safe & sound

Dudley's Community Safety Partnership

Domestic Homicide Review

under section 9 of the Domestic Violence Crime and Victims Act 2004

In respect of the death of a woman

In January 2018

Report produced for Dudley Community Safety Partnership by
Paula Harding
Independent Chair and Author
July 2019, revised July 2020

Abbreviations

AAFDA: Advocacy After Fatal Domestic Abuse
ACES: Adverse Childhood Experiences
Adult 3: the victim's ex-partner
CGL: Change Grow Live charity
CSP: Community Safety Partnership
CCG: Clinical Commissioning Group
CPN: Community Psychiatric Nurse
CPS: Crown Prosecution Service
DoH: Department of Health
DHR: Domestic Homicide Review
GP: General Practitioner
IDVA: Independent Domestic Violence Advisor
IMR: Individual Management Review – reports submitted to review by agencies
IRIS: Identification and Referral to Improve Safety - a general practice-based domestic violence and abuse training support and referral programme
MARAC: Multi-Agency Risk Assessment Conference
MBC: Metropolitan Borough Council
MECC: Making Every Contact Count
NCDV: National Centre for Domestic Violence
OASys: Offender Assessment and Sentence Management tool used in Probation Services
WMP: West Midlands Police

Glossary

- **Homeless in Priority Need** : in order for a local authority to have a duty to house someone who applies to them as homeless, they have to fulfil certain conditions including being in 'priority need' which is defined within section 189(1) Housing Act 1996 and the Homelessness (Priority Need for Accommodation) (England) Order 2002. For full details of who is considered to be in 'priority need', see the Statutory Guidance available at https://www.gov.uk/guidance/homelessness-code-of-guidance-for-local-authorities/chapter-8-priority-need
- **'Joint Screening'** was a multi-agency system that was designed to share police reports about domestic abuse where children were known to be in the household, with health and children's social care to determine the actions needed to keep children safe from domestic abuse.
- **Section 47 Assault:** refers is an offence under Section 47 of the Offences Against the Person Act involving actual bodily harm.
- **Staying Put:** often referred to as Sanctuary Scheme which is a local multi-agency scheme whereby home security measures can be added to a domestic abuse victim's home to provide an option for them to stay in their home with greater security

West Midlands Police provided the following services in this review:

- **Domestic abuse, stalking and harassment risk assessment model (2009).** There are three levels of risk identified by the model. Serious harm is defined as a risk which is life threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible.
  - **Standard risk**: current evidence does not indicate a likelihood of causing serious harm
  - **Medium risk**: there are identifiable indicators of risk of serious harm. The perpetrator has the potential to cause serious harm but is unlikely to do so unless there is a change in the circumstances.
  - **High risk**: there are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious. All high-risk cases will be referred to the Duty Inspector for consideration of a threat to life assessment
- **Non-crime domestic abuse report**: national recording standards require that police offices record domestic abuse incidents as crimes if there is evidence of a crime and as 'non-crime' where there is no evidence.
- **SIG Marker:** Street Interest Gazetteer is a marker attached to a specific location in police records alerting police officers and staff to particular information of relevance, such as domestic abuse being known at an address
- **Partnerships Team:** part of the Neighbourhood Policing Unit which receives referrals from officers in respect of individuals who may need additional support in any way.
- **Police Watch:** a police system whereby neighbourhood policing teams can make random checks on the property to ensure that the victim is safe

PREFACE

Members of the review panel offer their deepest sympathy to the family and all who have been affected by the death of the victim.

The family will be offered the opportunity to provide a statement about their mother and the impact of her death, prior to publication.

CONTENTS

GLOSSARY **2**

1. INTRODUCTION **5**

1.1 Aim and Purpose of a domestic homicide review *5*
1.2. Summary of the circumstances leading to the review *6*
1.3. Timescales *6*
1.4. Confidentiality and Anonymisation *7*

2. TERMS OF REFERENCE **7**

2.1. Methodology and Engagement with Family *7*
2.2. Independent Chair and Overview Author *8*
2.3. Members of the Review Panel *8*
2.4. Scope and Key Lines of Enquiry *9*
2.5. Time Period *12*
2.6. Individual Management Review Reports (IMRs) *12*
2.7. Agencies without contact *12*
2.8. The definition of domestic violence *13*
2.9. Parallel Reviews *13*
2.10. Equality and Diversity *13*
2.11. Dissemination *14*

3. THE HOMICIDE **14**

4. CHRONOLOGY **15**

5. OVERVIEW OF AGENCY INVOLVEMENT **28**

5.1 West Midlands Police *28*
5. 2 Primary Care *31*
5.3 Dudley and Walsall Mental Health Partnership NHS Trust *33*
5.4 Dudley Group NHS Foundation Trust *35*
5.5 Dudley Metropolitan Borough Council Adult Social Care *36*

6. THEMATIC ANALYSIS, LEARNING & RECOMMENDATIONS **37**

6. 1 Domestic Abuse and Coercive Control *37*
6.2 The 'Right to Know' *41*
6.3 Domestic Abuse, Substance Abuse and Mental Health *42*
6.4 Holding Perpetrators to Account *46*
6.5 Multi-Agency Risk Assessment Conference *47*

7. RECOMMENDATIONS **48**

7.1 Overview Recommendations *48*

8. CONCLUSION **51**

8. BIBLIOGRAPHY **52**

9. ACTION PLANS ..... ERROR! BOOKMARK NOT DEFINED.

1. INTRODUCTION

1.1 Aim and Purpose of a domestic homicide review

1. Domestic Homicide Reviews (DHRs) came into force on the 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by (a) a person to whom she was related or with whom she was or had been in an intimate personal relationship or (b) member of the same household as herself; with a view to identifying the lessons to be learnt from the death.

2. The purpose of a DHR is to:
   - Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
   - Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
   - Apply these lessons to service responses including changes to policies and procedures as appropriate; and identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra- and inter-agency working.

3. As well as examining agency responses, statutory guidance requires reviews to be professionally curious and find the "trail of abuse". The narrative of each review should "articulate the life through the eyes of the victim…The key is situating the review in the home, family and community of the victim and exploring everything with an open mind". (*Multi-Agency Statutory Guidance 2016, paras 8 and 9*)

4. Hence, the key purpose for undertaking a domestic homicide review is to enable lessons to be learned where a person is killed as a result of domestic violence, abuse or neglect. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.2. Summary of the circumstances leading to the review

5. This domestic homicide review concerns the death of the forty-four-year-old victim who was the mother of eight children and who was brutally killed by her fifty-year-old partner, when she was trying to leave him in January 2018.

6. The victim had suffered longstanding abuse for most of her life, alongside alcohol and substance misuse, homelessness and her children having been taken into care as a result of her neglect of them. She was nonetheless described by her children as doing her best for them whilst they were growing up and being very caring.

7. The victim and perpetrator began a relationship in 2013. The perpetrator had a long history of offending and was known to have posed a high risk of serious harm to his ex-partner who he continued to stalk and harass before he met the victim. He then went on to subject the victim to a wide range of domestic abuse, including threats to kill and the victim was referred to MARAC twice in the years which followed.

1.3. Timescales

8. Dudley Community Safety Partnership was notified of the death in January 2018. The decision to undertake a review was made in February 2018 and the Home Office notified the same day. Statutory guidance requires that a domestic homicide review be completed within six months, wherever possible. However, given the sensitivity of the criminal proceedings, a decision was made by the Independent Chair and Partnership to delay the review until criminal proceedings had completed. The first panel meeting was held in September 2018 promptly after being notified that the perpetrator was sentenced that month.

9. The panel met on four occasions and agreed the report in April 2019. The draft Overview Report was presented to Dudley's Domestic Abuse Strategic Group, who provide an internal quality assurance role for the Partnership, on 01.05.19. The Overview Report was endorsed by the Community Safety Partnership on 29.07.19 prior to submission to the Home Office.

1.4. Confidentiality and Anonymisation

10. This Overview Report has been anonymised and, where stated, redacted, in order to protect the identity of the individuals concerned and their families. The panel considered the use of pseudonyms for the victim and perpetrator in line with Statutory Guidance and as a means to humanise the victim's narrative. However, as there was no family engagement in this review with which to test out the suitability of pseudonyms, the panel concluded that it was inappropriate to proffer them and used the terms 'victim' and 'perpetrator' instead.

11. The report also features the victim's ex-partner, who was the father of her children, who has since died. He is referred to as **Adult 3**.

12. During the course of this review, the details have remained confidential, available only to participating professionals and their direct line management. This report has sought to extract sufficient detail from the victim's narrative for the lessons and recommendations to be understood, whilst balancing this need for confidentiality.

2. TERMS OF REFERENCE

2.1. Methodology and Engagement with Family

13. All local agencies were notified of the death and were promptly asked to examine their records to establish if they had been approached by, or provided any services to, the family and to secure records if there had been any involvement.

14. Arrangements were made to appoint an Independent Chair and Author for the review and agree the make-up of the multi-agency review panel. The Chair and review panel drafted the terms of reference and key lines of enquiry for the review.

15. The victim's family were notified of the domestic homicide review, invited to engage and provided with details of Advocacy After Fatal Domestic Abuse (AAFDA), a charity providing specialist advocacy support, as well as explanatory leaflets produced by the Home Office. Family liaison officers delivered the first letters by hand and explained the review but family members were deemed to have declined engagement. The perpetrator was contacted but also declined to engage with the review.

16. Family members were notified as the report progressed as well as when it was concluded and given an opportunity to comment. They will be notified again before publication of

the report and engagement and support will be offered by the Community Safety Partnership again at this time.

17. Agencies that had involvement with the victim and perpetrator were asked to provide a chronology of their contacts and an Information Management Review (IMR) analysing their involvement. Panel members were able to discuss the progress of the review reports and request further clarification and additional material, where needed before the overview report was drafted.

2.2. Independent Chair and Overview Author

18. The Independent Chair and Overview Author is Paula Harding, who has compiled the Overview Report, the Executive Summary and coordinated the integrated action plan. Paula Harding has over twenty-five years' experience of working in domestic violence and related services. Her senior local authority and third sector experience has spanned working in refuge, advice and outreach services; management of front-line services; training and development; policy formation and strategic commissioning. She completed an M.A. (Birmingham) in Equalities and Social Policy in 1997, focusing on domestic violence and social welfare, and is a regular contributor to conferences, national consultations and academic research. She completed the OCR certificated training funded by the Home Office for *Independent Chairs of Domestic Homicide Reviews* in 2013. She has also completed the on-line training provided by the Home Office: *Conducting a Homicide Review*[1].

19. Paula Harding worked for a large metropolitan local authority as the strategic lead for violence against women for more than a decade. Since leaving the statutory sector in 2016, Paula Harding has worked as an independent consultant, mainly engaged in domestic homicide and safeguarding adult reviews and supporting Women's Aid organisations. Beyond undertaking independent reviews, Paula Harding has not been employed by any agency in Dudley.

2.3. Members of the Review Panel

20. Multi-agency membership of this review panel was determined by the Independent Chair and consisted of senior managers and/or designated professionals from the key statutory agencies. Panel members had not had any direct contact or management involvement with the victim and they were not the authors of information reports provided to the review.

---

[1] Available at https://www.gov.uk/guidance/conducting-a-domestic-homicide-review-online-learning

21. Black Country Women's Aid deliver domestic abuse services in the area and provided particular expertise on gender, domestic violence and the broader 'victim's perspective' to the panel. They also provide a specialist, regional Stalking Support Service, and could provide specialist understanding on stalking and harassment which was relevant to this case. Likewise, CGL was a member of the panel to assist the review in understanding the role of substance abuse with the individuals' lives. Panel membership also benefitted from BME representation, contributing to the alertness of the review to the potential for conscious or unconscious bias in respect of race or ethnicity.

