DHR will respect equality and diversity, giving due accord to the nine protected characteristics.
    - The DHR will be conducted in an open and transparent way whilst safeguarding confidential information where possible.
    - The DHR will culminate in an Overview Report and Action Plan to effect change and disseminate lessons learned.

14. The DHR has considered each agency's involvement with Rosie and Robert at least three years prior to her death in August 2019, except for any other relevant information relating to domestic abuse prior to this date. This timescale was chosen and agreed by the panel in order to allow sufficient research of potential contacts and issues, in part because of the immediate lack of agency contact in the period immediately prior to the fatal incident. Whilst checking these records the panel sought to identify any other significant individuals who might be able to help the review by providing information.

- Whether family, friends or colleagues wanted to participate in the review. If so, ascertain whether they were aware of any abusive behaviour to the victim or her children, prior to the homicide (any disclosure, not time limited).

- In relation to the family members, friends or work colleagues whether they were aware if any abuse, what to do and of any barriers experienced in reporting abuse? Or best practice that facilitated reporting it?

- Could improvement in any of the following have led to a different outcome for Rosie, considering whether the work undertaken by services in this case are consistent with each organisation's:

  - Professional standards
  - Statutory multi-agency guidance
  - Local safeguarding arrangements
  - Domestic abuse policy, procedures and protocols

- Identify how the resulting information and report should be managed prior to publication with family and friends and after the publication in the media. Keep these terms of reference under review to take advantage of any, as yet, unidentified sources of information or relevant individuals or organisations.

5. Methodology

15. The decision to undertake the DHR was made by the Chair of the CSP. The DHR has followed the guidance provided by the Home Office, which sets out how the process should be undertaken, including the focus on the victim of domestic abuse.

6. Involvement of family, friends, work colleagues, neighbours and wider community

16. The panel has sought throughout the review to ensure that the wishes of the family members have informed the DHR Terms of Reference and are reflected in the DHR report.

17. Initial information about the review was given to the family by the domestic abuse coordinator and the police Family Liaison Officer (FLO) in a face to face meeting before commissioning the independent reviewer. During this meeting information was provided about advocacy and support services including those provided through Advocacy After Fatal Domestic Abuse (AAFDA).

18. Letters were also sent to Rosie's parents and siblings with details of contact numbers and email addresses. Council staff and the Chair did liaise with the FLO during the review and they shared the report with the family prior to being submitted to the home office.

19. The family also informed the FLO they had nothing to comment. The FLO also offered a conversation with the Chair, but they did not wish to take up that offer.

20. Contact was made more complicated by the Covid-19 pandemic which rendered face to face contact with the family and other colleagues impossible

7. Contributors to the review

21. Following an initial scoping exercise a number of agencies contributed to the review through the submission of Individual Management Reviews (IMRs) and summary reports. Those agencies were:

    - NHS Wakefield Clinical Commissioning Group (Primary Care)
    - Turning Point – Talking Therapies
    - Mid Yorkshire Hospitals NHS Trust
    - West Yorkshire Police
    - Bradford District Care NHS Trust (0-19 Service)
    - Children's Social Care
    - Primary Schools attended by Rosie and Robert's children

    People who were independent, in that they had no knowledge or connection with the case produced the IMRs and scoping reports.

8. The review panel members

Steve Appleton	Independent Chair and author
	Domestic Abuse Coordinator/Domestic Abuse Specialist – Wakefield Council/Wakefield District Domestic Abuse Service
	Service Director Communities – Wakefield Council
	Head of Safeguarding – Mid Yorkshire Hospitals NHS Trust
	Assistant Director of Nursing Quality and Professions, South West Yorkshire Partnership NHS Foundation Trust
	Superintendent – West Yorkshire Police
	Named Nurse for Safeguarding Children Bradford District Care NHS Trust
	Specialist Nurse Safeguarding Children– NHS Wakefield Clinical Commissioning Group
	Service Manager MASH – Wakefield Council
	Senior Operations Manager, Turning Point Talking Therapies
	Service Manager Inclusion, Assessment, Education and Inclusion, Wakefield Council

The Domestic Abuse Coordinator was also responsible for the managing of the local domestic abuse service and therefore represented that service and brought relevant expertise to the panel.

The members of the panel were independent and had no prior contact with the subjects of the DHR or knowledge of the case.

9. Chair of the review panel and author of the Overview Report

22. The Independent Chair of the panel and author of the DHR Overview Report is Steve Appleton. Steve trained as a social worker and specialised in mental health, working as an Approved Social Worker. During that time he worked with victims of domestic abuse as part of his social work practice. He has held operational and strategic development posts in local authorities and the NHS. Before working independently he was a senior manager for an English Strategic

Health Authority with particular responsibility for mental health, learning disability, substance misuse and offender health.

23. Steve is entirely independent and has had no previous involvement with the subjects of the DHR. He has considerable experience in health and social care, and has worked with a wide range of NHS organisations, local authorities and third sector agencies. He is a managing director of his own limited company, a specialist health and social care consultancy.

24. Steve has led reviews into a number of high profile serious untoward incidents particularly in relation to mental health homicide, safeguarding of vulnerable adults, investigations into professional misconduct by staff and has chaired a Serious Case Review into an infant homicide. He has chaired and written over 25 DHRs for local authority Community Safety Partnerships across the country. He has completed the DHR Chair training modules and retains an up to date knowledge of current legislation.

25. Steve has had no previous involvement with the subjects of the review or the case. He has not worked for the CSP before or with any of the panel members, so is entirely independent.

10. Parallel reviews

26. There were no parallel reviews undertaken in relation to this case. The DHR panel Chair and Community Safety team staff liaised with the Senior Officer in the case and it was confirmed that no inquest was held into Rosie's death.

