South Oxfordshire & Vale Safer Communities Partnership

DHR Overview Report

Chair

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Section One

Introduction and background

1.1 Introduction

This Domestic Homicide Review (DHR) examines the circumstances surrounding the unexpected death of Andrew in Abingdon, Oxfordshire in October 2014. The DHR was commissioned by the South & Vale Community Safety Partnership.

1.2 Purpose of the Domestic Homicide Review

DHRs came into force on 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Adults Act (2004). The act states that a DHR should be a review '*of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by —*

- *a person to whom he was related or with whom he was or had been in an intimate personal relationship, or;*

- *a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death'.*

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

1.3 Process of the review

A DHR was recommended and commissioned by the South & Vale Community Safety Partnership in December 2014 in line with the expectations of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2011. This guidance is issued as statutory guidance under section 9(3) of the Domestic Violence, Crime and Adults Act 2004.

The panel met for the first time in March 2015 following the appointment of an independent Chair. The independent author was appointed through a competitive tender process in December 2014 and January 2015. The first meeting also agreed the Terms of Reference for the DHR.

The panel has met on five occasions.

Panel Membership

The members of the panel were:

Dr. Louise Westmarland	The Open University (Chair of panel)
DCI Katy Barrow-Grint	Thames Valley Police
Steve Bishop	Vale of White Horse District Council
Karen Diver	A2Dominion
Lou Everatt	Probation Service
Mike Foster	Oxford Health NHS Foundation Trust
Liz Jones	Oxford City Council
Maria Melbourne	Oxfordshire County Council
Helen Ward	NHS Oxfordshire CCG

The Chair

The Chair of the panel was Dr. Louise Westmarland. Louise is a senior lecturer in criminology at the Open University. She is conducting this DHR as a private independent consultant and has completed a number of reviews in the past. Her expertise is in policing, homicide investigations and gender. She has written and published numerous books and articles over the past few years since completing her doctorate in 1998.

The Overview Report author

The independent author of the DHR Overview Report is Steve Appleton. Steve trained as a social worker and specialised in mental health, working as an Approved Social Worker. He has held operational and strategic development posts in local authorities and the NHS. Before working independently he was a senior manager for an English Strategic Health Authority with particular responsibility for mental health, learning disability, substance misuse and offender health.

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

Steve has led reviews into a number of high profile serious untoward incidents particularly in relation to mental health homicide, safeguarding of vulnerable adults, investigations into professional misconduct by staff and has chaired a Serious Case Review into an infant homicide. He has chaired and written DHRs for a number of local authority Community Safety Partnerships.

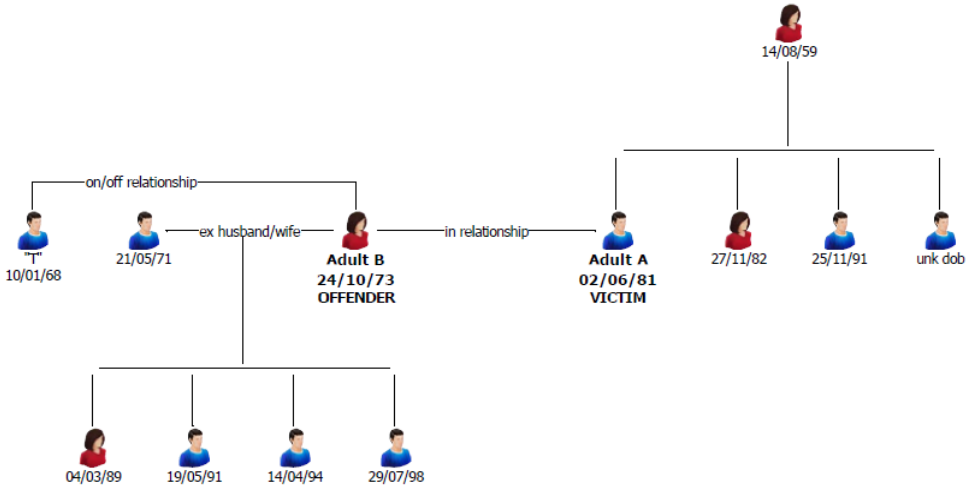
1.4 Subjects of the review

Andrew
White British male
Date of Birth: June 1981
Date of Death: October 2014

Barbara
White British female
Date of Birth: October 1973

1.4.1 Genogram

This genogram, taken from the Thames Valley Police Individual Management Review (IMR) explains the relationships of Andrew and Barbara with each other, their families and another of Barbara's partners. Family members not relevant to and not included in this review are not included.



1.5 Time Period

The DHR has focused on the two year period prior to the homicide, however where information about contact between agencies and Andrew or Barbara prior to that has been available this has been reviewed to provide any relevant context or information that might assist the DHR process.

1.6 Terms of reference

The DHR's specific terms of reference, as agreed by the panel were as follows:

This Domestic Homicide Review (DHR) will consider:

An overview of each agency's involvement in detail between the beginning of September 2012 and the end of October 2014 for both Andrew and Barbara. Further, the DHR will consider any other information of relevance from the beginning of September 2003.

Although the definition of 'relevance' will be at the discretion of the individual IMR writer's professional judgment and his or her organisations chief executive, this will include (for both Andrew and Barbara):

i) Any incidents or disclosures involving violence and abuse, or references to a vulnerable person.
ii) References to the misuse of alcohol and drugs
iii) Any housing or benefits assistance
iv) The engagement and offering of services and support, particularly relating to i) ii) and iii), above.

This will include relevant details of:

- Whether there was any previous known history of abusive behaviour between the couple, or with any other previous partners.
- Whether family, friends or colleagues want to participate in the review. If so, to ascertain whether they were aware of any abusive behaviour to the deceased, prior to the death.
- Whether, in relation to the family members, any barriers were experienced in reporting domestic abuse.
- Whether there was any contact with agencies in relation to substance misuse, the outcomes of any contact, and to what extent substance abuse was related to abusive or violent behaviour between the couple.
- Whether improvement in any of the following might have led to a different outcome:

a) Communication and information sharing between services including in relation to the safeguarding of children and adults
b) Communication within services
c) Communication to the general public and non-specialist services about available specialist services such as those aimed at supporting victims of domestic abuse.

- Whether the work undertaken by agencies in this case was consistent with:

  a) Organisational and professional standards
  b) Organisations' domestic abuse and safeguarding policies, procedures and protocols

- The response of the relevant agencies to any referrals relating to or concerning domestic abuse or other significant harm from (date) and any relevant earlier records. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons for these. In particular, the following areas will be explored:

  a) Identification of the key opportunities for assessment, decision-making and effective intervention in this case from the point of any first contact onwards with the deceased.
  b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.
  c) Whether appropriate services were offered / provided and/or relevant enquiries made in the light of any assessments made
  d) The quality of any risk assessments undertaken and if relevant, whether appropriate information sharing and handover occurred

- Whether thresholds for intervention were appropriately assessed and applied correctly, in this case.
- Whether any identified issues were escalated to senior management or other organisations and professionals, and if appropriate, carried out in a timely manner.
- Whether the impact of any organisational change over the period covered by the review had been communicated well enough between partnership agencies and whether that impacted in any way on agencies' ability to respond effectively.
- Whether any training or awareness raising requirements can be identified to ensure a greater knowledge and understanding of domestic abuse and safeguarding processes and/or services in the future.

- The review will consider any relevant protected characteristics as outlined by the Equalities Act 2010.
- The review will consider any other information found to be relevant.

1.7 Individual Management Reviews (IMRs)

IMRs were requested from agencies that had been in contact with or providing services to both Andrew and Barbara. IMRs and scoping information were also requested from other agencies with which they may have had contact.

The objective of the IMRs which form the basis for the DHR was to provide as accurate as possible an account of what originally transpired in respect of the incident itself and the details of contact and service provision by agencies with Andrew and Barbara.

The IMRs were to review and evaluate this thoroughly, and if necessary to identify any improvements for future practice. The IMRs have also assessed the changes that have taken place in service provision during the timescale of the review and considered if changes are required to better meet the needs of individuals at risk of or experiencing domestic abuse.

This Overview Report is based on IMRs commissioned from those agencies that had involvement with Andrew and Barbara, as well as summary reports, scoping information and an interview with Andrew's mother. There was also an interview with Barbara following her conviction for manslaughter, carried out by the DHR Chair, in prison.

The DHR Panel has received and considered the following Individual Management Review Reports (IMR):

- A2Dominion
- Avon & Wiltshire Mental Health Partnership NHS Trust
- Elmore Community Services
- Oxford Health NHS Foundation Trust
- Oxfordshire Clinical Commissioning Group
- Thames Valley Police
- South Oxfordshire Social Care
- Vale of White Horse District Council

1.8 Diversity

The panel has been mindful of the need to consider and reflect upon the impact, or not, of the cultural background of Andrew and Barbara and if this played any part in how services responded to their needs.

"*The Equality Act 2010 brings together the nine protected characteristics of age, disability, gender reassignment (with a wider definition) marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation*."[1]

There are further considerations relating to income and pay gaps, the gender power gap in public sector leadership positions and politics, and the causes and consequences of violence against women and girls, under the Gender Equality Duty.[2]

1.9 Confidentiality

The DHR was conducted in private. All documents and information used to inform the review are confidential. The findings of the review should remain confidential until the Overview Report and Action Plan are accepted by the Community Safety Partnership. The Overview Report has been anonymised in relation to Andrew and Barbara and family members.

1.10 Involvement with the family

Despite numerous attempts to contact them by phone and letter, despite being certain that these communications have been received, contact with members of Andrew's family was not been achieved during the writing of this Report. Following an earlier draft of the conclusions Andrew's mother agreed to meet with the DHR Chair for a discussion of the findings. She said she was happy with the findings but worried that the perpetrator would come to live near them again following her release from prison. As far as anyone is aware they did not contact any advocacy support despite being offered leaflets and contact information. The family were contacted via the police Family Liaison Officer (FLO) and by letter and phone by the DHR Chair.

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

1.11 Involvement with the perpetrator

The chair of the panel met with the perpetrator, Barbara, at the prison where she was being detained following her conviction for manslaughter on the grounds of diminished responsibility. The meeting took place on 3rd December 2015. The detail of the discussion can be found in Section 2.4

Section Two

Domestic Homicide Review Panel Report

2.1 Summary facts of the case

This overview report is an anthology of information and facts from agencies that had contact with, had provided or were providing support for Andrew and Barbara. The report examines agency responses to and support given to them and their families prior to the incident in October 2014.

Around 1900 in October 2014 members of the public noticed a man, now known to have been Andrew, shouting into his mobile phone, walking over a bridge by the River Thames near Oxford. At 19.18 the police received a 999 call from Barbara, from her boat, which was moored near the bridge. She was calling from a mobile phone, complaining that Andrew wanted to come onto her boat and that he was unwelcome.

Andrew and Barbara had been in a relationship for some time. Both were experiencing problems with accommodation and in the summer of 2014, had been living in tents on the riverbank near Oxford. Barbara's family had recently bought her a river cruiser to live on. This was moored near a bridge on the river but as this was only a temporary mooring spot she had been served recent eviction notices.

At 19.36 the police responded to a 999 call from a witness who had been moored on his boat on the Thames, near the bridge. He reported a man lying on the towpath in distress. The police found Andrew, seriously injured, with a stab wound to his chest. After initial first aid was performed by police and paramedics, he was taken by ambulance to the John Radcliffe Hospital in Oxford. Further life-saving attempts continued, but Andrew was pronounced dead at 21.47 that day.

Barbara was arrested from her riverboat which was moored a short distance away from where Andrew had collapsed. She was questioned the following day at the Police Station and charged in October 2014 with murder. She appeared the following day at Oxford Magistrates Court and was remanded in custody.

A forensic post mortem was carried out in October 2014 at the John Radcliffe Hospital. The conclusion of the post mortem was that death was caused as a result of a single stab wound to his chest.

A Plea and Case Management Hearing was held on 14 January 2015, where Barbara entered a 'not guilty' plea. Her murder trial began at Oxford Crown Court on the 7th April 2015; she was convicted of manslaughter on the 22nd April 2015.

A2Dominion provides the Oxford Domestic Abuse Service (ODAS). The DHR panel requested information from them to establish about details of any contact or involvement the service had with either Andrew or Barbara in the timeframe covered by the review.

Their enquiries revealed that A2Dominion received a referral on 28th September 2010 from Domestic Abuse Unit for Barbara in relation to a previous partner.

After attempts to contact Barbara she declined any service saying she now had an injunction and was now OK. Barbara did say she would call the Helpline if needed. There were no further calls or referrals to the Helpline for or from Barbara.

A2Dominion had no involvement with Andrew.

2.2 Analysis of individual management reviews

This section of the report analyses the IMRs and other relevant information received by the panel. In doing so it examines how and why the events occurred and analyses the response of services involved with Andrew and Barbara, including information shared between agencies, why decisions were made and actions taken or not taken. Any issues or concerns identified are a reflection of the evidence made available.

In doing so the panel have been mindful of the guidance relating to the application of hindsight in DHRs and have attempted to reduce it where possible. This is in accordance with the Pemberton Homicide Review conducted in 2008: "*We have attempted to view the case and its circumstances as it would have been seen by the individuals at the time. It would be foolhardy not to recognise that a review of this type will undoubtedly lend itself to the application of hindsight and also that looking back to learn lessons often benefits from that very practice*."[3]

The panel has also borne in mind the helpful statements contained in the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, led by Robert Francis QC:

"It is of course inappropriate to criticise individuals or organisations for failing to apply fully the lessons to be learned from the knowledge that is now available, and accepting in the light of that knowledge, not possessed at the relevant time, that more or earlier intervention should have occurred. It must be accepted that it is easier to recognise what should have been done at the time… There is, however, a difference between a judgment which is hindered by understandable ignorance of particular information and a judgment clouded or hindered by a failure to accord an appropriate weight to facts which were known."[4]

It is important that the findings of the review are set in the context of any internal and external factors that were impacting on delivery of services and professional practice during the period covered by the review.

[3] A domestic homicide review into the deaths of Julia and William Pemberton. Walker,M. McGlade, M Gamble, J. November 2008

[4] Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry Executive Summary pp23 Francis QC, Robert February 2013.

2.2.1 Thames Valley Police

Thames Valley Police (TVP) is the police service covering Buckinghamshire, Berkshire, Oxfordshire and Milton Keynes. It is the largest non-metropolitan force in England.

The Thames Valley Police Investigation Review Team was set up in April 2010 to deal with all IMR requests relating to vulnerable people. The selected team of officers are all accredited detectives with a background or knowledge in at least one strand of the Protecting Vulnerable People disciplines of Child Abuse, Domestic Abuse, Serious Sexual Assault and Vulnerable Adult investigations. The team is dedicated to IMR investigations. The team is entirely independent of any investigation or Police action for which IMRs are requested.

The IMR describes how Uniformed Patrol officers, Neighbourhood officers and PCSOs dealt with Andrew and Barbara on many occasions. Many of these officers have been spoken to in the writing of the IMR.

Andrew: the police summary

The IMR describes Andrew as a quiet man, from a complex background. He grew up with his parents and two brothers and two sisters (only one sister is in the genogram as only she appears in this review). In 2010 his father was imprisoned for sexual offences. The officers have said that Andrew could not read or write very well and appeared to have learning difficulties, although it was not known if this was diagnosed. He appeared incapable of making many decisions for himself and would rely on agencies such as Police to help him.

At the time of his death Andrew had a daughter who was 15 years old. She lived locally with her grandmother and is not discussed in this review. His mother, sister and brothers also live nearby. He had been known to TVP since 2002 as a suspect for burglary and other theft offences. He was a drug user, mainly cannabis and heroin, and over the years he had also been arrested for drugs offences, for both the possession and cultivation of cannabis. He took several overdoses.

Andrew appeared to want to maintain his relationship with Barbara. They were engaged to be married but would regularly separate then get back together a few days later. Barbara would also see other men, one in particular being Mark who appears in this review. Andrew did not like this and this was the cause of arguments between them.

Barbara: the police summary

Barbara had struggled with issues of alcohol dependence for a number of years and was often intoxicated when officers dealt with her. She was in a previous abusive relationship with her ex-husband, the father of her children.

She has four children aged between 16 and 26, a daughter born in 1989, and three sons born in 1991, 1994 and 1998; and her daughter has a seven year old child. The two younger sons are discussed in this review as they both lived with Barbara for part of the time. They are referred to as the youngest son (born 1998) and the older son (born 1994).

Barbara had also been involved in Domestic and Child Protection incidents with her children, particularly her two younger sons who lived with her for some of the review period. During the review period, the youngest went to live with his father and the second youngest son eventually moved out to be with his girlfriend.

The earliest report to Police in relation to Barbara was in 1997 where her ex-husband punched her, breaking her nose. There were other reports of Domestic Abuse, including several injury assaults, over the following years. Her children were on what was then known as the 'Child Protection Register' (now a Child Protection Plan) under the category of emotional abuse in 1999.

Police contact with Andrew and Barbara prior to the DHR timeframe

The chronology includes some of the main relevant incidents prior to the period cover by the DHR. There is limited information for some of these due to the length of time that has elapsed and some records no longer being available.

Since 2003 TVP have introduced many policies and guidance in relation to dealing with Domestic Abuse. As such, the earlier incidents contained in the chronology should be read simply to put into context the background of those concerned and they are not the current approach of TVP to Domestic Abuse incidents.

Although there are numerous incidents where TVP either had contact or responded, this Overview Report focuses principally on those related to Andrew's death, but draws upon the information in the IMR about those other incidents to inform the analysis and subsequent overall conclusions and recommendations.

TVP summary of the events around the fatal incident, October 2014

TVP received a 999 call at 19:20 hours from Barbara reporting that she was having trouble with her boyfriend, Andrew. The call taker reported that Barbara sounded very intoxicated and was abusive and swearing a lot. The call taker reported that Barbara would not answer the questions that she was asked.

Barbara told the call taker that she was on a boat but did not specify where. The Unique Reference Number (URN) noted that information from an officer revealed that Barbara was a regular caller and was a known alcoholic who had been living in a tent by the river. The officer giving this information said that he would attend the location shortly.

The incident was graded as 'urgent attendance' and was classified as 'crime – domestic violence'. The Duty Patrol Sergeant then updated six minutes later to say that the original officer was committed to dealing with another incident so other officers would need to attend.

A NICHE[5] report was created for a Domestic Incident (non-crime) and brief details were added at 19:34 hours that an intoxicated female (Barbara) was having trouble with her boyfriend (Andrew). It notes that she was abusive and not answering questions put to her by the call taker.

At 19:36 hours a member of the public called TVP via 999 to report that a male had said to him, "*Help me I've been stabbed*". The witness said that he was on a narrow boat in a mooring area in Abingdon. He stated that someone hit the top of his boat and said, "Help me I've been stabbed".

The incident was graded as 'immediate' and officers were dispatched within two minutes from the start of the 999 call. Several other officers were dispatched in the next few minutes. Within 12 minutes of the start of the call, officers were in the area trying to locate Andrew. It was initially classified as 'miscellaneous – fear for personal welfare' but was later re-classified as 'crime – murder'.

[5] NICHE is a system that can hold information about, for example; people, places and crimes and since 2012 has been used as a record of a person's time in Police custody. NICHE has taken over as the main system for TVP and existing CEDAR, Intelligence and custody databases have been combined and all can be accessed via NICHE.

The member of the public said that he went out and saw a male who was 20 or 30 yards away but he did not want to approach him. He said that he had just seen the male lying on the ground and was not sure whether to believe him or not in case it was a scam so thought it best to call 999. The URN notes that as the male had spoken, that he was both conscious and breathing at that time.

At 19:39 hours an ambulance was called. At 19:40 hours there is a note in the URN that this male may have been Andrew. A local Sergeant had passed on this information. At 19:43 hours the Control Room Sergeant updated the URN with instructions that:

- The priority was the welfare of the male.
- The attending officers were to be warned to have with them their Personal Protective Equipment (PPE)[6].
- The duty Sergeant was to be made aware.
- The scene was to be identified and preserved.
- Criminal Investigation Department (CID)[7] officers were to be made aware.

Control Room staff made attempts to call the female caller (Barbara) but the telephone went straight to voicemail. At 19:48 hours Uniformed Patrol officers arrived at the location and started to search for the boat and officers tried to locate Andrew and Barbara.

At 19:53 hours officers stated that they had located the male who had stab wounds to his upper right chest. He was unconscious but breathing and they asked for an ambulance to be sent to the scene. They said that the male was Andrew.

Other officers arrived and at 19:54 hours announced that they were commencing CPR on Andrew. Other officers started to guard the scene of the crime. Separate officers were to concentrate on identifying, locating and containing the suspect (Barbara). It was added that there were reports of Barbara being very drunk and a Taser[8] trained officer was en route to the location. A witness told officers that Barbara had a knife.

The ambulance arrived at 20:01 hours and the paramedics went to Andrew's location.

[6] This is the equipment held about the person of a Police officer which includes handcuffs, a stab proof vest and a baton.

[7] This incorporates the non-uniformed departments of mainly Detectives who investigate serious crime such as rape, murder and serious child abuse.

[8] TASER - Thomas A Swift's Electronic Rifle - a weapon firing barbs attached by wires to batteries, causing temporary paralysis.

At 20:05 hours an entry was added to the URN noting that Barbara had court bail conditions not to contact Andrew directly or indirectly. These had been placed on her on 18th August 2014. This relates to an incident of criminal damage to Andrew's belongings caused by Barbara. At 20:05 hours officers located the boat and at 20:07 hours Barbara was arrested. At 20:27 hours a doctor arrived at Andrew's location and he was taken to hospital, accompanied by a uniformed patrol officer. At 21:01 hours an officer at the hospital updated that there was no brain activity for Andrew and no change in his condition. At 21:52 hours the officer updated that Andrew had been confirmed as deceased at 21:47 hours.

Analysis of involvement

The TVP response to the incident in October 2014 was swift, appropriate and met the standards expected.

Barbara was a regular caller to TVP and the IMR finds that the call received at 19.20 in October did not immediately appear to be unusual, nor was the fact that she sounded intoxicated by alcohol.