22. The review panel members were:

Name	Designation	Organisation
Paula Harding	Independent Chair	-
Cate Webb-Jones	Adult Abuse Detective Inspector	West Midlands Police (Western region)
Christine Emery	Team Leader	Change, Grow, Live (CGL)
Christina Rogers	Head of Safeguarding	Dudley Group NHS Foundation Trust
Howard Woolfenden	Head of Safeguarding and Review	Dudley MBC Children's Social Care
Jamie Gutteridge	Team Manager, Tenancy Management	Dudley MBC Housing Services
Jane Atkinson	Designated Nurse for Adult Safeguarding	Dudley Clinical Commissioning Group
Katriona Lafferty	Community Safety Officer – Reducing Vulnerability	Dudley MBC Community Safety
Raj Lagan	Regional Head of Domestic Abuse Service	Black Country Women's Aid
Sharon Latham	Head of Safeguarding	Dudley and Walsall Mental Health Partnership NHS Trust
Sue Haywood	Head of Community Safety	Dudley MBC Community Safety

2.4. Scope and Key Lines of Enquiry

23. The review sought to address both the 'circumstances of a particular concern' set out in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016). In particular, the review sought:

- To establish what contact that agencies had with the victim and the perpetrator; what services were provided, individually and in partnership; and whether these services were appropriate, timely and effective?
- To establish whether agencies knew, or could have known, about domestic abuse. What actions they took to safeguard and meet the needs of the victim, and manage the threat from perpetrator.
- To consider how issues of mental health and substance misuse or any other issues of diversity impacted upon the delivery of services and whether needs or risk arising from these factors were addressed.
- To establish how well-equipped staff were in responding to the needs, threat or risk identified for the family through policies and procedures; management and supervision; training; capacity and resources to meet expected standards of practice.
- To establish what lessons can be learned from the case about the way in which professionals and organisations carried out their duties and responsibilities.
- To identify clearly what those lessons are, how (and within what timescales) they will be acted upon and what is expected to change as a result through the production of a multi-agency action plan
- To recommend to organisations any appropriate changes to such policies and procedures as may be considered appropriate in the light of this review

24. Specific questions were also directed to agencies and arose out of the summary of engagement initially provided by agencies:

Adult Services

- To provide the rationale for transferring the case to the 'Adults at Risk' team following the Multi-Agency Risk Assessment Conference (MARAC) referral and account for the delay in allocating the case.
- To specify which properties that the victim was thought to be living at.
- To consider whether the procedure for closing cases was followed; whether there was an escalation procedure following non-engagement and its relationship with the MARAC process.

Clinical Commissioning Group:

- How the GP records names of partners when domestic abuse is recorded with them?
- What notifications were received from the Emergency Department and how were they acted upon?

Dudley Group NHS Foundation Trust

- To consider how disclosure of domestic abuse were acted upon

- To consider whether there were opportunities to ask about domestic abuse when not disclosed by the victim.
- To consider whether there was sufficient professional curiosity to enquire about where the children lived.

West Midlands Ambulance Service

- To describe the assessment criteria and processes

West Midlands Police

- To provide a contextual summary of the victim's known experiences of domestic abuse prior to the dates in this TOR
- What immediate safeguarding actions were made for the victim when the perpetrator was removed each time?
- Were any referrals made for either the victim or offender in response to reported crimes, or not crimed (non-crimed), incidents?
- How much information about individual's prior history was made available to officers attending each incident?
- How was the victim dealt with when she disclosed that she was the violent one and provoked violence? Were her claims of undergoing diagnosis for a bi-polar condition checked and what was the follow-up to this incident?

Black Country Women's Aid

- To provide an analysis of how the service sought to engage with the victim and actions taken when they were unable to engage.

Children's Services

- To provide an information report featuring the dates of child protection proceedings for youngest children and how domestic abuse featured in the assessment of the parenting capacity of their father.

Dudley MBC Housing Services

- What was the nature of homeless prevention and assessment undertaken prior to the eviction in July 2014
- To provide a brief summary about the problems that the victim was known to be having in her tenancy prior to 2014
- To provide a summary of the circumstances through which the victim was known to be a 'Potentially Violent Person' and the processes involved for staff once a tenant has been described as such.

National Probation Service

- To provide a summary of the pre-sentence report completed on the offender in January 2012
- To identify whether there were any opportunities for intervention with the offender on his violence to others

2.5. Time Period

25. The panel agreed that the review should consider agencies contact with the victim and perpetrator and should focus on events from January 2012, when the perpetrator's domestic abuse towards his former partner was considered at MARAC alongside his conviction for possession of a knife, until the victim's death in 2018.

26. The timeframe was extended for the National Probation Service to January 2011 to enable the perpetrator's eighteen-month suspended sentence for an unrelated offence to be considered within the review.

2.6. Individual Management Review Reports (IMRs)

27. An IMR and comprehensive chronology was provided by the following organisations:

    - Dudley Group NHS Foundation Trust (hospital provider)
    - Dudley and Walsall Mental Health Partnership Trust
    - Dudley MBC Adult Social Care
    - Clinical Commissioning Group
    - West Midlands Police

28. In view of their more limited contact, chronology and or information reports were requested from:

    - Black Country Women's Aid
    - Dudley Metropolitan Borough Council Housing Services
    - Dudley Metropolitan Borough Council Children's Social Care
    - National Probation Service

29. All reports were authored by professionals who had not had any direct contact or management involvement with the victim.

2.7. Agencies without contact

30. The following agencies were contacted but confirmed that the couple had not been known to them or that their contact was not relevant to this review:

- CGL (addiction services)
- CHADD (local domestic abuse services and refuge provider)
- Staffordshire and West Midlands Community Rehabilitation Company

2.8. The definition of domestic violence

31. The Government's definition of domestic violence, which sets the standard for agencies nationally was applied to this review:

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

- psychological
- physical
- sexual
- financial
- emotional

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.
Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."[2]

2.9. Parallel Reviews

32. The homicide was subject to criminal proceedings and information provided to these proceedings has contributed to the context and background for this review. Beyond this, the review panel was not made aware of any other parallel proceedings.

2.10. Equality and Diversity

33. The review gave due consideration to each of the protected characteristics under Section 149 of the Equality Act 2010 as well as wider issues of diversity and vulnerability. The victim was a white heterosexual woman of UK heritage and the perpetrator was a Black, heterosexual man of UK heritage. The panel considered how race or ethnicity had the potential to affect the way in which agencies responded, or how agencies were accessed, but no adverse observations were made in this regard. However, both the

[2] https://www.gov.uk/guidance/domestic-violence-and-abuse

victim and perpetrator had mental health and substance misuse concerns and these issues of vulnerability feature in the report that follows.

34. Sex and gendered violence were considered particularly relevant to this review. In the three years preceding the victim's murder, seventy per cent of victims of domestic homicides were female and eighty-three per cent of victims reporting coercive control to the police[3] were female (Office for National Statistics, 2017). The role of race, sex, gendered violence, mental health and substance misuse have therefore been considered throughout this review.

2.11. Dissemination

35. The following recipients will receive a copy of the completed report:

- The victim's family
- Agencies participating in the review
- Agencies of Dudley's Community Safety Partnership, Dudley Safe and Sound
- West Midlands Office of the Police and Crime Commissioner

36. The report will be published on the Dudley Safe and Sound website

3. The Homicide

37. The victim had wanted to end her abusive and violent relationship with the perpetrator, and she had managed to leave him, but he convinced, or required, her to meet him for dinner at his home.

38. During the evening they had an argument and the perpetrator strangled and killed her. When concerned family members visited the home, the perpetrator tried to hide what he had done, but they saw the victim's body and alerted the police. By this time, the victim had been dead for over 24 hours. The perpetrator had not called for an ambulance but had apparently sat with her, watched television and gone out to get alcohol within that time.

39. The perpetrator claimed that the victim had attempted to attack him with a knife and that he had accidently killed her by restraining her to protect himself. However, witnesses had seen previous incidents where he had grabbed the victim around the

[3] 83% of victims were female where the victim's gender had been recorded. Gender had not been recorded in 22% of cases.

throat. Likewise interviews with family and friends revealed that he had been violent and had attacked the victim on previous occasions.

40. The perpetrator was convicted of manslaughter and received a fifteen-year sentence. The Judge commented on the callousness of his inaction after the death and said that he was a dangerous individual posing a significant risk to the public and particularly future partners. As a result, the Judge ordered that he would be monitored for five years longer than normal on release.

4. CHRONOLOGY

41. The victim had a long history of domestic violence and sexual abuse before she met the perpetrator and was therefore vulnerable in the context of future abuse. She disclosed to mental health workers that she had been sexually abused as a child and raped as a teenager. She started drinking at the age of fourteen in order to deal with these experiences and her drinking and drug taking went on to escalate over the course of her life.

42. As an adult, she suffered physical and emotional domestic abuse from her ex-partner with whom she had eight children. The relationship ended in 2006 after they had been together for eighteen years and it was not until 2006 that the police received any reports of domestic abuse. Thereafter, the victim made six reports of verbal abuse and nuisance calls regarding this ex-partner.

43. After the relationship had broken up, the victim remained in the family home, which was a local authority tenancy. Her family described her as having a ‘new lease of life’ and she became more social and outgoing. However, one of her children reported that the victim had been assaulted by her new boyfriend and as a result of her alcohol misuse and neglect, the children were taken into care later that year.

44. After a period of assessment, and despite her ex-partner’s domestic abuse, the youngest five children returned to their father and the oldest three to their mother in 2009. Concerns about neglect of the youngest children continued and children’s services and foster care became involved at various times until 2013 when they were de-listed from child protection plans.

45. It appears that the victim met the perpetrator during 2013. They lived a short time with the victim’s eldest child before the victim obtained a private tenancy. Whilst the perpetrator appears to have spent most of his time at the victim’s home, he maintained his own lodgings elsewhere throughout this time.

46. The perpetrator had been in a long-term relationship with his ex-partner between 1992 and 2009, during which time they had three children. It was not until the relationship ended that his ex-partner disclosed that he had been abusive to her throughout their relationship and she disclosed that he had previously strangled her and threatened to kill her and her children. He continued to harass her after the relationship had ended and was alleged to have been seen walking past her house with a large knife. As a result, her case was presented to MARAC.

47. The perpetrator had an extensive offending history stretching back for several years. More recently, in 2011, he received an eighteen-month suspended sentence for Driving with Excess Alcohol and Possession of Cannabis. Rehabilitation work was undertaken with him including referrals to an alcohol relapse scheme. However, he breached the terms of the suspension by failing to attend scheduled appointments with probation services, which resulted in him receiving two months immediate custody.

48. In January 2012, the perpetrator was convicted of possession of a bladed article for having threatened his ex-partner's brother with a knife, for which he received an eight-month custodial sentence. He was subject to automatic unconditional release which meant that on release he would not be subject to any statutory supervision by probation services. The National Probation Service had made a recommendation in his pre-sentence report for a suspended sentence to enable them greater scope for interventions to address the perpetrator's alcohol misuse, consequential thinking and conflict resolutions skills. As this was not granted, opportunities for him to complete interventions to address his violence whilst in custody or on release, were seen to be limited.

49. During this time, the perpetrator was assessed using the Offender Assessment and Sentence Management system 'OASys', a dynamic risk assessment tool utilised by the Probation Service to determine the likelihood of reoffending and risk of serious harm. The assessment, completed in January 2012, indicated that he presented a medium risk of reoffending and a medium risk of serious harm to the public whilst in the community. The case was heard at MARAC in February 2012 in order that protective mechanisms could be arranged for his ex-partner upon his release. His ex-partner was reported to have been "petrified" of the perpetrator and too scared to report his domestic abuse. She disclosed that he had been sending threatening texts to her and she also reported that the neighbourhood perceived the perpetrator as very frightening as well.

50. Following a dog bite in April 2012, the victim attended the Emergency Department for facial scarring that she had endured. This scarring went on to leave her feeling self-conscious and unable to return to work. Primary care health services (then Dudley Primary Care Trust) later went on to decline funding for plastic surgery but it is not known how this initial self-consciousness affected her as time went on.

51. In September 2012, the victim disclosed to her GP that she had a shoulder injury due to an assault but there was no indication that the GP had made further enquiries on the matter. Three months later she attended with back pain and no further enquiries appeared to have been made regarding the cause.

52. In June 2013, the victim disclosed her alcohol abuse to her GP but declined support for this as she felt that she was cutting down her alcohol intake herself.

53. In September 2013, the victim attended an appointment with a primary care mental health nurse following her GP's referral. She disclosed struggling with depression and anxiety and a long history of substance misuse following a number of previous abusive relationships. She was looking for support to cope with what she disclosed to be "domestic issues" that she still had with her ex-partner but reported being able to cope with her substance misuse. She was signposted to Victim Support, who provided domestic abuse services in the area at the time and given advice on dealing with depression and anxiety. She did not attend the follow-up appointment provided and was discharged back to the care of her GP.

54. In November 2013, the victim's ex-partner was diagnosed with cancer and the victim went on to support the children through their father's illness. The Family Adolescent Support Team became involved and a family group conference was convened. However, the victim did not engage with the process, but she continued to have regular contact with the children who described her as being very supportive throughout their father's illness until he died some years later.