11. Equality and diversity

27. "The Equality Act 2010 brings together the nine protected characteristics of age, disability, gender reassignment (with a wider definition) marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation."[1] There are further considerations relating to income and pay gaps, the gender power gap in public sector leadership positions and politics, and the causes and consequences of violence against women and girls, under the Gender Equality Duty.[2]

[1] Paragraph taken from Home Office Domestic Homicide Review Training; Information Sheet 14. P47
[2] Gender Equality Duty 2007. www.equalityhumanrights.com/.../1_overview_of_the_gender_duty

28. The panel considered the nine protected characteristics in the Equality Act. Sex, in relation to Rosie, was found to have direct relevance to the review. Women are around twice as likely to experience domestic abuse and men are far more likely to be perpetrators. The majority of domestic homicide victims are women, killed by men. [3]

29. On average, two women are killed each week by their current or former partner in England and Wales, a figure that has changed relatively little in recent years.[4] It impacts on women's health and independence, reduces their ability to work and creates a cycle of economic dependence. Women's inequality limits their ability to escape from abusive relationships; it can make it more difficult for them to enforce their rights and more likely to experience sexual harassment and violence.

30. The panel ensured that the review always considered issues relating to the nine characteristics in their thinking about the engagement and involvement of organisations and professionals and where identified, the impact of them on decision making and whether these presented a barrier to accessing support and assistance. From the information available to the panel there was no evidence that any of them were of direct relevance to Rosie and her experience and that they did not present barriers to her in seeking or accessing help or support. On that basis the judgment of the panel was that only sex was of direct relevance in this case.

12. Dissemination

31. The Overview Report will be sent to all the organisations that contributed to the DHR. In addition an appropriately anonymised electronic version of the Overview Report will be placed on the CSP website. A copy will be provided to the Police and Crime Commissioner.

32. Members of Rosie's family have been provided with hard copies of the Overview Report.

[3] Office for National Statistics. 'Domestic Abuse in England and Wales'. 2018. Crown Prosecution Service 'Violence against women and girls report.' 2018.
[4] Office for National Statistics 'Crime Statistics, Focus on Violent Crime and Sexual Offences, Year ending March 2016, Chapter 2: Homicide'. 2016

13. Background information (The Facts)

33. Rosie was a 30 year old white British woman, who lived in the Wakefield District. She had been in a relationship with Robert for a relatively short period. It is believed that the relationship started approximately six months before her death.

34. Rosie worked as a customer advisor in a local bank and had done so for a number of years.

35. Prior to being with Robert, Rosie had been in a 12 year relationship with another man, with whom she had a child, Child A who was six years old at the time of Rosie's death. It is understood that Rosie separated from the Child A's father in December 2018. She and Child A continued to live in what had been the family home until it was sold and she then moved to the address where the incident took place.

36. Rosie met Robert in February 2019 while on a night out with her sister and her husband. Robert was known to Rosie's sister through a mutual friend. At that time Robert was 31 years old. He lived with his mother. He had two children from a previous relationship, which had lasted for approximately eight years and ended in 2016. He was employed as a Public Service Vehicle Driver. He had an interest in body building and it is understood that he took steroids as part of this activity.

37. At about 5.37am in late August 2019, West Yorkshire Police received a call from staff at Pinderfields Hospital notifying them that Rosie had been admitted having suffered severe head trauma. Robert was arrested on suspicion of causing Rosie grievous bodily harm.

38. At 10.18am that day Rosie was pronounced life extinct at Pinderfields Hospital and at 11.33am Robert was detained in custody. Four days after Rosie's death Robert was formally charged with the murder of Rosie.

39. Robert was convicted of manslaughter at Crown Court in January 2020. He was sentenced to five and half years imprisonment. The Judge said, *"What exactly happened that evening only you can know, because there were no witnesses and the expert evidence and the inferences to be drawn from all the material in the case cannot lead to any definitive conclusions. But what is clear is that Rosie was found unconscious at the bottom of a flight of stairs, quite steep stairs in my estimation, face up and with her head pointing towards the front door. She*

had sustained fatal skull fractures caused by a severe impact at or near to the bottom of the stairs."

14. Chronology

40. A combined chronology was developed to support the panel in its work and the development of the Overview Report. What follows is a summary of the key parts of that chronology to assist the reader in tracking the course of events.

First contact with services

41. In July 2013 Rosie had her first contact with services via primary care when she attended her GP and described experiencing mood disturbance. She also had mild depressive symptoms and was prescribed anti-depressant medication. By October 2013 her depression was continuing and she also separated from her then partner.

Road traffic accident

42. In February 2014 Rose was involved in a road traffic accident (RTA) and was taken to the Emergency Department of Mid-Yorkshire Hospitals NHS Trust as a result of experiencing neck pain after the collision. She was examined and offered advice as well as pain relief, which she declined. This was her only contact with Mid-Yorkshire Hospitals NHS Trust.

Continuing low mood and depression

43. Rosie consulted her GP again at the end of February 2017 as a result of low mood. She was also concerned about her experience of occasional panic attacks. During the consultation she identified stress factors in her life, including arguing with her previous partner.

44. Rosie was reviewed in April 2017 by her GP and reported that her mood had improved but that she was consuming three or four bottles of wine per week, which the GP noted was above the recommended level in the national guidance. She was also having some problems sleeping and was prescribed medication to assist with this. At the end of April she reported to the GP that she was having on going issues with her former partner and was feeling low again. In May 2017 she was signed off work.

45. Rosie continued to experience low mood and anxiety and discussed a referral to Talking Therapies with her GP. This was a self-referral which is usual practice for services of this type.

Overdose

46. In June 2017 Rosie attended the Emergency Department of Pinderfields Hospital following a mixed overdose of ibuprofen, prescription medication and alcohol. The Psychiatric Liaison Team assessed her. She described her experience of low mood and relationship breakdown, which were in her opinion the trigger for the overdose. The contact was brief and she took her own discharge. A referral for her child was made by the Liaison Team to Children's Services. They were in contact in late June 2017, they concluded that there were no safeguarding concerns.

