



Domestic Homicide Review Overview Report:

Adult Z

Born: July 17, 1955

Died: December 31, 2011

Tony Blockley

Director: Johnston and Blockley Ltd

August 25, 2013

	Subject	Page
Introduction	Introduction	3
	The circumstances that led to the Domestic Homicide review	4
	Terms of reference of a review	7
	Scope of the review	8
	Methodology	11
	Participating Agencies	11
	DHR Panel Chair	12
	Overview Report Author	12
	The DHR Panel	13
	Parallel processes	16
	The facts	The Involvement of family members
Other avenues explored		18
Summary of what was known by agencies and professionals		20
Analysis	Analysis of how and why events occurred	21
	• What is domestic abuse (DA)	21
	• DA assessments	22
	• MARAC/Vulnerable adult	24
	• Family history	25
	• Information sharing	26
	• Near miss policy	27
	Summary of agency involvement and agency IMRs	30
	• South Yorkshire Police	30
	• Sheffield Teaching Hospitals Foundation Trust	30
• Rotherham NHS Foundation Trust	31	
• Victim Support	32	
	Comment in relation to key DHR issues	32
Conclusions and recommendations	Conclusions	35
	Recommendations	35

1. Introduction

1.1 Rotherham is a metropolitan district in the county of South Yorkshire and has a population 253,400 (as at 2007). It has a very diverse mixture of people and cultures. The majority of Rotherham's residents live in urban areas, with 50% living near Rotherham town centre and 38% living in smaller rural towns such as Thurgroft, which is where Adult Z and Adult 1 lived. Thurgroft is a former coal mining village. It is rural and is about 5 miles south east of Rotherham town centre. It is the largest settlement in the Rother Vale ward and has a population of 4,942 within 2,225 households. The village dates from the 20th century and it grew in support of Thurgroft Colliery, which began production in 1913. At its peak, around 2,000 people worked there but when it closed in 1991 there were only 650 employees. Since then, a degree of regeneration has taken place and some new houses have been built. Adult Z and Adult 1 (her husband) bought one of them in 2001, having met in 2000. They married in the same year and were still living together in the house at the time of the incident that led to Adult Z's death. The property was mortgaged and was jointly owned.

1.2 Strategic governance for domestic abuse and issues linked to the national Violence Against Women and Girls Agenda in Rotherham is held by the Safer Rotherham Partnership (SRP), which is the statutory community safety partnership for Rotherham. The work of the Safer Rotherham Partnership in relation to domestic abuse is supported by the local authority's Safeguarding Adult's Service, which provides operational management for domestic abuse coordination and Independent Domestic Violence Advocacy Service provision. Domestic Abuse, at the time of this incident, sat within the portfolio for the Elected Cabinet member for Adult Safeguarding.

1.3 Domestic Abuse is one of the four priorities of the Safer Rotherham Partnership and this is set out in the Joint Strategic Intelligence Assessment under the heading "Reducing the threat of harm to victims of Domestic Abuse, Stalking and Harassment, "Honour" based abuse and Forced marriage". The work in relation to Domestic Abuse is undertaken on the behalf of the SRP Domestic Abuse Priority Group (DAPG), which ensures the work of the Rotherham Domestic Abuse sector complies with the national agenda to End Violence Against Women and Girls. The DAPG provides strategic direction for the work of this sector and operational management of the Rotherham MARAC. The strategic approach ensures a coordinated response to victims of Domestic Abuse in the support and protection of victims while holding perpetrators to account through delivery against the following themes:

Prevent
Protect
Pursue

These themes provide focus to the sector's work in encouraging victims to disclose the abuse, and in the longer term reduce repeat victimisation. Rotherham is seeing an increase in referrals each year and is expecting this

trend to continue.

- 1.4 The SRP delegated the review process in line with the 2011 guidance to Domestic Abuse PG. DAPG commenced this role by undertaking a desk top review by the Domestic Abuse Coordinator to ensure that all DA policies within the partnership were contemporaneous and all policies referred to the need to risk assess Domestic Abuse cases. This was completed in June 2012. The Rotherham foundation hospital trust (TRFT) completed their review added to this following the homicide and IMR being completed.
- 1.5 In 2012, an agreement was made throughout South Yorkshire that the ACPO DASH Risk assessment tool would be adopted by all agencies.

2. The circumstances that led to the Domestic Homicide review

- 2.1 On 26th December 2011, Adult Z and her husband attended a party at her sister's house. While there, she jokingly complained about Adult 1 not helping her when she had slipped in the bath earlier that day, bruising herself in the process; she light-heartedly claimed that her husband did not care about her. The couple and Adult Z's father left the party together about 10:30pm. The Adult Z drove the car, agreeing to drop her father off at his home on the way. During the journey, an argument developed between Adult Z and Adult 1, in the presence of Adult Z's father, about the comments she had made about her fall in the bath. They also argued about something Adult Z's father had said during the party about his wife's death the year before. During the argument, Adult Z struck Adult 1, which was witnessed by her father.
- 2.2 They dropped Adult Z's father at his house and then went home. Rather than stay there, Adult 1 decided to go to his father-in-laws house, but before he left, he hid Adult Z's car keys. He later claimed he had done so to prevent her from drink driving, adding that his concern stemmed from the road traffic accident the couple had been involved in the year before.
- 2.3 He later told police that he went back home the following day after Adult Z had made several telephone calls and had sent some text messages asking about the car keys; he said he had not responded to the calls and texts and had decided to go home instead.
- 2.4 He said the argument from the night before continued as soon as he arrived home. He told the police during interview that he had intended to leave home for a couple of days and stay with his father-in-law while things calmed down. He said Adult Z presented him with a packed bag and they argued about what personal belongings he was to take with him. Adult Z had not included items of clothing she had given to him as Christmas presents. Adult 1 wanted to take them and Adult Z wanted to return them for refund.
- 2.5 The argument escalated and Adult 1 said he tried to pour white spirit over some clothing with the intention of spoiling it. During the argument, some of

the white spirit ended up on Adult Z. Somehow it caught fire and Adult Z became engulfed in flames. (During later police interviews, he gave conflicting accounts about the incident, but maintained throughout that it had been an accident).

- 2.6 At 6.02pm on December 27, 2011 the couple arrived together at the accident and emergency department of Rotherham District General Hospital. Adult Z had serious burns to her upper body and face.
- 2.7 She was taken to the resuscitation area where she was examined by a doctor. She was conscious and was able to respond to questions. Adult 1 was with her for most of the time.
- 2.8 Adult 1 told the doctor that his wife's injuries had occurred during an argument. He described how he had thrown some white spirit onto some clothing and that his wife, who had been smoking, had accidentally caught fire.
- 2.9 Medical opinion was that the Adult Z's condition was serious and that she required intubation and transfer to the Northern General Hospital for specialist burns treatment.
- 2.10 While the necessary arrangements to transfer her were being put into place, a senior nurse created an opportunity to speak with Adult Z alone; her experience and intuition made her suspect something was wrong. She asked Adult 1 to leave the room because they were going to ventilate his wife. When Adult 1 was absent, the Adult Z was asked whether there had been a history of domestic abuse in their relationship and whether her injuries had been caused intentionally. Adult Z was adamant there had been no domestic violence issues and that she did not want to involve the police or for her family to be told what had happened to her.
- 2.11 A short time later, Adult Z was ventilated. At 8.26pm she was transferred to the Northern General Hospital by ambulance. Adult 1 went with her.
- 2.12 While at the Northern General Hospital, Adult 1 told medical staff that there had been an on-going argument between him and his wife throughout the preceding 24 hours and that he had intended to stay at a relative's house, but before going he had planned to burn some clothing.
- 2.13 Adult 1 said he got a bottle of white spirit but before he could pour it onto the clothing, Adult Z attacked him. He said he threw the white spirit at her and the cigarette she was smoking set it alight. He added that the fire would not go out and he had tried to extinguish it by putting her in the shower. He then threw water on her and eventually managed to extinguish the flames.
- 2.14 Adult 1 said his wife did not want him to call for an ambulance or to tell the police what had happened. About 15 minutes later, after moisturiser had been applied to her burns, he took her to hospital in their car.