TVP has a policy for attendance and for grading response. The IMR finds that the grading for the call was in accordance with TVP policy, the classification of 'crime – domestic violence' was also correct. Although the response time for dispatching officers for an urgent attendance was breached by three minutes, but that attendance itself was within guidance in the policy. The Control Room also correctly linked the two calls incidents and acted quickly and appropriately.

The IMR rightly highlights the fact that preservation of life is the first responsibility for officers initially deployed to an incident. Uniformed Patrol Officers worked hard administering CPR to Andrew to try and save his life. TVP also called for an ambulance which quickly attended. Officers also commenced a 'scene guard' to protect the scene of the crime and to secure evidence within it. Officers swiftly established who the victim was and Andrew was identified by attending officers. They also quickly identified that Barbara was the suspect and she was promptly arrested.

On a previous occasion, the court bail conditions mentioned in the IMR had possibly been breached by Barbara in October 2014. She had been arrested for this but not charged with the breach as Andrew would not confirm the offence of assault for which Barbara was initially arrested had actually happened. Andrew would not provide a statement and there was no other evidence to prove that Barbara had been in contact with Andrew. The interviewing officer did take the initiative to arrest Barbara but could not charge her without evidence. According to TVP, no opportunities were missed with this incident.

TVP and domestic abuse in relation to Andrew and Barbara

Domestic Abuse Operational Guidance in TVP is regularly updated, the last time being in January 2015. Prior to that it was updated in July 2012, therefore that version was in use during the main review period. The Domestic Abuse policy was last updated in April 2013. The IMR uses those documents to compare what should happen with what actually happened in relation to Domestic Abuse incidents involving Andrew and Barbara.

Thames Valley's Operational Guidance states that all calls should be properly recorded and actioned as per the graded response policy and Control Rooms & Enquiries Department (CRED) Standard Operating Procedures.

There are incidents which have not been recorded as Domestic Abuse related incidents when they should have been. The following table explains the numbers and categories of incidents. It includes all incidents reviewed since **2003**.

Category	**Number**	**Percentage of total**
Domestic Abuse Incidents involving Andrew and Barbara	29	56%
Domestic Abuse Incidents involving Andrew and others	3	6%
Domestic Abuse Incidents involving Barbara and others	20	38%
Total number of Domestic Abuse Incidents	52	100%

The below table shows the number of incidents that were correctly recorded on CEDAR/NICHE and the number that was not.

Category	**Number**	**Percentage of total**
Domestic Abuse incidents with CEDAR/NICHE reports created	36	69%
Domestic Abuse Incidents without CEDAR/NICHE reports created	16	31%
Total number of Domestic Abuse Incidents	52	100%

The above equates to 31% non-compliance in relation to creating CEDAR or NICHE reports for Domestic Abuse incidents. The majority of incidents where CEDAR or NICHE reports were not created should have been done so at the first point of contact by CRED.

For example, in **April 2013** Andrew called Thames Valley Police to report that his ex-partner, Barbara, was causing problems for him. It was not identified what these problems were although officers did locate him to establish that he was fit and well. This incident (**Incident 31**) was 4 months prior to the actual first recorded Domestic Abuse incident between Andrew and Barbara on TVP's Crime Evaluation, Data Analysis and Recording database (CEDAR). Treating this incident accordingly could have given Thames Valley Police an earlier insight into the couple.

With **Incident 85** there was a Domestic Abuse related assault disclosed over the phone yet no CEDAR report was created nor was a Domestic Abuse Risk Assessment Form completed. The officer involved has been interviewed and has informed the review that he appreciates that a CEDAR report and Domestic Abuse Risk Assessment Form should have been completed. The National Crime Recording Standards require Police to record crimes reported and with Domestic Abuse incidents this is done at the first point of contact with the caller. Not recording this incident was not the error of the officers but rather by the CRED.

This is particularly relevant to the issue of TVP's recording of, and response to, domestic abuse in relation to both Andrew and Barbara. The IMR finds a number of incidents of domestic abuse or violence was not recorded when they should have been.

The IMR highlights confusion where incidents involve so called 'common-law' in-laws. TVP uses this term to refer to couples who are together but not married. So-called 'common-law' families are not specifically explained in the Thames Valley's Domestic Abuse Policy. This has since been clarified by the Detective Inspector from TVPs PVP Strategy Unit. Under these circumstances these types of incidents should be treated as Domestic Abuse as they are in 'the spirit of a Domestic Abuse incident'. This seems entirely reasonable as in effect they are family members due to the long term and intimate relationship between Andrew and Barbara.

This is not covered in the national definition of Domestic Abuse which states that 'Family members are: mother, father, son, daughter, brother, sister & grandparents; directly-related, in-laws or step-family'. The Thames Valley Police Domestic Abuse Standard Operating Procedure states that family members are, 'mother, father, son, daughter, brother, sister and grandparents, whether directly related, in-laws or step-family'. Common-law relatives are not mentioned.

For example, where Barbara has been involved in arguments with Andrew's family members, with whom she did not usually live, officers did not see these as being Domestic Abuse related incidents. Likewise there was a domestic incident involving Barbara and her son's girlfriend which was not classified as a Domestic Abuse incident but should have been. There were 5 incidents between Barbara and either

her son's girlfriend or Andrew's family. These were not classified as Domestic Abuse incidents but should have been.

This needs to be clarified in order that uniformed patrol officers are aware that common-law relatives should be included as family members with Domestic Abuse incidents. This will either be done nationally by the College of Policing via Authorised Professional Practice (APP)[9] or by Thames Valley Police in Force policy.

TVP Recommendation 1 – Thames Valley Police officers and staff to be made aware that common-law in-laws are family members in relation to Domestic Abuse incidents. This should be addressed by including this guidance in the Domestic Abuse Standard Operating Procedure and on the Domestic Abuse Risk Assessment Form (DOM5).

Incident 21 was a call from Barbara sounding very drunk. She stated that something may have occurred between her 18 year old son and his girlfriend but would not answer questions and was not making much sense. A neighbour then called at **00:19** hours and said that he had heard arguing coming from Barbara's house for the last hour and in the last 10 minutes it had escalated. He had heard someone say, "Get your hands off my throat". Uniformed patrol officers attended and updated that it was not a domestic incident and that Barbara was 'hammered' but happy as she had a new boyfriend. Her son and his girlfriend were staying there with a puppy and the comments were in relation to a disagreement about the dog.

This should have been recorded as a domestic incident at the point of the call to Thames Valley Police by the neighbour where it became apparent that a Domestic Abuse incident had taken place. A CEDAR report should have been created and a Domestic Abuse Risk Assessment Form completed. The CEDAR report should have been created by the CRED at the first point of contact. The report should have included the information that a witness had heard someone say "Get your hands off my throat". Although it may have been difficult to identify the offender/s and victim/s, the information should have been formally recorded. The officers involved have been spoken to (Police Constables P1 & P2) and they did not class this as a domestic incident as the argument was between Barbara and her son's girlfriend. The officers are now aware that this should have been treated as such.

[9] APP is authorised by the College of Policing as the official source of professional practice on policing. Police officers and staff are expected to have regard to APP in discharging their responsibilities. There may, however, be circumstances when it is perfectly legitimate to deviate from APP, provided there is clear rationale for doing so.

A sub issue in this section is with **Incident 140**. A CEDAR report was created for a Domestic Incident (non-crime) and it was treated as a Domestic Incident. A Domestic Abuse Risk Assessment Form was not completed however. It is recorded that a form had been completed the previous week. The officer who attended this incident has been spoken to and explained that around this time there would be an instruction from the Control Room Sergeant that if a form had been recently completed then this would not need to be done again. The Superintendent in charge of the CRED has been spoken to and this is incorrect; the Control Room would not give out this instruction as it is against policy and not in their remit. What they would not necessarily do in this situation is conduct more checks, such as on the Police National Computer (PNC), on the individuals, if there had been a very recent incident as not much would be likely to have changed on these systems. Attending officers should not assume that nothing has changed since the last risk assessment as, even if was earlier in the same day, the situation could have changed. Equally, the victim may be willing to disclose more than on the earlier occasion. The Domestic Abuse Standard Operating Procedure states that a Domestic Abuse Risk Assessment Form should be completed for all Domestic Abuse incidents. This is not discretionary, it is mandatory.

Domestic Abuse incidents where assaults are reported over the phone then denied at the scene

This is a common theme with incidents where both Andrew and Barbara were the caller as shown in this table.

Category	**Number**	**Percentage of total**
Domestic Abuse incidents where assaults are disclosed on the phone but later denied	5	10%
Total number of Domestic Abuse Incidents	**52**	

There were 5 incidents where assaults were reported during the initial call but then denied when officers attended and spoke to Andrew or Barbara. The incidents did not relate to serious assaults where injuries were apparent which made it more difficult for officers to have the suspicion to arrest. If there had have been signs of an offence having taken place, for example, injuries or disarray, then this review would expect an arrest to have been considered even if the apparent victim said that nothing had happened.

Intelligence checks by the staff in the Information Research Bureau (IRB) of previous incidents identify a certain amount of information about the people that they are researching. However, this is time consuming and they would not be able to go into the level of detail to identify that Andrew or Barbara would often call and report assaults during the initial call which they would then later deny. The Control Room staff pass the results of the intelligence checks to the attending officers at incidents and this information should be recorded on the Domestic Abuse Risk Assessment Form for the attention of the Risk Assessor.

If all this information was recorded on the Domestic Abuse Risk Assessment Form, even if the attending officer was not convinced that something had happened, then the risk assessment could have been different. The Uniformed Patrol officers attending the incident and the Risk Assessor in the MASH[10] would be aware that there had been previous disclosures of assaults on the phone which were not confirmed by the victim when officers attended. This information could suggest coercive control which would increase the risk to the victim and the risk level could be higher. Ensuring IRB and Control Room staff find out and relay this information to the Uniformed Patrol officers attending would enable this.

Risk assessments for Domestic Abuse incidents

A recurring theme with Domestic Abuse incidents relating to Andrew and Barbara was them declining to answer the questions on the Domestic Abuse Risk Assessment Form. There is information recorded in various places, such as the URN, where some of these questions have already been answered but are not subsequently recorded in the risk assessment. There appears to be a practice of sitting down with the victim and trying to ask a list of questions rather than having a conversation and using all sources to assess the risk. A large number of incidents resulted in no Domestic Abuse Risk Assessment Form being completed and yet one could have been, at least in part. For example, the question relating to frequency and escalation; the local officers knew the couple and, even if they did not, were told about them by Control Room staff via their personal radios.

During the initial call from Barbara mentioned above, she tells the call taker that Andrew had put his hands around her throat. The attending officer has been spoken to and has said that he did not factor this information in the risk assessment as, when he attended the house, Andrew denied that this had happened. He has looked at this incident again recently and feels that he would deal with this incident differently now (he had only one year of service as a Police officer at that time). He feels that this incident could have been risk assessed as a standard or medium risk

[10] The Multi-Agency Safeguarding Hub has representatives from several agencies working together to share information from the start of a referral. The Oxfordshire MASH representatives are from TVP, Social Services, Health, Council and drug and alcohol services.

incident and the reviewer has discussed with the officer erring on the side of caution if in doubt.

The Review also asked the officer about whether he would include information gleaned during conversation with a victim on a Domestic Abuse Risk Assessment Form even if they refused to complete it. He said he would do this more so now but not back then. A victim may say that they are not willing to answer the questions but may have already inadvertently answered some of them during conversation. Rather than marking the form that it had all been refused, this would then only relate to individual questions. The process should be conversational rather than simply putting a series of questions to a victim. Professional curiosity should prevail and even when the questions are not directly answered, the information that is elicited from all sources should be recorded to facilitate accurate risk assessment.

TVP Recommendation 2 – To remind supervisors to ensure that officers and staff use all available information for the Domestic Abuse Risk Assessment and that risk levels have been correctly set.

Risk management for standard risk Domestic Abuse

All of the Domestic Abuse incidents between Andrew and Barbara were graded as standard risk. The majority of these were correctly assessed; however there were a substantial number of these, 29 in total.

Since **2012,** work has been undertaken by Thames Valley Police in relation to the referral of domestic abuse incidents to a MARAC[1]. Since then Thames Valley Police have become more proactive in doing this, specifically:

If there are 3 domestic abuse incidents which have been graded 'standard' in a 6 month period, this will trigger a review by a Domestic Abuse Risk Assessor to ensure the grading is appropriate. If this review was to re-grade the risk to high then a MARAC referral would be triggered.

There are 21 Domestic Abuse incidents between Andrew and Barbara from **August 2013** to **October 2014** recorded on CEDAR or NICHE. This figure is different from the number in the earlier table as it does not include the URNs which are not correctly identified as Domestic Incidents or the final incident. If the incident was not recorded any further than the URN then it would not be reviewed by a Risk Assessor. It also does not include Domestic Abuse Incidents relating to Andrew or Barbara

[1] MARAC stands for Multi-Agency Risk Assessment Conference and is a monthly Multi-Agency meeting to manage the safety of victims of domestic abuse identified as being at high risk.

with other people. To break this down, there were 11 domestic abuse incidents within a 6 month period (**August 2013** to **February 2014**) and 17 in a 12 month period (**August 2013 to July 2014**).

Under the above system, a review should have been conducted after the third incident but was not. On the fourth incident (**Incident 68**), a risk assessor reviewed this incident on **10/09/13** and agreed that it was standard risk and noted that there had been 3 previous incidents. It was reviewed due to having been 3 or more incidents. No other action was taken. It was on **14/12/13** that a risk assessor next reviewed a Domestic Incident and again agreed that it was standard risk and no referrals were made.

The following reviews of incidents between Andrew and Barbara were conducted by PVP Referral Centre staff;

- **Incident 68** – Reviewed on **10/09/13** and remained as standard risk. No further action taken. This was the **4th** CEDAR recorded incident between Andrew and Barbara.
- **Incident 106** - Interim risk assessment of standard on **14/12/13**. No further action taken. This was the **8th** CEDAR recorded incident between Andrew and Barbara.
- **Incident 138** - Single Incident Review on **18/03/14** for more than 3 incidents. Remained standard risk. This was the **12th** CEDAR recorded incident between Andrew and Barbara.
- **Incident 140** - Reviewed on **31/03/14** and remained as standard risk. This was the **13th** CEDAR recorded incident between Andrew and Barbara.

Neither party was referred to or discussed at MARAC. In each TVP Local Policing Area there is now a Multi-Agency Meeting for the top 10 Domestic Abuse victims that are not high risk. This information is obtained from the Performance Database. This is a Multi-Agency meeting which looks at ways to manage the risk to victims of Domestic Abuse who do not come under the category of high risk and are therefore not discussed at MARAC. Uniformed Patrol Inspector P27 has informed this review that at the first of these meetings in the Abingdon area Andrew and Barbara were given as an example to other agencies of why this meeting was so important.

In Oxfordshire South and Vale these meetings aim to be held immediately after the monthly MARAC meeting which helps to engender the attendance of the correct partner agencies. Each Local Police Area (LPA) Commander is responsible and accountable for the work their teams are doing to deal with repeat victims and offenders.

TVP Recommendation 3 – To share this case study with Domestic Abuse Investigation Unit (DAIU) training courses and for PVP Referral Centre and MASH Detective Inspectors to discuss with Risk Assessors.

Handling of Child Protection incidents

There are some Child Protection incidents which have not been correctly recorded. There are some which are recorded as Domestic Abuse incidents which should have been Child Protection due to one of Barbara's sons being under 16 years old. There is also an incident where Barbara told Police she might hurt one of her children and this was not recorded or passed to Social Services.

The Police have powers under Section 46 of the Children Act 1989 whereby if a Constable believes that if a child is at risk of suffering significant harm in a particular situation then the officer may exercise powers under this Act to remove the child to suitable accommodation or if the child is in hospital or in a place of safety, take steps to keep the child there. A child cannot be kept in Police Protection for more than 72 hours and usually the child would be referred to the Local Authority to place into foster care. If attending officers had felt it appropriate, they could have considered using these powers with Barbara's younger children.

This review is concerned about the decision made to leave one of Barbara's sons who had gone missing and was found in her care whilst she was drunk **(Incident 116)**. The attending officer states that she would not have left him there if she was not happy but considering what was known of Barbara's previous behaviour and history, it may have been better to return her son to his father or to consider using the above Police Protection Powers. Feedback will be given to the officer and her line manager to inform her that, given the nature of the family, the child should not have been left with Barbara. In **Incident 128** TVP did make referrals to Social Services as her youngest son was in her care whilst she was drunk.

If the incidents involving Barbara's sons had been recorded as Child Abuse or Child Protection incidents, this would have meant that referrals would have been made to Children's Social Care and a Strategy Discussion or Strategy Meeting[11] would have taken place to decide on a course of action.

[11] The purpose of a Strategy Meeting or Strategy Discussion is to consider:

- The best way to investigate the allegations or concerns?
- The risks of harm to the child (or others)?
- How to support the child (and others) to be safe?

This could have led to a Section 47 Joint Investigation[12] being commenced with the potential for a Child Protection Conference[13] being held according to what was ascertained during the initial assessment and subsequent investigation. Alternatively it could have given rise to other support being offered and a strategy discussion or meeting would be the start of this. It is of note that Thames Valley Police to do not have a record of any other agency calling a strategy meeting or discussion.

Even recording an incident as Domestic Abuse then flagging the record for Child Protection would make the relevant Thames Valley Police staff aware and enable referrals to be made to Social Services.

What is positive is that for all Domestic Abuse incidents involving Andrew and Barbara where children were highlighted in CEDAR/NICHE to be present were referred to Children's Social Care.

Adult Protection CEDAR or NICHE reports not created at relevant incidents

There are several Adult Protection incidents which relate to Andrew or Barbara. On many of these occasions reports have been created on CEDAR, or latterly NICHE, to record actions taken. There are also many incidents where this was not done and should have been. This means that on some occasions opportunities were missed for Thames Valley Police to refer Andrew and Barbara to other agencies. This is not to say that these referrals were not made at all by Thames Valley Police, as they were, just not every time. What is apparent, as it is noted in various CEDAR reports, is that Barbara was under the care of the Mental Health Team so was receiving support. Police Constable P11 has informed this review that whilst dealing with Andrew at incidents, on several occasions he suggested that he should speak to a drugs support agency.

It is possible to create a NICHE report to record a particular type of incident, for example Domestic Abuse, but then flag the report for Adult or Child Protection or both. What is important is that the information is recorded on NICHE. This is expected of all officers and staff.

[12] Where there is reasonable cause to suspect that a child is suffering, or likely to suffer, significant harm, the local authority is required under s47 of the Children Act 1989 to make enquiries, to enable it to decide whether it should take any action to safeguard and promote the welfare of the child. The Police's primary responsibility is to undertake criminal investigations of suspected or actual crime. Where both Children's Social Care and the police have responsibilities with respect to the child, they must coordinate to ensure the parallel process of a section 47 enquiry and a criminal investigation is undertaken in the best interests of the child.

[13] A Child Protection Conference is a meeting held that involves the parents and professionals involved with a child, if professionals have serious concerns about the child's welfare. The people present at the conference share information about their involvement with the family, assess the risk to the child and decide if there needs to be a plan to protect the child.

There were occasions where intelligence reports were submitted, such as with **Incident 54** and **Incident 65**, and a CEDAR report was not created. This should have been completed by the attending or reporting officer as this would mean that consideration would have been given to making referrals to other agencies. At the time when these reports were submitted, Andrew had not been referred to any other agencies by Thames Valley Police. These were opportunities to do so. It is not acceptable to record information relating to Protecting Vulnerable People via intelligence reports.

TVP Recommendation 4 - Officers to be made aware that intelligence reports should not be used for recording Safeguarding issues. This should be recorded via NICHE reports for either Adult Protection or Child Protection.

There are a few occasions where consent has not been requested for referrals to be made. This has only been identified as happening a few times and Uniformed Patrol officers spoken to during the writing of this review are aware that consent needs to be sought. It has been identified in other Reviews that seeking consent is becoming more widespread. One officer explained how he had changed his practice from recording the consent in the URN or CEDAR/NICHE to making a written record in his PNB and asking the person to sign it.

It is important to note that although Adult Protection CEDAR/NICHE reports were not always created, officers did attend and did do their best to ensure that Andrew or Barbara were safe and as well as could be before leaving them. Even when faced with aggression from Barbara, they looked after her and made sure she received medical attention when she needed it.

Adult Protection referrals not made where the subject has attended hospital

There are 16 Adult Protection incidents where either Andrew or Barbara were taken to hospital after having taken overdoses. On 9 of these occasions Adult Protection CEDAR or NICHE reports were created, however referrals to other agencies were only made on 2 of the occasions. This was under the assumption that referrals would be made by hospital staff. This is incorrect to make this assumption and Police should make these referrals. This is particularly important as Thames Valley Police may have information that other agencies do not have.

Just because a person had been taken to hospital does not mean that TVP can guarantee that the staff will make the necessary referrals to Social Services. Police should make the referral regardless of the hospital visit unless it is clear that the person is already being cared for by the appropriate agencies and these agencies have all of the information which Thames Valley Police are in possession of. This has been brought up in a recent Vulnerable Adult Serious Case Review in **September 2014** where a recommendation was made that;

‘**TVP should make a referral (bearing in mind the issue of consent) unless it is clear that another agency is already dealing with the Vulnerable Adult and is aware of all the information known to TVP’.**

This action has been completed and implemented within Thames Valley Police. Officers and staff were informed via briefing slides for shift briefings. It was confirmed in **January 2015** that all Local Policing Areas briefings have the slide.

Training for all Thames Valley Police officers and staff about vulnerability is to be completed following a recommendation in another review.

Work by the Neighbourhood Policing Team with Barbara engaging in Anti-Social Behaviour

Barbara was a long term source of Anti-Social Behaviour (ASB). One set of neighbours particularly suffered from it. These neighbours were a young family with small children who were regularly kept awake by Barbara shouting and playing music loudly whilst she was drunk.

On some occasions an ASB Matrix[14] was completed and on some it was not. It appears that there were times that the concerns of the neighbours were overshadowed by Barbara’s own needs as a Vulnerable Adult.