Initial contact with Talking Therapies

47. At the end of June 2017 Rosie completed an online self-referral for the talking therapy service operated by Turning Point. A support worker contacted her by phone following receipt of the referral and assessment was booked for that same day. It is recorded that Rosie engaged in the assessment process and that she was accepted for guided self-help using a form of Cognitive Behavioural Therapy. Rosie took part in a welcome session and was then placed on a waiting list for self-guided therapy.

48. In July 2017 Rosie was contacted by the service to offer the first treatment appointment.

Health Visitor involvement

49. The Health Visitor first became involved with Rosie in July 2017. This followed concerns she had raised about her child's behaviour. The Health Visitor offered behaviour management advice.

Talking Therapy service contact

50. In July 2017 Rosie attended her first treatment appointment with the talking therapy service. She had a further session two weeks later. She did not attend the third planned session. By the end of August 2017 Rosie had not responded to calls from the service and her case was closed.

Contact with Primary Care

51. There were contacts with primary care services that are recorded prior to the timeframe for this review. Most of these related to Rosie's low mood, although there were other health matters for which she was successfully treated with antibiotics during mid-2018. In September 2018 she consulted the GP about knee pain and was referred for physiotherapy.

52. There were numerous routine appointments for minor illnesses (as described in the primary care IMR) between January 2019 and Rosie's death in August that year. The majority of these related to her ongoing knee pain.

Relationship with Robert

53. In February 2019 Rosie met Robert and they began a relationship in March the same year.

54. During Easter 2019 the first instance of domestic abuse was recorded, when Rosie and Robert were on holiday. Robert became verbally abusive towards her and threw a drink over her.

55. In May 2019 there was a second incident of domestic abuse when Robert threw a drink over Rosie during party. Rosie also told her sister that Robert had hit her on the back of the head with a bottle.

56. In June 2019 Robert engaged in coercive and controlling behaviour when he made Rosie delete contacts from her Facebook account.

57. At the end of July 2019 Robert took Rosie's handbag from her, containing money, keys and her phone, following an argument. She had to make insurance claims to replace the items which were not found.

58. In late August 2019, the Yorkshire Ambulance Service received a 999 call reporting that Rosie had fallen down the stairs and was not breathing. Paramedics attended and took her to hospital. Rosie had suffered a head injury.

59. West Yorkshire Police received a call from staff at Pinderfields Hospital notifying them that Rosie had been admitted having suffered severe head trauma. Robert was arrested on suspicion of causing Rosie grievous bodily harm. At 10.18am that day Rosie was pronounced life extinct at Pinderfields Hospital and at 11.33am Robert was detained in custody. Four days after Rosie's death Robert was formally charged with her murder. He was subsequently convicted at Crown Court in January 2020.

15. The views of Rosie's family

60. The council and the CSP had direct contact with Rosie's sister-in-law, who confirmed that her husband, Rosie's brother, did not wish to participate in the review. The panel also received confirmation via the Victim Support Homicide Service that Rosie's mother did not wish to participate in the review. Contact was attempted with other members of Rosie's family but they did not respond to the invitation to participate in the DHR. On that basis pseudonyms had to be chosen at random.

61. The panel recognises the gap in information that results from this lack of involvement, particularly in light of the limited contact with statutory agencies. The panel is satisfied that all reasonable efforts were made to both establish contact and to engage family members. Furthermore, the panel respects the wishes of family members not to take part in the DHR. Although they did not wish to take part in the review, family members were provided with copies of the final draft of the report and invited to make any comments, but they did not do so.

16. The views of the perpetrator

62. In accordance with the Home Office Guidance, the Chair of the DHR wrote to Robert to advise him of the review. Contact was established with the help of the police, probation and the prison where Robert is currently being held.

63. Despite a number of follow-up enquiries through the prison and probation services, including with Robert's allocated Offender Manager, and subsequent direct correspondence with Robert, no response was received.

64. The panel were satisfied that sufficient and appropriate attempts were made to contact and engage Robert in relation to the review. The panel also acknowledges his right not to respond, and not to participate in the review.

17. Overview

65. Drawing on information from the IMRs, this section of the report provides an overview of the contact between agencies and Rosie. It summarises the information known to the agencies and professionals about Rosie and any other relevant facts. It is deliberately structured by each agency as the appendicised chronology already provides a lateral timeline. It is important to state that the level of contact with statutory agencies was particularly limited in this case.

West Yorkshire Police (WYP)

66. WYP had only one contact with Rosie. This occurred when she was the victim of a theft from a car. WYP had no previous contact with Robert.

67. During the course of their enquiries, WYP were able to gather a range of information that has informed their IMR and provided the DHR panel with valuable insights into the history of Rosie and Robert's relationship. Although WYPs only contact was 'after the fact' this information is set out here because it includes relevant detail.

68. The WYP IMR indicates that a friend of Rosie's told them that Rosie had started an intimate relationship with Robert in March 2019, having first met him in February the same year. It is also understood that in the early part of their relationship, Robert was still conducting sexual relationships with another woman and this almost caused the relationship between Rosie and Robert to end, however, Rosie did not end things at this point.

69. During Easter 2019 Rosie, Robert, Rosie's sister and her husband travelled to Spain for a holiday. This was a celebration of Rosie's 30th birthday. The IMR states that on the first night of the holiday Robert became angry because Rosie was dancing near a group of men. He directed aggressive verbal abuse towards her, insulting her and then threw a drink over her.

70. This was the first time Rosie's sister had seen Robert behave in such a way. She later told WYP that she had seen Robert display possessive and aggressive behaviour towards Rosie, including checking messages on her phone.