- 2.15 A Specialist Registrar told Adult 1 that his wife's injuries were such that she may not survive and he suggested that he (Adult 1) should contact the police and tell them what had happened. (The review has been told that the Registrar at the Northern General Hospital intended to contact the police himself had Adult 1 not done so.)
- 2.16 At 1.53am on December 28, 2011, Adult 1 made a 999 call to the police and told them that he and his wife had had a '*domestic*' argument during which he had "*lost it*".
- 2.17 The police spoke to hospital staff and were told that Adult Z's injuries were potentially life threatening. At 2.59am Adult 1 was arrested on suspicion of assault. He told police during interview that he and his wife had argued after a party. The argument continued into the following day and it developed into one about what property he was going to take with him after he had decided to leave home for a while. He added that he had also wanted to make sure that Adult Z would not be able to obtain a refund on some clothing she had bought him for Christmas, so he decided to pour white spirit on them. He maintained throughout the interviews that what had happened to his wife had been an accident.
- 2.18 The police consulted with the prosecuting authorities who determined that there was insufficient evidence to prefer charges at that time. As the expiry of his custody time limit drew near, the police had no alternative but to bail him pending the outcome of enquiries into how the incident had really happened. The police imposed a bail condition that he should not visit his wife in hospital. When Adult 1 telephoned the hospital to ask about her condition, he was told that she was unlikely to survive. For humanitarian reasons, the police allowed Adult 1 to visit his wife before she died. He was accompanied by two police officers throughout the visit and he was warned that anything he may say could be used in evidence during any future proceedings. In any event, there was no conversation; tragically Adult Z never regained consciousness.
- 2.19 Despite the best efforts of the medical staff, Adult Z died at 1.20pm on 31st December 2011. A post-mortem examination established the cause of her death to have been inhalation of toxic combustible gases.
- 2.20 After a lengthy, costly and determined police investigation, Adult 1 was charged with murder on the basis of complex forensic evidence which indicated that the incident could not have happened in the manner he had described. On December 14, 2012, nearly a year after the incident, he was found not guilty of murder but guilty of the manslaughter of his wife. He was sentenced to 8 years imprisonment. The Reviewing Panel was told that Adult 1 intended to lodge an appeal but at that time it was unclear whether the appeal was against his conviction or the sentence. In March 2013, it became clear that the appeal was against sentence only. The panel met again on 27th March 2013 and agreed that the DHR should resume.
- 2.21 There was no recorded history of domestic violence or abuse between the

couple; they were known to the South Yorkshire Police, their General Practitioner and the Local Hospital Trust but not in a violent or abusive context. However, certain issues were quickly identified that warranted scrutiny about the way in which local professionals and organisations worked individually and together after Adult Z had been admitted to hospital. There were at that time, at the very least, indications that domestic violence and abuse had been a factor in the death of Adult Z.

- 2.22 On January 4, 2012, the Safer Rotherham Partnership determined that the Adult Z's death appeared to fall within the criteria of the Multi-Agency Statutory Guidance for the conduct of domestic homicide reviews' issued under Section 9(3) of the Domestic Violence, Crime and Victims Act (2004) in that Adult Z's death was caused by: *'a person to whom she was related or with whom she was or had been in an intimate personal relationship'*
- 2.23 The Consideration Panel decided that a 'small scale' domestic homicide review should be conducted to examine what happened, with particular emphasis on the role played by the respective agencies after the Adult Z had been admitted to hospital. The Safer Rotherham Partnership Executive Board agreed and the Home Office was notified accordingly.
- 2.24 The decision was ratified by the joint Chairs of the Safer Rotherham Partnership on January 11, 2012. Notice was given to the Home office on February 7, 2012 of the intention to carry out a domestic homicide review.
- 2.25 On January 4, 2012 all agencies were asked to seal their records and undertake checks of involvement with Adult Z and Adult 1. They were asked to undertake a review of their records and it was also agreed that the couple's General Practitioner would be asked to provide a report about any relevant contact there may have been with the Adult Z and/or Adult 1.
- 2.26 The timescales for the DHR as per the Home Office guidance have not been adhered to. This is due to the lengthy criminal justice and the changes to the report authoring, referred to at 8.4 in the report.

3. Terms of reference of a review

- 3.1 The purpose of the review was to:
- Establish what lessons are to be learned from the domestic homicide about the way in which local professionals and organisations work individually and together to safeguard victims of domestic abuse
 - Clearly identify 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 those lessons to service responses and include any appropriate changes to policies and procedures

Prevent future domestic homicides through the improvement of service responses for all victims of domestic abuse, and their children, through improved intra or inter-agency working.

4 Scope of the review

The review will:

- Seek to establish whether the events of December 2011 could have been predicted or prevented
- Consider the period of five calendar years prior to the death of Adult Z, subject to any information emerging that prompts a review of any earlier incidents or events that are relevant
- Invite responses from any other relevant agencies or individuals identified through the process of the review and request Internal Management Reviews by each of the agencies who have identified their involvement with the couple
- Seek the involvement of the family, perpetrator, employers, neighbours and friends to provide a robust analysis of what happened
- Take account of coroners or criminal proceedings in terms of timing and contact with the family
- Produce a report which summarises the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken and make recommendations regarding the safeguarding of victims of domestic abuse
- Undertake an assessment of the Partnership's existing procedures and protocols to ensure they are robust, reflect good practice and are understood by and adhered to by staff
- Undertake a review of recent and current awareness raising in relation to domestic abuse to ensure that all victims of domestic abuse and those who may be aware of it occurring know how to contact agencies to make them aware of the abuse, or for support and advice

4.1 The rationale for the review process was to ensure agencies are responding appropriately to victims of domestic violence by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with the aim of avoiding future incidents of domestic homicide and abuse.

The review identified the following general areas for consideration.

Family engagement

- How should friends, family members and other support networks and, where appropriate, the perpetrator, contribute to the review and who should be responsible for facilitating their involvement?
- How matters concerning family and friends, the public and media should be managed before, during and after the review and who should take responsibility for it?

Legal Processes

- How will the review take account of a coroner's inquiry, and (if relevant) any criminal investigation related to the homicide, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process?
- Does the review panel need to obtain independent legal advice about any aspect of the proposed review?

Research

- How should the review process take account of previous lessons learned from research and previous DHRs?

4.2 In order to reach a view on whether the death could have been predicted and/or prevented, each IMR author was asked to include information on and analysis of all the following issues specific to this case:

Diversity

- Are there any specific considerations around equality and diversity issues, such as ethnicity, age and disability that may require special consideration?

Multi agency responsibility

- Was the victim subject to a Multi Agency Risk Assessment Conference?
- Was the perpetrator subject to Multi Agency Public Protection Arrangements?
- Was the perpetrator subject to a Domestic Violence Perpetrator

Programme?

- Did the victim have any contact with a domestic violence organisation or helpline?
- Was either the victim or the perpetrator a 'vulnerable adult'?
- Were there any issues in communication, information sharing or service delivery between services?

Individual agency responsibility

- Was the work in this case consistent with each organisation's policies and procedures for safeguarding and promoting the welfare of adults and with wider professional standards?
- What were the key relevant points/opportunities for assessment and decision making in this case in relation to the victim and perpetrator?
- What was the quality of any multi-agency assessments?
- Was the impact of domestic violence on the victim recognised?
- Did actions accord with assessments and decisions made? Were appropriate services offered/provided or relevant enquiries made, in the light of assessments?
- Was there sufficient management accountability for decision making? Were senior managers or other organisations and professionals involved at points in the case where they should have been?

Case specific issues

(Post-incident issues regarding risk assessment were identified – please see later).

Additional issues

(None were identified).

Issues which relate to ethnicity, disability or faith which may have a bearing on this review

(None were identified).

Other DHRs in the region or nationally which are similar, and the availability of relevant research

(None have been identified at the time of writing).

5 Methodology

This overview report has been compiled from and analysis of the multi-agency chronology, the information supplied in the IMRs, the supplementary reports, interviews conducted by the DHR panel, consideration of previous reviews and findings of research into various aspects of domestic abuse.