Action was taken by the Neighbourhood Policing Team (NHP Team) to combat this. The local Police Community Support Officer (PCSO), C1, initially made contact with the council to seek help. This proved difficult as Barbara owned her property, via a mortgage.

PCSO C1 then sought help from the Environmental Health Office (EHO) and the neighbours were provided with diaries to keep a log of events. Unfortunately due to the ill effects that the ASB was having on the mental state of one of the neighbours, it was not always completed. PCSO C1 took the initiative to refer this neighbour to a GP for help. PCSO C1 kept requesting help from the EHO until eventually sound recording equipment was installed.

Eventually a house swap was arranged for the young family who were the main victims of the ASB. The Neighbourhood Supervisor wanted to ensure that the new family moving in were aware of the situation so history did not repeat itself. He went to see them and explained the situation; they stated that this did not concern them and they would be able to manage the situation. In fact they did seem to and soon

[14] This is completed to assess the risk to victims of ASB.

after Barbara's home was repossessed by the mortgage lender and she and her family moved out.

The Neighbourhood Policing team took clear ownership of their dealings with the families involved and worked hard to ensure that they were able to lead peaceful lives.

The following questions have been asked in the Terms of Reference and are answered in this section. Sections that are not relevant to the Police IMR are not included.

Whether there was any previous known history of abusive behaviour between the couple, or with any other previous partners

Andrew was neither subject to nor the recipient of abuse by previous partners. He had been involved in some standard risk disputes with his siblings but without violence.

Barbara had been in a long term abusive relationship with her husband during which she was physically abused.

There were incidents between Barbara and her children, mainly her 2 youngest sons, and mainly with Barbara as the perpetrator. Some of these fell into the category of Domestic Abuse when the victim was over the age of 16 and some were Child Protection incidents when one of her sons was under the age of 16.

Officers knew Andrew and Barbara and attended many Domestic Abuse incidents involving them. Some of these had Andrew recorded as the perpetrator and some Barbara recorded as the perpetrator. The many Domestic Abuse incidents between them are discussed in this Review.

Whether there was any contact with agencies in relation to substance misuse, the outcomes of any contact, and to what extent substance abuse was related to abusive or violent behaviour between the couple

There was extensive Police contact with Barbara whilst she was drunk and several contacts with Andrew whilst he appeared to be under the influence or drugs. Barbara's drinking is fundamentally linked to the violence between them, both physical and verbal. Almost every contact TVP officers had with Barbara was when she had been drinking. Officers describe a woman who was aggressive and abusive when she was drunk but could equally be affectionate, trying to embrace the officers. When she was sober she was described as a different woman who was polite and friendly towards officers.

Barbara was arrested on several occasions for committing offences such as Public Order offences whilst she was drunk. This was effective to protect both her and the public from her whilst she was being drunk and abusive. Referrals were made to Social Services and to the GP for the couple to try and arrange help for them. It is not known exactly what help they did receive, however Barbara was drinking until the day she was arrested for killing Andrew.

Thames Valley Police are aware that Barbara was under the 'Elmore Team' in Oxford who were supporting her with her alcoholism and other issues. She was also taking medication prescribed to her by her GP but it is not known exactly what it was for.

Whether improvement in any of the following might have led to a different outcome:

a) **Communication and information sharing between services including in relation to the safeguarding of children and adults**

There were 16 incidents which resulted in either Andrew or Barbara being taken to hospital after having taken overdoses. On some of these occasions referrals to Adult Social Care were not made under the assumption that this would be done by hospital staff. There were times when Thames Valley Police did make referrals to various Social Services departments and to the GP. These referrals were made verbally and via reports from the PVP Referral Centre.

Thames Valley Police would also regularly call for an ambulance to attend incidents where there was a concern for the physical welfare of Andrew or Barbara who harmed themselves on several occasions.

Uniformed Patrol officers also gave Andrew and Barbara contact details for Domestic Abuse support agencies.

On only one occasion was a referral made to Social Services in relation to children. Thames Valley Police have not recorded all incidents and not gathered sufficient information. Therefore, this information was not shared. It is not possible to say what the effect would have been to share information on every occasion but it would have given other agencies the opportunity to be involved.

b) **Communication within services**

The majority of incidents involving Andrew or Barbara resulted in a CEDAR or NICHE report being created. This is one of the ways in which Thames Valley Police officers and staff communicate and record actions taken. Any Adult Protection incident would then be reviewed by the Protecting Vulnerable People (PVP) Referral

Centre staff. Some of the Domestic Abuse incidents would also be reviewed as they were dip checked.

From **September 2012** a process was introduced across Thames Valley Police whereby 'Single Incident Reviews' take place. These reviews are now known as 'Risk Assessor Summaries'. These relate to all Domestic Abuse incidents where a child has been identified as being present and the crime or non-crime NICHE report is flagged as such. Each of these incidents is reviewed by a Risk Assessor in the MASH or PVP Referral Centre who then produces a summary detailing the incident, including any relevant information from the Domestic Abuse Risk Assessment Form and other sources of information such as the URN. The summary is recorded in Niche and an 'Information Share Report' is generated from Niche and sent to the relevant Children's Social Care department by email once a day, Monday to Sunday. In all Domestic Abuse cases between Andrew and Barbara after **September 2012** where it was recorded in CEDAR or NICHE a child was present at a Domestic Abuse incident, a referral was made to Children's Social Care.

Where CEDAR or NICHE reports have not been created for incidents, this has meant that information was not fully recorded and therefore the PVP Referral Centre or MASH would not have known and therefore not have been involved. This is not agreed practice and a record should be created for all Adult Protection and Domestic Abuse incidents. This will give the information to the MASH to enable them to share this with other agencies. A record should be made for all incidents and referrals made where there are Child Protection concerns.

Uniformed Patrol officers should also liaise with Sergeants and Control Room staff and supervisors to ensure that they had taken the correct action with incidents.

The main issue arises following Uniformed Patrol officers attending incidents and grading the risk level as standard risk. With the exception of a few reviews in the PVP Referral Centre, the incidents were not linked. This means that no-one was aware of all of the incidents and so the risk assessment was not fully informed. Therefore the risk management was not tailored to the individuals. This is not for the individual Uniformed Response officers to do but rather for the MASH or PVP Referral Centre to draw together. The Domestic Abuse Investigation Unit were not aware of the couple which meant that they did not conduct risk management as the unit only undertake this for medium and high risk victims. They do not complete risk management for standard risk victims.

Now there are Local Policing Area monthly meetings to discuss the top 10 Domestic Abuse cases that are not high risk and Andrew and Barbara would have certainly fallen into this group. This means that should this happen today they would have been discussed at the meeting which would not only have had other agencies

present but also different departments within Thames Valley Police such as the Domestic Abuse Investigation Unit and Neighbourhood Policing Team for the area.

Communication to the general public and non-specialist services about available specialist services such as those aimed at supporting victims of Domestic Abuse

A new Domestic Abuse Risk Assessment Form was introduced in **June 2012** and rolled out across Thames Valley Police in the first half of **2013**. There is a tear-off page on the rear of the form entitled 'Further Advice and Support' which lists contact details for Local Support agencies. In this case this would be the Oxfordshire Domestic Abuse Helpline and a phone number and website address are communicated to the reader. There are also National Support contact numbers, for example, Women's Aid and Victim Support.

Uniformed Patrol officers have confirmed that even if the victim declined to complete the Domestic Abuse Risk Assessment Form they would still give the victim contact details for other agencies using the tear-off page from the Domestic Abuse Risk Assessment Form.

All of the incidents between Andrew and Barbara were assessed as standard risk. Had there been medium or high risk incidents then the DAIU staff would have reviewed the incident and made contact with the victim to complete a Victim Safety Plan[15]. This would include giving information about other agencies, such as Women's Aid.

There is a pilot running in the Milton Keynes area of Thames Valley Police which relates to victims of Domestic Abuse graded at all levels of risk. This is in relation to the actions taken by the Uniformed Patrol officers upon first attendance to Domestic Abuse incidents. On the Domestic Abuse Risk Assessment Form the attending Uniformed Patrol officer completes a Victim Safety Plan with all victims of Domestic Abuse, whatever their risk assessment. This includes a section dedicated to making the victim aware of potential Police referrals to other agencies such as Housing, Crime Prevention and Social Services. It has been agreed that this will be implemented across the whole of Thames Valley Police.

There are other initiatives in Thames Valley Police relating to Uniform Patrol Officers dealing with the main repeat victims for their area and work has been conducted in this area. As discussed earlier in this review, the top 10 will now be discussed at the monthly risk management meeting on the Local Policing Areas.

[15] This involves a conversation with a victim to discuss the best way to protect them and help to the victim to protect themselves.

One of the PVP DCIs has been tasked to develop a local safeguarding framework to define safeguarding activities at Local Policing Area level which will include expected outcomes for Domestic Abuse standard risk repeat victims.

Thames Valley Police are seeking to commission some work to complement the above activity.

Whether the work undertaken by agencies in this case was consistent with:

a) Organisational and professional standards

During the review period Thames Valley Police did have, and still do have, a Professional Standards Department. Professional Standards investigates complaints and misconduct allegations against Police officers and staff. The department also works closely with the Independent Police Complaints Commission which sets the standards by which the Police should handle complaints. This review has not referred any officer, member of staff or any of their actions to either the Professional Standards Department or to the Independent Police Complaints Commission.

Apart from the policies and procedures detailed in this review, Thames Valley Police now has a Code of Ethics which officers and staff, up to the level of Chief Constable, sign up to.

The Code of Ethics was introduced by the College of Policing, following extensive consultation and became a Code of Practice having gained Royal Assent on **15 July 2014**. It is the written guide to the principles and standards that everyone in policing is expected to uphold.

The Code applies to everyone in Policing; officers, staff, volunteers and contractors. It applies both on and off duty. It both guides behaviour within the organisation as much as it informs how to deal with those outside.

The Code of Ethics is about conscience, not compliance. It is not a disciplinary code and is not used for the purposes of misconduct. It exists to encourage exemplary behaviour and good conduct. The focus of the code is on self-reflection and consideration of taking the right course of action before the event, rather than dealing with breaches after the event.

The officers spoken to, during the writing of this review, have shown their commitment to the Code of Ethics. Although not every decision was correct, it was done with the best of intentions. All of the officers have demonstrated clear compassion for Andrew and Barbara, even though both exhibited some challenging behaviour. Although the Code of Ethics was not in place throughout the whole review period it would not have been breached if it had.

b) <u>Organisations' Domestic Abuse and safeguarding policies, procedures and protocols</u>

Thames Valley Police have a Domestic Abuse Policy and a Domestic Abuse Standard Operating Procedure; both designed to guide officers as to how to approach Domestic Abuse incidents. The Thames Valley Police Domestic Abuse Policy updated on **February 2011** and **April 2013** states that the Force approach to Domestic Abuse will operate on the principles of "Intelligence Led Positive Intervention".

This means that:

- All Domestic Abuse incidents will be recorded and thoroughly investigated as a crime.
- Staff will positively intervene in <u>all</u> Domestic Abuse incidents.
- The level of intervention will be intelligence based.
- When considering the level of intervention the arrest of the alleged perpetrator must always be considered. Officers must be able to justify any decision not to arrest, and this must be authorised by their supervisor.
- The level of intervention will depend on the perceived risk of harm to victims or potential victims. Factors to be considered are:-
    - Alleged perpetrators and victims previous history (reported and unreported).
    - Risk indicators.
    - Officer's professional judgement.
- Whenever a member of staff considers that a victim may be at risk of harm, particularly where they could become the victim of a serious crime, they must refer the matter to a supervisor as soon as possible who will then consider what immediate action needs to be taken to reduce the risk.

As discussed elsewhere in this review, not all incidents have been recorded and treated as Domestic Abuse incidents.

Uniformed Patrol officers have intervened in all the cases that they were sent to although not everything has been recorded accurately. It is noted that the accuracy of police recording is important for the opportunity and effectiveness of partner interventions.

Checks have been completed by Control Room staff for incidents before or during Uniformed Patrol officer attendance.

If information is not recorded then it would not likely be shared with other agencies.

Although this review can see why the majority of incidents on their own were classed as standard risk, the sheer number of incidents would suggest that Thames Valley Police could not manage the situation and that intervention was required by other agencies. There is now an established mechanism to identify the top ten repeat Domestic Abuse victims on each Local Policing Area. Work is being developed with partners to create Multi-Agency Meetings for these cases, which may not reach the high risk threshold for MARAC meetings. This process would have highlighted the multiple standard risk incidents so the case could be brought to the attention of other agencies. This is not to say that the individual risk assessments were incorrect and the review would not expect Uniformed Patrol Officers to review previous incidents but would expect Risk Assessors in the Referral Centres to do so. This could have been done if a full review had been undertaken more often. Thames Valley Police did not carry out all of the required reviews but did conduct some reviews and it is not known what difference conducting all of the reviews would have made.

The Domestic Abuse Policy (updated **April 2013**) states that the role of the Police Officer is to investigate Domestic Abuse incidents as a crime. This means that enquiries should be made, for example house to house and CCTV, to try and ascertain what happened. Domestic Abuse on its own is not a crime but incidents should be thoroughly investigated as if they were crimes.

On not all occasions has this been thoroughly completed. Sometimes house to house enquiries have not been completed or parties documented.

The response of the relevant agencies to any referrals relating to or concerning Domestic Abuse or other significant harm from September 2012 and any relevant earlier records. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons for these. In particular, the following areas will be explored:

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

On the majority of occasions, Uniformed Patrol officers have attempted to complete a Domestic Abuse Risk Assessment Form upon initial attendance. They have also intervened in a variety of ways including separating the parties, arrest or by simply talking to those involved. When Uniformed Patrol officers attended Adult Protection incidents they have called ambulances, created reports and sought consent for referrals to be made to other agencies. They would generally create a CEDAR or NICHE report for Adult Protection and this would be viewed by the Vulnerable Adult Co-ordinator in the PVP Referral Centre. Referrals would then be made to Social Services or other agencies, such as the person's GP. It has been discussed in this review the fact that referrals were not made for some of the occasions where Andrew

or Barbara were taken to hospital. This was under the assumption that referrals would be made by hospital staff. This is incorrect to make this assumption and Police should make these referrals.

There is nothing recorded to show that information about Andrew and Barbara was passed to Thames Valley Police by other agencies.

b) <u>Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective</u>

Officers attended most incidents very quickly, even whilst covering a large geographical area. They completed actions based on what they were presented with at the time. This was often a verbal argument with Andrew who may have taken drugs and Barbara who was, more often than not, drunk. The action most taken was to separate the parties and this is reasonable for the immediate circumstances but did not solve the problem.

In relation to Adult Protection incidents the ambulances were always called by either Control Room staff or officers at the first sign of harm to Andrew or Barbara. Often Thames Valley Police were called by the Paramedics asking for officers to attend as they feared for their own safety as Barbara was known to be aggressive.

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

As Andrew and Barbara were always classified as being at standard risk of Domestic Abuse during incidents they were not directly referred to other agencies such as Women's Aid or Mankind[16]. The parties were however given contact details for these and for other agencies, on many occasions by Uniformed Patrol officers. Referrals were made to other agencies such as the GP or Social Services in order to find support from the correct services. The main issues with Andrew were in relation to his drug use and inability to cope well on his own. The main issue with Barbara was her alcohol use. They both made attempts on their lives and were taken to hospital a number of times for assessment and treatment. They were both repeatedly referred to other agencies for help to be offered.

Thames Valley Police are now developing Local Policing Area Multi-Agency Meetings for the top 10 Domestic Abuse victims. In this case we do not know if appropriate services were offered but this new process would facilitate that.

[16] Mankind offer support for male victims of Domestic Abuse.

d) The quality of any risk assessments undertaken and if relevant, whether appropriate information sharing and handover occurred

Most of the risk assessments completed by Uniformed Patrol officers and PVP Referral Centre staff were appropriate. The issue is not with each risk assessment completed by the individual officers but rather what Thames Valley Police as an organisation do with repeat standard risk Domestic Abuse cases. Not enough reviews were completed as with the Risk Assessor Summaries only Domestic Abuse incidents involving children are reviewed. This was complied with and referrals made to Children's Social Care on every occasion where children were identified as having been present in the CEDAR/NICHE report.

Information was shared with other agencies about Andrew and Barbara. The Review does not know exactly what information was passed but these agencies did know them. Risk Assessments should have been reviewed by the Risk Assessors in the MASH or PVP Referral Centre.

There are examples where not all of the information is recorded in the CEDAR/NICHE report which would mean that this was not passed to agencies. For example with Incident 152, Barbara initially disclosed on the telephone that Andrew had put his hands around her throat but later denied this. Professional curiosity should require the officer to find out why she had said this in the first place, further investigate it and record it. This information is important for the risk assessment and could have been useful to other agencies, such as Women's Aid, who may undertake their own risk assessment.

Whether thresholds for intervention were appropriately assessed and applied correctly, in this case

There was a requirement on many occasions for Thames Valley Police to intervene in the lives of Andrew and Barbara. This was because either one of them had called Police or a third party had. The intervention ranged from advice over the telephone by the call taker up to officers attending and arresting one of the parties or accompanying them to hospital.

An issue has been identified in relation to the large number of standard risk Domestic Abuse incidents which were not escalated to other agencies. Only medium and high risk Domestic Abuse incidents are subject to risk management by the DAIU officers or staff. Information sharing takes place where it is appropriate and proportionate. Standard risk Domestic Abuse incidents are now subject to risk management with the Domestic Abuse Risk Assessment Form section where Uniformed Patrol officers complete a Victim Safety Plan with all victims.

There is now an established mechanism to identify the top ten repeat Domestic Abuse victims on each Local Policing Area. Work is being developed with partners to create Multi-Agency Meetings for these cases, which may not reach the high risk threshold for MARAC meetings. This process would have highlighted the multiple standard risk incidents so the case could be brought to the attention of other agencies.

In some areas, including South Oxfordshire and Vale of the White Horse LPA, there are now Local Policing Area Multi-Agency Meetings to manage those top 10 Domestic Abuse repeat victims. The Detective Inspector from the PVP Strategy Unit has informed the Review that there are different procedures in each Local Policing Area for these meetings. Work is under development to provide clear guidance on common outcomes to be sought across all LPAs and good practice to achieve these.

Recommendation 5 - All Local Policing Areas should introduce an initiative to tackle repeat Domestic Abuse victimisation on a multiagency basis.

Whether any identified issues were escalated to senior management or other organisations and professionals, and if appropriate, carried out in a timely manner

The issues with Andrew and Barbara in relation to their substance abuse and apparent Mental Health issues were escalated to specialist staff in the PVP Referral Centre. They would refer to Social Services via referrals. These issues were not escalated to senior managers within Thames Valley Police and there is no reason that they should have been.

Given the risk assessments the incidents would not have been raised to senior officers or specialist departments at the time. This is because standard risk Domestic Abuse is not routinely brought to the attention of the DAIU. Today, Andrew and Barbara would be highlighted by the established mechanism within performance to identify top ten repeat cases, leading to multiagency response through the developing multi-agency meetings.

Whether the impact of any organisational change over the period covered by the review had been communicated well enough between partnership agencies and whether that impacted in any way on agencies' ability to respond effectively.

The way that Thames Valley Police approach Protecting Vulnerable People has changed greatly since **2003**. Prior to **October 2011** in each of the Domestic Abuse Investigation Units across the force was a Detective Sergeant for the area who would assess incoming cases. The DAIU staff would review Domestic Abuse Risk

Assessment Forms to ensure that the risk level was correct. They would also ensure that all Domestic Incidents had a risk assessment completed and if not would undertake an interim risk assessment until this could be properly done.

In **October 2011** PVP Referral Centres were brought in. This centralised the work for the 3 counties or 'Hubs'. Other agencies were informed that contact should be made through the PVP Referral Centre for requests unless it related to a live investigation where an officer was allocated to the case.

As of **September 2014** the Multi-Agency Safeguarding Hub (MASH) was introduced in Milton Keynes and soon followed in Oxfordshire and Buckinghamshire. MASHs will soon also be established in Berkshire. Each MASH replaces the existing PVP Referral Centres and in Oxfordshire this incorporates Police, Social Care, Probation, Education, Housing and Health. The aim of the MASH is to improve the way that agencies work together to protect vulnerable children and adults from harm, neglect and abuse.

The MASH co-locates safeguarding agencies, leads to better information sharing and decision making, identifies risk at an earlier stage, gives opportunity for early intervention and ensures a co-ordinated and timely response.

MASHs are already in place in many areas across the country. The process for making a referral from operational officers is largely the same.

CEDAR was replaced by NICHE in **May 2014** for recording crimes and crime related incidents. The process for officers reporting crime remains the same and the information is still recorded and shared with other agencies.

Whether any training or awareness raising requirements can be identified to ensure a greater knowledge and understanding of Domestic Abuse and safeguarding processes and/or services in the future

There are several learning points identified during the compilation of this review. Firstly in relation to the referring of Vulnerable Adults to other agencies when they attend hospital. This should be completed by Thames Valley Police staff who should not rely on Hospital staff doing this. A recommendation has already been made in relation to this.

Also it has been identified that not all officers consider incidents between so-called 'common-law' in-laws to be domestic incidents. This needs to be communicated across the force so opportunities for risk assessment and management are not missed. A recommendation has been made in relation to this.

It is also apparent that on some occasions not all information disclosed by the victim is used in the Domestic Abuse Risk Assessment Form. All information supplied by the victim, be it during the initial call or conversation or through a formal process of completing the form needs to be recorded and used for the risk assessment.

The review will consider any relevant Protected Characteristics as outlined by the Equalities Act 2010

Protected Characteristics have been considered during the writing of the review. It has been considered that Andrew may have had a learning difficulty or disability and officers were aware that he could not read or write. Addiction to alcohol does not count as a disability[17]. This has not affected the quality of the services given to either party.

Marriage is a Protected Characteristic and therefore by not classing incidents with so called 'common-law' families as Domestic Abuse incidents, they are not afforded the same level of risk assessment and management.

Despite unmarried so called "in-law" families not being clearly included within the national guidance on domestic abuse, TVP will amend its guidance explicitly to include unmarried "in-law" families and communicate this to staff.