71. Having returned from Spain, in May 2019 Rosie and Robert attended a party with Rosie's sister and her husband. The IMR describes how, when Rosie wanted to use a hot tub at the party, Robert became angry and again threw a drink over her, in front of the other guests at the party. Robert then left the party and Rosie followed him. Her sister then went to find Rosie and found her alone. Rosie told her sister that Robert had hit her on the back of the head with a bottle. He then returned in his car and Rosie left with him.

72. A friend of Rosie's told WYP that in June 2019 Robert had told Rosie to delete a number of people from her Facebook Friends list. When she did so, he asked her to block them as well. Rosie's friend said that Rosie later resisted these requests from Robert.

73. In July 2019 Rosie's sister and husband were on a night out in town when Rosie, who said she had been out with Robert in West Yorkshire, joined them. Rosie wanted to return to her home town and this had made Robert angry. He had taken her handbag from which contained her keys, mobile phone and money. She did not have it with her when she met up with her sister. Robert had also thrown Rosie's shoes into someone's garden and pushed her over, causing her to fall to the ground.

74. It is believed that this incident also related to an allegation Rosie had made to her sister about Robert attempting to strangle her while in the back of a taxi. Rosie's sister told WYP that Rosie had described other occasions when Robert had held her against the bedroom wall by her neck, threatened her on one occasion to force entry to the house and had broken her phone, taken it from her and then lost it causing her to make two insurance claims.

75. One of Rosie's friends told WYP that in August 2019 she had been present at a small party that Rosie and Robert attended. Robert had lost his temper and again threw a drink over Rosie, and they then spent the evening arguing.

76. In August 2019 Robert was away on holiday with his mother and his two children while their mother was on holiday abroad. On the penultimate day of the holiday Rosie and Child A joined them. A friend of Robert's received a Facebook message that Rosie and Robert were at a particular location in the town where they were on holiday. The IMR does not report anything specific about the holiday.

77. Having returned from holiday, and on the day preceding her death, Rosie had a visit at her home from her sister and they had arranged to visit a local pub,

which was hosting a festival. When Rosie's sister arrived she found that Rosie was not present but she arrived shortly afterwards, having taken Child A to her mother's house. Robert was with her, but then left in his own car. Rosie and her sister left for the pub at about 3.30 pm and while on their way there Robert phoned Rosie and told her that he had arranged for his father to look after Child B and C and that he would now join her at the pub.

78. At the pub, two female friends joined Rosie before Robert arrived. He brought her some sandals but did not stay at the pub. One of Rosie's friends then wanted to go and meet her father at another pub so Rosie and her other friend went with her. While walking there Robert called Rosie on the phone and told her he was at the pub to which she was walking with her friends. When they arrived he was there. They then left that pub for another, along with Robert and Rosie's friends' father.

79. They arrived at the third pub at about 7.20pm. While there Robert became angry and an argument took place between him, Rosie and her sister. At about 8.05pm Rosie left with her sister and while walking Rosie received a number of phone calls from Robert. Her sister then went to meet Robert to retrieve Rosie's keys, which were in his possession. She met him in the street and an argument took place. They all returned to the first pub they had visited and there was a further argument between Rosie and Robert. They then all left to go to a local social club. By this point Robert was intoxicated by alcohol.

80. After being there for about an hour, at 10.05 pm Rosie's sister decided to leave and went to a nearby taxi rank. Rosie told her sister that she and Robert were going to walk home and asked her sister if she wanted to join them. She agreed to do so. They got back to Rosie's house at about 11.25 pm and Rosie and Robert went into the house. Rosie's sister continued to walk to her own home on her own, talking to the victim on her phone throughout. She was not present when the incident took place.

81. Shortly after midnight, the IMR records that a neighbour heard a thud from inside Rosie's house. A few minutes later Robert knocked on the neighbours' door and asked her to call the police because Rosie had fallen down the stairs. The neighbour and her partner went to Rosie's house, and the neighbour performed CPR and her partner called an ambulance.

82. WYP had no prior contact with Rosie or Robert in relation to matters of domestic abuse, nor with family or friends.

NHS Wakefield Clinical Commissioning Group (CCG) – Primary Care Contact with Rosie

83. Rosie was registered with a GP practice in her home town. From the review of her medical notes, it does not appear that she had any significant medical history of note.

84. Rosie met with her GPs routinely, though not frequently for checks relating to her prescription for ongoing contraception and when she had symptoms of minor ailments.

85. The IMR indicates that Rosie did have a period of being treated for low mood between February 2017 and February 2018 which was attributed to work stress and the break up with a previous partner. It is understood that the relationship had been of an 'on and off' nature. The IMR indicates that the GP records show that Rosie reported the relationship was over in April 2017 but that in July 2017 there were attempts to restart the relationship, with it finished completely in December 2018.

86. Rosie's only other recorded contacts were for regular blood tests in relation to a diagnosis which appears to have started around June 2018.

87. Rosie had also been suffering with right knee pain (due to an old injury) and a referral was made to secondary care for the opinion of an orthopaedic surgeon.

88. The IMR notes that Rosie did miss some appointments, but these were always followed up by the Practice and further appointments were made in a timely way. Nothing is recorded to suggest that there was any particular reason or concern for any failure to attend appointments.

89. In April 2017 Rosie was advised by her GP to self-refer to Turning Point Talking Therapy Service. The GP records reviewed for the IMR indicate that Rosie did refer herself to this service and completed her course of therapeutic engagement and there were no concerns highlighted in the discharge letter to the GP from Turning Point.

90. There is nothing in the records reviewed for the IMR that indicates that Rosie was suffering from any stress after February 2018 or that she felt at any risk from Robert and there is no mention of these issues ever being discussed with her GP.