6 Participating Agencies

6.1 The following agencies were asked to give chronological accounts of their contact with Adult Z, Adult 1 and any children they were involved with during the 5 years prior to Adult Z's death:

- South Yorkshire Police
- The Village Surgery, Thurcroft, Rotherham
- Independent Domestic Violence Advocacy
- Choices and Options (a specialist Domestic Abuse support service)
- Rotherham Women's Refuge
- Apna Haq (The local Black Minority and Ethnic Refugee specialist support project for victims of domestic abuse)
- Rotherham Doncaster and South Humber (RDASH) – Mental Health
- RDASH – SMU (Clearways, the area substance misuse service)
- RDASH – (Lifeline, a service specifically dealing with alcohol misuse)
- Sexual Assault Referral Centre
- Rotherham Children's and Young People's Services
- North Lincolnshire Children's and Young Person's Service
- Rotherham Youth Offending Services
- Rotherham Metropolitan Borough Council Neighbourhoods and Adults Directorate
- Crown Prosecution Service
- HM Court Services
- The Children and Family Court Advisory and Support Service
- Victim Support Rotherham
- The Rotherham Foundation Hospital Trust

6.2 Each agency was required to report the following:

- A chronology of interaction with Adult Z, her family and/or Adult 1
- What action was taken
- Whether internal procedures were followed
- Conclusions and recommendations from the agency's point of view

6.3 All 19 agencies responded and those that had contact with Adult Z or Adult 1 prior to the death were:

- Their General Practitioner

- South Yorkshire Police
- The Rotherham Foundation Hospital Trust
- Victim support (who had been informed of the incident by South Yorkshire Police, but had not had any involvement with either party prior to the incident.)

There had been contact by their General Practitioner, South Yorkshire Police and the Rotherham Foundation Hospital Trust, prior to the incident and subsequent death, but this was not domestic abuse related.

- 6.4 During the DHR it became apparent that two of Adult Z's grand-children, who lived in North Lincolnshire, regularly stayed at her house. The CYPS for that area were asked whether there were any recorded concerns about them. There were none.

7 DHR Panel Chair

- 7.1 In January 2012 the Partnership consulted with the Home Office about the appointment of independent chairs for DHRs. The Home Office stated that such an appointment should not cause financial burden to the Community Safety Partnership. The Home Office also suggested reciprocal chairing arrangements could be made between Partnerships. This had been considered by the Safer Rotherham Partnership, in conjunction with West Yorkshire, but was not considered viable.

- 7.2 The Consideration Panel had serious concerns about independence issues associated with reciprocal chairing within South Yorkshire. The Panel decided that the review would be chaired by Mr Steve Parry, manager of the Safer Rotherham Partnership. He had no line management responsibilities for any of the agencies who were asked to produce IMR's.

- 7.3 In April 2012, the Home Office suggested that Mr Parry may not be wholly independent because of his position within the Safer Rotherham Partnership. The Partnership considered the issue and decided that because of its small scale and the fact that Mr Parry had no direct involvement with or line management responsibility for any of the agency representatives participating in the review process, it was appropriate for him to remain as DHR Chair. Also considered was the fact that Mr Parry had completed the Home Office domestic homicide review training packages, including the additional modules on chairing reviews and producing overview reports and had fulfilled the criteria detailed in the statutory guidance for domestic homicide reviews (section 5.10).

8 Overview Report Author

- 8.1 The Consideration Panel agreed that the overview report author would be Mrs Cheryl Henry-Leach, Domestic Abuse Coordinator for the Safer Rotherham Partnership. Mrs Henry-Leach has completed the Home Office domestic homicide review training packages, including the additional modules on chairing reviews and producing overview reports and also fulfils

the criteria set out in the statutory guidance for domestic homicide reviews.

8.2 Mrs Cheryl Henry-Leach was approached by the police, on behalf of the prosecuting barrister in the criminal prosecution of Adult 1. She was asked to submit an expert witness statement outlining the following:

- What constitutes domestic abuse or domestic violence
- Why victims of domestic abuse do not necessarily tell friends / family and professionals, including health staff, social workers and the police about the abuse
- How domestic abuse can affect the victims and their behaviour

8.3 The Home Office was consulted about the request and their view was that should Mrs Henry-Leach agree to provide such a statement it would not compromise her role of overview report writer.

8.4 In light of the comments expressed by the Home Office about the independence of Mr Parry and noting that there was need for the report author to be independent, a decision was made to outsource the writing of the overview report. In June 2013, it was agreed that Johnston and Blockley Limited, an independent company specialising in homicide and serious case review, would be asked whether they would be able to complete the report within tight timescales. They indicated an ability and willingness to do so.

8.5 One of its partners, Mr Tony Blockley, has now taken over responsibility for authoring this report. He is a specialist independent consultant in the field of homicide investigation and review. He has senior management experience in all aspects of public protection. He has been involved in numerous homicide reviews throughout the UK and abroad, was chair of MAPPa and was responsible for all public protection issues when he was head of crime in a UK police force. He has been involved in several DHR and serious case reviews. He is also a special advisor to a 3rd sector organisation that provides domestic abuse services (not in the area covered by the Safer Rotherham Partnership).

9 The DHR Panel

9.1 The consideration panel agreed the formation of a bespoke panel comprising of agencies that had had contact with the couple during the course of this incident as there had been no contact with any agencies prior to it with regard to domestic abuse issues.

9.2 The DHR Review Panel consists of:

- Steve Parry, Safer Rotherham Partnership Manager (Chair)
- Cheryl Henry-Leach, Domestic Abuse Coordinator and DHR Coordinator, Safer Rotherham Partnership
- Sergeant Helen Smith, South Yorkshire Police

- Helen Dennis, Safeguarding Adults Coordinator, Rotherham Metropolitan Borough Council
- Jo Abbott, Public Health Specialist (Mental Health and Domestic Abuse) - NHS Rotherham
- Ruth Fletcher-Brown, Public Health Specialist (Mental Health and Domestic Abuse) - NHS Rotherham
- Deborah Drury, Named Nurse, Adult Safeguarding, The Rotherham District Foundation Trust
- Emma Wells, Senior Probation Officer, National Probation Service, South Yorkshire
- Elisa Pack, Senior Service Delivery Manager, Victim Support, Rotherham
- Michaela Power, Service Manager, RDASH Mental Health

9.3 The following also accepted invitations to sit on the Review Panel to provide domestic abuse expertise as the Safer Rotherham Partnership coordinator was the report author at that time:

- Amanda Raven, Senior IDVA, Safer Rotherham Partnership
- Beverley Garbett, Choices and Options (specialist Domestic Abuse Support Agency)
- Tracy Smith, Rotherham Women's Refuge

9.4 Family members and friends and colleagues of the couple were invited to participate in the review process, but were not invited to attend the panel meetings in line with good practice identified during local serious case reviews. Adult 1 was asked to engage with the DHR but he did not respond.

9.5 The review panel met on the following dates:

21st January 2012
 21st February 2012
 26th April 2012
 28th June 2012
 4th September 2012
 23rd March 2013
 17th June 2013
 10th July 2013
 20th August 2013

- 9.6 The agenda for each meeting was appropriate; there was a good level of debate and appropriate challenge, themes were identified and recorded as they emerged and the minutes and actions were promptly circulated and the latter closely monitored.
- 9.7 South Yorkshire Police initially queried whether the incident fell within the definition of a DHR due to Adult 1's account that the injury and death were the result of an accident. Following a review of the guidance and advice from the Home Office it became clear to the panel that the incident did fall within the scope of a DHR in that Section 9(3) of the Domestic Violence, Crime and Victims Act (2004) states, *'In this section "domestic homicide review" means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom he was related or with whom he was or had been in an intimate personal relationship, or was a member of the same household as himself'*.
- 9.8 South Yorkshire Police provided regular updates about the progress of the murder investigation. They stressed the complexity of the case particularly in relation to forensic evidence. It was clear that the investigation was going to take some considerable time to complete and it was also evident that family members and friends of the couple, who were to be invited to participate in the DHR, would likely become witnesses during any forthcoming trial. A decision to suspend the review was therefore taken to avoid any possibility of compromising the judicial process. It was also agreed that the panel would continue to meet in the event of any information coming to light that ought to be shared.
- 9.9 Early in the review process, SYP requested clarification that that Co-ordinated Action Against Domestic Abuse (CAADA) would have expected the police to have immediately told the domestic abuse sector about the incident even though, before being ventilated, the Adult Z had told nursing staff that her injuries had been sustained accidentally. A telephone call was made to CAADA on January 24th 2013. During discussion with a CAADA Leading Lights assessor, it was confirmed that the level of injury sustained by the Adult Z and the fact that Adult 1 had said his wife's injuries had been inflicted during an argument were in themselves reasons why the responding agencies (in particular the Police) should have involved other agencies. In addition, CAADA noted that the professional judgement of The Rotherham Foundation Hospital Trusts nursing staff recognised the need for Domestic Abuse screening to be undertaken and this should have triggered referral to MARAC and IDVA given the nature of the presenting injuries.
- 9.10 Unlike the other agencies within the Safer Rotherham Partnership, the police had used the SPECCS + risk assessment tool (Separation, Pregnancy, Escalation, Culture, Stalking and Sexual Assault). A criticism of the tool is that it does not involve any professional judgement. The police assessed the interim risk level as 'medium' with the intention to revisit the assessment once the Adult Z was able to contribute to it. The medium risk level was not high enough to trigger notification to MARAC and IDVA at this stage.