Learning for Thames Valley Police

It is apparent that so-called 'common-law' families are not treated the same as married relations by some officers and consequently not treated as Domestic Abuse incidents. Outlining this for officers would enable them to correctly identify a Domestic Abuse incident and implement the appropriate risk management. This will either be addressed by the College of Policing via APP or Thames valley Police will write this into Force policy. A recommendation has been made in relation to this.

It is apparent in this review that there are incidents where information is volunteered by the parties that would facilitate the (at least) part completion of a Domestic Abuse Risk Assessment Form. When actually attempting to complete the form with the victim and then faced with a refusal, the forms are often marked as 'refused'. Training and Guidance requires officers to complete a Domestic Abuse Risk Assessment Form in all cases as far is practical. When viewing the URN and CEDAR/NICHE report, it is apparent that they have in fact already answered some of the questions. This should be reflected on the form to aid risk assessment.

An issue has been highlighted where an officer did not complete a Domestic Abuse Risk Assessment Form at an incident as one had been completed the previous

[17] From https://www.gov.uk/definition-of-disability-under-equality-act-2010

week. This is not acceptable and should be done at every new domestic incident. Even within the same day circumstances can change and often do which is why a further incident occurs. This means that information was not correctly recorded and therefore important information can be missed. It has also been highlighted that intelligence reports have been used to record information relating to safeguarding which should not happen either. As discussed earlier, a recommendation has been made about this.

The learning from this review supports new initiatives with partner agencies such as Local Policing Area Multi-Agency Meetings for the top 10 Domestic Abuse victims. Andrew and Barbara would have certainly fallen into this group and been subject to monthly discussions at the meetings. This may not have prevented the Andrew's death but would have ensured a joint approach.

Recommendations

1. Thames Valley Police officers and staff to be made aware that common-law in-laws are family members in relation to Domestic Abuse incidents. This should be addressed by including this guidance in the Domestic Abuse Standard Operating Procedure and on the Domestic Abuse Risk Assessment Form (DOM5).
2. To remind supervisors to ensure that officers and staff use all available information for the Domestic Abuse Risk Assessment and that risk levels have been correctly set.
3. To share this case study with DAIU training courses and for PVP Referral Centre and MASH Detective Inspectors to discuss with Risk Assessors.
4. Officers to be made aware that intelligence reports should not be used for recording Safeguarding issues. This should be recorded via NICHE reports for either Adult Protection or Child Protection.
5. All Local Policing Areas should introduce an initiative to tackle repeat Domestic Abuse victimisation on a multiagency basis.

Conclusions of TVP IMR

It is important to try and identify who is the victim and who is the perpetrator with Domestic Abuse cases. It was easy to identify the victim at the point Barbara stabbed Andrew and killed him. Prior to this it is more difficult. Barbara had been a

victim of Domestic Abuse in a previous long term relationship. Many officers have been spoken to in order to write this review and they have all struggled to definitively identify who was the victim and who was the offender. They have said that Andrew was a drug user with possible learning difficulties who was incapable of making many decisions for himself. Barbara is an alcoholic whose personality would be aggressive when she was intoxicated. This case does appear to be a case of a vulnerable couple engaged in a relationship. Seemingly neither of them had knowledge of how healthy relationships should be and how to behave.

For some victims of Domestic Abuse, calling the Police is a frightening thing to do and something which, for various reasons, they shy away from. We do, thankfully, live in an age where many people are not afraid to call Police for help. Andrew and Barbara certainly fitted into this category which is evident from the large number of contacts made by them. As shown in **Incident 167**, Barbara asked Police officers for a lift so that she did not have to 'commit a crime' to be taken where she wanted to go. This was one of many reasons that she would call Police.

Thames Valley Police could have better identified the vulnerability of Andrew and recorded the facts more accurately. Although Thames Valley Police did not make referrals to partner agencies on every occasion, other agencies were aware of Andrew and Barbara. It is not possible to say whether the outcome would have been different.

DHR Conclusions about Thames Valley IMR and involvement

A reoccurring theme in the IMR relating to domestic abuse incidents involving Andrew and Barbara was their declining to answer the questions on the Domestic Abuse Risk Assessment Form. A large number of incidents resulted in no Domestic Abuse Risk Assessment Form being completed when it might have expected to have been.

Neither Andrew nor Barbara was referred to or discussed at MARAC as they were not regarded as high risk individuals. The IMR states that on each Local Policing Area there is now a Multi-Agency Meeting for the top 10 Domestic Abuse victims that are not high risk. This is a Multi-Agency meeting which examines ways to manage the risk to victims of domestic abuse who do not come under the category of high risk and are therefore not discussed at MARAC. The IMR states that at the first of these meetings in the Abingdon area Andrew and Barbara were given as an example to other agencies of why this meeting was so important. In Oxfordshire South and Vale these meetings aim to be held immediately after the monthly MARAC meeting which helps to engender the attendance of the correct partner agencies. Each Local Police Authority Commander is responsible and accountable for the work their teams are doing to deal with repeat victims and offenders.

The IMR shows that there are some Child Protection incidents that were not correctly recorded. There are some which were recorded as domestic abuse incidents which should have been Child Protection due to one of Barbara's sons being under 16 years old. There is also an incident where she told Police she might hurt one of her children and this was not recorded or passed to Social Services. This highlights a gap in recording and information sharing.

There are 16 Adult Protection incidents in the IMR where either Andrew or Barbara was taken to hospital after having taken overdoses. On nine of these occasions Adult Protection CEDAR or NICHE reports were created, however referrals to other agencies were only made on two of these occasions. This was under the assumption that referrals would be made by hospital staff. As the IMR states, it is incorrect to make such an assumption and Police should make these referrals. This is particularly important as TVP may have information that other agencies do not have. The IMR helpfully states that police should make the referral regardless of the hospital visit unless it is clear that the person is already being cared for by the appropriate agencies and these agencies already have the information that TVP has.

There was extensive Police contact with Barbara whilst she was drunk and several contacts with Andrew whilst he appeared to be under the influence or drugs. The IMR concludes that Barbara's drinking was fundamentally linked to the violence between her and Andrew, both physical and verbal.

The IMR shows that almost every contact TVP officers had with Barbara was when she had been drinking. It is notable that referrals were made by TVP to Social Services and to the GP for Andrew and Barbara to try and arrange help for them.

The IMR concludes that the majority of incidents between Andrew and Barbara were appropriately classed as standard risk, the large number of incidents would suggest that Thames Valley Police could not manage the situation and that intervention was required by other agencies. Whether it merited a higher risk classification due to volume of incidents may be debatable, however there is no evidence to suggest that officers or staff minimised the issues.

The TVP IMR is a thorough and detailed document that addresses a range of issues arising from the incident and the contact between the police and Andrew and Barbara over a number of years. This Overview Report has focused on the key issues and notes that the learning from the IMR is supporting new initiatives with partner agencies. These include the Local Policing Area Multi-Agency Meetings for the top 10 Domestic Abuse victims.

It is clear that Andrew and Barbara would have come within the remit of this group and as such would have been subject to monthly discussions at the meetings. It

seems unlikely that this would have prevented Andrew's death but it would have ensured a more joined up approach across agencies in understanding and attempting to address the issues of those people who are in regular contact with the police in relation to domestic abuse issues but do not appear to be of high risk.

2.2.2 Oxfordshire Clinical Commissioning Group (OCCG)

The General Practitioner (GP) service is a universal service that provides primary medical care to families 24 hours a day both at the local practice where a family is registered and through the Out of Hours service. It provides holistic medical care (to include physical and psychological health care) for families from birth to death.[18]

It is important to remember that GPs are not directly employed by the NHS. Rather, they are independent contractors commissioned by NHS England.

Both Andrew and Barbara were well-known to the GP practice in Faringdon. Andrew was registered at White Horse Medical Practice since birth until he died. Barbara was registered at the same practice for the greater part of the period 2003 to August 2014. Barbara re-registered at the Malthouse surgery in Abingdon in August 2014 but was never consulted there.

The IMR briefly restates the overarching history of Barbara, in summary this shows that she drank heavily as a young woman. She married and had her first child at the age of 15 (the first of 4). She lived with her husband and family in a house two doors away from Andrew, who was seven years younger than her. Barbara separated from her husband in 2009.

The IMR briefly restates the overarching history of Andrew who was unmarried and lived for much of his life at his family home in Faringdon. He is thought to have had mild learning difficulties. It is not clear from the notes how long Andrew and Barbara were in a relationship and were living together, as neither are referred to by name in each other's records.

[18] Sheffield DHR Overview Report, Cantrill, Prof. Pat December 2011

GP Contact with Andrew

The IMR finds no history of domestic violence in Andrew's GP records. In a psychiatric assessment on 17th October 2013, he disclosed that he had been arrested for assault 'many years previously'. He also described an assault by his partner that day. There is no reference to this or any episodes of domestic violence in his GP notes. There are references to heavy alcohol consumption in some A&E communications, though the IMR finds that these are not coded within the GP records.

Andrew had no presentations with drug misuse problems until 2013 (see below), although he was recorded in one letter from the Emergency Department in 2004 attendance as having been a previously heavy drinker of one bottle of spirits a day.

The IMR finds that Andrew attended the Emergency Departments of Great Western Hospital and John Radcliffe Hospital on several occasions, and had several formal psychiatric assessments there. These were lengthy and full summaries were available in the general practice notes, and on every occasion he was signposted to relevant drug misuse services. It is not clear from the GP records that he followed this up.

Andrew attended the GP practice on 7th October 2013 and reported that he had phoned *Frank* (a drug misuse helpline) and requested to be referred for enrolment on a Subutex programme (*medication to treat heroin misuse*). He told his GP Dr. C. that he was going away to stay with an aunt for two months. Dr. C. explained that he would need to be referred to drug misuse services, and that this would not possible if he was out of the area.

Andrew was advised to register temporarily with his aunt's GP, (who would presumably be able to refer to local drug misuse services) and advised if he wanted to pursue a drug misuse referral in Faringdon, to return for an appointment when he returned from his aunt's. He did not pursue this (and was back in the Oxfordshire area in one month). He was encouraged by psychiatric services to self-refer to Talking Space (psychological service). He had attended the GP surgery five times between August and October 2013. These attendances were with anxiety, discussion of self-harm and drug misuse and requests for sickness certification. Following this he did not attend the GP practice any further although frequent reports were received from the Emergency Departments and Out of Hours service, detailing issues with recurrent overdoses and drug misuse. It was clear from these that Andrew had been repeatedly signposted to appropriate services.
From the information available, the IMR concludes that, the GPs were supportive and directed Andrew to various services, and prescribed antidepressant medication to help with anxiety.

GP contact with Barbara

Barbara had various interventions over many years to help with her alcohol dependence but none were very successful. The GP records show that she saw a consultant addictions psychiatrist, for four sessions in 2004 and was reported to have cut down on her drinking to only once a week following this.

In 2006 she was reported to have had a residential detoxification programme at Broadway Lodge near Weston-super-Mare for six weeks. Later, in 2009, Barbara was referred to the practice counsellor in Faringdon but the waiting list was full and she was not re-referred.

In 2011 she was referred to the Community Mental Health Team for help with alcohol and offered four sessions and advised to engage with the drugs and alcohol team. She attended only one session and although self-referred once to SMART (*support for alcohol and drug misuse*) she did not engage more with them.

She received help from the Shaw Trust in 2010 (a voluntary organisation helping disabled/disadvantaged people with housing and work) and reported to the GP that she found this helpful but stated she did want to engage with other agencies. The Community Mental Health Team recommended referral to the Elmore team in 2011 (who provide flexible support and advice for people with complex problems in Oxfordshire). She engaged with them and they found her some temporary housing. She was still in contact with Elmore in April 2013.

Barbara consulted GPs fairly frequently between September 2012 and October 2014, but the IMR finds that this consulting behaviour was chaotic. This pattern of chaotic engagement had been the case throughout the previous decade as well.

GPs tried to engage with Barbara and encouraged her to attend regularly and to take her medication regularly, but she often did not attend for follow up appointments (as evidenced by the fact that her prescriptions were prescribed short term on an acute basis, but often ran out). She often rang the practice for sickness certificates and repeat prescriptions at short notice, attended late (recorded on two occasions), attended after having been drinking (on two occasions), and rarely came back to see the same doctor despite encouragement to do so.

The IMR describes how people with personality disorders, as Barbara had been diagnosed, are often prescribed antidepressants and often have a diagnosis of depression recorded, but antidepressants are not always helpful in this situation particularly combined with alcohol and taken on an irregular basis.

In some cases, people living with these issues can frequently overdose impulsively on medication and combine it with alcohol, this was the case with Barbara. The IMR finds that this can make it difficult to manage prescribing in primary care. GPs tried to address this with her but she did not engage with this nor did she engage with other measures which might have helped, e.g. support with alcohol reduction or Complex Needs services (as signposted by psychiatric services).

GPs contacted other agencies to get help for Barbara, including letters to Housing, the Benefits department, and a phone call to the Community Mental Health team.

Analysis of involvement and lessons learned

Andrew and Barbara attended White Horse Medical Centre separately and were treated for their anxiety symptoms with antidepressants and provided with medical certification. The IMR shows that there is good evidence that the GPs tried hard to engage them and offer help with substance misuse and housing issues.

The IMR states that it is not clear what other intervention could have been offered and that even if there were, their history of non-engagement hampered attempts to provide support and it is reasonable to assume this would have been the case whatever options had been offered.

Both Andrew and Barbara had detailed psychiatric assessments that were appropriately communicated to the GP. These confirmed that all appropriate signposting to relevant services had occurred.

The IMR found that there was no policy for coding of Vulnerable Adults at White Horse Medical Centre, and that this applies to many GP practices. Andrew and Barbara could be described as having been vulnerable, certainly if applying the definition of vulnerable set out in the '*No Secrets'* guidance. Both had a range of factors that made them vulnerable, and coding these factors is good practice, for example drug misuse, personality disorder, and learning difficulties, as well as coding 'vulnerable adults'.

Although the records are comprehensive, the lack of coding of Andrew and Barbara as vulnerable meant that this information would have been harder for those professionals not familiar with them to establish this. However their vulnerability was well known to the doctors treating so it seems unlikely that coding would have influenced the outcome.

The IMR states that Andrew was thought to have had some mild learning difficulties although the nature of these is not recorded. The IMR suggests that it is possible that his learning difficulties made it problematic for him to recognise his own

vulnerabilities and to access services to which he was signposted. Although this is possible there is no way of determining this.

The IMR finds that the change in Andrew's attendance pattern after April 2013, to repeated, chaotic health service seeking behaviour including drug misuse and repeated overdose, could have been noted as a safeguarding issue in a vulnerable adult. This might have prompted more professional curiosity and more vigorous attempts to safeguard him by the GPs. However, the GPs seeing Andrew had known him for a number of years and believed this would not have changed the outcome. That may well be the case, but the failure to enquire more fully or to consider a safeguarding alert in response to this changing pattern of presentation constitutes a missed opportunity to gather more information, to alert other agencies and to plan in a more co-ordinated way, how services could address his vulnerability and behaviour.

Barbara had reported being agoraphobic and unable to leave the house without either drinking alcohol or taking diazepam. This made attendances at the surgery difficult and may have affected engagement with counselling services. GPs did undertake consultations on the phone, and provided medication and sickness certificates following phone consultations and they followed good practice by trying to encourage regular engagement with a regular doctor, and attendance at the surgery. Although both Andrew and Barbara were registered with White Horse Practice until August 2014, the practice did not know that they were in a relationship or that they were living together.

Had this information been recorded, available or shared within the practice it would have provided those involved with a broader and more accurate view of the issues they were both experiencing, which in turn may have informed care planning and response.

Barbara was known to have been a perpetrator of domestic violence in the past, but this was not coded on her notes, despite the serious nature of her risky behaviour when drunk (two episodes of arson). There is no enquiry about domestic violence in either set of GP notes. The IMR found that the practice did not have a domestic violence policy covering vulnerable adults (like many general practices). This was an omission that while perhaps not directly impactful in relation to the incident, is a gap in the policy suite that should now be reasonably expected of a GP practice.

It does not appear that the GP practice had a domestic violence policy.

2.2.3 Avon and Wiltshire Mental Health Partnership NHS Trust

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) is an NHS secondary care provider of mental health services across a catchment area covering Bath and North East Somerset (B&NES), Bristol, North Somerset, South Gloucestershire, Swindon and Wiltshire.

AWP provides services for people with mental health needs, with needs relating to drug or alcohol dependency and mental health services for people with learning disabilities. The services AWP provides in Swindon and Wiltshire are available for those people who live in Faringdon area, given its proximity to Swindon. In addition AWP provides a liaison psychiatry service at the Great Western Hospital in Swindon.

Contact with Andrew

Andrew had four contacts with the AWP liaison psychiatry service at the Great Western Hospital (GWH) in Swindon between 3rd August 2013 and 10th November 2013. On 3rd August, he attended the emergency department following an impulsive overdose of 10 co-codamol tablets. During the assessment Andrew stated that he was born in Oxford and brought up in Faringdon by his mother and father; and that he was one of 9 siblings.

Andrew described abuse from his father and heroin use for three years when he was younger, but stated he had been clean for many years now. He did admit to smoking cannabis daily, and to occasional use of alcohol.

Andrew reported that his recent difficulties included the fact that his grandmother had recently been diagnosed with a terminal illness and that the job centre had suspended his benefits as he had not attended recent appointments. He stated that he wanted to move in with his girlfriend (Barbara), but couldn't do this until he received his benefits. Andrew said that he had been arguing a lot with Barbara.

On the evening of the overdose Andrew had been out for the evening with Barbara who had been drinking heavily and became unwell when at home. During this time she had taken off her engagement ring, which Andrew had misinterpreted to suggest she wanted to end their relationship, so he took the overdose in order to give himself a buzz.

Andrew denied taking the tablets to end his life. He had reported his actions to Barbara who immediately contacted an ambulance. During the assessment Andrew reported previous self-harm in 2005 and 2013, but had never been seen by mental health services. The assessment found no evidence of self-neglect and he denied any suicidal intent or future plans of self-harm. He denied any recent changes to his

mood, and described his mother and Barbara as protective factors against further self-harm.

The assessment summary concluded that Andrew had taken an impulsive overdose, to get a buzz; he denied taking it with the intent of ending his life or any further thoughts or plans of self-harm. Andrew agreed to contact his GP if he felt his mood worsen and he was given contact phone number for the Samaritans.

Three days later, on 6th August 2013, Andrew was seen and assessed again at GWH, by the same practitioner from the Mental Health Liaison team he had seen on the 3rd August, following an overdose of 25 co-codamol tablets.

Andrew stated that following his previous overdose three days earlier he had contacted his family to see if they could lend him any money, unfortunately they could not. He had contacted the job centre on the 5th August, who told him he needed to sign on for 7th August, in order for his benefits to re-commence, he reportedly felt very angry and upset about this.

Andrew reported taking the overdose impulsively in front of Barbara's adult stepson and then left the house. The stepson informed Barbara who contacted the Police, who found him and took him to hospital.

During the mental state examination, there was no evidence of any abnormal thought disorder. Andrew denied taking the tablets to end his life, stating he took them as he felt frustrated. He denied any further thoughts of self-harm and was future focused regarding attending the job centre the following day to sign on.

A GP appointment was made for him for 7th August 2013, to discuss the possibility of counselling. He was again advised to contact his GP or the out of hour's service if he felt his mood deteriorating again.

Later that month, on the 30th August 2013, Andrew was assessed by a different practitioner from the Mental Health Liaison Service at GWH, following another overdose of x 30 co-codamol tablets and five Fluoxetine tablets. It was also reported that he had taken heroin and crack cocaine, but he denied this. Barbara was present during the assessment and she presented as intoxicated.

Andrew admitted during the assessment that he was using cannabis on a daily basis. He further stated he had taken the overdose following the recent death of his grandmother, he also stated that he had split up with Barbara although she had accompanied him to GWH in the ambulance. Barbara reported that she needed to '*get her head together*'.

Again Andrew denied wanting to kill himself, but stated that he needed help with problems, which are related to sexual abuse he said he suffered as a young boy. He also admitted that he took the overdose to get attention from Barbara. He described concerns regarding a pending court appearance on the 9th September 2013, related to an incident of assault. He denied having any current suicidal ideas or intent, and requested counselling to help with his abuse issues. A referral was made to his GP for counselling in relation to his sexual abuse issues and he agreed to continue with his prescribed medication. He was given some helpline contact numbers, as he did not wish to speak to the Samaritans.

Three days later, on the 2nd September 2013, Andrew was seen and assessed by another practitioner form the Mental Health Liaison Service at GWH, following an overdose of 24 paracetamol. He described ongoing relationship problems and felt that Barbara was sending him mixed messages. He described feeling constantly stressed due to his relationship with her, and was also worried about his court appearance on the 9th September. He also stated that he had his grandmother's funeral to attend. He described an argument with his mother, during which he took the tablets impulsively, he then went to Barbara's house and had a heated argument with her, during which time his mother had realised he had taken another overdose and contacted the Police, who arranged transport to GWH.

Once again Andrew denied any current suicidal ideation, he felt that he needed help for his problems in relation to the sexual abuse he suffered and again reiterated that he takes overdoses to get attention from Barbara. During the mental state examination he was reported as being friendly and cooperative, with no evidence of self-neglect. He described feeling stressed and angry regarding his relationship difficulties but denied low mood, and according to the IMR he was focused on the future; agreeing to attend counselling sessions through his GP and denied any thoughts or plans for self-harm/suicide.

The assessing practitioner did consider the recent overdoses, which had all been small impulsive overdoses following which he had sought help, however the likelihood of further overdoses was assessed as high due to the unresolved issues from his past and the ongoing relationship difficulties with Barbara.

Another referral was made to the GP regarding counselling in relation to the sexual abuse issues.

During all assessments of Andrew the risk of harm to self and towards others were deemed as low. The IMR records that on 10th November 2013, he presented at A&E at GWH following an overdose but that he was discharged without being seen by the Mental Health Liaison Service.