91. The IMR also states that there were no family or friends that were of significance to the Practice other than Child A, who was also registered with the Practice.

NHS Wakefield Clinical Commissioning Group (CCG) – Primary Care
Contact with Robert

92. Robert was registered at a different GP practice to Rosie. The IMR author notes that it was not possible to establish which practitioners from the practice saw Robert, in part this was as a result of difficulties in accessing staff at the practice, in part this was as a result of the COVID19 and its operational impact on primary care.

93. The GP notes indicate that Robert was seen throughout the later part of 2013 with symptoms of mood disturbance. The exact detail of this is not known and it falls outside the timeframe for this DHR, but it is mentioned because he reported similar symptoms of low mood again in April 2017.

94. There is no record of what was thought to be the cause of the low mood in 2013. However, in 2017 it was recorded in the GP notes that Robert's low mood was attributed to Child B's ill health. This period of low mood lasted through April and May 2017.

95. After this time Robert only attended for minor ailments. Throughout the timeframe covered by this DHR, Robert was not on any routine medication.

96. The IMR also states that there were no family or friends that were of significance to the Practice.

Turning Point Talking Therapies

97. Turning Point is a national charity that provides a range of support services across England. One of those services is Talking Therapies, delivered as part of the national Improving Access to Psychological Therapies (IAPT) programme, designed to increase the amount and speed of access to these services for people with mild to moderate mental health problems.

98. Rosie self-referred to Turning Point following discussions with her GP in June 2017. This is the usual route for referral to the service. She was assessed in late June 2017 and attended a welcome workshop.

99. She then attended two Step Two treatment sessions with the service in the middle and the end of July. As is common practice, these sessions took place over the telephone.

100. The exact detail of the nature of the sessions is not clear, but it the IMR notes that at assessment Rosie stated she was not in a relationship, had experienced depression and felt that this was a causal factor in the relationship issues that she had experienced. Research referred to by Relate has suggested that people in troubled relationships are three times as likely to experience depression as those who aren't. Unhappy or unsupportive relationships are a known risk factor for depression. Relate have suggested that 60% of those with depression consider relationship problems to be the main cause of their illness.[5] During the assessment the worker did note the details of Child A, but there were no issues identified in relation to the Child and no concerns with regard to safeguarding.

101. Rosie stated that these depressive episodes resulted in her 'pushing people away' and that this contributed to the relationship issues she described. The IMR describes how the treatment intervention, known as Behavioural Activation, resulted in a swift and positive response to Rosie.

102. Behavioural Activation is a therapeutic intervention that is often used to treat depression. It is a structured, brief psychotherapeutic approach that enables people to learn to cope with their negative thoughts and feelings and increase positive awareness and behavioural changes.[6]

103. Turning Point sent a full discharge letter to Rosie's GP once the service intervention was completed in July 2017. The intervention was noted to have been successful and the discharge was agreed with Rosie.

104. There were no issues in relation to domestic abuse or family violence raised or concerns identified during the course of Rosie's engagement with the service.

Mid Yorkshire Hospitals NHS Trust (MYHT)

105. MYHT had two contacts with Rosie, only one of which was in the timeframe covered by the DHR. The first, in June 2017 was just outside the timeframe but has been included as it was close to the start date for the DHRs enquiries.

[5] Helen Undy , Relate, 2016 https://www.relate.org.uk/sites/default/files/publications/uploads/relationships-and-mental-health-briefing-may-2016.pdf
[6] https://positivepsychology.com/behavioural-activation-therapy-treating-depression/

106. This first contact was with the Emergency Department (ED), when Rosie presented following an overdose of alcohol, sertraline (an anti-depressant drug) and ibuprofen. Rosie attended the ED with her mother. She was invited to talk with the liaison psychiatry team. She initially declined that offer, but then changed her mind.

107. On discussion with the liaison psychiatry team, Rosie described how she was experiencing low mood and that the issue that had caused her to take the overdose was relationship breakdown.

108. Rosie was advised to stay in hospital overnight for further observations, but she declined and took her own discharge. The IMR notes that referrals were made for follow up with local mental health services and to Children's Social Care in respect of Child A. This was done to ensure that the child was safeguarded following Rosie's overdose.

109. Rosie's next contact with MYHT was in April 2019. She attended the ED with a knee injury. She described having had a previous injury to her knee a few years previously. She had turned and twisted her knee, which had caused pain and swelling. She attended the ED with a friend and the IMR notes that there were no concerns about how the injury was sustained, and no issues relating to domestic abuse were identified. Routine care was provided and Rosie was referred for an MRI scan on her knee. This took place two days after her ED attendance.

110. The MRI scan revealed torn ligaments in her right knee and Rosie was scheduled to undergo surgery. It does not appear that this took place as there is no record of the procedure being undertaken.

111. Rosie was taken to the ED on the morning of the incident under review. She was taken there by ambulance. She had had a serious injury resulting from the backward fall down the stairs. She had an open fracture and intracranial bleeding. Emergency care was provided to her in an attempt to stabilise her condition. She was then transferred to Leeds General Infirmary where she subsequently died from her injuries.

112. MYHT had no contact with Child A during the timeframe covered by the DHR.

113. MYHT had no contact with Robert during the timeframe covered by the DHR. They did have contact with Child B and Child C. The IMR describes the detail of

these contacts. They have not been detailed in this Overview Report as they are not directly relevant to the DHR.

Bradford District Care NHS Foundation Trust (BDC)

114. The principle contact between BDC and Rosie was in relation Child A. Rosie had become concerned about some aspects of the child's behaviour.

115. The contact was provided by the 0-19 service, who provided a routine Healthy Child Programme Offer to Rosie and Child A between June and July 2017. This was a limited and brief intervention lasting only three sessions.