55. In March 2014, the victim contacted the police for the first time regarding her relationship with the perpetrator. She said that she had recently broken up with him, but he had entered her home whilst she was out and had refused to leave. The police removed the perpetrator, who was extremely intoxicated and took him to his home address. The incident was recorded as domestic abuse and intelligence checks were undertaken revealing that no previous domestic abuse was recorded involving the couple although the perpetrator's domestic abuse of a previous girlfriend was noted. Current risk was reviewed by a supervisor and graded as standard with no further safeguarding deemed necessary. DASH was considered but not undertaken as the victim was seen to find his presence a nuisance rather than potentially violent.

56. In May 2014, the local authority landlord took court proceedings to evict the victim as a result of many problems with the tenancy including rent arrears; neglect of the property; not allowing contractors access to undertake repairs and safety checks; nuisance and not using the property as her principal home. Most of these tenancy problems had existed for several years during which time, neighbours had reported the

victim to be aggressive and threatening and Housing Services also saw her as abusive and threatening to staff.

57. In response to the notice, the victim contacted Housing Services and was assessed as not having a 'priority need' for accommodation under the homeless provisions of the Housing Act 1996, which meant that the authority did not consider that they had an obligation to rehouse her permanently. Although she had disclosed anxiety, depression and alcohol problems, these were not considered to be of a degree which would unduly impair her ability to find accommodation for herself and therefore incur a duty for the local authority to assist her as someone in 'priority need'. She did not disclose any domestic violence and the local authority went on to offer her hostel accommodation and advice on gaining private rented accommodation which she declined.

58. In June 2014, the victim made several visits to the GP where she disclosed that she had started to drink again, had split up with her boyfriend and had been arrested.

59. In July 2014, the victim received a caution for criminal damage having smashed a relative's window whilst drunk. It is not known if any referral was made for the victim to alcohol support services.

60. In August 2014, the police received a complaint from an acquaintance of the couple saying that they were staying at his home and spending all his money on alcohol and cigarettes. All parties were intoxicated, and the couple left the property at the police's request. However, the victim returned shortly afterwards and was abusive to police officers for which she was arrested for a public order offence and for resisting arrest. She pleaded guilty to resisting arrest but was found not guilty of the public order offence and was given a conditional discharge for six months. A small quantity of cannabis had been found on her possession and she admitted to using cannabis but denied alcohol abuse. She was not charged for possession of cannabis as the quantity was so small.

61. The victim visited her GP several times during this period. In the October she told the GP that she had been arrested in a friend's home and had sustained some bruising at the time of the arrest. By November 2014, she informed the GP that she was homeless and staying with friends and relatives until further accommodation could be found.

62. In December 2014, the police attended a local takeaway restaurant following a report that the victim had been assaulted by the perpetrator. She was slightly intoxicated and told police that he had punched her several times at home the day before and bruising and swelling to her left eye, cheek and scalp were evident to officers who went to the victim's address and arrested the perpetrator who was intoxicated.

63. By the time officers returned to take the victim’s statement, she was also heavily intoxicated and so an interview was undertaken the next day. The victim stated that she was afraid of him and had never seen him so angry. On this occasion, they had returned home after drinking and she had eaten some food straight from the frying pan before going to sleep. She was awoken by him hitting her head with the frying pan and punching her repeatedly to the face. He was very apologetic after the assault but the next day, when she resisted giving him money to get more alcohol, he said that he would have killed her but did not know what to do with the body. She had taken the opportunity to go to the takeaway when he was hungry, to phone the police.

64. On previous occasions, she reported that he hadn’t assaulted her but had cut up her clothes and urinated on her papers. On one of the four occasions that they had split up previously, she had returned for her clothes to find that he had laid out a hammer and some knives on the floor, saying that he had got them ready for her. She told the police that she thought at this time that he had schizophrenia.

65. The police assessed the victim as facing high risk. The perpetrator denied domestic abuse, saying that he found domestic abuse abhorrent. He claimed that the injuries were accidental, and that the victim had assaulted him. During the interview, he advised the police about the victim’s alcohol and cannabis misuse, her previous experiences of domestic abuse and the fact that her children had all been taken into care. He was bailed with conditions not to contact the victim.

66. The Crown Prosecution Service initially stated that there was insufficient evidence to charge the perpetrator. However, the Domestic Abuse Team formally appealed this decision and a charge for common assault was authorised. In the meantime, the police were informed by the victim’s daughter that he had breached these conditions, the victim retracted her statement and the case was dismissed at court.

67. On the advice of the police, the victim attended the Emergency Department to have her injuries assessed. This was the only occasion that she disclosed domestic abuse to the hospital, and she told staff about the nature of the assault and her having been locked in the room for some time before being able to get out to report the incident. It was assessed that she sustained soft tissue facial injuries, a head injury and a possible broken nose. The victim also advised that she had eight children under the age of sixteen who did not live with her. There was no evidence that the hospital checked these details with children’s services or provided the victim with sources of support for domestic abuse.

68. The victim expressed her doubts to the police about the relationship being over and blamed herself for the violence, saying that she could become nasty when she consumed alcohol. She consented to Police Watch, which involved her details being

passed to the Local Neighbourhood Team so that random checks could be made. She also agreed to a referral to the Independent Domestic Violence Advisor and a referral to Stay Put, which assists in making a victim's address more secure. A Street Interest Gazetteer (SIG) marker was attached to the address to alert the police in the future to domestic abuse in the household.

69. Later in the month, the perpetrator was offered an appointment with primary care mental health services having been referred by his GP but did not attend this appointment or another that was offered a month later and was discharged back to his GP.

70. The victim was informed that her case would be heard at a MARAC on 8th January 2015. Actions arising from the MARAC included for the victim to be referred to Adult Social Care for an assessment to establish her care and support needs. There was a delay in allocating the case and a social worker did not try to make contact until two months later eventually reporting back to MARAC that she had been unable to contact the victim having found that she had been evicted the year before and had insufficient information from MARAC to establish risk.

71. As alcohol had been an issue for both the victim and the perpetrator, the police were also to refer both parties to the Atlantic Recovery Centre in respect of their substance misuse, but this was not done. No domestic abuse was reported to the police for eighteen months after this time.

72. In March 2015, the victim was seen by the primary care mental health nurse who had first seen her in 2013 and she continued to report her long history of depression, anxiety, domestic abuse and drug and alcohol abuse. She described her relationship with her ex-partner to continue to be strained but stated that she had a new partner. However, in this new relationship she described them both drinking and having violent arguments. The nurse discussed the impact of alcohol and drugs on her mood and signposted her to Dudley Counselling Service as she had not taken up the suggestion to go to Victim Support that had been recommended previously.

73. In August 2015, police officers attended a report of a disorder where it was alleged that the perpetrator and his son had assaulted two other people, and this was caught on CCTV. Whilst his son was arrested and charged, the perpetrator evaded arrest and failed to attend the police station for arrest and interview. He was not at home on the two occasions when the police came to arrest him. As time went on, no further action was taken as it was believed that the limitation of proceedings for common assault of six months had expired. Had he been interviewed and charged, he may have received a short prison sentence as had happened with his son on this occasion.

74. In September 2015, the perpetrator was seen by the primary care mental health nurse. He disclosed that he had experienced anxiety and depression since the age of eighteen and taken an overdose at the time. He advised that he was taking his anti-depressant medication prescribed by his GP and was offered Cognitive Behaviour Therapy, but he did not opt-in to the service and was discharged back to his GP.

75. In October 2015, the victim asked her GP whether she was suffering from Bipolar Disorder as she had difficulty in controlling her temper, had frequent outbursts and had experienced domestic abuse. She advised that it was her friend who had suggested that she was bi-polar but there was no indication that her relationship with the person who was suggesting her illness or that domestic abuse was explored further. It was not clear from the records whether the disclosure concerned current or previous domestic abuse.

76. Early in 2016, the victim told the GP that she had been binge drinking but asked to be started again on anti-depressants and be referred to mental health services. The GP referred the victim to primary mental health services in January, February and March but she did not attend until the March appointment. She talked about her mood swings, history of abuse and her struggle to attend appointments. She stated that she could lash out during arguments and had lashed out at her partner and so she isolated herself from social situations and wanted a diagnosis and treatment. The practitioner concluded that a referral to secondary mental health services through her GP was needed. The victim disclosed to the GP that she had been violent towards her partner and thought she had a personality disorder and so a referral was made to psychology services.

77. In June 2016, three calls were received by the police in the space of 30 hours. At midnight on 16th June 2016, the victim dialled 999 from a call box close to her home, stating that she wanted her ex-partner, the perpetrator, removed from her address. She said that he was getting threatening and aggressive, had been violent in the past but 'not today'. When the police arrived, the perpetrator had already left the property. As no offences were disclosed and the victim had said that she wasn't frightened of him, the officers noted the previous assault in December 2014 and concluded that there were no safeguarding issues, and it was standard risk. There was no mention of alcohol being a factor. Intelligence checks were completed the following day in order for the case to be discussed at a regular multi-agency screening meeting in respect of children potentially at risk through domestic abuse, known as 'joint screening'. It was assessed as requiring no further action as the children lived with their father and the report was filed without a DASH being completed.

78. On the following day, the victim dialled 999 again, sounding upset and stating that she had let her ex-partner back into the property and he was getting very aggressive. Again, the perpetrator had left the property before the police arrived. The victim was provided with a card giving details of the National Centre for Domestic Violence (NCDV). No DASH

was completed, and the report was reviewed by the sergeant who confirmed the standard risk assessment for the same reasons as the day before. Again, there was no mention of alcohol being a factor.

79. Later that night, the victim dialled 999 from her mobile, reporting that she had been hit by her ex-partner, the perpetrator. She stated that she had run away from him and that he had chased after her. The police provided an immediate response and the perpetrator was arrested for assault. The victim said that they argued again and that he grabbed her by the hair, punched her twice to the face and thrown her to the floor. He then refused to leave the premises. She had grazing to her arms, and pain and discomfort to her face, and it is recorded that a statement was not taken because she was intoxicated. The allegation was recorded as a section 47 assault and the risk determined as medium on the information available at the time. The officer has recorded that there were no previous incidents between the two parties.

80. The perpetrator, who had been too inebriated to be interviewed at first, stated that he had not assaulted the victim in the three years that they had been in a relationship, but they did have arguments and she had assaulted and bitten him. He went on to say that the victim had mental health issues and was an alcoholic. He denied assaulting the victim but said that they had both been drunk.

81. The police tried to contact the victim by home visits and by phone but could not locate her until early July 2016, by which time checks had been undertaken and her previous high risk identified. However, the victim then denied the assault and claimed her injuries to be accidental. She stated that she had ‘battled’ bi polar for ten years and was not taking any medication, and this made her paranoid. She wanted help and had an appointment at the local psychiatric hospital on the following day. She stated that she was always shouting at the perpetrator. On the basis that both the victim and the perpetrator had denied the assault and there were no witnesses, the report was filed with an assessment of medium risk in view of the previous reports. The report was not reviewed by the Domestic Abuse Safeguarding Team because medium risk safeguarding was the responsibility of the Domestic Abuse Investigation team and the investigation had been concluded.

82. In the meantime, an allegation of assault had been made against the victim by her neighbour. She alleged that the victim had assaulted her by jumping on her, kicking and punching her, pulling her hair and biting her left breast. Her neighbour had attended hospital. However, she did not show her injuries to the officer and did not wish to provide a statement or attend Court. The victim was not spoken to by the Police about the allegation and the report was filed.

83. In July 2016, the victim attended her appointment with the Early Access (mental health) Service where she recounted her previous disclosures and confirmed that she did not want to report her early abuse or rape. After talking about the domestic abuse that she had experienced from the father of her children, the victim spoke of having long-standing thoughts that she would be better off dead but stated that she would never act on these thoughts because of her children. She also disclosed that she had difficulty with anger and could get violent for stupid things. She said that she attacked her boyfriend all the time and she had often called the police to get him out of her home. As a result of the assessment, she was referred to secondary mental health psychology service and given details for addiction services, Citizen's Advice Bureau and the mental health crisis team.

84. On 3rd August 2016, a third party contacted the Police, reporting that they had called the victim who had asked them to get the Police. As it was identified there had been previous reports of domestic abuse at the location, a supervisor was despatched and found the victim outside her home saying that the perpetrator had attacked her and caused swelling to her eye and he had climbed out of the window to escape. The officers could see the perpetrator in the premises and were informed that he may be in possession of a knife, so entry was forced.