Contact with Barbara

Barbara had four contacts with the AWP liaison psychiatry service at the Great Western Hospital (GWH) in Swindon between 20th September 2013 and 6th March 2014. On the 20th September 2013 she was seen and assessed at GWH by the Mental Health Liaison Service following an overdose of 14 Naproxen tablets and 10 pints of lager. She told the liaison practitioner that she received support from mental health services in Witney, and that she took overdoses regularly and self-harmed, cutting, although, she had not done this for six months.

Barbara said that she lived with her 19 year old son and his girlfriend and that she had another four children, the youngest of whom lived with his Dad. She said that her parents are separated. Barbara stated she did not have a good childhood, and was not willing to disclose any further information regarding this. She described a long history of alcohol abuse, and had previously been in rehab in 2004. She admitted to drinking 20 units a day, and was suffering withdrawal symptoms, for which she received medication.

Barbara stated that her ex-partner (Andrew) keeps harassing her and going to her house, which she said she had informed the Police about. She said he had agoraphobia, and stated that she could only go out if accompanied or intoxicated. She described financial problems, such as arrears with her mortgage, and council tax, but states she is getting some support with this.

Following an argument with Andrew in the street, Barbara said she started drinking. She recalled going to Andrew's house and having another argument, and then returning home, where she continued to shout out loud. The Police had arrived and were going to arrest her for breach of the peace, she stated she had taken the tablets prior to their arrival and informed the officers in attendance.

Barbara was assessed as looking disheveled and suffering from alcohol withdrawal. She stated that she had taken the overdose impulsively and did not intend to end her life. She denied any current thoughts of self-harm. She agreed to seek help and engage with the local alcohol services, and identified her children as protective factors. The assessment found no evidence of abnormal thought processes, and Barbara demonstrated good insight, identifying alcohol as a major problem for her. She was referred to the Alcohol Liaison Team at GWH. Contact was made with Witney CMHT, who agreed to follow up after discharge from GWH.

On the 11th December 2013 Barbara was admitted to the emergency department at GWH, following self-harm, cuts, to her lower left arm with a glass, whilst intoxicated with alcohol. Andrew was present. She told the assessors that on the 10th December 2013 her son (unknown which one) had stolen two pouches of tobacco from her. She said that he was then physically violent towards her kicking her in the face and

then left. She then stated that she contacted the Police, who did attend but didn't do anything.

Barbara had asked the Police officers to leave and she started to drink wine. She described smashing a glass and cutting her arm out of frustration, the Police were called and she was taken to GWH via ambulance. Barbara denied any suicidal intent or plan during the assessment. She described ongoing financial issues with her ex-husband and youngest son. She was anxious regarding a court appearance on the 12th December 2013, where she has been accused of assaulting her son. (The IMR does not record which son) According to the assessment, Barbara demonstrated good insight into her situation. She did also confirm that she had not attended her recent appointments with her CMHT. It was agreed that Witney CMHT would contact Barbara to arrange follow up.
She was sent home with Andrew.

On the 7th January 2014 Barbara was seen and assessed by the Mental Health Liaison Service following an overdose of 12 Sertraline tablets (100mgs) and a bottle of Lambrini wine.

Barbara reported that she had large debts and bills which included council tax, housing benefit and water rates. She was due in court for the assault on her son, which had been postponed until the 19th January 2014, and was also expecting to have to attend court regarding the repossession of her house. She stated that she had depression but that she was not compliant with her treatment. Barbara also stated that she felt helpless due to her problems, and was drinking, she was unsure why she took the overdose, Andrew was with her and she requested he did not call an ambulance, but he did. On arrival she told the ambulance that she had not taken an overdose, after the crew had left Barbara then started to be very sick and so contacted the ambulance again who took her to GWH

During the assessment Barbara denied wanting to kill herself, but stated that she wanted some respite from her problems. She was not keen to stay and see the Alcohol Liaison Service at GWH. It was agreed that she would return home with Andrew. She requested an appointment with Witney Community mental Health Team (CMHT), and a message was left for her keyworker. She also stated that she had appointment with the SMART Alcohol Service, which she said she would attend.

On the 6th March 2014 Barbara was seen and assessed by the Mental Health Liaison Service following an overdose of 16 Naproxen tablets and an unknown quantity of paracetamol with a bottle of Lambrini wine. She said she had ongoing financial problems, being in arrears with her mortgage, council tax and utility bills. She stated that she had recently missed a medical appointment for review of her benefits and a home assessment that had been arranged was then cancelled. As a result her benefits had been stopped and she had no income.

Barbara stated that she had no money to heat her house and was currently living in her bedroom. She said that her house was due to be repossessed in the coming weeks; she was unable to sort out her finances and that, as before, her agoraphobia prevented her from attending appointments. She did state that she had an appointment to see a support worker from the Elmore team who would assist her with her money worries.

Barbara said that she had taken the overdose with the clear intention of being admitted to GWH and being referred to the Mental Health Liaison Service. She believed that the team would sort out her benefits and facilitate her getting some money. She denied any suicidal intent although she did acknowledge that she felt frustrated at her current financial situation. During the mental state examination Barbara was animated and vocal, reportedly becoming verbally abusive at times when she was advised the mental health liaison service would not sort out her benefits.

She denied any suicidal intent, with no thoughts to harm self or others. She was referred to Alcohol Liaison Team at GWH. It was agreed that GWH would her contact her support worker and inform him of admission to GWH and she was given information and contact details for Citizen's Advice Bureau.

Following this assessment Barbara was seen by the Alcohol Liaison team, who gave her additional information regarding a charity debt service. The Alcohol Liaison Service did liaise with social services regarding safeguarding concerns for her 15 year old son, as she had regular contact with him and it appeared to them that there were concerns regarding the amount of alcohol he was consuming at the time.

Analysis of involvement and lessons learned

It is clear from the IMR that both Andrew and Barbara attended the A & E department at GWH numerous times and always following an overdose, using either prescription medication alone, or mixed with alcohol.

They were both assessed appropriately and thoroughly by the Mental Health Liaison service provided by AWP at the GWH assessments were conducted to a good standard and agreed action was appropriate. Andrew in particular was seen on more than one occasion by the same practitioner, which provided some consistency in the knowledge of his history.

Andrew and Barbara were seen and assessed by the same practitioner within the mental health liaison service in September 2013, both presenting following an overdose and referring to relationship difficulties as a stressor, however the practitioner did not establish that they were in a relationship together. This

highlights the need for professionals to ask the right questions of individuals when they present to services in order that they can gather all relevant information that might inform their assessment.

The mental health assessment of both partners included consideration of their risk, particularly in the context of their repeated presentations. Both Andrew and Barbara were assessed as being of low risk to themselves and others. This was only with the exception of Barbara's presentation on 7th January 2014, where the risk to herself was deemed as medium due to her debt problems, excessive drinking and impending court appearance.

Andrew was never assessed as requiring any further follow up other than from his GP, with advice to continue with his prescribed medication and request counselling for his childhood trauma.

Barbara was already well known to services within Oxfordshire. The AWP liaison service appropriately contacted the CMHT in Witney to seek follow up for her.
She was also appropriately referred to the Alcohol liaison Team based at GWH, on two occasions.

What does emerge from the IMR is that communication by AWP to the separate organisations involved with Barbara, the drug and alcohol service and OHFT, was not clearly documented within the records, with no evidence to suggest that any of the actions from previous assessments had been completed. This is a deficit in recording, which while not having a direct bearing on the eventual incident, means that gathering an accurate picture of the actions and follow up agreed was impeded.

Both Andrew and Barbara were assessed on an individual basis, and when they presented together, it is not clear that questions were directed to either one to establish the nature of their relationship, and how that might be influencing their respective presentations.

The risk of harm to others or domestic violence was never identified as a risk, despite both partners having a history of violence towards each other as well as other people when intoxicated, and both having to attend court as a result of these altercations.

It appears that awareness of issues of domestic abuse was not routinely covered within the assessment process and questions were not asked. It may be that neither of them would have been willing to disclose issues of domestic abuse in such a setting, or in front of each other, or indeed to have seen their behaviour as being domestic abuse. Nonetheless, the absence of inquiry on these issues is a deficit in the assessment process.

The response of the IMR author to the panel’s enquiry about recommendations can be found in Section Four.

2.2.4 Oxford Health NHS Foundation Trust

Oxford Health NHS Foundation Trust (OHFT) provides specialist mental health care services. It does this through both inpatient and community based services, some of which are delivered in partnership with Oxfordshire County Council Social and Community Services Directorate.

OHFT had already completed an internal Root Cause Analysis investigation and produced a report outlining the findings of that investigation. This report, as has become regular practice, was provided to the DHR panel having been reviewed by OHFT in the light of the terms of reference for the DHR.

Contact between OHFT and Andrew

The IMR states that Andrew had a long history of substance misuse and emotional problems. It confirms that he had been living in the Abingdon area and reported living in a tent and a boat as well as sofa surfing. He has a number of attendances to services when in he was in crisis. He had previously lived in Faringdon and had accessed mental health services in Wiltshire.

The first contact recorded between Andrew and OHFT was on 2nd August 2014. He presented to the Emergency Department Psychiatric Service on having taken an overdose during an argument with his girlfriend. He was assessed by Dr 6. When he was interviewed he was coherent and happy to talk. He had capacity to make treatment and personal decisions. He did not have suicidal intent. He cited the main issue as housing. He was asked if he wanted anyone involved from his family but he declined.

Dr. 6 contacted the crisis services in Swindon and obtained a history from the duty worker. They confirmed multiple similar presentations with overdoses. Andrew said that he had given up heroin three days before the assessment but did not demonstrate any withdrawal symptoms. He admitted he had a problem with alcohol but was not looking for help at this time. His GP was contacted and advised that they could refer to Mental Health Services should there be deterioration in his mental state.

On 17th August 2014 Andrew was detained under Section 136 of the Mental Health Act by the Police and taken to a place of safety. This was following a report to the police from Andrew that his partner (Barbara) had assaulted him. Andrew reported that he had been expressing suicidal ideas and again said that there was an argument with his girlfriend. He had a Mental Health Act assessment with Approved Mental health Professional (AMHP) 2, Section 12 doctor, Dr. 8 and SpR Dr 7.

Andrew told the assessing team that he and Barbara were living in a tent and that this put them under strain. The IMR states that during the assessment Andrew was noted to be coherent and rational without intoxication but that he was keen to leave the assessment. The IMR notes that the assessment did not reveal any symptoms of major mental disorder but it was noted that he had had substance misuse problems.

The final assessment was in October 2014, two days before the incident. Andrew had presented at the Emergency Department Psychiatric Service in Oxford after Police had called an ambulance because he was expressing suicidal ideas. He had called the Police because he said Barbara had assaulted him. He told the Liaison Nurse who was conducting the assessment that he had declined to make a formal statement.

The IMR states that the records show there were no overt signs of injury noted at the Emergency Department, that Andrew was clean, coherent and had capacity to make treatment decisions. His tidy presentation was noted to be inconsistent with his report of living homeless in a chaotic boat.

The Liaison Nurse assumed that there had been a formal assessment of domestic violence (DASH) via the Police and gave Andrew some information in domestic violence and an agency called ‘Clean Slate’ for victims.

The IMR records that the Liaison Nurse was of the opinion that the presentation and argument were connected with alcohol misuse and not major psychiatric disorder. Andrew said that he wanted to prove to Barbara that he was not using heroin and asked for a urine test. He did admit to misusing alcohol. He was advised to access drug and alcohol services and appeared happy with the assessment and was keen to leave.

Contact between OHFT and Barbara

The OHFT IMR includes contact with Barbara that is outside the timeframe covered in the Terms of Reference of the DHR, however, it is included in the Overview Report to provide the broadest context to her history of alcohol use and its links to her behaviour and contact with statutory services.

Barbara was first referred to mental health services by her GP when she was 16, in July 1990. She had a 15 month old child and was 'under the supervision of social services'. The GP referral made reference to Barbara's difficulty in coping with her child, and alcohol abuse. An assessment was undertaken by a Community Psychiatric Nurse (CPN1) with whom Barbara continued to have contact until May 1991. It was agreed that there would be no further contact until after her second child was born as she could not attend appointments at the GP surgery whilst pregnant. No reason is given as to why this was the case.

Part of the plan for input included a referral to a psychologist for specialist intervention in relation to childhood sexual abuse. Barbara did not attend the assessment appointment for the Childhood Sexual Abuse group on the 30th January 1991, according to the clinical notes this was as a result of the group being held in Oxford rather than Abingdon where Barbara resided.

Whilst there was no specific care plan, risk assessment or discharge plan from this intervention, the IMR states that there are clear clinical notes made from each visit and that this was in accordance with good practice at the time which was prior to the introduction of the Care Programme Approach (CPA).

Contact with CPN1 was restarted on the 11th September 1991 at the CPNs instigation following the birth of Barbara's second child, a son. Children's Social Services became involved with the family, this was in the context of previous concerns that her daughter was failing to thrive as a result of Barbara's disorganised lifestyle.

Barbara had no contact with mental health services between 1992 and 1997 when she was seen at the Barnes Unit at the John Radcliffe Hospital in Oxford following an impulsive overdose of Aspirin and Flucloxacillin. The overdose was taken after drinking heavily. During the assessment at the Barnes Unit, she described alcohol use of fifty or sixty units per week for the preceding six months. At this time she had three children having had a third child in 1994. The outcome of this assessment was an agreement to refer to alcohol services.

Barbara was subsequently assessed by drug and alcohol service in December 1997, during this assessment she disclosed that she had found out she was pregnant with her fourth child two weeks previously and had reduced her alcohol intake to fifteen units a week as a result. During this assessment, Barbara also disclosed that her husband had assaulted her the previous week resulting in a broken nose. There is no record of any safeguarding process being followed.

She continued to have regular contact with a CPN from the Drug and Alcohol service and was discharged from the Drug and Alcohol service in March 1998. The IMR states that in the notes of her last appointment there is reference to her youngest son 'burning the upstairs of her house down'. There are no other references to this incident in her clinical notes.

Three years later Barbara's clinical records include a GP referral to Dr 1 following an alleged incident of fire setting in her home in February 2001. The referral was made at the request of the court. Her clinical notes include the minutes of an initial family support conference convened by Oxfordshire County Council as a result of the alleged fire setting.

According to the clinical notes, Barbara had no further contact with either mental health or drug and alcohol services until 25.6.2001 following a re-referral to the Community Mental Health Team by her GP. This re-assessment concluded that her main presenting need continued to be her use of alcohol, which exacerbated her temper control and dysthymic mood problems. It was suggested that a referral to an anger management group could be considered once Barbara's alcohol use was under control.

Barbara was subsequently referred on to the Alcohol Service, and she had an initial appointment offered for October 2001. In the intervening period, there was a request from Oxfordshire County Council to share information to inform the Family Support Conference process. Clinical information was shared subsequent to consent being obtained from Barbara.

She was seen for two appointments by a CPN from the Specialist Community Addictions Service between 3rd and 29th October 2001. The GP letter from this meeting makes reference to Barbara being accompanied by a worker from Home Start, therefore indicating that she had engaged with support from that service. At the time of the initial assessment she reported consuming 16-20 units of alcohol per day. Barbara attended one further follow-up appointment, but then did not attend subsequent appointments. There is no record of a clear discharge plan or agreement made, and no further clinical notes made until she was re-referred to the service at the end of July 2002. She did not attend the appointment offered to her at this time.

A psychiatric assessment of Barbara was completed in October 2002 at the request of Didcot Magistrates court following her remand on bail after a conviction of Assault occasioning Actual Bodily Harm. The pre-sentence report completed by the Probation Service recommended a full psychiatric report be commissioned prior to sentencing. The eventual sentence is believed to have been an 18 month Community Probation Order.

The psychiatric report completed gives a diagnosis of Emotionally Unstable Personality Disorder (EUPD)[19] and Alcohol Dependency. The IMR states that this is the first time in her clinical records that there is a record of the EUPD diagnosis, despite the described presentation being consistent over a number of years. The doctor's opinion was that Barbara could usefully address her dependency on alcohol and that he could provide this on an outpatient basis. The doctor ends his report by stating that as Barbara had not contacted him, he would not be seeing her again.

The IMR states that in December 2003 Barbara's clinical notes refer to her being remanded in custody for Arson with Intent to Endanger Life between 4th December 2003 and 27th January 2004. References to this incident in her clinical notes are limited to the Mental Health Act assessment which was completed whilst she was in police custody. The doctor involved in the assessment (Dr5) completed a detailed report which was sent to Barbara's GP. Included in that report is a summary of the alleged offence as reported by Barbara:

On the night before the [child protection] case conference was due to be held, she had gone out to play darts and drink as usual, and had seven or more pints of Carlsberg. On the way back home in a taxi with friends, she had become angry with someone who was picking on her best friend, but then calmed down. When she got home, she went to bed and had a smoke. The next thing she knew, she woke with the duvet on fire. She put the duvet out with her hands and arms, sustaining some superficial burns. She was very angry with herself and cut her wrists as a result. The Police and Fire Brigade were called and she was detained.

The clinical impression reported by Dr5 was one of no evidence of mental illness, clear evidence of personality disorder and 'clearly harmful use of alcohol'. The management plan from the assessment was for Barbara to remain in police custody, to present to her GP for further help with alcohol problems, with a suggestion of a referral to the Community Alcohol and Addictions Team.

Following her release from custody on the 27th January 2004, Child Protection conference minutes refer to Barbara returning to the family home. She was re-referred to the Community Addictions Service by her GP on the 28th February 2004

[19] Characterised by emotional instability, intense and unstable relationships, repeated emotional crises and deliberate self-harm.

at the request of the Area Child Protection Committee. At the time of this referral, she was reporting to her GP that she had not had a drink since being remanded to prison, however treatment for alcohol dependency was being requested.

Barbara was offered an outpatient appointment with Dr2 on the 25th March 2004 which she attended, the GP letter resulting from this appointment details no alcohol consumption since the 4th January 2004. The letter also references a reported improvement in the relationship between Barbara and her then husband since her remand to custody. She had three further appointments with Dr2 with the last one taking place on the 8th July 2004. By the time of the last appointment, she had restarted drinking but was denying drinking to excess. The IMR states that handwritten clinical notes detail one further outpatient appointment with Dr2 on the 9th September 2004, the only reference to discharge in the handwritten clinical notes is the notation 'D/C', there is no explanation as to the reason for the end of treatment and the written records contain no GP clinic letter from this appointment.

Following the cessation of outpatient treatment with Dr2, there is no record of Barbara having contact with OHFT services until 2nd September 2009. The IMR does not establish why she had no contact with services between 2005 and 2009. On 2nd September 2009 Barbara was seen at the Barnes Unit following an overdose of painkillers.

This assessment described the context of the overdose as consumption of eight cans of lager and a reaction to a number of incidents.

This assessment includes a completed risk assessment and Beck Suicide Intent Scale, with a full mental health assessment including reference to Barbara's social circumstances. The assessment includes reference to her family circumstances at the time; she reported residing with her husband and her three younger children, with her daughter living in her own home with her own child. Barbara reported that her husband had asked her for a divorce but that had subsequently changed his mind. This assessment concludes with 'action to be taken' which includes informing 'children and families' of her drinking in front of her children and grandson, and discharging her to the care of her GP. This assessment is detailed and the outcome appears appropriate, however, there is no evidence in the notes available of the referral to children and families taking place. This assessment was sent to Barbara's GP.

At this time Barbara was referred to Talking Space (*Talking Space is the name of the Improving Access to Psychological Therapies service in Oxon provided by OHFT*) by her GP in response to this presentation, the referral makes reference to the overdose on the 2nd September 2009. She was sent an 'opt in' letter by Talking Space, and phoned the service to opt in, however the Counsellors 'list' was closed and she was discharged in January 2010. The IMR states that there are no paper

files relating to Barbara's contact with the service, which, according to the IMR indicates that she was not seen but it also states that there is no clear record of the decision making in this instance.

Barbara was referred to Talking Space once more by her GP, this referral was rejected by the service at the triage stage due to her main presenting problem being related to her use of alcohol. Talking Space records indicate that a response was sent to her GP recommending alcohol services be considered. A letter was sent to Barbara dated 11th May 2010 following this decision which advised her to consider contacting SMART alcohol services (*SMART was at this time commissioned by the Drug and Alcohol Action team (DAAT) to provide alcohol and substance misuse community support services*), the letter provided her with the phone and email contact details for SMART.

Barbara's next contact with OHFT services was on the 2nd October 2010 when she presented to the Barnes Unit at the John Radcliffe Hospital, following taking 6 x 2mg tablets of Diazepam with eighteen cans of beer. There is a detailed assessment undertaken by Dr 6 which includes a full history, Risk Assessment and Becks Suicide Intent Scale. This presentation is also referred to in her GP records, indicating communication between the Barnes Unit and Primary Care. Barbara denied remembering how paramedics were called to her. The assessment concluded that she was a low risk of suicide, moderate risk of self-harm and high risk of alcohol misuse. The IMR found that there was a clearly stated plan as a result of this presentation: for Barbara's GP to be informed, for her to self-refer to SMART and for her to continue with her current medication regime.

Barbara's next contact with OHFT services was on the 29th March 2011 when she was seen for an assessment appointment by CPN5 from the CMHT covering her home area. A full assessment was undertaken at her home address, as this was specifically requested in the GP referral. The outcome of the assessment was that she would be seen for four sessions of intervention with CPN5, these interventions would focus on supporting Barbara to engage with SMART to address her alcohol use and the Complex Needs Service to address issues relating to her diagnosis of EUPD.

CPN 5 made the referral to SCAS on behalf of Barbara who was offered an appointment with CPN 6. She did not attend this appointment, she was sent a follow-up letter asking her to make contact with the team and was then discharged from SCAS when this did not happen. She attended one follow up appointment with CPN 5, and then did not attend the subsequent planned appointments, there is a letter on file from CPN 5 to Barbara asking her to make contact within two weeks or she would be discharged.

Barbara made contact with the CPN in what is described in a letter to her GP from CPN 5 as a 'tearful answerphone message'. In the same letter, dated 8th September 2011, CPN 5 refers to Barbara self-referring to SMART and having a brief engagement with them. At the time of her discharge from the CMHT, she was self-reporting a reduction in alcohol consumption and an improvement in being able to leave her home. She was discharged from the CMHT at this time, as the planned four appointments had taken place, albeit over an extended period of time.