CAADA's view is that had the DASH risk assessment tool been used, the threshold to invoke the MARAC process would have been reached. South Yorkshire Police did inform Victim Support; however there is a local protocol whereby the police would refer persons within the medium risk category to 'Choices and Options'. This was not done by the police because victim consent is necessary.

- 9.11 In March 2013, once the panel had been made aware that Adult 1 had been sentenced to 8 years imprisonment for manslaughter, and that an appeal he had lodged was against sentence rather than conviction, the DHR was re-convened. The police provided a comprehensive update on the case. They said that as far as they were aware none of Adult Z's family or friends had witnessed any abusive or controlling behaviour by Adult 1 although work colleagues had given evidence at the trial that shortly before the incident; she had intimated an intention to end the relationship when the couple returned from holiday in early 2012. The panel then discussed and agreed which individuals close to Adult Z they wanted to invite to participate in the DHR.
- 9.12 It had been discovered during the police investigation that during the mid-1980's, Adult 1 had had a son to a previous wife (Adult Z and her family had been unaware of this). The former wife had described to the police during the murder investigation a very abusive relationship with Adult 1, but no corroborative evidence was available. Her evidence was not admissible during the trial (medical records no longer existed and eye-witnesses to what had happened were dead).
- 9.13 The police also told the panel that throughout the trial, Adult 1 had not shown any remorse for what he had done. They mentioned CCTV footage that had been used during the trial which showed the couple entering the accident and emergency department of the hospital shortly after the incident. Despite her serious injuries, he appeared on the footage to be unsupportive and uncaring towards her. It was agreed that this would be included in the chronology with a view to demonstrating the controlling nature of Adult 1. In addition the police also explained that Adult 1 had hidden Adult Z's keys and not responded to texts which were considered abusive behaviour.

10 Parallel processes

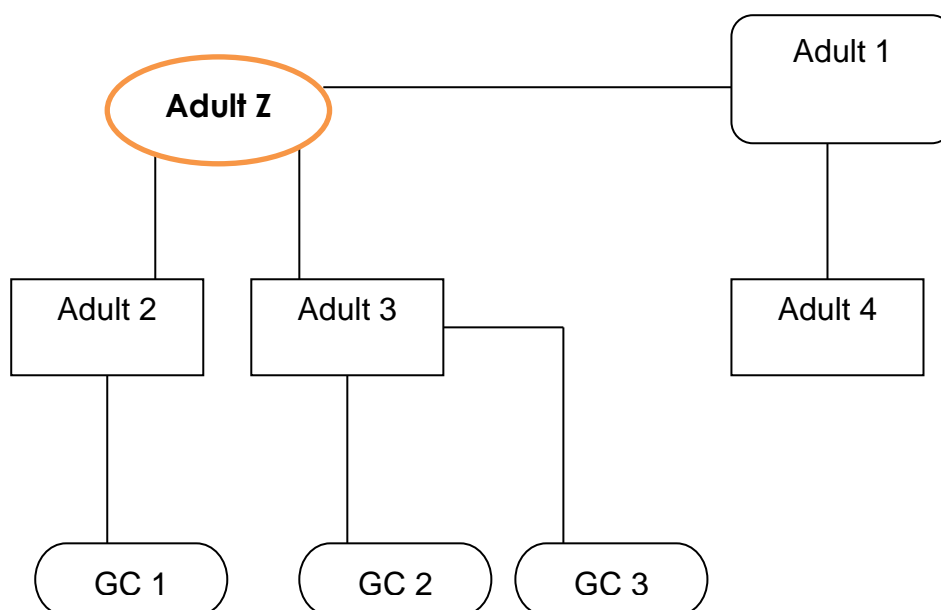
10.1 Inquest / Criminal Investigations

As mentioned previously, there was a thorough and protracted police investigation into the circumstances of the death of Adult Z, and a subsequent murder trial. Adult 1 was found guilty of manslaughter and was sentenced to 8 years imprisonment. He has appealed against his sentence, but not his conviction.

Although the death of Adult Z was referred to the Coroner, no inquest will take place because all the evidence and information about her death was aired during the murder trial.

11 The Involvement of family members

11.1 Family Composition



- 11.2 The panel agreed that the review would benefit from the involvement of family members; it was recognised that they may have an important role to play especially as the various agencies knew very little about the lifestyles of the couple.
- 11.3 Adult Z had two sons (Adults 2 and 3) from a previous marriage. She also had three grandchildren (GC1, 2 and 3). None of them lived with the Adult Z and Adult 1 but visited frequently. They had not been at the house during the night of December 26, 2011.
- 11.4 As mentioned already, Adult 1 had a son from a previous marriage, something Adult Z and her children did not know about until recently.
- 11.5 It was agreed initially that the police family liaison officer (FLO) would be the most appropriate person to inform the family of the DHR process was about and to ask for their contributions to it. The FLO reported that the family were adamant they did not want to participate and added that they remained supportive of Adult 1 and they believed him when he said Adult Z had sustained her injuries accidentally.
- 11.6 The FLO sought the help of the Victim Support National Homicide Service but they refused to accept the referral on the grounds that (in their view) the circumstances of Adult Z's death did not amount to a 'homicide' in that she had died as a result of an accident. Victim Support have limited funding and a strict referral criteria. One of those criteria is that they can only accept referrals that have resulted from criminal acts. At the time of the referral from the FLO the injuries to Adult Z were still considered accidental. The Consideration Panel reviewed the statutory guidance on the issue and was of

the opinion that the National Homicide Service should have accepted the referral. Rather than have no family liaison about the DHR process, the decision was made to continue utilising the services of the police FLO. In any event, the family chose not to engage with the DHR.

- 11.7 When the criminal proceedings against Adult 1 came to an end, the police FLO began to withdraw from the family. The panel then discussed how the family should be told about the resumption of the DHR process. By that time it was evident that the Home Office recommended that family liaison should be separate from the police so the panel agreed that it would write to the sons and friends of the Adult Z and the former wife of Adult 1 to offer support from other agencies such as AAFDA (Advocacy After Fatal Domestic Abuse) in line with emerging DHR best practice.
- 11.8 The Safer Rotherham Partnership feels that the issue of whether the Victim Support National Homicide Service should decline to engage with a family in such circumstances as this should be reviewed.
- 11.9 The Safer Rotherham Partnership also holds the view that clearer guidance from the Home Office about what constitutes a 'homicide' would be helpful. Both of these issues form recommendations in this report.
- 11.10 When contacted after the trial, Adult 3 intimated he may be willing to meet with the Chair and Report Author, but Adult 2 made it clear that he did not want to be involved in the review. The panel agreed that the Chair would write to Adults 2 and 3 to formally ask them to participate and that letters would also be sent to two friends of Adult Z, her sister, the former wife of Adult 1 and Adult 1 himself.
- 11.11 Adult 2 again declined to participate and both Adult 1 and Adult 3 did not respond to the letter. One of the friends responded and intimated she would meet with the Chair and Report Author on the condition that the other friend accompanies her. Both have recently been spoken to by the Chair and Mrs Cherryl Henry-Leach (see below). The former wife of Adult 1 did not respond.

Other avenues explored

- 11.12 Adult Z's father was very frail and the police said he was not in the best of health. In May 2012 he had self-referred to the Rotherham Victim Support office and an appointment was made to see him the following day. He did not attend that appointment and when contacted by Victim Support staff he explained that he had obtained a counselling appointment and wanted to follow that course of support. In light of all this information a decision was made not to invite him to participate in the DHR.
- 11.13 Consideration was given to contacting Adult Z's brother but the panel decided against it because he had been estranged from his sister for many years.
- 11.14 The question of whether to contact Adult 1's son was also debated. The police investigation had established his complete ambivalence towards his

father; he considered him to be a stranger and had no memories of him as a parent. The panel took the view therefore that there was no merit in contacting him.