85. The perpetrator was arrested on suspicion of assault and searched on arrest and was not found to have any weapons on his person. The victim did not have any visible injuries and refused to provide a statement or complete the DASH risk assessment. However, she had told the officers attending that after the assault, he had locked her in the flat and so she climbed out of the window. Enquiries were made with neighbours, but there was no reply. The DASH risk assessment was completed on the information available, and graded as standard, with the rationale that although previous incidents were noted on the report, the perpetrator was in custody. The response sergeant reviewed the report and identified that the victim was at high risk.

86. The perpetrator denied the assault but said that he had only pushed her away as she was attacking him and clawing at him. He repeated that the victim was under the mental health team and claimed that she suffered from both bi-polar and schizophrenia. He was observed to have visible scratch marks to his left shoulder and upper arm and grazing on his face, chest and right arm, consistent with his account. Again, the evidence was not seen to meet the threshold for charging but on the basis of her history, the sergeant referred the case to the Safeguarding Team to review.

87. The Safeguarding sergeant requested officers make contact with the victim to discuss the incident; complete a DASH; discuss a contact plan; ensure that she had the means to contact the Police in an emergency; place a SIG marker on her address and discuss referrals to domestic abuse services, home security and for a non-molestation order.

The victim responded by saying she had antagonised the perpetrator and that it was possible that the small bruising that had appeared on her face had been as a result of her head butting the wall. She said that she was waiting to be diagnosed as Bipolar so that she could have treatment and start to feel better but said that the perpetrator also had mental health issues which he was not addressing. The victim declined all referrals including to alcohol recovery services saying that she did not drink too much. However, she agreed to complete the DASH assessment, which was re-classified as medium risk and consequently not referred to MARAC. Consideration was given to a prosecution without her support, however, the police considered that there was insufficient evidence to proceed.

88. On 8th August 2016, the victim attended her appointment with Enhanced Primary Care and advised that she had not been taking her medication as she should and had got into a fight with her neighbour. She was provided with details for anger management sessions and advised that the service was considering her for counselling to address past issues around rape, domestic abuse and her children being in care.

89. On 18th August 2016, the victim was brought to the Emergency Department by ambulance. She was intoxicated and stated that she was struggling with her mental health and depression. She left before being seen and the hospital contacted the police asking for them to undertake a 'safe and well'[4] check on her. They contacted the Psychiatric Liaison Team based in the hospital who confirmed that she was known to them and wrote to the GP recommending a mental health review in the community.

90. In order to be able to undertake a safe and well check, the police requested more information from the hospital and spoke with the Sister. She was unaware of the request for police intervention as nothing had been mentioned during handover between their shifts. The police log was therefore closed.

91. On 31st August 2016, the Psychological Wellbeing Service phoned the victim to undertake screening, but the conversation was difficult to undertake as the victim was inebriated. The practitioner considered that she may be suitable for Dialectical Behavioural Therapy, however, the victim did not respond to the letter and was referred back to her GP.

92. On 15th October 2016, the victim contacted the police to report that her partner was shouting at her, but that he had already left the address when they arrived. No DASH was completed but as no offence had been reported, both parties were separated and the victim was staying with friends that night, the report was filed with the

---

[4] When conducting safe and well checks (also referred to as welfare checks) on people who are vulnerable, the police are required to locate people at risk of harm and seek to manage any safeguarding risk

Neighbourhood Policing Team. Here it was reclassified as medium risk as there had been no details of previous incidents within the initial assessment. Alcohol was not mentioned for either party.

93. On 15th December 2016, the victim dialled 999 reporting that her partner was threatening to kill her because he thought she was a 'grass'. When the police arrived, with a supervisor, the victim was outside the premises shouting at the perpetrator and both parties were drunk. To prevent any further argument, the perpetrator was taken at his own request to his brother's address. A third party was present who stated that the perpetrator had not made any threats. A domestic abuse non-crime report was created as no offence could be substantiated. Nevertheless, the risk was graded as high on the basis that the victim had been discussed at MARAC in 2014, and that there had been 6 incidents in 6 months, 8 in total. The officer recorded that both parties were alcoholics, cannabis users, and there was 'an element of mental health'. The sergeant agreed with the risk assessment and identified that support is required for both parties.

94. Two days later, the perpetrator was arrested on suspicion of criminal damage, whilst he was heavily intoxicated. A third party had reported seeing damage to the victim's door and that the perpetrator was removing items from the premises. The perpetrator was held in custody until it was possible to speak to the victim on the next day, which was good practice. The victim advised that the damage had not been caused the day before and that the perpetrator was probably merely looking for money and cigarettes from her. The third party declined to make a statement. The incident was recorded as a domestic abuse non- crime and standard risk, but the DASH form was not completed, as it was not mandatory at the time. In the absence of any evidence with which to charge the perpetrator, he was released without charge the following day.

95. The Domestic Abuse Safeguarding Team tried to contact the victim over the next five days without success. They were wanting to complete the DASH from the incident on 15th December and undertake safeguarding actions. A SIG marker was still applicable to the address.

96. The victim was discussed at MARAC on 30th December 2016. A referral was made to the Independent Domestic Violence Advisor (IDVA) from MARAC. The substance misuse services based at Atlantic House was to offer support to both parties and a housing manager was to review the housing situation in respect of the perpetrator. The Safeguarding Officer reached the victim on 10th January 2017 and she agreed to an IDVA referral. She had been waiting for an appointment with mental health services and was experiencing problems with her landlord not undertaking repairs and so the officer said that they would support any housing application she made.

97. On 10th February 2017, the Police received an agitated phone call from an unknown caller, who was likely to be the victim herself, stating that the victim was going to stab the perpetrator and he was goading her to do it. The call handler recorded previous domestic abuse at that address; the perpetrator's offending history and the high-risk nature of the relationship on the log for the attending officer's attention.

98. Two double crewed response vehicles were swiftly dispatched with a police supervisor in the latter vehicle. When the police arrived at the victim's house, they found the couple sitting calmly on the sofa, both denying any knowledge of disturbances. Although the officers could not recall the incident, they agreed that it was normal practice to speak with each individual on their own at such times. The victim denied having made the call and, although officers would have ideally obtained a non-crime domestic abuse number for this unusual report, the log was retrievable to inform future responses.

99. In April 2017, the victim's ex-partner died and the younger children, who had been living with him, went to live with their older siblings.

100. In May 2017, the victim contacted the police from a mobile phone saying that the perpetrator was refusing to leave her home and had threatened her children, stolen her television and threatened to kill her and put her in a body bag. She said that she was on her way back home and was going to stab him when she got there. She also said that she thought the perpetrator was a dangerous man and 'she thinks he could kill her'.

101. The call handler identified previous history and known high risk and graded the call for an emergency response. Furthermore, upon hearing a man and a woman arguing, deployed an 'open shout' for any officer to attend. At that time, West Midlands Police were experiencing a high demand for service and there were no police units available to respond, but a supervisor was made aware of the situation and was providing advice. The call handler phoned the victim back after she had ended the call and encouraged her to leave the premises rather than continue to make threats against the perpetrator, which she eventually did. Whilst waiting for officers to be free to attend, the police contacted her back two more times to make sure that she was safe at a friend's home.

102. Officers were not available to attend until over two hours later, and on arrival spoke with the victim at her friend's home. They woke the perpetrator up, who was asleep on the victim's sofa, and described as 'extremely intoxicated' and he left the premises.

103. Officers spoke at length with the victim who denied that there had been any dispute or threatening behaviour prior to the call. She assured officers that she had no intention of ever stabbing him but had been frustrated when officers were unable to attend immediately and remove the perpetrator from her home. The incident was closed on the basis that the victim had contacted the Police to get him removed and did not intend to harm him. Although the victim had made threats to the perpetrator as well as

reported his threat to kill her, the incident was not recorded as a domestic abuse incident.

104. Later that month, the victim told her GP that she had recently ended an abusive relationship and that she had moved out of home because there was a risk that her abusive partner may return. She told the GP that the police were involved and the GP noted that she had their safeguarding contact details. Later in May, she informed the GP that her ex-partner was harassing her by walking back and forth outside her home and there was no restraining order in place. The GP advised the victim to contact the police and noted the harassment in the referral to the Early Access (mental health) Service as she was low in mood and had increased anxiety. When the Community Psychiatric Nurse (CPN) phoned the victim, a man answered the phone saying that the victim was not there and hung up. The CPN contacted the GP Practice to check if there were any alternative contact details but not finding any, offered the victim an appointment by post which the victim did not attend and therefore discharged her back to her GP.

105. In July 2017, the victim's neighbour contacted the police complaining that the victim had spat in her face and said that she was going to kill her when she had asked her to turn her music down. Shortly afterwards, the victim phoned to complain about her neighbour saying that she had tried to smash her window. Both calls confirmed that each had returned to their address so there was considered to be no immediate risk of harm. A police officer took a statement from the neighbour, but the neighbour did not want the police to take any further action as the victim was thought to be intoxicated at the time and the neighbour was planning to move. The matter was filed without the victim being spoken to so as not to antagonise the victim whilst her neighbour's move was being arranged.

106. In September 2017, the victim contacted the police as she could not get the perpetrator, who was extremely intoxicated, to leave her home. Response officers attended and took the perpetrator to his mother's address. The incident was recorded as a domestic abuse incident. She said that she had no injuries and she made no disclosures of violence being used against her. A previous high-risk incident was noted but the report was filed by the officer's supervisor and assessed as standard risk on the basis that it was a verbal argument and that the perpetrator had been removed. A DASH form was not completed, in keeping with local police policy at the time, which left the completion of the DASH up to officer's professional judgement,

107. In January 2018, the perpetrator killed the victim. The perpetrator was assessed by mental health practitioners whilst in police custody and there was no evidence of psychosis, thought disorder or paranoia.

5. OVERVIEW OF AGENCY INVOLVEMENT

108. This section considers the Individual Management Review and information reports completed by individual agencies and the outcomes of discussions with the review panel concerning improvements to services in the future.

5.1 West Midlands Police

109. West Midlands Police responded to twelve domestic abuse incidents between the victim and the perpetrator from March 2014 onwards. All but one of these incidents was identified as domestic abuse and many of the reports involved both parties being intoxicated. This factor often frustrated police officer's attempts to take the necessary statements and determine whether offences had been committed. However, in all cases where domestic abuse was identified, the Police took positive action to either remove or arrest the perpetrator if he had not already left the premises.

110. Of the twelve domestic abuse incidents, crimes were recorded on four occasions. The perpetrator was arrested each time and one of these incidents proceeded to prosecution but was later discontinued as the victim withdrew her statement and there was insufficient evidence to proceed. Nonetheless, this second report stood out as particularly good practice, whereby the Police challenged the Crown Prosecution Service decision not to charge when they had identified that the victim was at high risk. On each other occasion, the police considered that a lack of evidence prevented further action and the victim either declined to provide a statement or withdrew her statement in most cases. Consideration was seen to have been given to undertaking an evidence-led prosecution at times, but each time the police considered that there was insufficient evidence to corroborate the allegations.

111. The review observed how there were a number of occasions when the high-risk history of the couple led to the assessment of risk being heightened even where the circumstances of the incident would not otherwise have warranted it, which was also good practice. However, there were other times when the level of risk did not reflect the perpetrator's prior high-risk history as they should have done.

112. This variation in response was seen to have been frustrated by the frequent inebriation of the couple as well as the absence of a consistent approach to completing a Domestic Abuse, Stalking and Harassment Risk Assessment (DASH) which was not mandatory at the time.

113. Although the level of risk was graded each time that domestic abuse was recognised, there were few occasions when a DASH was completed. The victim's intoxication will have prevented the DASH being completed on some occasions and she declined to provide a statement or complete the DASH with officers during three other incidents. However, throughout this time, the completion of DASH was not mandatory within West Midlands Police and officers could use their professional judgement regarding its completion. Since 2017, West Midlands Police have made the completion of the DASH mandatory in line with national guidance and officer's compliance with this requirement is audited.

114. On four occasions, threats to kill or harm were raised. On the first two occasions, Police officers treated the concerns arising from the combination of domestic abuse, mental health and substance misuse holistically and she was referred to MARAC with the safeguarding actions that this entailed. From a criminal justice perspective however, both parties were drunk and in the absence of a witness statement, no further action was taken at the time beyond removing the perpetrator from the scene although safeguarding officers followed up when the case was referred to MARAC.