The IMR finds no record of Barbara having contact with OHFT services during the period 8th September 2011 and 22nd April 2013, when she was assessed by Liaison Nurse 1 (LN1) from the Barnes Unit at the John Radcliffe Hospital.

The presentation at the Barnes Unit was following an overdose of 27 co-codamol, 21 sertraline and 7 diazepam with 4-5 pints of cider. This overdose was reported to be in the context of her arrest following a 'disagreement' with her partner's (identity of partner not known) sister. Barbara reported that she was not charged following this incident, but that when she returned home she was woken in the early hours of the morning by 'someone's hands around her throat'.

Barbara alleged that her neighbour and two others (all women) had entered her home and assaulted her. She reported this to the police who had followed up with evidence collection during the day. That night, Barbara had contacted the police expressing concern that the women were coming back, and was informed by Police that she was not subject to a 'witness protection programme'. Barbara responded to this by taking the overdose impulsively. She stated that any intent to die was fleeting and that her intent was to 'chill out'. Police attended her address and she was taken to hospital.

There is a detailed assessment completed following this presentation, LN 1 made contact with the Elmore Team who Barbara was engaged with at this time, and it was agreed for them to prioritise contact with her.

The week following this contact, Thames Valley Police called the OHFT Community Acute Service for advice. Police had been called to Barbara's home address on the night of the 29th April 2013 as she was expressing thoughts of harming someone with a knife. She had been consuming alcohol all day leading up to making these statements. The precipitating factors to this were reported to be the same as the presentation the previous week.

The Community Acute Service referred Barbara to the local Community Mental Health Team. She was visited by CPN 7 together with her key worker from the Elmore Team. The IMR states that there is a detailed assessment on file which concludes her low mood and impulsive behaviour is driven by her use of alcohol. Barbara stated she had no plans to seek help for her use of alcohol and that she

believed she was in control of her drinking, reporting only consuming alcohol at the weekend. It was agreed with Barbara that there was no role for the CMHT and that the Elmore Team, whose ongoing support she was reported to value, would remain involved. The assessment was sent to her GP.

Barbara was referred back to the CMHT by her GP on the 2nd August 2013 requesting assistance to address her agoraphobia and an appointment was offered for the 2nd September 2013. In the intervening period, she presented to the John Radcliffe Hospital following an overdose of 16 Naproxen and 4 Diazepam with two bottles of wine. When assessed by LN 1 from the Barnes Unit. She denied any suicidal thoughts or plans, and denied knowing how she had arrived at hospital, the assessment conclusion on this occasion was similar to previous assessments:

"39 year old woman who has presented following an impulsive, low intent overdose in the context of excessive alcohol consumption that has reduced her impulse control and ongoing social and relationship stressors against a background of long term agoraphobia and chronic alcohol dependence."

The management plan formulated from this presentation was for Barbara to self-refer to LASARS (Local Area Single Assessment and Referral Service: single point of contact for people accessing drug and alcohol services), she was given advice regarding self-management, and contact was made by LN1 with the Elmore Team asking for them to make contact the next day. The existing CMHT referral would be progressed.

Barbara did not attend the CMHT appointment offered to her on the 2nd September 2013. A further appointment for 16th September 2013 was offered and she attended this appointment with CPN 4. The assessment undertaken at this appointment concluded that alcohol was having a significant impact on her mental state. She acknowledged this but indicated that she was not motivated to change.

The IMR states that Barbara was aware that her anxiety was related to her use of alcohol and whilst stating that she had reduced her alcohol intake, acknowledged that this was only as a result of financial difficulties. In order to support her to engage with the appropriate services, a number of sessions on 'acceptance and commitment interventions' were arranged with Support Time and Recovery Worker 1 (STR 1). A further referral to complex needs was also suggested, which CPN 4 made on the 10.10.2013. CPN 4 completed a detailed risk assessment in the required format.

Barbara's notes include a copy of information from Thames Valley Police sent to the CMHT via Oxfordshire County Council Social Care dated 21st October 2013. This report refers to an incident where Police were called to Barbara's home following an injury sustained to her head; she is reported to have been intoxicated at the time and sustained the injury following a fall. There is no record in her notes of the CMHT following up this contact, or reference to it being discussed with her when she was seen on the following day by STR 1. Throughout her engagement sessions with STR 1, records indicate that there was a clear focus on Barbara preparing to engage with complex needs and of working to address her anxiety through graded exposure to leaving her home. Her clinical notes indicate difficulties in completing the planned course of sessions with STR 1.

A Care Programme Approach review took place on the 5th December 2013 with CPN 4 and STR 1. This review agreed that Barbara would be discharged from the CMHT, as she was not able to engage with the planned interventions. CPN 4 sent a discharge letter to her GP, copied to Barbara, clearly stating that she was advised to engage with alcohol services, and in the longer term with Complex Needs. These difficulties in engagement coincided with Barbara not attending the Complex Needs Service (CNS) information session on the 5th December2013. CNS offered her the opportunity to make contact with them if she wished to attend an information session in Witney. She did not do so and subsequently she was discharged from the CNS on 15th January 2014 with a letter copied to her GP.

There was no record of contact between Barbara and OHFT services between 5th December 2013 and 9th August 2014 when Thames Valley Police contacted the Mental Health Street Triage Service.[20] Barbara's clinical notes refer to information being given to Thames Valley Police after she had '*Jumped in Abingdon River and fished out by TVP.'* As Barbara was not a current patient of OHFT at this time, and had no other contingency plan in place, she was taken to A&E by ambulance. There is no record of her being referred to or seen by mental health services following this incident.

There was no further contact between Barbara and OHFT services prior to the incident.

Analysis and lessons learned

The OHFT IMR provides a lengthy and detailed narrative concerning the history of both Andrew and Barbara and their contacts with OHFT and its predecessor

[20] Street Triage is a service provided by OHFT, its function is to provide a point of contact between Thames Valley Police and Mental Health services. The intent is to provide appropriate information and advice for police where they have contact with people who may be known to mental health services, and by doing so reduce the use of S136 MHA powers.

organisations stretching back to 1990. This background has been included in this Overview Report as it provides helpful context and history about the difficulties and challenges that both adults lived with in terms of their backgrounds, their use of alcohol and drugs and the issues in their relationship.

Andrew

Andrew had a history of substance misuse, alcohol and heroin. He had limited contact with mental health services provided by OHFT, the majority of his more recent contacts having been with the liaison services provided by AWP at the Great Western Hospital in Swindon. Similarly his primary contact with mental health services in Oxfordshire took place following overdoses during presentation at the Accident and Emergency Department at the Oxford Radcliffe Hospital in Oxford.

The IMR shows that thorough assessments were conducted and that the assessment of risk was regularly updated. The risk of domestic violence was well understood by those who interacted with him and this was recorded. He was also assessed to be a risk to others and had a history of assault.

It is clear from the IMR that Andrew did not demonstrate any symptoms of major mental disorder and retained capacity to make treatment decisions throughout involvement. It also concludes that from the information available, which is also the case with the AWP IMR, that his prime issue was substance misuse.

A referral to Substance Misuse Services at the first encounter with mental health services may have been helpful, however, Andrew did not express interest in attending. There are substance misuse and alcohol services available via GPs through shared care schemes. There were also a number of lower threshold services available that he could have been signposted to. It is not clear that referral to such services, or advice giving would have resulted in any meaningful engagement with those services by Andrew, given his history of non-engagement with statutory services.

As with many parts of the country, the commissioning and delivery of substance misuse services are parallel and separate from Oxford Health NHS Foundation Trust Mental Health Services. The IMR rightly highlights that more effective means may be needed to facilitate and promote better joint working and clearer referral routes between mental health services, including liaison services and drug and alcohol services.

During Andrew's final assessment there was a clear picture of domestic violence (victim and possible perpetrator) and a significant risk factor in the form of substance misuse. This was again clearly noted on the risk assessment. What was missing was a formal way of assessing and then sharing that information back to the Police

(such as Domestic Abuse Risk Assessment). Such a mechanism would be helpful in ensuring inter-agency working and information awareness, including awareness of any past history of violence and any MARAC.

Barbara

Throughout the time period for this DHR, Barbara's presentation remained consistent with a diagnosis of Alcohol Dependence Syndrome and Emotionally Unstable Personality Disorder. This had been established some years previously as described in the previous section of this report. She has had no admissions to mental health inpatient care, no detentions under the Mental Health Act 1983 and was not subject to S.117 of the Mental Health Act aftercare within the timeframe for this DHR.

Barbara's problematic use of alcohol is a consistent feature of her presentation to mental health services over a lengthy period prior to the timeframe covered by this DHR. The assessments reviewed for the IMR clearly indicate that the wider issues she faced, including problems with housing and money, arose as a result of her use of alcohol.

As will be highlighted throughout this Overview Report, Barbara was reluctant to engage with alcohol services which were consistently offered to her. GP referrals were often made to mental health services whose only focus could be to support her to engage with alcohol services and the Complex Needs service– therefore the referrals appear circular.

Although Barbara did not meet the criteria for secondary mental health care, it is clear that mental health professionals were aware of the complex nature of her presentation and of her difficulties. The CMHT interventions were focused on supporting her to engage with services that were more able to address the fundamental nature of her presentation, specifically alcohol services and Complex Needs. It is evident from the information in the IMR that Barbara's engagement with these services was ambivalent at best.

The CMHT had attempted to engage with Barbara even though she did not meet the criteria for a service from them. Despite their best efforts, she continued to be hard to engage, did not keep appointments and was reluctant to accept advice or help.

In relation to issues of domestic abuse, these issues were known about and asked about, but the extent of knowledge, how it was used and shared to inform other agencies is not clear.

The IMR states that mental health staff said that they would not ordinarily raise a safeguarding alert where a service user disclosed or made reference to domestic abuse. This is a deficit in practice which requires attention. As an example Andrew had four contacts with services in the context of apparent domestic abuse, specific advice was only given on the fourth contact.

Mental health services responded appropriately to the presentations of Andrew and Barbara. Detailed assessments were conducted and there was good liaison with other services. Ultimately, neither of them met the criteria for secondary care mental health services, given their lack of mental disorder.

2.2.5 Elmore Community Services

Elmore Community Services is a registered charity that provides high quality services for marginalised and disenfranchised people throughout Oxfordshire.

Elmore was established in 1989 after an Oxford research project identified the weaknesses of service provision for people deemed 'difficult to place'. Elmore aims to work with people with complex needs (including mental health) who do not easily fit into existing service provision or who need support to access service provision in their local community. They identify gaps and barriers in current provision and use this information to lobby for, and create and implement models of working that address these issues.

The information in the IMR was gathered from the Elmore database and the entries for Barbara; this included her client notes and risk assessment. The worker who had been her lead no longer works for the agency, so it was not possible to speak to him directly. The author of the IMR never had contact with Barbara but line-managed her case, and so was tasked with writing the IMR from information supplied by her caseworker.

Barbara was taken on as a client of Elmore Community Services on the 17th January 2012, after referring herself. Elmore works with vulnerable individuals with complex and multiple needs. They work flexibly to try and support individuals in ways tailored to their specific needs.

The initial assessment (dated 9th January 2012) does not mention Andrew, but notes that Barbara had split from her husband three years previously, and that there had been a history of domestic violence between them (with both as aggressor and victim at times). At the time of the assessment Barbara was living in a private tenancy, though it was not clear to Elmore if she had a tenancy agreement.

Barbara stated that she had suffered from agoraphobia for seven years and would only go out if she had had a drink. She said she was on antidepressants at the time of assessment and had a history of cutting herself (not with suicidal intent), with the last incident in December 2011 when her mood dropped. She said that she had issues with alcohol for around 13 years, and that a trigger for this was when she was experiencing domestic violence from her husband when she was pregnant. She identified that relationship difficulties were a subsequent trigger for her increasing her alcohol use over the years. She stated she had no issues with drugs at that time.

Following the assessment Barbara was taken on as a client with an initial plan to offer short-term support to her to get on the correct benefits, in part to help her maintain her accommodation. The plan also talked about helping her find daytime activities, obtaining support regarding her wish for a divorce, and also to try and link her in with alcohol support services.

The IMR states that when they first started working with Barbara she was 'very vulnerably housed following the break-up of her marriage'. She has stopped receiving her sickness benefit due to missed appointments and she was dipping into her housing benefit for living expenses. She was in arrears with her rent and Elmore helped and supported her at appearances at court and in attempts to sort out her benefits. They were in consultation with the local Council who agreed to pay £50 per month towards her mortgage, but she was still in considerable debt with her council tax. Her house was eventually repossessed and Elmore advised her to get onto the local council to submit a homelessness application.

The IMR notes that Andrew is not mentioned in the notes for some time. There is reference to a male being present when Barbara was seen at home on the 9th November 2012, but it is not clear if this was Andrew or not. The same male was again present on the 23rd November 2012, and said he was staying with Barbara as he was homeless.

The IMR records that on a visit by Elmore on the 6th February 2013, Barbara noted that her male partner was staying with her, and the worker thought that this may be the male who had previously been present. During this visit she was notably drunk, but it was felt safe to continue with the visit.

The IMR records that on the 6th March 2012 and 8th March 2012, the notes show that Barbara was spoken to on the phone and was very intoxicated with alcohol. In the first call she was distressed due to issues with her son's girlfriend who was often in the home. In the second call, she said the police were with her and her boyfriend (identity still not confirmed in the notes at this point). Initially she said that the police were present because her partner had cannabis on him, but then later said it was because she felt threatened by her neighbour. The member of staff did not directly speak to the police. The call was ended as it was felt she was too incoherent to speak with, but it notes she was laughing with her partner at the end of the call.

Barbara was spoken to on the 11th March 2012 and was sober, and said that her boyfriend had been threatened via her Facebook account. She said she did not want to report this to the police, but he did. She was visited again on the 18th March 2012 and was sober. She said during this meeting that a new neighbour had taken an overdose, and that the neighbour's brother (identified in the notes as Andrew) had come round to ask for help.

The IMR records that a note from the 24th April 2012 states that Barbara wanted to ask her partner to move out, as he had not helped her when she had been assaulted by three females. It seems that this was in the context of her partner owing money to someone, and that Andrew's sister had allegedly assaulted Barbara. An entry dated the 29th April records a telephone call with Barbara saying she was staying in her room due to being fearful after the assault. It also says that her ex-partner had been asking her to let him come and stay.

The IMR finds that there is nothing else of note until Barbara's case transferred to her final worker in July 2013, and the workers letter/chronology details his involvement with her up to the point of closure with the service. Her case was closed on the 10th September 2014 after a period of non-engagement. Elmore generally has a remit to work with clients for up to two years, though this can be extended if there is a clear role and specific goals to be completed. In Barbara's case, she had been open to the service for 32 months, and in the months preceding her case closure, the IMR finds that Elmore had found it very difficult to achieve any positive interventions due to difficulties contacting her.

In her last contact with the service on the 1st August 2014, Barbara stated that she was sleeping in a tent by the river with Andrew. Barbara informed Elmore that she was in contact with the council who were following up on possible accommodation for her, and also that she was waiting to be seen by the Connection Outreach team (which would have been a prerequisite for entering hostel accommodation). As Elmore does not have direct access to accommodation, it was felt that all of the appropriate agencies were aware of Barbara at the time of the closure of her case.

Analysis and lessons learned

The IMR is necessarily concise but conveys effectively how Elmore attempted to engage with Barbara and to maintain contact with her over a lengthy period. The service did seem to be particularly appropriate for her, given that it works with people who are hard to engage with statutory services and those who are actively drinking.

The Elmore team made numerous efforts to maintain their contact with Barbara but she exhibited her pattern of disengagement throughout the time that her case was open. Despite this Elmore attempted to connect her with a range of services that might assist in addressing her housing, financial and alcohol problems.

The Elmore team kept Barbara's case open well beyond the usual period they would work with someone, which demonstrates that they were committed to trying to assist her and were prepared to go beyond what would have been expected of them. The decision to close her case was entirely appropriate in the circumstances. Elmore were not able to offer any further assistance but had ensured other agencies were aware of her difficulties.

2.2.6 Oxfordshire Adult Social Care – Vale Team

Adult Social Care (ASC) in Oxfordshire provides services for vulnerable adults, those with physical disability and older people who require information and guidance to enable their safe independence, this can include provision of care to enable them to remain safe at home or in a care placement.

ASC provides support and guidance to carers of service users and works in partnership with health and housing colleagues to provide people centred services.

Contact with Andrew

The IMR found that the only contact ASC had with Andrew was an ambulance report that was forwarded to his GP on 5th September 2013 and the request he made for bus fare to return home in October 2014 from the emergency medical unit at the John Radcliffe Hospital.

Contact with Barbara

The IMR records that ASCs principle contact was the provision of an Appropriate Adult for Barbara following her arrest in October 2014. The social worker concerned, who was interviewed for the IMR, attended one session of the police interview.

Prior to the incident the only interaction the Vale Team had with Barbara was the receipt of police reports of previous incidents and sharing these with the GP and the Mental Health Team who were the main support for her. ASC were not involved or aware of the housing issues being experienced by Barbara. The IMR makes clear that ASC would not have accepted a referral as those housing issues would be outside the scope of their eligible needs framework.

The wider difficulties that Barbara experienced did not fit within the eligibility criteria of ASC as she was independent and able manage her own life unless intoxicated. ASC did not receive any referrals from the GP or from any other agency requesting ASC involvement. Their IMR also states that there were no requests logged from the Housing Team.

The safeguarding referrals sent onto the Vale Team related to Barbara's behaviour whilst intoxicated.

Analysis of involvement and lessons learned

The ASC IMR demonstrates that there was only minimal contact with Andrew, and that contact did not result in any need for further assessment or ongoing intervention and support.

The IMR shows that ASC had limited information about Barbara's chaotic lifestyle, over doses and alcohol problems. Her needs, such as they may have been, were not those that would have necessitated ASC involvement and they did not fit within the eligibility criteria for assessment or services from ASC. As such ASC was not actively involved with Barbara.

Barbara's children were not acting in a caring role for her, and as such ASC would not have referred them onto the young carer's team for support.

Whilst the National Institute for Health and Care Excellence (NICE) guidelines [NG27] were not in place at the date of Andrew's death in October 2014, the recommendations which were published later, in December 2015 would have been relevant. As they were both vulnerable adults the NICE guidelines regarding the transition between inpatient hospital settings and community or care home settings for adults with social care needs would have been helpful. Andrew was said to have undiagnosed learning difficulties and drug addictions; Barbara was an alcoholic agoraphobic. The guidelines suggest that adults in these situations need extra help and support, especially where there is some indication, as in this case, that homelessness was an issue.

2.2.7 Vale of White Horse District Council

Vale of White Horse is a local government district of Oxfordshire. The main town is Abingdon, other towns include Faringdon and Wantage. Vale of White Horse District Council (VOWHDC) provides a range of council services for the people who live and work in the Vale of White Horse area. These include housing services including homelessness and homelessness prevention, the provision of housing and council tax benefits and community safety and licensing.

The IMR examines the contact that VOWHDC had with Andrew and Barbara in the period 1 September 2012 to 31 October 2014 as set out in the terms of reference for the DHR. It also covers contact between them and the council's Benefits and Housing teams prior to 1 September 2012.

Both Andrew and Barbara were known to VOWHDC prior to 1st September 2012, however the IMR found contact in that period was minimal, and centred around benefit claims and housing register applications. The first contact during the review period was between Barbara and the VOWHDC benefits contractor when she made a benefit claim. The benefits team was made aware of her long-standing health and social welfare difficulties through her support worker.

The first contact with the housing team in the review period was on 17th April 2014 when Barbara was facing homelessness due to her home being repossessed. This was the first of a number of contacts with Barbara by housing and LSP (Local Service Point) staff. They were aware of her benefits and lifestyle issues as they had previously referred her to Elmore Community Services for support.

Barbara was not declared statutorily homeless, and did not meet the threshold in terms of health issues or vulnerability to attract higher priority on the councils housing register. She was offered temporary accommodation through the *'No Second Night Out'* service and through Connections, which she refused, preferring to stay with friends and then to camp at Hales Meadow with Andrew.

Barbara was placed on the waiting list for accommodation at the Vineyard (supported housing in Abingdon), which appeared to be the only option she was keen to pursue. She was also provided with floating support by Connections and her housing case worker maintained contact with her throughout this period. She was also on the housing register, which allowed her to bid for more permanent accommodation.

During the timeframe covered by the DHR there was one contact with Andrew, also in connection with housing. Andrew and Barbara became known to VOWHDC's property team through a report from its moorings contractor of a couple camping on Hales Meadow, which is council-owned, and begging for food from other boat

owners. They later moved to a boat moored on council-owned moorings also at Hales Meadow.

During the period that they were camping on Hales Meadow or living on the boat moored on the River Thames at Hales Meadow, face to face visits were carried out by VOWHDC's environmental warden and moorings contractor.

Some complaints had been received about anti-social behaviour (ASB), and the Police had been called on a number of occasions, but VOWHDC staff did not see anything which led them to be concerned about violence or abusive behaviour between the couple.

Andrew and Barbara's case had been raised at JATAC (Joint Agency Tasking and Co-ordination - a multi-agency group which meets to discuss a multi-agency approach to cases) and no concerns had been raised about violence or domestic abuse. Apart from the minor ASB issues and housing issues; neither of them appeared on any agencies' 'radar' as far as VOWHDC staff were aware.

During the period 11 August to October 2014, discussion was taking place within VOWHDC about whether or not to move the couple off Hales Meadow, firstly from their tent and later from the boat, but any formal action was being withheld whilst a housing solution was being sought.

Latterly the property team was becoming increasingly concerned for the couple's safety in their tent due to potential flooding in the area which happens each year and could put the couple in danger.

A notice to vacate the mooring was served on Barbara in October 2014 as the boat had been moored for more than the permitted five days. It is understood that VOWHDC would have been willing to be flexible about this.