- 11.15 Finally, as mentioned above, the panel decided to attempt to contact friends and neighbours of the couple even though the police investigation had not unearthed any evidence from them to indicate a history of domestic violence between the couple.
- 11.16 Two friends agreed to engage with the DHR. One had worked with the Adult Z for 27 years and the other for 10 years. At the time of their engagement it was made clear to them that additional support was available if they required it. When the meeting was arranged the additional support was discussed, including arrangements for on-site parking.
- 11.17 They both said they had developed a friendship beyond work, but Adult Z was a private person who did not socialise very much, either with friends or family. They described her as someone who did not easily develop close friendships, but when she did, she was a very supportive and loyal person. They both said the Adult Z was not aggressive by nature, but if she felt aggrieved, she would challenge the other party about their behaviour.
- 11.18 They said they were aware that Adult Z had been married three times. One former husband had left her in debt and the other had been violent and abusive towards her so she left him. They said Adult Z had had to rebuild her life and finances after those failed marriages and in their opinion that was why she had tried to make a success of her marriage to Adult 1. Their view was that she did not want it to fail or for others to perceive that she had failed and they felt that as a result her tolerance levels regarding abusive behaviour within her relationships may have been elevated.
- 11.19 They stated that Adult Z was very much a family person and that she doted on her grandchildren. They added that although Adult Z frequently argued with her father, she was an extremely dutiful daughter. She lived for her holidays and she was excited because she and her husband were due to go to Cuba in January.
- 11.20 The two friends were of the opinion that Adult Z was unhappy with her relationship with her husband. They said that in the 6 months preceding her death she had become introverted and had lost weight. She had had health issues and Adult 1 had lost his job which had put more pressure on their relationship in the weeks before she died. She also disclosed to her friends that she was not looking forward to Christmas with Adult 1.
- 11.21 Both said that Adult 1 tended to be a moody individual and that Adult Z would do all she could to appease him. The Adult Z had told them that she would do anything for a quiet life. The friends felt Adult 1 was guilty of '*mental cruelty*' towards her, citing as an example an occasion when Adult Z changed channels on the television without his consent after which he '*sulked*' for 5 days. Neither of the friends thought Adult 1 was physically violent towards

her, but did say that because she was very petite and he was a big man, he would dominate her when they argued.

- 11.22 A specific point they both said was that Adult Z was very careful and took pride in her appearance. They both considered it significant that any injuries that would have been caused if she had survived would have affected her appearance drastically. A fact that they felt Adult 1 would have known.
- 11.23 The friends did not think the incident that brought about the death of Adult Z had in any way been premeditated.
- 11.24 They finished by saying that in their view there was nothing the Partnership could have done to have anticipated or prevented Adult Z's death. They stressed that she had been an incredibly private person and would have been unlikely to have sought support from agencies even if she had felt the need for it. However, they did think there was merit in the Partnership looking at how awareness of domestic abuse that did not include physical violence was raised and that there should be recognition that older women experience it as well as younger people.

12 Summary of what was known by agencies and professionals

Adult Z

- 12.1 The Police had been involved with Adult Z on six occasions before her death:
- 2008 – Two incidents where she reported youths causing a nuisance outside her place of work
 - 2005 – A report by Adult Z of a car being burnt out in the library car park
 - 2004 – Adult Z received a police caution for failing to report a road accident
 - 2004 – Adult Z had her purse stolen in a supermarket
 - 2002 – Adult Z had her purse stolen from an unattended bag at work

(There was no mention of Adult 1 in any of these incidents).

Adult 1

- 12.2 The Police had contact with Adult 1 between 1971 and 1980 for offences of dishonesty. He was convicted of five offences of burglary and was either fined, given a supervision order or a community service order. There was no further contact between the Police and Adult 1 until he telephoned them during the early hours of the morning of December 28, 2011 to say his wife had been admitted to hospital.
- 12.3 The couple's GP stated there had been contact with Adult 1 in January 2012 when he requested help because he was having difficulty sleeping. The GP said that the events that led up to the incident were not discussed in any detail. The GP stated that other contact the surgery had with the couple did

not involve domestic abuse or violence, substance misuse or mental health issues.

- 12.4 Rotherham Victim Support had no contact with Adult Z or Adult 1, before Adult Z's death. Their only involvement had been the receipt of a routine referral by the police once a crime report for assault had been submitted after she had been admitted to hospital. Because Adult Z was in hospital, in line with their standard practice, Victim Support 'pended' the case until such time as the police notified them it was appropriate to contact her.
- 12.5 The Rotherham Foundation Trust's involvement with Adult Z and Adult 1 began when the couple arrived at the hospital after the incident. For medical reasons Adult Z was transferred to the Sheffield Teaching Hospital (Northern General) Trust.

13 Analysis of how and why events occurred

- 13.1 This section of the report seeks to examine why events unfolded as they did and to identify any areas for improvement in practice. The key issues are set out below; many do not warrant detailed discussion because the couple were not known to the agencies in a domestic violence or abuse context.

The key issues:

- What is DA
- DA assessments
- MARAC/Vulnerable adult
- Family history
- Information sharing
- 'Near miss' policy

What is DA

Analysis

- 13.2 Nothing has emerged as a result of this review to question the awareness of domestic abuse issues within any of the agencies involved. However there appears to be a lack of corporate understanding throughout agencies of what constitutes a homicide for the purposes of a domestic homicide review
- 13.3 Hospital staff was clearly concerned that domestic abuse may have been a factor but their concerns were not escalated to senior management. A Registrar did insist, however, that Adult 1 contact the police himself.
- 13.4 South Yorkshire Police conducted a risk assessment after Adult Z had been

admitted to hospital and they became aware of the incident. They categorised the risk to her as medium and, with the exception of Victim Support, did not notify other agencies of the incident at the point of them becoming aware of it.

DA assessments

Analysis

- 13.5 A domestic abuse assessment is best defined as a critical evaluation of information for the purpose of guiding decisions on a complex, public issue. It is recognised that the principle model for assessing risk is in the Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model.
- 13.6 There is clear difficulty with assessments in that they are an objective evaluation but made through subjective considerations, consequently they may vary from organisation to organisation and person to person.
- 13.7 However assessments are critical to ensure issues are identified and can be addressed appropriately. They also enable critical services to become involved at an appropriate level, which when linked to information sharing and organisational responsibility, affords protection to the victim and preventative opportunities in respect of the perpetrator.
- 13.8 Inevitably, when organisations differ in the way they identify, assess and determine risk there is a greater chance that potential victims and perpetrators will be overlooked and opportunities to intervene will be missed.
- 13.9 The requirements of the assessment are twofold, firstly those where the victim or perpetrator provides information with regard to domestic abuse, but equally and arguably more so where neither provide that information, but it is suspected.
- 13.10 As mentioned previously, the police had set an interim risk assessment of 'medium' using the SPECCS + assessment tool. The current CMS 11 system used by SYP incorporates SPECSS and has a free text field where the professional judgement of officers can be recorded. However, the guidance around SPECSS + is not explicit in highlighting the need to use and record professional judgement. The police IMR states:

'When officers attend at a domestic related incident, it is normal practice for a number of questions to be put to the victim, the responses to which are an indicator to those setting the subsequent level of risk as to the level of threat posed. In this case, the questions were clearly not put to [Adult Z] as she was ventilated and unable to respond. However, it was known that she had indicated to medical staff at the hospital that her injuries had been caused accidentally. This was prior to her ventilation. The initial incident as reported by [the suspect] was that the white spirit had been accidentally spilt, albeit during the course of an argument. In view of the lack of an account from

[Adult Z], together with the claims that these were accidental injuries and NO previous incidents at all between this couple, led the assessor to set the risk level at medium. Clearly, it was extremely difficult in this case to set an accurate or true risk level due to the lack of information. However, given the seriousness of the injuries sustained, an interim level of medium was set. It is clear that the Sergeant carrying out this assessment had every intention or re-visiting this level when more information from the victim was available...'