116. At the end of June 2017 Rosie's GP contacted the family's named Health Visitor by phone to advise that Rosie had presented with low mood and that she was struggling to manage Child A's behaviour. It was agreed that the Health Visitor would contact Rosie to see what support she might need or could be offered.

117. The day following the referral from the GP, the Health Visitor phoned Rosie. She told the Health Visitor that Child A was hitting, kicking and biting as well as having temper tantrums. The Health Visitor provided Telephone advice about managing Child A's behaviour. A face-to-face appointment was also arranged.

118. That appointment took place 10 days later as planned. The detail of the advice provided is not detailed. Rosie was advised to contact the Health Visitor again if she felt she needed further advice or support.

Children's Social Care

119. Rosie was referred to Children's Social Care by her GP in June 2017. The GP advised that Rosie had been suffering from depression and had presented to the ED having taken an overdose (as set out in the MYHT IMR). The taking of the drugs and alcohol that led to the overdose was done while Child A was in the home, hence the referral.

120. The GP advised Children's Social Care that Rosie had telephoned her parents after the overdose and they took her to the ED. Because Rosie discharged herself, no mental health assessment had been completed. The GP was confident that Rosie had no plans to harm herself and was keen to seek support.

121. The GP advised that he had increased Rosie's anti-depressant medication. He advised that Child A's father did not live with Rosie, and that she had mentioned some behaviour problems that Child A was experiencing.

122. The referral was screened in MASH and a discussion took place with her Child A's nursery and with Rosie. The outcome of the screening process was that Rosie was accessing appropriate support, the Health Visitor was also engaged and that Rosie did not wish further input. On this basis the case was closed.

School scoping information

Primary School attended by Child A

123. The school provided a short scoping report for the DHR. This report indicated that the school saw Rosie most days but they had no contact with Robert. Rosie took Child A to school and collected the child each day. She also attended parent's evenings and other parent events.

124. The school confirmed in their scoping report that there were never any concerns in relation to Child A, her parenting or the relationship between Rosie and Child A's father. The school was not aware of Rosie's relationship with Robert.

Primary School attended by Child B and Child C

125. The school provided a short scoping report for the DHR. This report indicated that they had contact with Robert in the normal ways, but they did not have any contact with Rosie. Robert did attend parent's evenings.

126. The school scoping report indicates that the school were aware of an argument between Robert and his children's mother who was a member of staff at the school. This argument took place in November 2018. This was because Robert had become aware that she was in a new relationship. It is reported that Robert shouted at his children's mother and smashed something in the house. The school report indicates that there were no concerns for the children and the children's mother raised none. The matter was not reported to the police.

18. Analysis of the information in the Individual Management Reviews

127. It would be usual to provide a detailed analysis of the IMRs by organisation in the Overview Report. However, with so few organisations having any direct

contact within the period covered by the DHR, the author has sought to provide a more overarching analysis of the limited information available, but grouped by organisational contact where possible.

128. It is clear that the only sustained contact that any statutory agency had with Rosie was primary care. She had infrequent contact but was able to access the service whenever she needed it.

129. The principle contact related to ongoing checks in relation to contraception, although Rosie did present to the GP with symptoms of depression.

130. It is clear from the IMR that Rosie was able to communicate effectively with her GP about issues that were of concern to her and all the interventions and inputs provided to her were appropriate and of a good standard.

131. There was no evidence of domestic abuse in Rosie's presentations to her GP and as such no routine enquiry was undertaken. It could be suggested that any professional should make such an enquiry, but without any evidence to indicate it being necessary it is understandable that no such enquiry was made. There were no identified issues in relation to Rosie being an adult at risk.

132. There was good communication between the GP practice and other agencies, in particular with BDC in relation to health visitor input and with Children's Social Care. There was also good communication with other secondary care services in relation to Rosie's knee injury.

133. The GP gave appropriate advice when suggesting that Rosie refer herself to Turning Point to access IAPT services from the agency.

134. It is clear from the IMR that the GP practice adhered to both local and national policies and procedures. It is also noted that the practice held information about domestic abuse and that leaflets and information for patients was readily available within the practice. The practice also had relevant safeguarding processes and policies in place. The IMR shows that recording was of a good standard.

135. The prescription of anti-depressant medication conformed to national prescribing guidance and regular review of that medication took place.

136. Both practices have been proactive in learning about and responding to domestic abuse.

137. The CCG IMR makes one recommendations in relation to continuing to raise awareness of issues relating to coercive and controlling behaviour.

138. Although WYP had no contact prior to the incident and there was no evidence presented to them beforehand in relation to matters of domestic abuse, it is clear from the IMR that they conducted a thorough enquiry. In so doing they were able to gather a wide range of intelligence that has proved helpful in building a clearer picture of the relationship between Rosie and Robert.

139. The Police IMR records that Robert may have used steroids, linked to his interest in body building. Case reports and small studies have indicated that anabolic steroids can increase irritability and aggression.[7] This has been reported by some people who use them and has been in noted in several information sources, including research on the psychological and behavioural effects of steroids.[8]

140. The short input from Turning Point appears to have been helpful to Rosie. Her initial referral was responded to promptly and resulted in a quick introduction to the service.

141. An appropriate form of intervention was offered and delivered. That intervention followed national good practice and was evidence based.

142. Although a copy of the treatment plan was not shared with Rosie, as this was not practice at the time, it is clear that the service has updated and revised its operational policies and this sharing now takes place routinely.

143. No safeguarding concerns were identified during the limited period of engagement.

144. The communication between Turning Point and primary care was of a good standard. In particular, it was good practice to share the details of the outcome of the assessment and later, a discharge summary, with the GP practice.