115. On the next two occasions, the circumstances surrounding each disclosure were far from clear. The third call was from an un-named person, thought to be the victim, in February 2017. She appears to have spoken to police about her thoughts of stabbing him because he was goading her and winding her up. When the police arrived with their supervisor, the couple were peaceably watching television on the sofa and denied any disturbance or having made the call.

116. The fourth call regarding threats was made by the victim in May 2017 where she said that she was bi-polar and threatened to harm the perpetrator as a result of the threats that he had made to her. He had allegedly threatened to put her in a body bag. Both parties were talked to separately again to explore these threats, which were not made explicit again. The circumstances surrounding each of these disclosures were far from clear and, when arriving at the scene, the circumstances did not meet the degree of alarm that the calls themselves had raised. Officers were aware of the previous history, which had been logged for them by the call handler, and it was evident that they spent time with the victim to enable further disclosure of the facts, but none were forthcoming. Despite the difficulties in marrying the information in the original call to the circumstances when they attended, West Midlands Police recognised that these two incidents should have been recorded with a 'non-crime' domestic abuse number in addition to the log, and a DASH completed. This may then have facilitated a further review by a specialist domestic abuse supervisor and contributed to a more holistic picture and recognition that relationship breakdown indicated a change in circumstances and potentially risk for the victim.

117. The perpetrator denied domestic abuse when questioned each time, and often undermined the victim by referring to her mental ill-health but the Police did not appear to take heed of his attempts to make counter allegations against her except in August 2016 when his own injuries were consistent with his allegations. Moreover, this did not prevent the Police from rightly treating the perpetrator as the primary aggressor and grade the risk to the victim as medium risk.

118. The victim blamed herself for the violence on several occasions, saying that she provoked the perpetrator and explaining about her own mental health concerns. There was no indication that this self-blame was challenged or that mental health services were asked to confirm her mental illness, despite her case having been considered twice at MARAC.

119. Given that the perpetrator was known to suffer from depression and was inebriated on most occasions, West Midlands Police gave consideration to how referrals for additional support were being made. The Police have had a referral system in place since 2013 whereby officers could make referrals to a Partnership Unit in the Neighbourhood Policing Teams from which onward referrals could be made for individuals needing additional support.

120. Whilst referrals to domestic abuse and alcohol treatment services were made as a result of the MARAC, it did not appear that there had been engagement to gain consent for referrals to other agencies, such as alcohol treatment services, on several other occasions. Likewise, there was no evidence of referring the victim to domestic violence services on other occasions.

121. The Police were able to show how their officer's awareness of the need to refer to other agencies had been steadily increasing over the years as a result of ongoing training. Between 2015 and 2018, referrals in the area have tripled. Moreover, their process for obtaining consent from individuals and making referrals is being streamlined as a result of the introduction of portable mobile devices where referrals, as well as DASH, can be input with individuals directly at the scene.

122. As improvements have already been made in compliance with completion of the DASH, making referrals to support services, and the introduction of portable mobile devices, a recommendation has been made in this review for West Midlands Police to provide evidence of these improvements and their impact. The victim's disclosure in December 2014 provided them with a very clear catalogue of domestic abuse in terms of physical violence but the risk assessments undertaken since that time varied considerably. This, together with multi-agency issues surrounding the MARAC will be addressed in the thematic section to follow.

123. The review considered a procedural issue, unconnected to domestic abuse, in relation to common assault that the perpetrator had been accused of in August 2015. As six months had elapsed, and the perpetrator had evaded contact with the police during this time, it was assumed that no further action could be taken due to the limitation of proceedings to seek a voluntary interview with the suspect in such cases. However, it was pointed out that if the Crown Prosecution Service is alerted to the evidence of common assault within the six months, it is possible to hold the case open and evade this limitation to proceedings. In this way, it would have been possible to hold the perpetrator accountable for his violence despite his elusiveness and avoidance of the police. At the time of writing, this point of learning is being circulated to all officers and staff.

5. 2 Primary Care

124. The perpetrator had attended his GP Practice infrequently with long term depression and anxiety. The GP made several referrals to mental health services, but the perpetrator declined to engage with them. There was no record of a mental health diagnosis. He first disclosed his alcohol abuse to the GP in 2014 but by the end of 2015 suggested that he had been abstinent for a long period. In February 2016 he told the GP that he had been binge drinking, but this did not appear to lead to any signposting or referral to alcohol treatment services.

125. The victim was registered with a different GP Practice and had been treated for depression and anxiety since 2013 but her compliance with medication was intermittent.

126. GPs did offer to refer the victim to substance misuse services at various points but each time she declined saying that she wanted to manage this herself. Practitioners did not appear to have explored triggers for the alcohol abuse and binge drinking and did not appear to have considered that these may have been a symptom of abuse in themselves.

127. The victim had been quite open with GPs about her experiences of domestic abuse and what she saw as her culpability for violence in her current relationship. Before she disclosed it directly, there was no indication that doctors had considered the domestic abuse that she was experiencing to be current. Rather than refer her to domestic abuse services, they appear to have defaulted to mental health services to support her. In response to stalking she told the GP that she did not have a non-molestation order, but the GP provided no guidance on services that might help her access one.

128. Staff in the Practice did not recognise the subliminal signs of domestic abuse or make routine enquiry as recommended by the National Institute for Health and Care Excellence (NICE, 2016) and the Royal College of General Practitioners (2012). Moreover, the victim's questioning of her own pathology and whether she had a Bipolar or a personality disorder warranted further enquiry in the context of her disclosures of domestic abuse.

129. At the time, there was no formal route for information to be shared at MARAC with primary care services. In the absence of a direct disclosure, the GP Practice would therefore not have been aware that the victim's case had been heard at MARAC. Information sharing between MARAC and primary care was introduced in 2017 and all practice staff are now alerted to the case being heard at MARAC through a discreet code on patient records.

130. Dudley Clinical Commissioning Group has recognised that more needed to be done to improve the identification and response to domestic abuse and meet the NICE Quality Standard on Domestic Violence and Abuse [QS 116] (2016). Moreover, they recognised the need for staff to understand the relationship between domestic abuse and alcohol abuse for those experiencing abuse and the particular risks inherent in stalking.

131. The Clinical Commissioning Group was able to identify improvements that have been made in recent years to the primary care response to domestic abuse, with particular reference to safeguarding training of all staff and enhanced training on DASH and MARAC for clinicians. In order to consolidate these changes, the Clinical Commissioning Group has been rolling-out the Identification and Referral to Improve Safety (IRIS) programme across GP practices in Dudley since November 2018.

132. The IRIS Programme is a general practice based, domestic abuse, training, support and referral programme, which seeks to provide a skilled, care pathway for domestic abuse. The programme recruits a clinical champion from each practice and delivers training, electronic prompts for clinical enquiry, care pathways and an enhanced referral pathway to specialist domestic violence services. It also provides information and signposting for perpetrators of domestic abuse who disclose to primary care.

133. Although the funding and infrastructure is available, each GP practice has to volunteer to be involved in IRIS as it is not a mandatory part of national contracts for general practice. The two practices concerned have both volunteered to become 'domestic abuse informed practices', under the IRIS scheme.

134. Further details of the recommendations for primary care and the actions arising are featured in the action plans at the end of this report.

5.3 Dudley and Walsall Mental Health Partnership NHS Trust

135. The victim had been referred to both primary and secondary mental health services on numerous occasions. They were aware of her history of abuse, substance misuse and vulnerability and referred her to the relevant services to address the needs identified. However, the victim did not attend the follow-up appointments after the initial assessments were undertaken. She therefore did not receive services for her recurrent anxiety and depression but was discharged back into the care of her GP each time. She was not open to mental health services at the time when her case was heard at MARAC nor at the time of her death.

136. The perpetrator was referred to mental health services three times, only attending one appointment and not following up with the recommended therapy thereafter.

137. The Trust reflected that there were clear indicators that the victim was being abused but there was no evidence that those indicators were explored further with her. Neither had mental health practitioners explored the triggers for her substance and alcohol misuse or the reasons for her children having been removed from her care and custody given to her ex-husband who had been violent and abusive to her. Although this domestic abuse was seen to have been in the past, the expectation of practitioners since then would be to discuss these types of concerns with the Trust's safeguarding practitioner or with children's services.

138. Although the victim was provided with leaflets and signposted to drug and alcohol services, there was no evidence that any direct referrals had been made. There appeared to be an assumption that the victim would take ownership in seeking help with her alcohol and substance misuse issues. The expectation of practitioners since then has been that practitioners would take more responsibility in supporting someone to access these services where needed.

139. Likewise, the Trust considered that practitioners had lacked professional curiosity about domestic abuse and recognised that the expectation of practitioners since this time would be for them to complete a Safe Lives DASH risk assessment, refer to domestic abuse or sexual violence services and refer to MARAC if she was considered to be facing high risk. An example of this lack of professional curiosity was revealed where the Community Psychiatric Nurse did not link the time when the man answered the victim's phone with the victim not attending her appointment and how this could have been an indicator of domestic abuse. Likewise, the referral received from the GP revealed stalking behaviour, but the practitioner did not question whether the GP's response for the victim to contact the police was a sufficient response.

140. Although the Trust's Domestic Abuse Policy was published in 2014 and was available to inform staff of expected practice in responding to domestic abuse, Dudley and Walsall Mental Health Partnership NHS Trust has strengthened its approach to domestic abuse in recent times. They have developed a robust internal pathway for MARAC cases; introduced a system of alerts for domestic abuse whereby a clinician reviews every alert; delivered domestic abuse training as part of the mandatory safeguarding training requirements involving face-to-face as well as online training; made domestic abuse training on domestic mandatory for nurse validation and made continuous professional development on domestic abuse mandatory for doctors in the Trust. Moreover, a dedicated specialist practitioner represents the Trust at MARAC and domestic abuse strategic groups. In this way, had the victim been referred to mental health services more recently, then it would have been expected that an alert would have been raised on her case, reviewed by a clinician and not closed without being signed off by a manager.

141. The Trust appeared to have experienced problems maintaining engagement with both the victim and the perpetrator. At the time the Trust had a 'Supporting Positive Engagements' policy for managing circumstances where individuals repeatedly cancelled or failed to attend appointments. The guidance contained within the policy encourages practitioners to consider the barriers to engagement including alcohol or substance misuse. Whilst staff tried several times to contact both individuals, it was not evident that either overcoming these barriers or safeguarding concerns drove their responses.

142. The Trust's progress in responding to domestic abuse has been reflected in the 72.5% increase in the number of cases recognised to involve domestic abuse and safeguarding compared to three years ago. Its mandatory training on domestic abuse has reached over 92% of practitioners. However, in order to strengthen its responses further, the Trust has made the following recommendations for itself. Further detail of how these recommendations will be implemented is contained within the action plans that follow this report:

- To ensure that all professionals continue to access the safeguarding practitioners for advice and that they play a key role in the early identification and response to domestic abuse and coercive and controlling behaviour.

- To ensure that all professionals complete their mandatory domestic abuse training and for the Safeguarding Team to promote and encourage staff to attend external training sessions.

- To continue to work effectively with partner agencies in order to maintain and promote safeguarding awareness in order to protect the vulnerable people we work with.

- To identify themed DHR case studies to be included in the safeguarding newsletters, domestic abuse training and bulletins which are circulated to all Trust staff.

- To develop the of 'Top 10 Safeguarding Tips' which will support staff in their day to day practice by sharing key learning points.

- To review the Supporting Positive Engagements – a policy for managing those who do not attend appointments, make cancellations or disengage. The policy provides guidance for adult mental health practitioners to be mindful of the barriers to engagement when making decisions in response to those that do not attend

- As an area of good practice, the Trust will ensure that staff are alert to non-verbal behaviours and be encouraged to collate a genogram to understand the family network from the perspective of Adverse Childhood Experiences (ACEs).

5.4 Dudley Group NHS Foundation Trust

143. The Dudley Group NHS Foundation Trust is the main provider of hospital and adult community health services to the populations of Dudley.

144. The victim attended the Trust's Emergency Department on five occasions during the period considered by the review, four of which were in 2012. Although alcohol was a feature of each attendance, there was no documented evidence to suggest that staff considered that the depression and alcohol may have been a symptom or coping mechanism for domestic abuse or refer her to domestic abuse or alcohol treatment services.