- 13.11 The police IMR continued '*...Following the death, the police fulfilled their role in ensuring that they considered the need for a Domestic Homicide Review and as such, made partner agencies aware and the circumstances in which [Adult Z] had died.*
- 13.12 As mentioned previously in this report, the panel has been told that CAADA would have expected the domestic abuse sector to have been told about the incident before Adult Z died regardless of the fact the police had been unable to interview her because she had been ventilated and despite the fact that the Adult Z had said she had sustained her injuries accidentally. They point to the fact that Adult 1 had admitted that the injuries had been sustained during an argument and that they were serious. The review notes that once the police officers investigating the incident received information that the injuries were not consistent with the story provided by Adult 1, they did not believe that the injuries sustained had been caused accidentally.
- 13.13 Importantly, the only agency in the partnership not using the DASH risk assessment tool is the South Yorkshire Police although they do refer to MARAC using ACPO DASH.
- 13.14 Whereas the issue of risk assessment had no bearing on the tragic outcome for Adult Z, had it been undertaken with the DASH tool, based on the accounts given at the time of the Adult Z's hospital admission, the level of injury sustained and the use of professional judgement (particularly the views of the officers that were investigating the case and responding nursing staff), the risk would undoubtedly have been assessed as 'high' and MARAC and IDVA referrals would have been triggered.
- 13.15 Although the police IMR stated [that] '*...It is clear that the Sergeant carrying out this assessment had every intention or re-visiting this level when more information from the victim was available.*'...and '*...Following the death, the police fulfilled their role in ensuring that they considered the need for a Domestic Homicide Review and as such, made partner agencies aware and the circumstances in which [Adult Z] had died...'*, the panel were concerned about what may have happened had Adult Z survived and either could not or would not tell the truth about what had happened to her. South Yorkshire Police are clear that they would have continued with the investigation in light of the findings of the initial forensic tests not supporting this account.
- 13.16 The officer who led the criminal investigation has been spoken to during this review. The panel is convinced that had Adult Z survived, the investigation would have continued with the same vigour as it did after her death and

would have resulted in a prosecution irrespective of whether Adult Z made a complaint or co-operated with the investigation.

- 13.17 What is less clear is whether, had Adult Z survived and maintained her stance that her injuries had been caused accidentally, a referral would have been made to MARAC. This is something South Yorkshire Police has been asked to consider. They have stated that if she had survived and the forensics confirmed that this version was not correct the case would have been referred to MARAC.

MARAC/ Vulnerable Adult

Analysis

13.18 **MARAC**

The MARAC process is well established within the region and there is a clear and unambiguous process surrounding it. Training and awareness has been provided and the process has been independently assessed and approved by CAADA.

- 13.19 The need for professional judgement to be applied has been mentioned in the previous section; if a professional has serious concerns about a victim's situation, they should be able to refer the case to MARAC. There are occasions where a case gives rise to serious concerns even if the victim has been unable or unwilling to say what had happened.

- 13.20 The IMR submitted by the Rotherham NHS Foundation Trust highlights an issue directly relevant to this. Nursing staff intuitively knew something was wrong, even though Adult Z had made a negative disclosure about the circumstances in which she had received her injuries. They engineered a situation whereby they could speak to Adult Z when she was alone and asked whether domestic abuse had been involved. They should be congratulated for seizing the initiative to do so but their concerns were not escalated to senior management even though internal policy dictates that serious injuries with positive potential indicators for domestic abuse should be.

- 13.21 It was not clear from the IMR what would have happened had the concerns of the nursing staff been referred to senior management. The issue has now been clarified. The Senior Registrar who advised Adult 1 to contact the police had made it clear to the Consultant in charge of Adult Z's care that if he (Adult 1) failed to do so, he intended to contact the police himself. The panel is in no doubt therefore that management at the hospital were determined that the police would be made aware of the incident.

- 13.22 Clarification has also been sought as to what the hospital would have done had Adult Z survived and continued with a negative disclosure. All medical and nursing staff receives basic adult safeguarding awareness training when they join the Trust. They are aware therefore of their duty of care

responsibilities. The medical staff acted proactively when, intuitively, they knew something was wrong. The panel is confident they would have sought advice from the adult safeguarding team with a view to escalating their concerns to the appropriate agency had Adult Z survived. The hospital staff that have undergone safeguarding adults training are aware that referral to the police and to the adults safeguarding teams does not require the consent of the individual if they have reason to believe there is a risk to the individual or to the wider public.

13.23 The IMR rightly makes the point that although there is national guidance in place for medical staff to refer gunshot and knife wounds to the police without the consent of the victim, there is no guidance available about reporting other serious life threatening injuries, such as the serious burns sustained by Adult Z in this case. This should not be taken as an indication that the lack of guidance would have influenced the decision making process at the hospital about reporting their suspicions to the police though. As mentioned previously, the panel is in no doubt that had Adult 1 not contacted the police, the hospital would have done.

13.24 **Vulnerable Adult**

There is nothing to suggest that Adult Z was a vulnerable adult within the definition of Law Commission Report of 1997.

Family history

Analysis

13.25 Neither the family of the Adult Z or Adult 1 has participated in this review although some were witnesses during the criminal proceedings. No evidence was forthcoming from any of them that domestic abuse had been a factor in the couple's relationship.

13.26 The former wife of Adult 1 was traced during the police investigation. She said Adult 1 had been physically violent and abusive towards her during their relationship and that he had beaten her on a daily basis. He had also thrown her down a staircase, and she says this resulted in her miscarrying. She added that they had married in 1985 and that the relationship did not last long. Her evidence was not admitted at the murder trial because of an absence of corroboration – family members who allegedly witnessed the abuse are dead and medical records that may have been maintained in the 1980's were not available. The former wife was invited to participate in this review but did not take up the invitation.

13.27 The absence of any engagement by the family and the former wife of Adult 1 mean that this aspect of the DHR cannot be progressed further.

Information sharing

Analysis

- 13.28 The TRFT acknowledge they should have told the police of their concerns about how Adult Z received her injuries. Their IMR stated...*'Currently there is no national guidance regarding referral to police without consent unless there are gunshot or knife injuries. Given the seriousness of the injuries and staff having concerns about possible domestic abuse, clear guidance on contacting the police would have been useful'...**'Due to the immediacy of the need to intubate [Adult Z], it is not clear if, had the police had been contacted, that they would have been able to speak with [Adult Z]. However, with hindsight if they had been made aware they could have initiated their procedures/investigations earlier as appropriate. This would not have affected the outcome for [Adult Z]'*. It seems therefore that the lack of national guidance about reporting injuries other than those caused by firearms or knives did not influence the decision making process of the senior medical staff in this particular case.
- 13.29 The issue of risk assessment and associated lack of immediate referral has been discussed above, as has the lack of guidelines about medical staff notifying the police of serious injuries suffered by a patient, other than gunshot and knife wounds. The MARAC protocols to which health agencies are signed up to, state that where professional judgement is applied and it indicates the risk is high (or was high at the time of the incident), it should be referred to the IDVA and MARAC, even if the victim has not consented. The IMR author advised the panel that training delivered to nursing staff in 2011 covered this point and that their internal policy was clear on the issue.
- 13.30 Not only did neither police nor medical staff make a referral to MARAC, they did not contact the IDVA Service. The police stated [that]...*'The IDVA service in particular was not contacted. This was carefully considered by the staff involved in this investigation in the initial early stages and there were specific reasons for this: the initial accounts given by both [Adult Z and Adult 1] were that it had been a terrible accident and secondly, [Adult Z] was quickly ventilated and sadly, was never in a position to speak to the IDVA service...'*
- 13.31 Should agencies fail to share information properly then the picture will remain incomplete. Whilst the sharing of information in this case after Adult Z had been admitted to hospital would not in any way have altered the tragic outcome for her
- 13.32 Agencies involved in the review have all commented that if Adult Z had survived they would have informed MARAC and IDVA.

'Near Miss' policy

Background

- 13.33 Since DHRs became a statutory requirement, the responsibility for conducting them in Rotherham falls to the Domestic Abuse Priority Group (DAPG). This group has the representation and specialist expertise required to undertake the role, as outlined in the statutory guidance for DHRs.