145. Rosie had only a short time in treatment and contact with Turning Point, it does appear to have been helpful to her, in so far as it provided her with strategies

[7] National Institute on Drug Abuse https://www.drugabuse.gov/publications/research-reports/steroids-other-appearance-performance-enhancing-drugs-apeds/how-does-anabolic-steroid-misuse-affect-behavior

[8] Bahrke MS, Yesalis CE, Wright JE. Psychological and behavioural effects of endogenous testosterone and anabolic-androgenic steroids. An update. *Sports Med Auckl NZ*. 1996;22(6):367-390.

that she could utilise to improve her mood and coping. However, the extent to which she was able to use those strategies is not clear.

146. The Turning Point IMR does not make any recommendations.

147. Rosie's contact with MYHT was similarly limited and centred on her presentation to ED following overdose and with a knee injury.

148. It appears from the IMR that her contact with the ED on both occasions resulted in appropriate treatment, intervention and onward referral. In relation to the overdose, it is clear that she was advised to stay in hospital and it was hoped she would see the psychiatric liaison service.

149. She chose not to do this and so there was no opportunity for them to conduct a more thorough examination of her mental state, nor to arrange any further input from specialist services.

150. Appropriate referrals were made in the context of Rosie's presentations and it is clear that action was taken to safeguard Child A following Rosie's overdose. The referral to secondary care mental health services was made but engagement was voluntary and it does not appear that Rosie took up this option.

151. It is clear that relevant information about the contacts between Rosie and MYHT was shared in a timely way with colleagues in primary care and referrals to other services, including Children's Social Care were made.

152. The levels of training in respect of safeguarding within the ED service at MYHT are of a good standard in terms of staff reach and issues relating to domestic abuse are well covered.

153. The MYHT IMR does not make any recommendations.

154. BDC had only limited contact with Rosie, which arose from a detailed referral from her GP. The principle contact arose following her disclosure that she had concern about Child A's behaviour.

155. The level of detail provided by the GP as part of the referral process was high and enabled the service to make informed decisions about the intervention to be offered.

156. The 10 days between the referral and initial phone contact with Rosie and the face-to-face visit was within usual timescales for non-urgent input. Although the intervention provided was brief, it is clear that more could have been offered in terms of parenting support had Rosie felt that to be necessary. The Health Visitor had no ongoing safeguarding concerns for Rosie or Child A and closed the case at the appropriate time.

157. The Health Visitor did consider Rosie's mental health and reached the judgment that she was mentally well, and held no concerns about her mental state or her ability to look after Child A.

158. Rosie does appear to have received an appropriate and timely response, although the exact detail of the advice given to her is not clear. Nevertheless, it was a rapid response and there is evidence of effective and through communication between the Health Visitor and the GP.

159. The scoping information provided by the two schools is helpful in so far as it confirms contact between Rosie and the school in relation to Child A, and between the school and Robert and his children.

160. The BDC IMR does not make any recommendations.

161. Children's Social Care conducted an appropriate MASH screening process and were able to determine that Rosie was in receipt of necessary support and so no further input or action was undertaken. In the context of the information available to them this was an appropriate decision.

162. It does not appear that Children's Services were aware of the issues relating to Rosie's depression and mental health. The assessment undertaken focused solely on Child A. While this is understandable, it was a gap in the knowledge of Rosie's wider circumstances and how they might be impacting on her and her child. It cannot be said with any certainty that possession of this information would have made any direct difference to the outcome of the assessment but it was a gap in the process.

163. The other issue to note is that Children's Social Care did not have any contact with Child A's father as part of the assessment process. Had they done so this might have revealed helpful information that would have informed the assessment process and given a more holistic view of the circumstances in which both Rosie and Child A were living.

164. No recommendations were made in the Children's Social Care IMR.

165. The schools were not in possession of any information about the relationship between Robert and Rosie. Although there was reference to an incident at the school in 2018, between Robert and his ex-partner, there were no concerns and no report was made.

19. Conclusions

166. Having reviewed and analysed the information contained within the Individual Management Reviews and having considered the chronology of events and the information provided, the panel has drawn the following conclusions relating to organisational involvement and come to more general conclusions about this case.

167. The contact between statutory agencies, Rosie and Robert was very limited. They had not been engaged with any services or agencies in the period covered by the DHR in relation to domestic abuse matters. Their contacts with agencies was largely routine, the result of general health concerns, or in the case of Child A, proactively driven by her.

168. Aside from the routine GP input with Rosie, the inputs and interventions of other services are notable by their brevity. This is not a direct criticism; indeed the IAPT service is specifically intended to be brief. However, this brevity meant that it was not possible for any wider or more detailed probing to take place or for a fuller picture of Rosie's circumstances to emerge.

169. Rosie and Robert were in essence unknown to services. There does not appear to have been any indication of domestic abuse in Rosie's previous relationship, certainly none that was reported or known about. The fact that the relationship with Child A's father was 'on/off' may have been a contributing factor to her mental health difficulties, but this cannot be said with certainty.

170. Rosie entered into the relationship with Robert fairly soon after the final break with her previous partner. It does appear that almost from the start, the relationship with Robert was characterised by incidents of coercive and controlling behaviour. These manifested themselves through monitoring of her phone, seeking to limit or block her contacts with friends on social media and a distrust of her more generally when in the presence of other men.

171. The incidents of domestic abuse that were revealed in the course of the WYP enquiries following Rosie's death reveal a pattern of coercive and controlling behaviour that on occasion resulted in acts of physical aggression towards here. The incident when Robert took Rosie's handbag, containing her phone, keys and money could be characterised as an example of economic abuse. Rosie had to make insurance claims to recover the costs of replacing her phone. Robert's behaviour restricted Rosie's access to her money and her ability to communicate. It is concluded that she was therefore a victim of economic abuse in this instance and of coercive and controlling behaviour more generally in her relationship with Robert.

172. Some of those incidents of domestic abuse resulted in Rosie being pushed or shoved. Such action was eventually the cause of her death.