145. Likewise, the victim made one disclosure of domestic abuse in 2014, saying that her children lived elsewhere and there was no indication that she was referred to domestic abuse or alcohol treatment services or the whereabouts of her children checked. In this way, there were missed opportunities to explore alcohol concerns further; to potentially enable a disclosure of abuse; to promote her engagement with specialist services and to potentially safeguard children. However, it was recognised as good practice for the Emergency Department to liaise with the police for a 'safe and well' check to be undertaken when the victim had left the department before treatment.

146. The perpetrator also had two attendances at the Emergency Department which were alcohol related and it was not evident that the triggers for alcohol consumption had been explored or that he was referred to alcohol treatment services. Indeed, the Trust now seeks to embrace the preventative public health programme of 'Making Every

Contact Count'[5] which relies upon the identification of opportunities for encouraging behavioural change in these types of situations.

147. On one occasion, the victim had attended the Emergency Department with chest pains which were found to be a lower respiratory infection, probably arising from the mould conditions in her home. There did not appear to be any signposting to private sector housing services who could assist in pursuing issues of disrepair.

148. In 2014 when the victim disclosed domestic abuse there was limited domestic abuse information included in the Trust's safeguarding training and the Dudley Group was not represented or receiving information from MARAC. Since this time, the Trust has made training on domestic abuse and routine enquiry mandatory and domestic abuse responses have improved. The Trust has strengthened its multi-agency links; improved incident recording of domestic abuse; ensured that a named nurse attends MARAC and introducing a system for flagging all victims heard at MARAC. Moreover, Dudley Group, working with Black Country Women's Aid, has just secured funding for an Independent Domestic Violence Advisor to be based in the Emergency Department.

149. As well as these developments, the Trust has made further recommendations concerning how it will continue to work towards meeting NICE Quality Standard on Domestic Violence and Abuse [QS 116]. In particular it seeks to enhance awareness and understanding of staff about the connection between domestic abuse and substance misuse and the need to make referrals to addiction services and domestic abuse services. It also seeks to build staff awareness about domestic abuse as a parenting risk factor and the impact upon the child and. How they will meet these recommendations is featured in their action plans.

5.5 Dudley Metropolitan Borough Council Adult Social Care

150. The victim's case had been referred to Adult Social Care from MARAC early in 2015. There was a delay in allocating the case to a social worker and so no contact was made for two months which was attributed to high and complex workloads. However, this

---

[5] The NHS Five Year Forward View call for a radical upgrade in prevention and public health and outlined the need to increase the support available for people to improve their health and wellbeing. Making every contact count (MECC) is an approach to behaviour change that utilises the millions of day to day interactions that organisations and people have with other people to encourage changes in behaviour that have a positive effect on the health and wellbeing of individuals, communities and populations. More information is available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/769486/Making_Every_Contact_Count_Consensus_Statement.pdf

significant delay in allocating the case also suggested a lack of recognition of the need to prioritise an urgent response to MARAC cases.

151. The social worker attempted to contact the police and the assistant team manager to establish more contact information. However, it was not until months later, after telephone calls, a home visit and letters, that the social worker became aware that the victim had been evicted from her home address during the previous year. Unable to contact her, the case was closed and the MARAC administrator notified. As well as delays, there were concerns that the service had received insufficient information from the MARAC regarding contact with other agencies such as domestic abuse or addiction treatment in order to commence their assessment. Moreover, Adult Social Care identified that there was a reliance upon the IDVA to refer any concerns into their service, without having knowledge of whether the IDVA had engaged with the victim or not.

152. Their IMR referred to the lack of any feedback to the MARAC about being unable to fulfil the task and there did not appear to be a system of internal supervision or escalation when the task could not be fulfilled.

153. Adult Social Care have identified that the introduction of the Adult Multi-Agency Safeguarding Hub (MASH) in September 2017, has significantly improved their responses to MARAC. The Adult MASH now has a dedicated MARAC representative; the same person attends each time contacting social workers who are already involved; outcomes are routinely chased; MASH staff are familiar with DASH assessments and the IDVA service; MARAC cases are prioritised by the MASH alongside other known risk factors and matters escalated where needed.

154. A later section will consider MARAC issues arising for all agencies and seek assurances from Adult Social Care that the improvement in outcomes for their service users experiencing domestic abuse can be evidenced across their services.

6. THEMATIC ANALYSIS, LEARNING & RECOMMENDATIONS

6. 1 Domestic Abuse and Coercive Control

155. A key function of domestic homicide reviews is to contribute to a better understanding of domestic abuse (Statutory Guidance, 2016, Section7).

156. The victim had experienced abuse for most of her life but her report to the police in December 2014, provided a significant insight into her experiences of domestic abuse. She described:

- physical violence, whereby the perpetrator had punched and kicked her and put his hands around her throat
- threats to kill, whereby she alleged that the perpetrator said that he would have killed her but didn't know what to do with body; she alleged that he had laid a hammer and knives out saying that he had got them ready for her
- intimidating behaviour, whereby he admitted to having cut up her clothes and urinated on her papers
- financial abuse, whereby he demanded, with menaces, money for alcohol

157. She described how she felt frightened and trapped, using the opportunity of going out for food to phone for help. The police rightly identified this occasion as high risk and this information should have followed through into the assessment and response to every subsequent reported incident. This was particularly the case as the perpetrator had posed a high risk to his previous partner and had a long history of offending behaviour, including the possession of a weapon.

158. After this occasion, the perpetrator went on to make counter-allegations to the police and appears to have been trying to undermine the victim's credibility and cast doubt upon her testimonies. This type of behaviour demonstrates how perpetrators can seek to distort the perspective of professionals as well as their victims. Counter-allegations need to be viewed through the prism of coercive control and it was to the police's credit that the perpetrator's counter-allegations did not divert them from their course until there was evidence consistent with his account. Respect, who provides services to men as victims or perpetrators of domestic abuse, provides a toolkit to assist front-line practitioners to identify, "who is doing what to whom and with what consequences" (Respect, 2019)[6].

Stalking

159. This global view of the perpetrator's abusive behaviour was further hampered in relation to his stalking behaviours. In his previous relationship, the perpetrator had displayed highly threatening stalking and harassment. His ex-partner reported to the police that, after separation, the perpetrator had sent her threatening texts as well as walking up and down in front of her home carrying a knife. It is unlikely that the victim would have been aware of this, but nonetheless felt menaced when she reported to her GP that he had been walking up and down in front of her home too and the GP advised her to

[6] The toolkit is available at https://www.respect.uk.net/resources/19-respect-toolkit-for-work-with-male-victims-of-domestic-abuse

contact the police. This information was relayed to mental health services in the GP's referral, but they did not appear to make further enquiries with her either and the police did not become aware of the stalking behaviour on this occasion.

160. Evidence has revealed that stalking behaviour should always be taken seriously as stalking usually involves fixation and obsession. For this reason, it is a key indicator of the risk of serious harm within the Domestic Abuse, Stalking and Harassment Risk Indicator (DASH) routinely used by the police and many agencies to measure risk. In research on domestic homicides, stalking behaviours were present in ninety-four percent of the cases and "the seriousness of stalking should not be measured solely by the severity of the stalking action. Many stalking activities appear non-serious and 'low level'" (Monckton-Smith et al.,2017, p.12). In this way, both the GP Practice and mental health services missed an opportunity to support the victim to report the stalking that she had experienced. Although the police were not aware of stalking on this occasion, it was considered that had other agencies understood the significance of stalking as a threat, then further enquiry and support could have been generated as well as a referral to Black Country Women's Aid who are independent and specialists in stalking and harassment.

Self-blame, violence and 'gaslighting'

161. The victim disclosed to several agencies how she was violent to others, including her partner. She blamed herself, saying that she became nasty when she was drunk. Indeed, there was evidence that she had been aggressive to the police and housing services in earlier times. However, it was also possible that her violence and aggression masked her tendency, on occasion, to blame herself for the domestic violence that she was experiencing. It did not appear that consideration was given by agencies to the possibility that she was subject to coercive control and being manipulated into blaming herself for the violence at these times. This type of manipulation is often referred to as 'gaslighting' and describes how a person can be manipulated into questioning their own memory, perception or sanity. The victim disclosed to a number of agencies that she was bi-polar or had a personality disorder, despite her not having any diagnosis or assessment concerning mental health concerns of this nature. It was possible that this perception of herself could also have been an indicator of this type of manipulation.

162. It is not known whether the victim was violent to the perpetrator or, if she was violent, whether this violence was in self-defence. Nonetheless, she reported having provoked the perpetrator's violence. Disclosures concerning provocation in this way should always be sensitively explored further as self-blame, misunderstanding and denial will often serve as coping mechanisms for those experiencing domestic abuse (Stark, 2009).

Separation

163. Unbeknown to agencies, the victim was separating from the perpetrator at the time of her death. Although there was no evidence that agencies knew at that time, they had been alerted to the victim's attempts to separate several times previously. Separation is a key indicator and trigger of heightened risk and recent separation is already a key factor for agencies to consider when they are assessing the risk of serious harm from domestic abuse through the DASH. This homicide adds to the national picture that the most dangerous time for victims of domestic abuse, is when they leave an abusive relationship (Humphreys and Thiara, 2002).

Learning Points: Understanding Domestic Abuse

- A perpetrator's history of violence and stalking must inform future assessments of risk
- Perpetrators of domestic abuse will often manipulate their victims and lead them to believe that they are responsible for provoking the abuse and make them doubt their sanity through relentless emotional abuse and coercive control. Perpetrators of domestic abuse will also manipulate professionals in an attempt to discredit their victims and draw attention away from their own abusive behaviour.
- Stalking behaviour has featured in the vast majority of domestic homicides. Although the behaviour need not appear serious, it should always be an indicator of high risk.
- Separating from a domestic abuse perpetrator is the most dangerous time for victims and children and agencies should work with the victim to strengthen their safety plans at this time rather than assume that separation will lead to safety.

Recommendation 1: Understanding Domestic Abuse
Dudley Safe and Sound should review and seek assurance about the degree to which agencies support front-line staff and their supervisors to understand this breadth and range of domestic abuse, coercive control and stalking behaviours as well as identify and respond to risk.

Recommendation 2: Raise public awareness
Dudley Safe and Sound should continue to raise public awareness specifically about domestic abuse, coercive control, stalking and harassment

6.2 The 'Right to Know'

164. The Domestic Violence Disclosure Scheme was rolled out to police forces in March 2014 at the same time as the victim first reported domestic abuse from the perpetrator to the police. The scheme did not give the police any new powers but provided domestic violence related guidance to the them on the exercise of their common law power to disclose information where it is necessary to prevent crime. The scheme, commonly referred to as Claire's Law, contains two elements: 'the right to ask' and the 'right to know' (Home Office, 2012,2016).

165. Whilst the victim did not appear to have asked about her partner's history, the review considered whether there were opportunities for disclosing to her, information about his history of violence under the 'right to know'. This seemed particularly the case when his risk to her was being considered at MARAC. Indeed, before the perpetrator began a relationship with the victim, he already had a history of domestic violence and stalking and was known to have been a high-risk domestic abuser. However, there was some disagreement amongst the panel as to whether the perpetrator's record would have reached the threshold for such a disclosure. Whilst the perpetrator had a history of violence, his offending history related to theft, drug and vehicle offences and possession of a bladed article. For some, the absence of a conviction for violent offences meant that the disclosure of his having been a high-risk threat at MARAC, two years earlier, would have been disproportionate for the purposes of preventing crime. For others, his pattern of violence and stalking behaviours were important information to share with the victim when she herself had been referred to MARAC because of the risk that he then posed. Indeed, knowing this history may have enabled the victim to consider her self-blame and responsibility for the violence that she was experiencing as well as objectively help her to understand the threat that the perpetrator posed to her.

166. Making a 'Claire's Law' disclosure is now a standard consideration of the MARAC. Whilst the Domestic Violence Disclosure Scheme provides specific guidance to the police, all agencies need to be aware of its application in order to contribute to a co-ordinated response to domestic abuse.

Learning Point: Domestic Violence Disclosure Scheme
In certain circumstances, domestic abuse victims may have both a 'right to ask' and a 'right to know' about their abuser's violent history and all agencies need to be alert to these possibilities when working with victims of domestic violence and abuse.

Recommendation 3: Domestic Violence Disclosure Scheme
Dudley Safe and Sound should ensure that the Domestic Violence Disclosure Scheme is well known by agencies and the public alike.