The 'near miss' policy

- 13.34 In line with Home Office advice and emerging good practice in relation to DHRs, Domestic Abuse Priority Group (DAPG) agreed they should undertake reviews of cases where serious incidents of domestic abuse had taken place and agencies thought domestic homicide had narrowly been avoided, particularly where lessons could be identified that would prevent the occurrence of domestic homicides in the future. This 'near miss' policy was in the development stage at the time of the incident that led to Adult Z's death but all the agencies concerned had agreed that incidents would be referred to DAPG as soon as they were able to do so during the development phase.
- 13.35 DAPG has now established a local definition of 'near miss' domestic homicide, when a referral should be made, how and by whom.
- 13.36 The policy takes into account of the following areas of concern:
- Cases of domestic abuse involving forced marriage and 'honour' based violence
 - Cases of domestic abuse where there is minimal or no agency involvement
 - Cases where the victim was reluctant to make a disclosure of domestic abuse
 - Cases of domestic abuse involving 16/17 year olds
 - Cases of domestic abuse involving vulnerable adults
 - Cases of self-harm and self-neglect where there was a history of domestic abuse
- 13.37 Its definition of 'near miss' domestic homicide is, *'An incident where a victim of domestic abuse has sustained a potentially life threatening injury, or serious harm, or significant impairment, and the incident and/or circumstances related to it, give concerns about the way local professionals and services work together to safeguard victims of domestic abuse'*
- 13.38 DAPG has also proposed that the definition of serious harm underpinning Domestic Abuse, Stalking and Harassment (DASH) risk assessment should be applied and enhanced in cases of 'near miss' domestic homicides.
- 13.39 Serious harm relates to an injury or condition that is life threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible.
- 13.40 The purpose of any review of a 'near miss' domestic homicide should be to:
- Establish what lessons are to be learned from the review regarding the

way local professionals and organisations work individually and collectively to safeguard victims of domestic abuse

- 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 of the review
 - Apply those lessons to service responses including changes to policies and procedures as appropriate
 - Prevent domestic violence homicides and ensure improved service responses to victims of serious incidents of domestic abuse (and their children) through improved intra and inter agency working.
- 13.41 The criteria for a 'near miss' domestic homicide should be the same as it would be had a homicide taken place. Included in the policy are the following explanatory notes:
- 13.42 'Intimate personal relationship' should include relationships between individuals aged 16 or over, who are or have been intimate partners regardless of gender and sexuality
- 13.43 Serious incidents involving family members (e.g. in the case of 'honour based violence') should be included
- 13.44 DAPG should review cases where case management gives cause for concern about the way professionals worked together to safeguard the victim. This will ensure that DAPG retains a degree of selectivity over cases to be reviewed and the review process is not replicating existing procedures
- 13.45 Cases involving attempted suicides following a history of domestic abuse should be referred to DAPG as a 'near miss' domestic homicide if the case gives rise for concern about the way local professionals and services work together to safeguard victims of domestic abuse. This will ensure that lessons can be identified in those cases in line with confirmation from the Home Office that that the term 'death' within the statutory DHR guidance includes suicides where domestic abuse issues were or were suspected to have been an issue prior to the death.
- 13.46 In line with the statutory guidance for DHRs, any panel reviewing a 'near miss' domestic homicide should include representation from agencies with specialist domestic abuse expertise and DAPG will agree this on a case by case basis.
- 13.47 The decision to undertake a review of a near miss domestic homicide should be a multi-agency decision, which would mirror the local arrangements for serious case reviews in relation to children.
- 13.48 DAPG has a degree of flexibility to ensure it considers circumstances where a professional's judgement indicates that some element of victimology (e.g. 16/17 year olds reluctant to disclose the domestic abuse, ethnicity, gender, etc.) is a particular point of concern and requires a coordinated response to be reviewed.

Analysis

- 13.49 The police IMR states '*...In August 2011, the Safer Rotherham Partnership through the Domestic Abuse Partnership Group came to the agreement that all 'near-miss' domestic homicides would be referred to the Group. The PPU Detective Inspector was aware of this agreement, however, at this point, both [Adult Z and Adult 1] were both referring to the incident as accidental in nature. It was at the point that she had died and suspicion had begun to grow in terms of how the white spirit could have been ignited, that it then became a possible murder investigation and a referral was made under the Domestic Homicide Review process procedures. The agreement that had been made via the DAPG was that near-miss referrals would be put on the agenda for the next such scheduled meeting. Clearly, events overtook this in that [Adult Z] then passed away and the Domestic Homicide Review process superseded the near-miss agreement.*
- 13.50 With the exception of South Yorkshire Police the panel is of the view that there should have been no doubt that the circumstances surrounding the admission of Adult Z to hospital amounted to a 'near miss' domestic homicide. The police knew her injuries were life threatening and that they had arisen out of a domestic situation. Homicide is the killing of one human being by another; it can be lawful or unlawful. Whether the injuries had been caused accidentally or intentionally was irrelevant. South Yorkshire Police remain of the view that this very quickly became a murder inquiry and so it was not appropriate to follow the near miss process as it had been superseded by the DHR process.
- 13.51 The near miss agreement in place at this time had been subject to discussion. South Yorkshire Police were concerned about the subjective nature of the process and consequently a local definitive protocol was under development. In the interim period the near miss policy that was in place identified that once an agency had formed the view that an incident was a near miss, in addition to referring to MARAC and IDVA, they would contact the Domestic Abuse Coordinator (DAC) to agenda the case. This would ensure the DAC was able to track the case and ensure it was referred to MARAC and IDVA as appropriate. South Yorkshire Police were involved in the discussion and would have been aware of this position.
- 13.52 The police and medical staff should have referred the matter to DAPG. Whether either agency would have placed the matter on the agenda for the next scheduled DAPG meeting is not clear.
- 13.53 Recommendations from this aspect of the review relate to 'near miss' referrals not being made straight away (as opposed to waiting for the next scheduled meeting) and that the Home Office should be invited to give consideration to promulgating the example of good practice in respect of the 'near miss' policy. (Anecdotal evidence suggests that such reviews are identifying more learning opportunities than full DHRs).

14 Summary of agency involvement and agency IMRs

- 14.1 IMRs are intended to review the respective organisations processes and involvement with the relevant case and also provide analysis of the service each provided.
- 14.2 As mentioned previously, only the following agencies were required to provide an IMR:
- South Yorkshire Police
 - Sheffield Teaching Hospitals Foundation Trust
 - The Rotherham Foundation Hospital Trust
 - Victim Support
- 14.3 They have all been quality assured by the responsible agency, by the original author and Panel Chair. Where appropriate the IMR's have been challenged and revised within agreed timescales.
- 14.4 Where agreement was not reached, the issue was placed before the panel for consideration. The panel also interviewed the IMR authors.

The IMR's

South Yorkshire Police

- 14.5 The police had very little contact with Adult Z or Adult 1 prior to the incident that led to the Adult Z's death. The IMR focuses largely on issues around the risk assessment which was set at 'medium', which led to non-referrals to MARAC and the IDVA. It also explains why the 'near miss' policy was not followed.
- 14.6 The IMR lacks any critical analysis of the events in question it does not identify any lessons learned or make any recommendations.
- 14.7 The panel challenged the IMR and at the request of South Yorkshire Police consulted with CAADA and established that they (CAADA) would have expected referrals to have been made. Even though the 'near miss' policy was still in its development stage the panel, with the exception of South Yorkshire Police, were of the opinion that South Yorkshire Police had not followed it.

Sheffield Teaching Hospitals Foundation Trust

- 14.8 The IMR outlines what happened when Adult Z was transferred to the Sheffield Hospital from Rotherham. It provides an account of the medical care Adult Z received and also what Adult 1 had told medical staff about the incident. It also sets out the liaison that took place between the hospital and the police.
- 14.9 The panel sought clarification about what would have happened had Adult 1

not contacted the police as he had been advised to do so by the Consultant. The panel was assured that the Consultant would have taken it upon himself to inform the police in those circumstances.

Rotherham NHS Foundation Trust

- 14.10 The IMR deals with the admission to hospital of Adult Z and her initial medical care. It provides a useful summary of the Adult 1's explanation as to how his wife's injuries had been caused. It describes the good work of the nursing staff that identified potential domestic abuse indicators and who provided a safe environment in which to probe further.
- 14.11 It identifies the need to strengthen policy around managing negative disclosure with positive indicators and also that DASH risk assessment training had previously been aimed at maternity and child health staff but had been opened up to A&E and Community Staff since September 2011.
- 14.12 It explains that a DASH risk assessment was not completed due to the negative disclosure and the level of training the staff had received but added that the priority at the time had been to preserve the life of Adult Z when she was in the A&E department.
- 14.13 Highlighted is the fact that guidance to refer gunshot and knife wounds to the police without the consent of the victim exists, but there is no such guidance in respect of other serious life threatening injuries.
- 14.14 The IMR recommends that DASH Risk Assessment training should include reference to how to manage negative disclosure and that the programme to train Band 6 and above A&E staff in undertaking DASH risk assessments should be completed. In addition it advocates that active support should be given to A&E staff undertaking DASH risk assessments, that the domestic abuse policy should be revised to reflect negative disclosure, that domestic abuse information should be available to all staff via the Trust's intranet and that the identified need for guidance on reporting life threatening serious injuries directly to the police should be escalated to national level.
- 14.15 **Note:** The IMR also states that a doctor and nurse could not be interviewed within time limits required for completion of this review. This is a matter of concern, especially as the DHR has been significantly delayed because of the lengthy police investigation and the subsequent murder trial. It is not clear what efforts were made to speak with the doctor and nurse once the DHR was re-convened after the trial or what consideration may have been given to interviewing them while the police investigation was still under way.