173. Friends and family members witnessed some of the incidents of domestic abuse that were described in the WYP IMR. Recent work done by WYP has shown that in the course of their investigations into homicide locally, some victims of domestic homicide had experienced abuse prior to their deaths and no reports had been made to the police even when known about by friends and family.

174. This may point to a wider lack of awareness of domestic abuse among members of the public and unwillingness to report it. This could be for a variety of reasons, not least a wish not to be seen to be interfering in the private lives of others. It may also be that the nature of coercive control, although now gaining greater prominence, is not widely known about or understood by members of the wider public and thus by families of those who experience it.

175. The panel considered the incident in 2018 between Robert and his ex-partner. The information provided showed that there were no concerns and no report was made, on that basis, it was concluded that this incident be noted by the panel but that further exploration was not proportionate for the learning that would be gained.

176. The lack of family input to this DHR means there remain gaps in the knowledge and information available to the review panel. However, it is clear that Rosie did experience domestic abuse throughout her relationship with Robert. It remained largely hidden from agencies, but was observed by others. It is not clear if Rosie identified herself as a victim of domestic abuse.

177. As the presiding Judge observed in his summing up during Robert's trial the actual events of the night in question are known only to Robert. That Rosie lost her life through as a result of domestic abuse is clear.

178. It is not possible to say with any certainty whether such probing or professional curiosity would have revealed more information, led to direct action, or indeed, have encouraged Rosie to take any action herself.

20. Lessons learnt

179. Domestic abuse and violence (DVA) is highly prevalent, particularly among women.[9] It accounts for 11% of all crimes reported to police in England and Wales, and more than one in four women and around one in six men have experienced DVA since the age of 16. However, official figures are likely to be an underestimate, because much DVA remains hidden.[10]

180. It is widely acknowledged that asking individuals about their experiences of domestic violence and abuse is more likely to encourage disclosures.[11] "It has been found that routinely asking women about domestic violence is more appropriate than 'ad hoc' enquiry that may rely on stereotypical views around which groups of women are likely to experience domestic violence. Routinely asking gives the message that it is acceptable to disclose domestic violence and that no one is being specifically targeted for enquiry (which could have safety implications)" [12] Routine Enquiry is simply finding a way of asking people directly and confidently about DVA.

181. The use of routine enquiry may have assisted the development of a more holistic view of Rosie's circumstances and possibly information about domestic abuse. It may be that professionals could have probed further and more deeply, rather than focusing solely on her presenting issue and not using a wider lens in assessment or intervention. The evidence for the wider use of routine enquiry is continuing to emerge.

182. Given that on average high-risk victims live with domestic abuse for 2.3 years and medium risk victims for three years before getting help[13], the use of routine enquiry can be an effective method, not only in identifying domestic abuse, but doing so more swiftly than might otherwise be the case.

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[9] Routine enquiry for domestic violence and abuse in sexual health settings, Lyus, L. & Masters, T. British Medical Journal http://dx.doi.org/10.1136/sextrans-2017-053411

[10] ibid

[11] Piloting Routine Enquiry in Leeds GP Practices 2016 https://www.leeds.gov.uk/domesticviolence/Documents/GP%20Pilot%20Report%202016%20Final.pdf

[12] Domestic violence in work with abused children, Hester, M. and Pearson, C. JRF 1998

[13] SafeLives Insights Idva National Dataset 2013-14. Bristol: SafeLives 2015

183. Coercive control 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 controlling behaviour is designed to make a person dependent by isolating them from support, exploiting them, depriving them of independence and regulating their everyday behaviour. [14]

184. Coercive control by its nature it can often be hidden from others, notably family and friends as well as professionals.

185. This case demonstrates that coercive control may not always be recognised as such by the victim, or indeed their family, friends or professionals in contact with that victim. The lesson to be learnt is that work remains to be done to raise awareness of coercive control, encouragement to victims to recognise and report it, and for agencies to respond to it appropriately. This work is already being done. Wakefield also have a Domestic Abuse Communication Campaign Plan which sets out the objectives, messages and calendar of campaigns for 2021-22. A domestic abuse training offer is being delivered across the district and is available to multi-agencies, this offer includes awareness of coercive control and domestic abuse, how to spot the signs and the services available to support victims.

186. The DHR has revealed the limited nature of contact with agencies, and once again demonstrated that very often, domestic abuse can be largely hidden from view. It has also shown how it often requires a greater degree of professional curiosity to reveal it to those agencies that come into contact with victims but that in many circumstances this is difficult to achieve.

21. Recommendations

1. This section of the Overview Report would usually set out the recommendations of the DHR panel and also the recommendations from the IMRs. The DHR panel recommendations would have the intention of addressing system wide issues and to support and build upon those recommendations already made and being acted upon in the IMRs.

2. Given the limited statutory agency involvement, that those limited contacts did not relate to domestic abuse or violence, and that there was no evidence

[14] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/coercive-control/

of such abuse or violence, the panel has concluded that there is only one recommendation to make arising from this DHR.

- The use of routine enquiry across all statutory bodies in Wakefield should be strengthened and embedded in day-to-day practice. This particularly needs to be the case in GP practices and other health settings, for example the Emergency Department. However it should be further developed in other public sector agencies.

- Training should be provided where needed, but ultimately the test of effectiveness is the change in day-to-day practice and this should be subject to regular review.

- In making this recommendation the panel notes the work already undertaken in Wakefield and West Yorkshire more broadly, which represents a strong commitment to this practice.

- The analysis of Children's Services found that an assessment regarding the victim's child did not include information on the victim's mental health and overdose nor was there contact with her child's father to inform the assessment. Since the IMR was completed and the DHR undertaken local work has been undertaken by Children's Services to ensure that any circumstances affecting a parent's wellbeing and ability to parent must be included in any assessment. Given this work has been done, no recommendation was deemed necessary.