Analysis of involvement and lessons learned

The IMR demonstrates that VOWHDC was aware of Barbara's chaotic lifestyle, mental health and alcohol problems, housing and financial concerns. The council was not aware of any previous history of abusive behaviour or violence involving either Andrew or Barbara. It appears that appropriate services were offered at the right time and in a timely way. Barbara was assessed in accordance with housing legislation and standard practice. In common with other offers of assistance from statutory agencies, Barbara did not take up options available to her.

Although she was appropriately referred to other agencies for a temporary housing solution to be found, VOWHDC contact was maintained with her by the housing

needs officer T, and when she was not available by another housing officer or a member of the local service point staff. This ensured that VOWHDC had up to date information about the situation.

VOWHDC held back from taking enforcement action to move the couple from council-owned land whilst housing options were being sought. This demonstrates that they recognised the issues in play and were prepared to make some allowances in the hope that a practical solution could be found, without impacting further on Andrew or Barbara.

Although VOWHDC did issue Barbara with an enforcement letter whilst she was staying on the boat as it had overstayed the normal five day mooring limit, it is understood that in reality the council was unlikely to take legal action. VOWHDC has stated that in the small number of cases where boats overstay the five day period they have been issued with warning letters such as the one issued to Barbara. In previous cases the boat occupiers contacted the council and were given leave to stay longer. Barbara was also advised to contact VOWHDC to gain permission to stay beyond the five days. It may have been that the threat of legal action caused her anxiety, but this cannot be substantiated.

There is no evidence from the IMR that VOWHDC staff had any cause for concern in relation to violent behaviour or abuse in relation to Andrew or Barbara or that they asked about it.

2.2.8 A2Dominion

A2Dominion provides the Oxford Domestic Abuse Service (ODAS). The DHR panel requested information from them to establish details of any contact or involvement the service had with either Andrew or Barbara in the timeframe covered by the review.

Their enquiries revealed that A2Dominion received a referral on 28th September 2010 from the Police Domestic Abuse Unit for Barbara in relation to a previous partner.

After attempts to contact Barbara she declined any service saying she now had an injunction and was now OK. Barbara did say she would call the Helpline if needed. There were no further calls or referrals to the Helpline for or from her.

A2Dominion had no involvement with Andrew.

2.2.9 Oxfordshire Children's Social Care

Children's Social Care (CSC) had a range of contacts with Barbara in relation to her children over a lengthy period. Although not within the scope of the DHR, the panel requested scoping information from CSC in order to provide context and background to its considerations of the case. In this Overview Report, the most recent contacts with Barbara's youngest son are detailed for information as they fall within the timeframe of the DHR

On 25th May 2013 Barbara's youngest son called the Police after being 'slapped' around the face by his mother. Barbara was arrested and he returned to live at his father's address. He was regarded as being safe and therefore the case closed.

On 24th July 2013 there was a Domestic Violence report from the Police. There had been an argument between Barbara and the partner of her elder son. Her partner confirmed that the younger son no longer lived at the house and therefore case closed

On 20th August 2013 there was a Domestic Violence report from the Police. Barbara had allegedly hit Andrew around the face with a curtain rod. Barbara claimed self defence and Andrew refused to co-operate with the investigation. Younger son was not present at incident and does not live at the address, therefore case closed

On 9th September 2013 there was Domestic Violence report from the Police. Barbara shouted verbal abuse at Andrew in the street outside the house. Younger son was still not living at the property therefore the case was closed.

On 20th December 2013 there was a Domestic Violence Report from the Police. Barbara was complaining that older son (not a child) has posted abusive comments about her on Facebook. There was no further action for CSC.

On the 11th January 2014 CSC received an Ambulance Report. Barbara had been taken to hospital (the reason was not given). Younger son was missing from his brother's and returned to his father's address. No further action taken.

11th February 2014 younger son was reported missing, later found and said he had been at home all day. During the search for him officers visited Barbara and reported concerns that she was drunk at 3pm. Child Protection information shared due attending police officers concerns about younger son's support network. The contact record notes that if a return interview is required for him then the Early Intervention hub will undertake this. There was no further action.

On 30th March 2014 CSC received a Domestic Violence report from Police. Andrew reported that Barbara had returned home drunk, an argument commenced and Barbara is alleged to have thrown two cabinets down the stairs. Andrew left for the night to stay at his mother's house 'two houses away'. Younger son was not present and did not live at this address. There was no further action.

On Friday 2nd May 2014 CSC received a report from GWH Accident & Emergency Department in Swindon. Barbara was admitted to hospital while drunk and alleged that younger son had assaulted her. Minor facial injuries were noted, but Barbara did not intend to press charges. The Assessment team contacted the Addictions Support Worker who was working with younger son around his mother's alcohol use and his own drinking. She agreed to liaise with Early Intervention hub regarding any additional support that he requires. No further action and case closed

In October 2014 the Emergency Duty Team were made aware by Police that Barbara had been arrested for attempted murder. A case record check was undertaken and the child protection history noted. The assessment team contacted younger son's father who confirmed that he had not had recent contact with Barbara. A written agreement was signed to prevent any unsupervised contact between younger son and his mother. Case Closed

What emerges from this summary is a range of contacts between the agencies and CSC in relation to Barbara. All resulted in either limited communication or no action, primarily because her younger son was not present or impacted by the incidents of domestic abuse that had taken place of were alleged.

The chaotic nature of Barbara's lifestyle is well reflected in the summary of incidents with the timeframe of the DHR. This scoping information therefore provides helpful insight to complement that offered by the other IMRs.

It is not possible to offer any meaningful analysis other than that CSC acted appropriately in responding to reports and communicated effectively with other agencies.

2.3 Views of the family

In conducting this review the panel has sought the views of family members in order to inform its understanding of the incident and the events that led up to it. The chair has attempted to meet with the following members of the family:

Andrew's mother
Andrew's sister

Despite numerous attempts to contact them by phone and letter, and sadly, despite being certain that these communications have been received, contact with members of the family leading to their contributing to it has not been achieved. A draft of the Overview Report was shared with Andrew's mother and she said she was happy with the conclusions.

2.4 Summary of meeting with perpetrator

The chair of the panel met with Barbara on 3rd December 2015 The interview was conducted at HMP Send where she was being detained following her conviction for manslaughter on the grounds of diminished responsibility.

The purpose of the interview was to enable Barbara to provide her own view of the events leading to the incident and to provide information regarding her personal background, circumstances, relationships and to establish if there were any other areas of review that the panel needed to undertake in the light of the interview itself.

The interview was arranged by the prison locally and they reported that Barbara had been unsure about it at first, but then agreed on the basis that it might prevent similar situations and help others. Prior to meeting it was arranged with prison staff that support would be available after the interview if the questions had led to distress.

At the beginning of the interview the DHR procedures were explained to Barbara; it was made clear that there was no obligation for her to take part in the process and she did not have to answer any questions with which she was uncomfortable.

After this introductory preface Barbara had a responding statement of conditions which amounted to an assertion of her continuing insistence of her innocence of the offence of killing Andrew, and that she would be responding on that basis. This was agreed.

The areas of discussion were shared with Barbara at the beginning of the interview and were as follows:

1. What was her relationship like with Andrew? Was there any domestic abuse?
2. Could anything have been done at any time to prevent Andrew's death?
3. Were there times when interventions might have helped?
4. Did they not find services attractive? If not why/how not? e.g. alcohol services/Elmore for example?
5. Concerning the services they did access, was it voluntary or carrot and stick?
6. Did Andrew protect you – e.g. from services?

2.4.1 What was her relationship like with Andrew? Was there any domestic abuse?

Barbara explained that when they were alone in her house things were usually OK between them. She explained that she paid the bills, Andrew was 'childish' and had learning disabilities which meant he had never learnt to read or write. He didn't recognise the need to reserve some money from their benefit payments to buy essentials and would sometimes 'blow £100 of it on weed' which was about half of their fortnightly allowance. Although she had lived just a couple of doors from his family for many years, with her husband and children, she had never wanted or anticipated a relationship with Andrew, partly because he was several years younger. She said he claimed he had a crush on her since he was 15 years old, and ended up being 'obsessed' with her. Regarding domestic abuse, she said that if they had an argument she would retreat to her room in her house and / or he would go back to his mother's house.

It seems that one of the ways her relationship with Andrew persisted, despite her claims that she often wanted to finish it, was a mutual dependence. Andrew would help Barbara by walking with her to the shops or going to buy her things, when she couldn't leave the house due to her agoraphobia; Andrew was able to be in an adult relationship with sex and affection in a house away from his mother and family, albeit very nearby.

Things become more difficult once she had to leave her house as it was about to be repossessed as she was in arrears with the mortgage. The threatened repossession resulted in her going to live with at his mother's house, where his two younger brothers also lived and the 'council lady' complained about her staying there.

Almost inevitably tensions arose when she moved into Andrew's family home. Barbara said Andrew's brothers would seem to be continually planning 'What can we argue (with Barbara) about today?' Andrew's mother would interfere in their relationship, saying 'leave him alone' if they argued, or conversely, begging her to forgive her son if Barbara said it was over. Andrew was aged 33 at this point and Barbara described him as being tied to his mother's apron strings.

This family interference, in Barbara's eyes, seemed to be an aggravating issue between them, at least in the latter part of the relationship leading up to Andrew's death, with Barbara saying the relationship was over, and Andrew begging her to have him back. From the evidence Barbara offered in the interview there certainly seemed to be some substance to this claim. One of the episodes she recounted in some depth was the series of overdoses that Andrew was recorded as having which led him to be takes to accident and emergency by ambulance on several occasions.

Barbara explained this was a pattern of behaviour that was aimed at getting her attention following a breakup. For example, she told him it was over, but as he was obsessed with her, he would take an overdose, call the police and ambulance but then refuse to go with them to hospital. The police would then call her, and she would say *'We're not together' (i.e. in a relationship), but the police would say, 'Come on (nickname for Barbara) – come with us, he won't go otherwise'*. She says she often felt manipulated back into the relationship by the police who encouraged her to help them – and as she said, she would think *'Here we go again*', but she was actually trying to get away from Andrew.

She explained, for example, that for three months there was a court order that he was not to come to her house, *'…but he'd follow me – once I jumped off a bridge into the canal to try to escape him – he'd given me a black eye, but I just took it as 'mild' (domestic abuse)'*. This was two months before the fatal incident. Interspersed with these examples throughout the interview Barbara would stop and reflect and say –*'…but this is just my version – Andrew isn't here to defend himself or put his side of the story'.*

On several occasions when recounting these aspects of their relationship Barbara became distressed, at one point sobbing quite uncontrollably. The interview changed direction to the services she had accessed to change the subject, and this seemed to be easier to discuss.

2.4.2 Services accessed

A few times during the discussion Barbara alluded to the police and their role in their relationship problems and her arrest and charge, saying '*the police didn't do their job properly'*, or '*this would never have happened if the police had done their job properly'*. This largely seemed to be about the evidence they collected and presented regarding the court case for Andrew's death, which is beyond the remit of this Review.

She also complained that the police kept helping A to get back to her, when she wanted it to finish the relationship. When prompted to explain why, she said she knew she said and did stupid things when she was drunk, but that they said she was a 'lovely person' when sober, implying that she was well known to the local officers of whom she had a generally good opinion.

Her explanation of her experiences of accessing services seems to accord with the version the DHR panel has heard from the IMRs received. This included, for example, that she had tried to engage with various people who tried to help her but they insisted she had to be sober at the time of the meeting. Having problems such as agoraphobia mean that, in her words, she needed a '*couple of bevvies to go out to meet them, or to see them at the house*'. This would then lead to them saying she was drunk and to '*a circle of guilt and shame'*.

Prompted to talk about her GP or Elmore, as potentially positive aspects of her service use she said that Elmore were OK, but wouldn't come to the house after an allegedly violent situation following an episode she said was caused by Andrew's sister, and as she couldn't go on a bus and couldn't afford a taxi, and Elmore then wanted her to meet them in a café, '*they were not so much use'*.

She said the GP also would not come to her house. At some point in the past she had some therapy for agoraphobia, which started with walking down her driveway with the counsellor and asking how she felt about it. She said, *'I just felt like a plonker'* and this therapy had not been very useful or at all successful as she could not see the point of it.

2.4.3 Events leading up to Andrew's death

Returning to events leading up to Andrew's death, following the repossession of her house and inability to live in his mother's house, Barbara was, in her own words, '*in a pickle'*.

It is not exactly clear from Barbara's account if she and Andrew were 'back together' at this point, but around this time she managed to find a friend's caravan to live in, but when Andrew turned up early in the morning following her first night there, demanding to see 'his girlfriend', the owner of the caravan (who had told her she should not tell anyone she was living there) said she would have to pack her things and leave.

We then moved onto a period where a male friend offered to let her stay at his house, 'on the settee', which became problematic as he wanted sex in return, and her subsequent moving into a tent on the riverbank. She recounted this time with some fondness as Andrew used to visit her there, and they would sit around the campfire on an evening. This was spoiled however when she was attacked and beaten and robbed one night by a man known to her (not Andrew or the person where she had been staying). Again, she said the police did not do their job properly in investigating or arresting this person, in her eyes and this resulted in her feeling unsafe in the tent and leading to her parents buying her the river boat.

When arrested on suspicion of Andrew's murder Barbara was found to have over 20 bruises on her body that she could not explain. Towards the end of the interview, reflecting on her life, she said that her problems had all started 20 years before when she had found that drinking seemed to make her life easier. Married at a very young age (16) with a young baby and toddler to manage, her former husband was a 'lazy dad' and although social services were involved, she was left to do it all. She says she was told she was useless, mad and accused by him of having an affair with the 15 year old friend of one of her bothers. She said this was ridiculous as she'd only just met him, in his presence, but an argument ensued and her husband tried to strangle her, giving her a black eye and broken nose. He punched her 20 times and broke a kitchen cupboard with her nose. Her explanation was interspersed with '*I probably deserved it' and 'I used to get sloshed and cause mayhem in the street – I couldn't cope*'.

When asked if she had ever considered contacting local domestic abuse services during this period or when she had been in violent situations, or being pursued by Andrew, her response was an unequivocal 'no, never'. When she was asked why not she simply shrugged, and she said something that implied she thought it was 'normal'. When asked if she would have known who to contact, such as a women's refuge, she said no. She said she was ashamed of her situation and her drinking, suggesting that she was trying to keep it within the family. She also mentioned her

bothers at various points in the conversation, as in explaining what she had done when her first husband had beaten her very badly, saying she went to them and the police were contacted but it is not clear if he was charged with assault.

2.4.4. Conclusions from the interview with Barbara

The interview lasted for about 90 minutes in a room where privacy was assured. The questions stated at the beginning of the interview were not all covered in depth as some were too distressing and the questions about agency responses or things that could have helped prevent Andrew's death tended to lead to complaints about the police around the murder investigation. It seems clear that Barbara did not consider herself a victim of domestic abuse but regretted her drinking and had been manipulated by some men throughout her life. She was still grieving for Andrew, and was, in the opinion of the Chair of the DHR, genuinely upset at the memories and in the accounts she provided but was open and honest in her responses.

3. Relevant research

As Dobash and Dobash concluded in 2009, having studied the UK Homicide Index and analysed hundreds of cases of domestic homicide between 2004 and 2007, victims are typically women, of an average age of around 31 years old (Dobash and Dobash 2009, p. 13). The perpetrators in their study, both male and female, were of an average age of between 30 and 34 years, with a range from ages 15 to 56. Andrew was 33 at the time of his death and Barbara was 40.

The homicide which is the subject of this Review involved a co-habiting couple, but in this case, with the fairly uncommon characteristic that the perpetrator was female, and the victim male. As such, for the Review, gender is considered to be one of the equality categories to note under the Equalities Act.

As the Home Office data on the relationship between victim and principal suspect for 2012- 2013 suggests;

> 'Female victims were more likely than male victims to have been acquainted with the principal suspect (75% and 49% respectively). Female victims were far more likely than male victims to be killed by a partner or ex-partner (45% and 4% respectively) and less likely to be killed by a stranger.' (ONS 2014, p9).

Whilst the NICE guidelines [NG27] were not in place at the date of Andrew's death in October 2014, the recommendations which were then published in December 2015 would have been relevant. As they were both vulnerable adults the NICE guidelines regarding the transition between inpatient hospital settings and community or car home settings for adults with social care needs would have been

helpful. Andrew was said to have undiagnosed learning difficulties and drug addictions; Barbara was an alcoholic agoraphobic. The guidelines suggest that adults in these situations need extra help and support, especially where there is some indication, as in this case, that homelessness was an issue. Although it is not known how many people with disabilities, including mental illness or incapacity, are killed by their partners each year, it would seem that 'intersectionality' may play a part. In this sense, people who suffer from multiple disadvantages such as poverty, vulnerability, and a disabling condition may be especially at risk.

As a couple, and individually, Andrew and Barbara were clearly in need of help from various agencies and were frequent callers to the police, perhaps when they felt it was their only available option. They also called on the ambulance service, following each others' overdoses, which might indicate that they were needing help at a time of day when other agencies would not be available. Their calls included, but were not exclusively about, domestic abuse. Some were of a seemingly trivial nature, unrelated to traditional police work or 'crime'. The frequency of their calls meant that officers who responded usually knew of them and that, presumably, that their situation was not going to be easily resolvable. Long standing research on police attendance at this type of incident, where there are many, varied calls from a household known to the police, suggests that officers become cynical and disinterested. As Westmarland has argued, calls involving 'just a domestic' are often seen as 'rubbish' calls in police cultural terms (2001, 2011, p.25-26). As Myhill asserts, from his recent research into police responses to domestic violence, 'officers' understanding and conceptualisation of domestic violence is frequently at odds with the reality of coercive control: cases are regarded as serious only if the current incident involves injurious physical violence' (2017, p.15).

As there is no specific crime of 'domestic violence' or 'partner violence' it is difficult to estimate exactly how many cases of such abuse are reported nationally, or perhaps more significantly, how many are not reported. As Hester and Westmarland, N, (2006) have argued, this can cause problems estimating the extent of the problem, not only a national picture, but also for individual cases;

> 'Domestic violence involves patterns of violent and abusive behaviour, over time, rather than individual acts. However, the criminal justice system is concerned with specific incidents and it can therefore be difficult to apply criminal justice approaches in relation to domestic violence' (2006, p. 35).

This problem of defining domestic violence, such as in the case of Andrew and Barbara, has been the subject of new laws which attempt to show that some abusive behaviours may not involve physical violence or injuries. For example, evidence of 'coercive control' (Stark 2007) suggests that sometimes domestic abuse is hidden from view, even from those who seek to help victims. As Evan Stark claims:

‘Not only is coercive control the most common context in which [women] are abused, it is also the most dangerous’. Stark (2007)

A Home Office research paper (2015, p.3) uses a cross-Government definition of domestic violence and abuse[1] outlines controlling or coercive behaviour as follows:

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: a continuing 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]

There is some lack of clarity as to whether either Andrew or Barbara was being ‘controlled’ or coerced by one of them over the other, or by each other at different times in the relationship. In the TVP IMR there is some evidence that Andrew was using his overdoses to seek Barbara’s attention. Barbara claimed that the police tried to get her to go to hospital in an ambulance following one of his overdoses, as he would not do so without her. She maintained that she once jumped off a bridge into the river to escape from Andrew, but on other occasions she seemed happy to have his help and companionship. As an alcoholic agoraphobic Barbara needed ongoing help to obtain her prescriptions, sign on for benefits, attend appointments and go to the shops for alcohol, amongst other daily tasks. She was in difficult situation as most helping services would not see her if she was intoxicated but she found it difficult to leave the house without a drink or someone to go with her. In a sense this left her ‘isolated’, although it was not as a result of Andrew’s action, as he was one of her means of coping.

This is not to minimise the number of references to potentially serious violent behaviour evidenced by the TVP IMR both by the perpetrator and others in her life. Aside from the non-violent incidents, and calls that were classed as Anti-social Behaviour (ASB) incidents there were several threats of violence and references to knives and potential strangulations. Incidents where ‘hands around throat’ are mentioned are now recognised by some commentators as one of the trigger moments where domestic abuse may be escalating to a potentially lethal level. On the other hand, as many officers in the area knew the couple and the level of frequency of their calls and the seemingly trivial, the ongoing nature of them being viewed, in police cultural terms as problem that was not easily solved, may have led to the normalization of their behaviours and difficulties.

As Myhill argues, ‘Given that officers appear to still exercise considerable discretion in relation to their knowledge of coercive control, and the impact this understanding has on their decision-making might be regarded as the most pressing priority for further research in this area’ (2017, p. 15).

[1] The definition is supported by the following explanatory text: 'This definition, which is not a legal definition, includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.'

[2] The cross-government definition of domestic violence and abuse is not a legal definition and includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

Section Four

Conclusions

4.1 Conclusions

This section sets out the conclusions of the DHR Panel, having analysed and considered the information contained in the IMRs within the framework of the Terms of Reference for the review. The chair of the DHR is satisfied that the review has:

- Been conducted according to National Guidance and best practice, with effective analysis and conclusions of the information related to the case.
- Established what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support vulnerable people and victims of domestic violence.
- Identified 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.
- Reached conclusions that will inform recommendations that will enable the application of these lessons to service responses including changes to policies and procedures as appropriate; and
- Will assist in preventing domestic violence homicide and improve service responses for all vulnerable people and domestic violence victims through improved intra and inter-agency working.

The conclusions presented in this section are based on the evidence and information contained in the IMRs and draws them together to present an overall set of conclusions that can be drawn about the case.

4.1.1 Conclusions of the DHR panel

Having reviewed and analysed the information contained within the IMRs and having considered the chronology of events and the information provided by Barbara (the perpetrator), the panel has drawn the following conclusions.

1. That there had been numerous calls to the police which would suggest they were a couple with troubles but volume by itself would not be indicative of a probable serious outcome.

   In terms of seriousness of risk, for example as to whether the case might have been referred to a MARAC, the Panel concluded that it would not have been deemed within the remit. It also would not have been considered in the top ten repeat meeting as did not meet the threshold at the time.