6.3 Domestic Abuse, Substance Abuse and Mental Health

Compounding Effect of Repeated and Sustained Abuse

167. In later adulthood, the victim described to mental health practitioners how she had begun drinking at the age of fourteen as a way for her to cope with the sexual abuse that she had experienced in childhood. By adulthood, she was binge drinking three-to-four times per week but felt that she could manage this herself. She had told a mental health practitioner that she could consume three bottles of vodka daily and she had smoked cannabis for twenty-five years.

168. Women who have experienced domestic and sexual abuse are three times more likely to be substance dependent than those who have not (Rees et.al., 2011). Likewise, experiencing domestic abuse can cause a severe loss of self-esteem, anxiety, depression, panic attacks and disorientation (Feder et al, 2006, Rose et al, 2011; Department of Health, 2017). In this way, women experiencing domestic abuse are far more likely than others to be using or needing mental health and substance misuse services.

Identification of domestic abuse

169. It has been shown that individuals experiencing domestic abuse are often reluctant to disclose information and want someone to ask them directly about domestic abuse. The victim had been relatively open with health professionals about prior experiences of abuse but there was little in the way of routine enquiry regarding her current vulnerability to abuse, particularly in the light of her mental health and alcohol concerns.

170. Health professionals have a privileged position in identifying potential domestic abuse. The National Institute for Health and Clinical Excellence provides a list of evidence-based health markers that are indicators of abuse including depression, anxiety, panic attacks, alcohol abuse and substance misuse (NICE,2016). Appropriate and sensitive routine enquiry must be standard practice across all services that women with experience of abuse come in to contact with and it was reassuring to the panel to see the improvements that were already being made in this regard for mental health services, GP services and the Emergency Department in the area. The introduction of the IRIS scheme into GP Practices, the introduction of an Independent Domestic Violence Advisor into the Emergency Department and mandatory training for mental health practitioners were seen as particularly positive.

Engaging Women Experiencing Multiple Disadvantage

171. Multiple disadvantage is a term used to refer to individuals who face a compounding set of problems. When used in relation to women, it usually refers to the compounding effects of domestic and sexual violence and abuse where those effects usually include mental ill-health, substance misuse, homelessness, poverty and removal of children (National Commission on Domestic and Sexual Violence and Multiple Disadvantage, 2019). Recent peer research has described how women facing multiple disadvantage often describe how they felt "further trapped by social stigma that labelled them as problematic, complex, chaotic, damaged or harmed" (AVA and Agenda, 2019, p.7).

172. Although agencies struggled to meaningfully engage the victim in mental health or substance misuse services, the review did not find evidence that agencies responding to the victim's multiple disadvantage, labelled or stigmatised her in this way. Nevertheless, it was recognised that further consideration needs to be given to how agencies harness the range of responses that an individual may need and delivers services in such a way that supports and enables their engagement.

173. We have seen that in respect of her anxiety and depression, the victim had not taken anti-depressants with sufficient regularity for them to be effective and it is likely that their effectiveness could well have been impinged by binge drinking and alcohol abuse. She made several attempts to engage with mental health services, disclosing previous domestic and childhood abuse, but did not engage past the first contact. Mental health services did not find this type of presentation unusual, recognising that individuals will often be more motivated to seek help at certain times than others. However, there is a need for agencies to pro-actively to consider how to maintain engagement, particularly where someone has multiple needs and disadvantage and is known to be facing high risk through domestic abuse.

174. Although it was not consistent, various agencies encouraged her, at times, to attend alcohol treatment services, but she declined each time saying that she could manage. Likewise, she declined counselling services to deal with her historic abuse as well as declined a referral to the Independent Domestic Violence Advisor (IDVA) service when this was offered through the MARAC. This service would have been well placed to act as a key worker, harnessing the range of agencies that she may need whilst providing a service to help her deal with her current and historic abuse. However, none of this signposting or referral activity was able to engage the victim in an effective way.

175. Black Country Women's Aid, who run the IDVA service were required to pro-actively engage with the victim in connection with the two MARAC meetings. They outlined their processes for engagement when they were unsuccessful in contacting or engaging a victim. These processes included attempts to conduct joint visits with any agency who is

already successfully engaging with the victim but there was no evidence that this was considered in this case.

176. Since this time, Black Country Women's Aid advised the review that they have further reviewed and adapted their case management styles to ensure they are actively working with partner agencies to exhaust all avenues with hard to reach clients. This includes offering to attend joint visits and exploring with referring agencies other ways of being able to engage with women affected. Black Country Women's Aid staff have been trained as lead professionals and are encouraged to arrange professionals' meetings if they are persistently faced with the same issues and have growing concerns. Staff will also request safe and well calls by calling 101 if they have cause for concerns when a client suddenly disengages. Senior members of the team are encouraged to challenge early closures and to ensure all avenues of contact have been exhausted. All case closures are completed by senior team members and all incoming referrals are overseen by the senior team. A recommendation has been made to provide evidence to the Community Safety Partnership about the impact of these developments.

177. Nonetheless, the panel considered that the introduction of the IRIS scheme would have been particularly beneficial to the victim in this case. The victim appeared comfortable making disclosures to the GP and to primary care mental health workers but not able to take the next step into therapeutic or psychological intervention. Had a domestic abuse worker been able to take a direct referral from primary care, as happens under the IRIS scheme, then this pathway may well have felt timelier for the victim, at the point where she felt able to disclose her experiences.

Trauma Informed and Gender Informed Responses

178. There is a growing body of research which explores the needs of women with mental health and substance misuse issues experiencing domestic abuse (Alcohol Concern & AVA,2016; AVA and Agenda, 2017, 2019). The recent report from the Women's Mental Health Taskforce (Department of Health and Social Care & Agenda, 2018), explored the need for both trauma-and-gender-informed practice and for service structures that support them. They described 'trauma-informed' services as those "which recognise the impact of trauma, often through violence and victimisation, avoid any likelihood of re-traumatisation for staff or service-users and which identify recovery from trauma as a primary goal" (p37). Moreover, trauma-informed practice for women acknowledges mental ill-health and substance misuse as legitimate responses to life events.

179. The Taskforce further recognised that trauma-informed services are complementary to gender-informed services, which take account of and respond to the particular lives and experiences of women. Trauma-informed services

“ensure that staff have the right competencies to work with women, that the environment makes women feel safe and welcome, and that appropriate structures are in place to be able to deliver this kind of service. These types of approaches also take account of the ways in which different parts of a woman’s identity can overlap and result in different experiences of disadvantage” (Department of Health and Social Care & Agenda, 2018, p.33)

180. The Taskforce have developed a set of trauma-and-gender informed principles, intended to be used as a high level and strategic tool to help providers, practitioners and commissioners at a local level consider the specific needs of women with mental illness, including substance misuse.

181. Dudley is a pilot area in the region for the ‘Adverse Childhood Experiences’ approach being promoted by the West Midlands Violence Prevention Alliance, a multi-agency partnership that applies a public health approach to violence prevention.[7] There is a growing body of evidence to show that experiences during childhood can affect health throughout the life course (Felitti et al.,1998). In response, the ACEs approach promotes the development of a trauma and adversity informed workforce and, in this way, helps to meet the expectations set out by the Women’s Mental Health Taskforce. However, being trauma-informed without being gender-informed would not necessarily have helped the victim in this case. She needed agencies to understand the compounding effect of different forms of male violence against her throughout most of her life and how these led to her vulnerability to abusers, to her self-blame and most likely contributed to her mental ill-health and substance misuse.

Learning Point: Multiple Disadvantage and Domestic Abuse
The victim experienced male violence and abuse throughout most of her life and her substance misuse and mental ill-health could well have been as a consequence and means of coping with this abuse. At times she felt able to reach out for help but always retreated again from onwards referrals to specialist services.
Services need to consider how they organise their responses to engage better with those experiencing multiple disadvantage. Services need to be both trauma-and-gender-informed to be able to respond effectively

[7] The West Midlands Violence Prevention Alliance includes regional representation from West Midlands Police, Public Health England, Office of the Police and Crime Commissioner, NHS Trusts, Clinical Commissioning Groups, Education, Local Authorities, Voluntary Sector and the West Midlands Mental Health Commission

Recommendation 4: Trauma and Gender Informed Services
Dudley Safe and Sound and Safeguarding Boards should seek assurance from agencies that services and pathways are trauma-and-gender informed and flexible enough to effectively engage with women facing multiple disadvantage, using the West Midlands Domestic Violence Standards and the trauma-and-gender informed principles of the national Women's Taskforce on Mental Health as guides.

Recommendation 5: Enabling Engagement with Specialist Services
Black Country Women's Aid to provide evidence of effective interventions and engagement methodology for victims who present with multiple and complex issues that may have resulted in them disengaging from other services.

.

6.4 Holding Perpetrators to Account

182. We have already seen that the perpetrator had a history of violence and was known to be a high-risk perpetrator of domestic abuse. This review has demonstrated that all agencies need to appreciate the impact that a perpetrator's abusive history should have on assessments of risk to subsequent victims.

183. From December 2016 onwards, the victim disclosed to the police that the perpetrator had made threats to kill or harm her on four occasions. We have seen that, although she was referred to MARAC initially, on the following two occasions, the circumstances were far from clear and were neither logged as 'non-crime domestic abuse' nor a DASH undertaken, missing the opportunity for a specialist supervisor to review the circumstances and holistically consider whether there were indicators of coercive control. Her Majesty's Inspectorate of Constabulary (HMIC)[8] recognised that, "It is extremely important that officers view the single incident they are attending against the wider history of abuse or criminal behaviour…[in order to]… understand the history of the abuse and establish whether this is a pattern of events." (HMIC, 2014).

184. For the police, the introduction of electronic handheld devices will assist them to access information about a perpetrator's history at the scene and promote a more holistic and global view. It may also enable the DASH to be completed more easily at the scene with the victim. However, other agencies will hold information that the police may not be party to, so it is equally important that all agencies recognise the significance of an abuser's violent history.

---

[8] Since this time, Her Majesty's Inspectorate of Constabulary (HMIC)has been amalgamated with other emergency services to become Her Majesty's Inspectorate of Constabulary, Fire and Rescue Services (HMICFRS)

Learning Point: Holding Perpetrators to Account
A perpetrator's history of violence must inform future assessments of risk and information sharing where appropriate

Recommendation 6: Perpetrator's History of Violence
Dudley Safe and Sound should seek assurance from its agencies that they are able to accurately record and access records on an abuser's previous violent history and apply this to current risk assessments and responses.

Recommendation 7: Policing Domestic Abuse
West Midlands Police should provide evidence of the improvements made in the policing of domestic abuse to Dudley Safe and Sound, particularly compliance and impact of the changes concerning: the mandatory completion of DASH; referrals to specialist domestic abuse and alcohol treatment agencies, and the impact of portable mobile devices.

6.5 Multi-Agency Risk Assessment Conference

185. The effective running of a MARAC is a crucial element of the local, co-ordinated community response to domestic abuse (STADV, 2013).

186. The victim was referred to MARAC twice and there were a number of ways in which the responses were inadequate. Firstly, it was noted that the MARAC actions in 2016 were the same as those in 2014 indicating that some actions had not initially been carried out and that there was not an adequate method of monitoring these actions and holding agencies accountable. Indeed, during these periods, agencies were responsible for monitoring their own actions without that collective accountability. Secondly, the urgency of responding to a MARAC case was not reflected in Adult Social Care's delay in allocating the case. Thirdly, GPs, as trusted professionals and holders of the breadth of health interventions that a victim may be accessing, were not engaged with MARAC at the time. Fourthly, some agencies, had not been recording MARAC cases effectively, making it difficult to identify their service users who were already known to be facing high risk. Lastly, as we have already seen, the IDVA service was unable to engage with the victim and therefore the victim's voice, concerns and own safety plans could not inform the proceedings and plans to keep her safe.

187. Since this time resources to administer and manage the MARAC in Dudley have improved as a result of the regionalisation of the process. The Office of the Police and Crime Commissioner in the West Midlands now directly resources the MARAC Co-ordinators and administrators across the West Midlands region, leading to greater oversight, management, tracking and accountability for agencies. Local responsibility is,

however, maintained: when agency actions are not completed, the matter is escalated to Dudley's MARAC Steering Group for review. GP Practices are now engaged with MARAC and agency recording methods about MARAC cases have improved. Moreover, the links between MARAC and offender management were strengthened by the re-organisation of policing responses to domestic abuse whereby specially trained domestic abuse offender managers became embedded in local investigative domestic abuse teams.