Victim Support

- 14.16 This IMR merely confirms that Victim Support was notified of the incident. They were unable to help Adult Z because she could not talk to anyone so arrangements were put into place to do so once she was able. Adult Z died before that could take place.

14.17 The IMR makes no recommendations.

15 Comment in relation to key DHR issues

Multi agency responsibility

15.1

- Was Adult Z subject to a MARAC/ MAPPA?

No. Other than the incident that led directly to her death, there were no known incidents that would have led to a referral

15.2

- Did Adult Z have any contact with a domestic violence organisation or helpline?

No.

15.3

- Consideration should also be given to whether either the victim or the perpetrator was a 'vulnerable adult'

Neither was regarded as a vulnerable adult.

15.4

- Were there any issues, in communication, information sharing or service delivery, between services?

The issues arising relate to the lack of a referral by the police to trigger the MARAC process and the fact that the 'near miss' policy was not invoked by the police or medical staff. Medical staff did not notify the police about their suspicions as to how Adult Z's injuries had been caused, but they did tell Adult 1 to contact the police. They have assured the panel that they would have contacted the police themselves had Adult 1 not done so.

Family engagement

15.5

- How should friends, family members and other support networks and where appropriate, the perpetrator contribute to the review, and who should be responsible for facilitating their involvement?

Efforts were made by the panel to include others in the review, including Adult Z's family and Adult 1, but they chose not to participate. Two friends of Adult Z have been interviewed; their contribution was much appreciated.

15.6

- How matters concerning family and friends, the public and media should be managed before, during and after the review and who should take responsibility for this?

The panel decided that all media and communication matters would be handled by a joint team drawn from the South Yorkshire Police, the Rotherham Foundation Trust and the Safer Rotherham Partnership.

It was agreed that the overriding aim was to protect the family from unwanted media attention so a reactive press statement was developed to cater for any enquiries that may have been made. Its purpose was to explain what a review was, why and who commissioned it and to stress that the review works closely with the family throughout the process.

An executive summary of the review will be published on the Safer Rotherham Partnership website, with an appropriate press statement available to respond to any enquiries. The recommendations of the review will be distributed through the partnership website, the partnerships operational and strategic domestic abuse groups and applied to any other learning opportunities with partner agencies involved with responding to domestic abuse.

Legal Processes

- 15.7
- How will the review take account of a Coroner's inquiry, and (if relevant) any criminal investigation related to the homicide, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process?

Many of the potential contributors to this review were likely to be witnesses in the murder trial. An early decision was made that the review would be suspended until the judicial process came to an end. When Adult 1 was sentenced to 8 years imprisonment for manslaughter and it had been confirmed that his appeal was against sentence rather than conviction, the review re-commenced.

There will not be an inquest into Adult Z's death because all the matters relevant to such proceedings were aired during the criminal trial.

- 15.8
- Does the Review Panel need to obtain independent legal advice about any aspect of the proposed review?

No conflicts or issues have been identified that would suggest this will be necessary.

Research

- 15.9
- How should the review process take account of previous lessons learned i.e. from research and previous DHRs?

Previous DHR's have been scrutinised during this review to elicit best practice.

Individual agency responsibility

- 15.10
- Was the work in this case consistent with each organisation's policies and procedures for safeguarding and promoting the welfare of adults,

and with wider professional standards?

The Rotherham NHS Foundation Trust identified some training needs about risk assessment and domestic abuse awareness. It also highlighted an issue about suspicions of abuse not being escalated to senior managers.

- 15.11
- What were the key relevant points/opportunities for assessment and decision making in this case in relation to the victim and perpetrator. What was the quality of any multi-agency assessments?

The only agency not using the DASH risk assessment tool was the South Yorkshire Police. They use SPECCS + the guidance of which does not explicitly involve professional judgement. The panel has been told that CAADA would have expected the domestic abuse sector to have been told about the incident regardless of the fact that the police had been unable to interview Adult Z and despite the fact that Adult Z had she said she had sustained her injuries accidentally. They point to the fact that Adult 1 had admitted that the injuries had been sustained during a domestic argument and that the injuries were serious.

Had the risk assessment been undertaken with the DASH tool, based on the accounts given at the time of the Adult Z's hospital admission, the level of injury sustained and the use of professional judgement, the risk would have been assessed as 'high' and MARAC and IDVA referrals would have been triggered.

- 15.12
- Was the impact of domestic violence on the victim recognised?

There was no record of domestic violence or abuse affecting Adult Z before the incident that resulted in her death.

- 15.13
- Did actions accord with assessments and decisions made? Were appropriate services offered/provided or relevant enquiries made, in the light of assessments?

Due to the circumstances already described, no services were offered to the Adult Z or Adult 1.

- 15.14
- Was there sufficient management accountability for decision making? Were senior managers or other organisations and professionals involved at points in the case where they should have been?

The only issue about a lack of management accountability was identified in the TRFT IMR in that suspicions the medical staff had about domestic abuse were not escalated to senior managers

16 Conclusions

- 16.1 None of the agencies that make up the Safer Rotherham Partnership could

have done anything to anticipate or prevent the tragic death of Adult Z at the hands of her husband. Neither Adult Z nor Adult 1 was known to any agency in a domestic abuse context.

17 Recommendations

The following recommendations are made:

National

- 17.1 Consideration should be given to the national guidance for reporting gunshot and knife injuries without the consent of the victim being reviewed with a view to including life threatening injuries caused by other means.
- 17.2 The Home Office is invited to consider the current 'near miss' policy identified by the Safer Rotherham Partnership for wider dissemination and implementation.
- 17.3 The Home Office is invited to consider the provision of greater clarity around the definition of a DHR to include victim suicide and serious injury
- 17.4 At a national level, consideration given to the Victim Support National Homicide Service funding and policy, with particular reference to engagement following criminality and clearer guidance as to what constitutes a 'homicide'.

Safer Rotherham Partnership

- 17.5 The Safer Rotherham Partnership is well aware that raising public awareness of domestic abuse is an on-going process. The partnership should be clear that Domestic Abuse is wider than physical violence and should include all types of abuse, including coercive control. It should also include that abuse is age neutral affecting both women and men.

The public awareness programme should be delivered regularly throughout the year and be accessible to all. It should be examined to ensure it identifies all aspects of abuse and that it can deliver appropriate outcomes.
- 17.6 The Safer Rotherham Partnership 'near miss' policy should be updated to require immediate notification to the DAPG via the DAC rather than delaying referrals to the next scheduled meeting.
- 17.7 The SRP MARAC Protocol and near miss protocol should be updated and explicitly state the need to share information where there is an indication of serious injury and professional judgement indicates this should be assessed as high risk should be referred to MARAC and IDVA without delay
- 17.8 In the absence of national guidance, the Safer Rotherham Partnership should develop a local protocol to ensure life threatening injuries caused by

other means are identified and highlighted appropriately

- 17.9 IMR author training should be provided to all agencies within the Safer Rotherham Partnership and to 3rd sector organisations. The training should include critical analysis as a key component.
- 17.10 DAPG should continue to pursue the development of a performance management framework
- 17.11 The Health and Well Being Board should commission a scrutiny review of domestic abuse support provision by cabinet members.
- 17.12 Inevitably, when organisations differ on the identification, assessment and level of service provided there is a greater chance that potential victims and perpetrators will be overlooked and opportunities to intervene will be missed.

There should be a standardisation within the Safer Rotherham Partnership of risk assessment processes including risk assessment tools.

- 17.13 Domestic Abuse training for all agencies within the Safer Rotherham Partnership should include what to do in the event of negative disclosure and that further information re Domestic Abuse is available to all staff via its website.

Individual Agency

- 17.14 South Yorkshire Police should review their assessment process and provide further training and/or awareness for staff.
- 17.15 Domestic Abuse training for the Rotherham NHS Foundation Trust should include what to do in the event of negative disclosure and that further information re Domestic Abuse is available to all Trust staff via its website.
- 17.16 The Trust's training programme for Band 6 and above A&E staff in undertaking DASH risk assessments should be completed.
- 17.17 The Trust should give active support to A&E staff undertaking DASH risk assessments and their domestic abuse policy should be revised to reflect negative disclosure.