188. We have seen that there were many shortcomings in the Adult Social Care response to MARAC and that many of these have been alleviated as a result of the introduction of the Adult MASH. The review is therefore making a recommendation that Adult Social Care provides assurance that these changes can demonstrate improvements in outcomes for victims facing high risk from domestic abuse.

Recommendation 8: Adult Social Care response to MARAC
Adult Social Care should provide evidence of how it has improved its response to MARAC and achieved outcomes for domestic abuse victims in the following areas:

- Prioritisation of MARAC cases and workload capacity of staff enabling an urgent response
- Co-terminosity between Multi-Agency Safeguarding Hub and MARAC
- Effective communication between Adult Social Care MARAC representative and allocated social workers
- Effective internal escalation and feedback to MARAC when task cannot be fulfilled
- Effective working relationships with IDVA service

Recommendation 9: MARAC
Dudley Safe and Sound should consult with the Office of the Police and Crime Commissioner and evidence how the recent improvements to MARAC arrangements have impacted upon agency involvement, victim safety and holding perpetrators to account.

7. RECOMMENDATIONS

7.1 Overview Recommendations

Recommendation 1: Understanding Domestic Abuse

Dudley Safe and Sound should review and seek assurance about the degree to which agencies support front-line staff and their supervisors to understand this breadth and range of domestic abuse, coercive control and stalking behaviours as well as identify and respond to risk.

Recommendation 2: Raise public awareness

Dudley Safe and Sound should continue to raise public awareness specifically about domestic abuse, coercive control, stalking and harassment

Recommendation 3: Domestic Violence Disclosure Scheme

Dudley Safe and Sound should ensure that the Domestic Violence Disclosure Scheme is well known by agencies and the public alike.

Recommendation 4: Trauma and Gender Informed Services

Dudley Safe and Sound and Safeguarding Boards should seek assurance from agencies that services and pathways are trauma-and-gender informed and flexible enough to effectively engage with women facing multiple disadvantage, using the West Midlands Domestic Violence Standards and the trauma-and-gender informed principles of the national Women's Taskforce on Mental Health as guides.

Recommendation 5: Enabling Engagement with Specialist Services

Black Country Women's Aid to provide evidence of effective interventions and engagement methodology for victims who present with multiple and complex issues that may have resulted in them disengaging from other services.

Recommendation 6: Perpetrator's History of Violence

Dudley Safe and Sound should seek assurance from its agencies that they are able to accurately record and access records on an abuser's previous violent history and apply this to current risk assessments and responses.

Recommendation 7: Policing Domestic Abuse

West Midlands Police should provide evidence of the improvements made in the policing of domestic abuse to Dudley Safe and Sound, particularly compliance and impact of the changes concerning: the mandatory completion of DASH; referrals to specialist domestic abuse and alcohol treatment agencies, and the impact of portable mobile devices.

Recommendation 8: Adult Social Care response to MARAC

Adult Social Care should provide evidence of how it has improved its response to MARAC and achieved outcomes for domestic abuse victims in the following areas:

- Prioritisation of MARAC cases and workload capacity of staff enabling an urgent response
- Co-terminosity between Multi-Agency Safeguarding Hub and MARAC
- Effective communication between Adult Social Care MARAC representative and allocated social workers
- Effective internal escalation and feedback to MARAC when task cannot be fulfilled

- Effective working relationships with IDVA service

Recommendation 9: MARAC

Dudley Safe and Sound should consult with the Office of the Police and Crime Commissioner and evidence how the recent improvements to MARAC arrangements have impacted upon agency involvement, victim safety and holding perpetrators to account.

7.2 Individual Agency Recommendations

Recommendations for Dudley Group NHS Foundation Trust

Recommendation 1: Funding to be secured for an Independent Domestic Violence Advocate in the Emergency Department.

Recommendation 2: Continue to work toward meeting the NICE Quality Standard on Domestic Violence and Abuse QS116

Recommendation 3: Domestic abuse training to continue to emphasise the connection between domestic abuse and substance misuse.

Recommendation 4: Emergency Department staff to receive bespoke training in regard to alcohol misuse and local services available to give advice and support.

Recommendation 5: Safeguarding training to continue to discuss self-neglect and possible indicators.

Recommendations for Dudley and Walsall Mental Health Partnership NHS Trust

Recommendation 1: To ensure that all professionals continue to access the safeguarding practitioners for advice and that they play a key role in the early identification and response to domestic abuse and coercive and controlling behaviour.

Recommendation 2: To ensure that all staff complete their mandatory domestic abuse training and for the Safeguarding Team to promote and encourage staff to attend external training sessions.

Recommendation 3: To identify themed DHR case studies to be included in the safeguarding newsletters, domestic abuse training and bulletins which are circulated to all Trust staff.

Recommendation 4: For the Trust to develop the of Top 10 Safeguarding Tips which will support staff in their day to day practice by sharing key learning points.

Recommendation 5: As an area of good practice, the Trust will ensure that staff are alert to non-verbal behaviours and be encouraged to collate a genogram to understand the family network. This is following compilation of the combined agency chronology as it is now evident that both the victim and the perpetrator had troubled childhoods and they both experienced stressful or traumatic events, including physical and sexual abuse. Children raised in environments where violence, assault and abuse are common will often come to believe this behaviour is normal and therefore find it difficult to establish and maintain healthy relationships. These ACEs (Adverse Childhood Experiences) are strongly related to the development and prevalence of a wide range of health problems throughout a person's lifespan and overtime could have contributed to them both developing negative coping mechanisms.

Recommendations for Dudley Clinical Commissioning Group

Recommendation 1: Monitor the impact of the IRIS Programme within primary care

Recommendation 2: Continue to work to meet NICE Quality Standard on Domestic Violence and Abuse

Recommendation 3: Domestic abuse training to emphasise the importance of 'asking the question'

Recommendation 4: Raise awareness of domestic abuse, National Centre for Domestic Violence and stalking amongst professionals and patients

8. CONCLUSION

189. The victim had experienced male violence for most of her life and suffered those life experiences that are often seen as the consequences of abuse including substance misuse, mental ill-health, a period of homelessness and her children being removed from her care. Her experience of domestic abuse from her partner, the perpetrator, was wide ranging and she was referred to MARAC twice. She often blamed herself for the violence that she was experiencing and there was insufficient challenge when she articulated these concerns. There were also missed opportunities to disclose the perpetrator's violent history to her under the Domestic Violence Disclosure Scheme which could have helped her to reconsider her self-blame.

190. The perpetrator had a history of violence to others and had posed a high risk to his previous partner, but this history of high risk was not always taken into account in future risk assessments and at times, it was observed that an incident-based rather

than a holistic approach to risk had been followed. The absence of witness statements which were sometimes declined and sometimes withdrawn, together with the absence of other evidence, meant that the perpetrator was not held accountable for his violence and abuse.

191. The review has seen that Dudley can demonstrate many improvements in its co-ordinated response to domestic abuse since agencies' involvement with the victim: West Midlands Police have made completion of the DASH mandatory, in line with national expectations and improved their manner of referrals to other agencies; the MARAC has been resourced and organised at the regional level; mental health services have made domestic abuse training mandatory and both GPs and the Emergency Department will have training and pathways to Independent Domestic Violence Advisors. Each of these improvements in agency responses would have been beneficial to the victim in this case. Nonetheless, victim engagement is critical.

192. Agencies experienced difficulties engaging with the victim to complete the DASH; to assist with prosecutions of the perpetrator; to provide mental health services or to refer her to specialist domestic abuse or substance treatment agencies. Their engagement was often hindered because of her inebriation and the times when she did seek engagement with mental health services were often short-lived. It was noted that the introduction of the IRIS programme approach in primary care would have been of particular benefit to victim as it was here that she most readily sought help. Likewise, applying a trauma-and-gender-informed approach, as recommended by the Women's Mental Health Taskforce (Department of Health and Social Care, 2019), could help all agencies to improve their engagement with victims who face multiple disadvantage.

8. BIBLIOGRAPHY

Alcohol Concern and AVA (2016) *Domestic abuse and change resistant drinkers: preventing and reducing the harm: Learning lessons from Domestic Homicide Reviews*. Available online at: https://avaproject.org.uk/wp-content/uploads/2016/09/Alcohol-Concern-AVA-guidance-on-DA-and-change-resistant-drinkers.pdf

AVA and Agenda (2017) *Mapping the Maze.* Available online at: https://avaproject.org.uk/mapping-maze-report-launched/

AVA and Agenda (2019) *Breaking Down the Barriers: Findings of the National Commission on Domestic and Sexual Violence and Multiple Disadvantage.* Available online at: https://avaproject.org.uk/breaking-down-the-barriers-findings-of-the-national-commission-on-domestic-and-sexual-violence-and-multiple-disadvantage/

Department of Health (2017) *Responding to domestic abuse. A resource for health professionals*. Available online at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/597435/DometicAbuseGuidance.pdf

Department of Health and Social Care and Agenda (2018) *The Women's Mental Health Taskforce: Final Report*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/765821/The_Womens_Mental_Health_Taskforce_-_final_report1.pdf

Feder, G.S., Hutson, M., Ramsay, J., Taket, A.R. (2006) Women Exposed to Intimate Partner Violence: Expectations and Experiences When They Encounter Health Care Professionals: A Meta-analysis of Qualitative Studies. *Arch Intern Med.* 2006;166(1):22–37

Felitti, V.J. et al. (1998) Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. *American Journal of Preventive Medicine*, Volume 14, Issue 4:245 - 258

Home Office (2016) *Domestic Violence Disclosure Scheme (DVDS) Guidance*. Available online at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575361/DVDS_guidance_FINAL_v3.pdf

HMIC (2014) Everyone's business: Improving the police response to domestic abuse. Available online at: https://www.justiceinspectorates.gov.uk/hmicfrs/publications/improving-the-police-response-to-domestic-abuse/

HM Government (2016) *Violence against Women and Girls Strategy 2016 – 2020*. Available online at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/522166/VAWG_Strategy_FINAL_PUBLICATION_MASTER_vRB.PDF

Home Office (2015) *Controlling or Coercive Behaviour in an Intimate or Family Relationship Statutory Guidance Framework*. Available online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/482528/Controlling_or_coercive_behaviour_-_statutory_guidance.pdf

Home Office (2016) *Violence Against Women and Girls. National Statement of Expectations.* Available online at: https://www.gov.uk/government/publications/violence-against-women-and-girls-national-statement-of-expectations

Humphreys, C. and Thiara, R. (2002) *Routes to safety: Protection issues facing abused women and children and the role of outreach services* (Bristol: Women's Aid)

Monckton Smith, J., Orcid, J.,Szymanska, K. and Haile, S. (2017) *Exploring the Relationship between Stalking and Homicide*. Suzy Lamplugh Trust.

NICE (2014) *The evidence statements. Domestic violence and abuse - how services can respond effectively.* Available online at:
https://www.nice.org.uk/guidance/ph50/evidence/evidence-statements-pdf-431661277

NICE (2016) *Quality Standard* [QS116]. Available online at:
https://www.nice.org.uk/guidance/qs116/chapter/Quality-statement-3-Referral-to-specialist-support-services-for-people-experiencing-domestic-violence-or-abuse

Office for National Statistics (2017) *Statistical bulletin. Domestic abuse in England and Wales year ending March 2017.* Available online at:
https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwales/yearendingmarch2017#domestic-homicides

Respect (2019) *Respect Toolkit for Work with Male Victims of Domestic Abuse.* Available online at:
https://www.respect.uk.net/resources/19-respect-toolkit-for-work-with-male-victims-of-domestic-abuse

Royal College of General Practitioners (RCGP), IRIS and CAADA (2012) *Responding to Domestic Abuse: Guidance for General Practices.* Available online at:
http://www.rcgp.org.uk/clinical-and-research/resources/a-to-z-clinical-resources/domestic-violence.aspx

Safer Lives (2017) *10 Principles of an Effective MARAC.* Available online at:
http://www.safelives.org.uk/sites/default/files/resources/The%20principles%20of%20an%20effective%20MARAC%20FINAL.pdf

Standing Together Against Domestic Violence (STADV) (2013) I*n Search of Excellence. A Guide to Effective Domestic Violence Partnerships.* Available online at:
http://www.standingtogether.org.uk/sites/default/files/docs/In_Search_of_Excellence.pdf

Stark, E. (2009) *Coercive Control*. *How men entrap women in personal life*. Oxford University Press

University of Bristol (2011) *IRIS Commissioning Guidance*. Available online at:
http://www.rcgp.org.uk/clinical-and-research/clinical-resources/domestic-violence.aspx