   That Barbara saw alcohol addiction as a potential barrier to her receiving help. This was because she often needed alcohol to overcome her fear of

leaving her house and most agencies seem to regard the abuse of alcohol to exclude their ability to intervene. This made attending appointments an issue. Despite this she received CMHT services and both Andrew and Barbara were both signposted towards drug and alcohol services. One third sector organisation, Elmore, is prepared to see clients with ongoing drink problems in their own home and they provided support for longer than their normal remit. This arrangement broke down when Barbara's home was not considered a safe place for the Elmore workers to visit.

2. That families should be linked together more effectively, for example GPs to connect partners to each other, and step children need to be seen in the same way as birth siblings, as well as so-called 'common law' in-laws being viewed as family members.

3. That changes in patterns of behaviour might be recognised in future by GPs, for example, Andrew had suddenly begun to present as a suicide risk at A&E, having previously had only limited contact with medical services. This changing pattern of presentation may indicate the worsening of problems or the development of new difficulties in a vulnerable individual.

4. That agencies should be made more aware of potential domestic abuse and that gendered conceptions should be highlighted. There was a question as to whether Andrew might not have been asked about domestic abuse, as he was male. Whilst recognising that domestic abuse is more often perpetrated by men on women, agencies should give greater consideration to the possibility of men being the victims of domestic abuse.

Section Five

Recommendations

5.1 Recommendations

This section of the Overview Report sets out the recommendations made in each of the IMR reports and then the recommendations of the DHR panel.

5.1.1 Recommendations made in the individual IMRs

Thames Valley Police

1. Thames Valley Police officers and staff to be made aware that so-called 'common-law' partners and in-laws are family members in relation to Domestic Abuse incidents. This should be addressed by including this guidance in the Domestic Abuse Standard Operating Procedure and on the Domestic Abuse Risk Assessment Form (DOM5).

2. To remind supervisors to ensure that officers and staff use all available information for the Domestic Abuse Risk Assessment and that risk levels have been correctly set.

3. To share this case study with DAIU training courses and for PVP Referral Centre and MASH Detective Inspectors to discuss with Risk Assessors.

4. Officers to be made aware that intelligence reports should not be used for recording Safeguarding issues. This should be recorded via NICHE reports for either Adult Protection or Child Protection.

5. All Local Policing Areas should introduce an initiative to tackle repeat Domestic Abuse victimisation on a multiagency basis.

Avon & Wiltshire Mental Health Partnership NHS Trust (AWP)

Following discussions within the Panel the IMR from AWP raised a number of questions which the Chair requested clarification. These questions were as follows:

- Was domestic abuse considered for either Andrew or Barbara and if not, what was the barrier to exploring, and if it was what did they do? For example, the Panel debated whether the gender of the victim may have been significant.
- Do the staff have domestic abuse training and is there a domestic abuse policy and procedure, if so can we have a copy?
- On page 13, 2nd paragraph it says there was no evidence to suggest that any of the actions from previous assessments had been completed. Is this normal for them not to have the evidence, and if so what is the implication of that and could the process be improved and if so how?
  Page 13, 3rd paragraph it says they were not identified as being at risk despite both having a history of violence, could they explain why they were not identified? In addition does the IMR Author think that more could have been done to identify the risk of violence towards their partner and if so what?
- Is there any organisational learning they could take from this?
- Are there any specific recommendations?

In response AWP sent a copy of their Domestic Abuse Policy and the following responses:

Was domestic abuse considered for either Andrew or Barbara and if not, what was the barrier to exploring, and if it was what did they do? For example, the Panel debated whether the gender of the victim may have been significant.

- *Domestic abuse, was never considered for either Andrew or Barbara, the assessments which occurred, reviewed the presenting issues and ongoing stressors, which included financial debts, awaiting court experiences and relationship difficulties. The risks assessments identified risk to self and others but with no specific attention to DV.*

Do the staff have domestic abuse training and is there a domestic abuse policy and procedure, if so can we have a copy?

- *Domestic Violence training is available through the Local Authority and as part of the Trust training, staff members regular attend the Local Authority training, and we have a Swindon representative, team manager who attends the Locality MARAC meetings.*

- *There is a Swindon Freedom Programme currently underway, which has been advertised to our service users.*

- *The Freedom Programme aims to increase women's ability to take control of their own lives & provides an opportunity to develop ways of thinking and behaving to protect themselves, their children and others from harm.*

5.1.2 DHR recommendations

Having analysed and commented upon the findings of the IMRs and reached a set of conclusions the DHR makes the following recommendations for local action:

1. We recommend that local health and social care commissioners continue to invest above or at the current level in third sector services, such as The Elmore Team, whose work with those individuals such as those in this case who are hard to engage should be commended. Many people, like those in this case are on the cusp of eligibility for statutory services and the third sector plays a crucial part in ensuring that people are able to receive support and help. Ensuring they have sufficient resource and capacity, alongside greater certainty over their funding would enable them to continue their work and plan more effectively.

2. We recommend that data from the Police is reviewed for repeat callers to 101 or 999 in relation to domestic abuse, whatever the risk in order to capture the longer term picture of harm people could be facing. This data can then be shared to problem solve to reduce the risk of those involved using the multiagency partnership.

   Update: The data of the 'top ten' repeat victims and offenders is now available across the Thames Valley. In Oxfordshire these 'top ten' individuals are discussed after the MARAC in a meeting called 'Cause for Concern' (with the same partners who are engaged in problem solving high risk domestic abuse). Each partner agency can also bring cases to this forum who fall out of the top ten data set, where they feel additional problem solving by all agencies would assist.

3. We recommend that all agencies demonstrate their understanding of the impact of coercion and control by current or former partners. New legislation now sets out the parameters for this element of domestic abuse and local organisations must demonstrate how they have embedded knowledge of these new elements of the law in the practice of their staff. At the very least the basics of the law (below) should be conveyed and emphasised to all statutory and voluntary organisations.

   The offence of controlling or coercive behaviour

   Section 76 of the Serious Crime Act 2015 provides that:
   (1)A person (A) commits an offence if—
   (a)A repeatedly or continuously engages in behaviour towards another person (B) that is controlling or coercive,

(b)at the time of the behaviour, A and B are personally connected,
(c)the behaviour has a serious effect on B, and
(d)A knows or ought to know that the behaviour will have a serious effect on B.
(2)A and B are "personally connected" if—
(a)A is in an intimate personal relationship with B, or
(b)A and B live together and—
(i)they are members of the same family, or
(ii)they have previously been in an intimate personal relationship with each other.

4. We recommend that all local organisations remind and re-iterate to their staff in writing, the responsibilities and legal obligations in relation to safeguarding of adults and children and provide assurance that this has happened.

   We further recommend that multi-agency review of repeat referrals relating to safeguarding should be monitoring through the Oxfordshire Safeguarding Adults Board.

   The OHFT IMR states that mental health staff said that they would not ordinarily raise a safeguarding alert where a service user disclosed or made reference to domestic abuse. This is a deficit in practice which requires attention.

5. We recommend that the CCG work with GP practices to ensure that they have processes in place to understand and identify the needs of individuals who present with mental health and /or alcohol problems and who may be in complex, coercive and possibly abusive relationships. This will facilitate a clearer view of the relationships of the individual and their consequent needs. GP practices should undertake IRIS (Identification and Referral to Improve Safety) training to help with such issues.

   http://www.irisdomesticviolence.org.uk/iris/about-iris/about/

This training should ensure that sufficient emphasis should continue to be given to male victims of domestic abuse in its policies and procedures. We would encourage staff working in all local agencies not to make assumptions about the 'normal' or expected victim of domestic violence.

With this in mind we particularly point to the need to be professionally curious and to ensure that professionals consider that domestic abuse may be being directed towards a man, as well as towards a woman. In addition, that as domestic abuse is complex and multifaceted, that a victim of either sex might also be a perpetrator in some cases.

6. References

Hester, M. and Westmarland, N. (2006) Domestic violence perpetrators, *Criminal Justice Matters,* 66(1), p 34-5.

Home Office, (2015) *Controlling or Coercive Behaviour in an Intimate or Family Relationship. Statutory Guidance Framework*. London: Home Office

Myhill, A., (2017) Renegotiating domestic violence: police attitudes and decisions regarding arrest. *Policing and Society*, 29(1) 2019

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NICE guidelines [NG27] Published date: December 2015.

https://www.nice.org.uk/guidance/ng27/chapter/Recommendations.

Stark, E. (2007*) Coercive Control. How Men Entrap Women in Personal Life*. New York: Oxford University Press.

Westmarland, L, (2001)(2011) Gender and Policing. Sex, power and police culture. Willan: Devon

Combined chronology

This chronology covers the period from 1 September 2012 to October 2014. In the course of the panel's work, information about the background of Adult A and Adult B was gathered and reviewed. This provided helpful context their respective histories and contact with statutory services. It has not been included in this chronology as it falls outside the timescale and scope of the DHR.

This chronology has been compiled from the information and chronologies provided with the IMRs received by the panel. It includes a range of information, but necessarily focuses on those incidents and issues that either provide context or helpful historical background and those that are especially pertinent to the incident under review.

Adult A = Andrew Adult B = Barbara

Event	Outcome	Source
This outlines what led to the contact	This outlines the outcome	This outlines where the
		Information originated
Adult B - DNA assessment for CSA group.	Health Visitor concerned regarding daughter's failure to thrive as a result of Adult B's 'disorganised lifestyle'.	Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
Adult B - Agreed no ongoing contact with CPN until after birth of baby		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
Adult B - Contact with CPN1 restarted		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report

Adult B - Assessment for CSA group to be re-offered		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
Adult B - Seen by Barnes Unit at JR following admission for O/D in the context of low mood, heavy alcohol use		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
Adult B - First appointment with community addictions service, 6/52 pregnant. Regular contact planned during pregnancy.		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
Adult B - Discharged from Community addictions team as CPN leaving and declined transfer to another worker.		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
Adult B - Initial family support conference convened by OCC Social care as a result of the alleged fire setting.		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
Adult B - Referral to Dr 1 from GP following incident of alleged fire setting at home on 10.2.2001. Referral at court's request		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
Adult B - 'Follow-up appointment' with Dr 1, following re-referral from GP, although no		Oxford Health NHS Foundation Trust Root

referral associated with this assessment can be found on file. Major issue remains alcohol dependency, no evidence of mental illness-on-ward referral to 'alcohol counsellor'.		Cause Analysis Investigation Report
Adult B - Request from children and families to share information regarding support provided to Adult B, following a Family Support Conference process. Information shared on 23.8.2001 following consent being obtained.		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
Adult B - Referral from Consultant Psych to the addictions service.		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
Adult B - Handwritten case-notes by CPN from addictions service. Plan to address alcohol use.		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
Adult B - Re-referral from GP to addictions service. Contact from children's team. Reference to pending court case for assault. Agreed to keep case 'open' following contact from social worker in the children's team.		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
Adult B - Seen by Consultant from community addictions service. Diagnosis of Emotionally Unstable PD, alcohol dependency,	Report for magistrates court following conviction for ABH	Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report

Adult B - Children's services report states that Adult B received an 18/12 probation order for the offence referred to above.		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
Adult B - Family support plan agreed, only mental health element is to continue to engage with Dr 2, Consultant from the addictions service		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
Adult B - Initial Child Protection case Conference held for all four children, Outcome was to place on the Child Protection Register under Category of emotional abuse	On 22.1.2003 Police were called to an incident where Adult B had put her hand through a window whilst under the influence of alcohol, that there may have had been violence involved and that the children may have been exposed to this. The eldest child had called child line who in turn had called the police. He is reported to have witnessed Adult B engaging in self-harm whilst intoxicated. Adult B arrested for breach of the peace. Reports of similar incidents being repeated, oldest child reporting distress at the incidents between her parents, and the fact that her father had left the home.	Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
Re-referral to the community addictions service by Adult B's GP		Oxford Health NHS Foundation Trust Root

		Cause Analysis Investigation Report
Appointment with Specialist Community Addictions Service, Adult B did not attend. Discharged back to GP		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
Adult B - Child protection review case conference.	All four children to remain registered under emotional abuse	Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
Adult B - Appointment with SCAS Dr 2 Further appointments on 7.8.2003, 14.08.2003 and 11.9.2003. Discharged from SCAS following successfully addressing alcohol use.	Reported a reduction in alcohol use, started part time work as a cleaner and improved relationship with husband. Incidents reported of self-harm whilst intoxicated. Adult B reported that the current probation order had the effect of stopping her from acting violently whilst intoxicated.	Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
Adult B - Mental Health Act Assessment in Abingdon Police Station whilst in custody for arson with intent to endanger life. Outcome, no detention to go through Criminal Justice route.	Adult B reported context of fire, smoking in bed whilst intoxicated awoken by duvet on fire, then made cuts to wrist, denied suicidal or self-harm intent. Outcome was remand to Prison. Charges dropped and subsequently released 27.01.2004	Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report

MC1468214/03 – Arson with Intent to Endanger Life Adult B cut her wrists with glass and then set fire to her bed using a cigarette lighter. Her children were in the house at the time and damage was caused to her duvet, bed and carpet. The children were uninjured.	Adult B was charged with arson with intent but the case was discontinued before it reached court. The children were put on the Child Protection Register and Social Services remained involved after the case was discontinued.	Thames Valley Police IMR
Adult B - Apt with SCAS Consultant		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
Adult B - DNA SCAS appointment		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
Adult B - Child Protection Case Conference	All four children to remain registered under emotional abuse	Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
Adult B - Appts with SCAS		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report

Adult B - GP records indicate alcohol detox on this date, no other information in notes.		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
Adult B		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
MC3159418/08 – Assault ABH Adult A and his brother were said to have assaulted another male.	They were arrested and interviewed and said they were acting in defence of their mother who the other male had assaulted. The report states that the male suspected of assaulting their mother had learning difficulties and could not recall events. No charges were brought against Adult A or his brother.	Thames Valley Police IMR
MC3239171/08 – Assault without injury Adult B slapped her 17 year old son across the face.	She was arrested but not charged due to insufficient evidence. Initially the incident was classified as a Domestic Abuse incident but then changed to a Child Protection related incident. CAIU were informed and a report was made to Social Services.	Thames Valley Police IMR

MC3364556/09 – Assault without injury Adult B's ex-husband grabbed her by her throat and pushed her down some stairs	He was arrested but Adult B would not support proceedings. He was given a Police caution.	Thames Valley Police IMR
Adult B - Assessed by staff at the Barnes Unit following overdose of 19 co-codamol	Found out that an ex-boyfriend had died, had drunk 8 cans of lager. Friend took her to hospital, husband and son in the house at the time of the overdose.	Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
Adult B - GP records state stab wound to chest alleged assault by 15 year old son.		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
MC3444856/09 – Cruelty/Neglect of Children A Social Worker spoke to Adult B's younger two sons at their school and they disclosed physical abuse from Adult B. They were aged 11 and 15 at the time. They said that she had stamped on the hands, feet and body of the youngest child and the older child said that she had bitten him on his arms and neck. The Social Worker said that they appeared terrified when they told her what had happened. They also said that she was always drunk and this would make her aggressive and abusive and that they had to fend for themselves.	A Strategy Meeting was held on the same day and the children were interviewed. Adult B was arrested and interviewed about abusing and neglecting her children. An Initial Child Protection Conference was held on 03/11/09. Adult B was no longer living in the family home and the children were being cared for by their father so they were not placed on a Child Protection plan at this time.	Thames Valley Police IMR

	Adult B was not prosecuted with any offences as there was insufficient evidence to charge her.	
Adult B - Reports record separation from husband at this time, eldest child (daughter living with her own family, 3 sons living with their father).		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
Adult B - EDT Referral The police had received a call from a concerned neighbour about Adult B's behaviour. Notes state a long history of alcohol use and known to MHT. When she was in hospital the children's father moved back into the address to care for them. The neighbour reported that Adult B had been out on the street screaming and shouting during the day. Earlier this evening she was shouting again and apparently kicked the children out of the house.	Police checked the home twice re the welfare of the children. Adult B was described and drinking but not drunk. No significant concerns raised.	Adult Social Care Vale Team Individual Management Review
Adult B - Access Team. EDT report copied to Clare Fox at Family Support South and receipt confirmed		Adult Social Care Vale Team Individual Management Review
Adult B - GP records: alcohol use 100 units a week, describing 18/12 history of panic attacks. Reference to referral to Talking Space.		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report

MC3676203/10 – Assault without injury Adult B was assaulted by her ex-husband when he punched her face.	Adult B was assessed as being at medium risk of Domestic Abuse. Adult B's ex-husband was arrested and charged by Police however the case was discontinued by the CPS citing that there was not enough evidence to provide a realistic prospect of conviction as it was 'one word against another'. The DAIU offered safety advice to Adult B in line with policy.	Thames Valley Police IMR
Adult B - Assessed by staff at the Barnes Unit following presentation at A&E following overdose of diazepam tablets. Plan to discharge home and self-refer to SMART to address alcohol use		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
Referral to Abingdon CMHT by Adult B's GP. Ongoing issues with alcohol, depression, personality disorder and agoraphobia. Requesting first appointment at home address.		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
Adult B - Appointment at home address with CPN from CMHT		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
Adult B - Referral to SCAS from CPN		Oxford Health NHS Foundation Trust Root

		Cause Analysis Investigation Report
Adult B - DNA'd home appointment with CMHT		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
Adult B - DNA'd assessment appointment with SCAS		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
Adult B - DNA'd further appointment with CMHT		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
Adult B - Letter from CMHT CPN, following up phone message left by Adult B over the weekend.		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
Adult B - Appointment with CMHT CPN		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
Adult B - DNA'd appointment with CMHT at home address.		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report

Adult B - DNA'd appointment with CMHT.		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
BG4016188/12 – Assault ABH Adult B accused a male of having bitten her fingers.	The male was arrested and interviewed and said that he acted in self-defence. No further action was taken.	Thames Valley Police IMR
BG4032669/12 – Adult Protection Adult B was living in a multi-occupancy house with a male with learning disabilities. She was said to be taking advantage of him and had verbally abused him, and got him to buy her alcohol. The victim also said that housemates (not named who) had slapped him in the face but not caused visible injuries.	Police liaised with Social Services and a multi-agency approach was used to tackle the issues. Alternative accommodation was arranged for the victim but he would not move. A harassment warning was issued to Adult B and Social Services continued to monitor the situation.	Thames Valley Police IMR
MC4072166/12 – Domestic Incident (non crime incident) Adult A had an argument with his sister who threatened to stab him as she was annoyed that he was smoking cannabis.	Officers made numerous attempts to speak to Adult A who did not engage. The incident was graded as being standard risk and no further action was taken.	Thames Valley Police IMR
URN 1118	Police attended and spoke with a male housemate who said that she had threatened him with a knife.	Thames Valley Police IMR

Adult B called TVP to report that she thought her housemates in a multi-occupancy house had stolen some property from her. She threatened to take matters into her own hands.	Adult B was arrested for stealing money from one of her housemates. The house was searched but no weapon was found.	
URN 1485 This was a call from Adult B to say she had locked her son (age 18) out of the house. He owed her money and she wanted advice as to whether she could keep his television as payment. She sounded intoxicated at the time but was adamant there had not actually been an incident and she just wanted advice on how to deal with the situation.	The URN noted that this was a civil matter with possibly a domestic element. The URN was closed and officers did not attend. Adult B's son was 18 at the time and therefore this could have qualified as a domestic incident. There did not however appear to be any actual incident, just Adult B asking for advice. Although this should have been attended to treat it as a Domestic Incident this review can understand why the decision was taken not to.	Thames Valley Police IMR
URN 1534 This was a call from Adult B's ex-husband advising TVP that he was attending Adult B's home to collect belongings for his son (age	Officers attended to ensure that the peace was kept and this was resolved without any problems.	Thames Valley Police IMR

18). He was concerned that Adult B would cause problems.	Officers attended to prevent a 'breach of the peace' which is the correct action given the circumstances.	
URN 389 Adult B called TVP to complain that officers had assisted her 18 year old son to gain entry to her address. She said that she had been asleep in the property at the time so did not witness this happening. She was not happy as she thought the officers had taken her son's side and he owed her money.	It was established that the officers had only attended to prevent a breach of the peace (see URN 1534 – 03/09/12 – Incident 12).	Thames Valley Police IMR
URN 1374 This was a call from neighbours complaining of lots of noise coming from Adult B's house in the form of drilling, sawing and hammering.	The URN was updated that this was sorted out amicably between the neighbours. This was just one of many calls made by Adult B's neighbours. Often these were noise complaints with no offences attached.	Thames Valley Police IMR
Adult B - Telephone consultation (assumed with partner but name not recorded) Not currently registered at practice	Request for visit because patient unable to stop having orgasms. No drugs. Advised wait and see.	NHS Oxfordshire CCG Individual Management Review for General Practitioners

Adult B - Face to face consultation	1.Depression, run out of medication, prescribed antidepressants (28 days) 2. agoraphobia, diazepam issued (7 tablets) Sickness certificate issued for 6 months 3. alcoholism 4. hoarse voice, inhaler prescribed	NHS Oxfordshire CCG Individual Management Review for General Practitioners
MC4169452/12 – Harassment Adult A called TVP to report that his partner Adult B was receiving a large quantity of unwanted letters, text messages and calls from a named male. The male had been asked to stop but had carried on with the contact. Adult B had been friends with this male and, both being alcoholics, they would drink together. She had since started a new relationship with Adult A but the male was still contacting her when he was drunk. This was making Adult B feel harassed which is why Adult A contacted TVP on her behalf.	Uniformed Patrol officers spoke with Adult B and then made several attempts to make contact with the male and issue a Harassment Warning. They were unable to locate him; however the harassment stopped as soon as the report was made so it was thought that mutual friends had warned him. On 04/02/13 the report was filed with the agreement of Adult B. It was deemed as not proportionate to carry on trying to find him when he had stopped the harassment. The male should have been issued a Harassment Warning (now Police	Thames Valley Police IMR

	Information Notice) but the male could not be easily located. The contact ceased and Adult B did agree to the crime being filed, which was proportionate, and there are no issues with this.	
URN 1223 This was a call from a neighbour complaining about noise from Adult B's house at 22:43 hours. The noise had awoken the caller's children and they could not get back to sleep and were due at school in the morning. The caller had tried to speak to Adult B but could not get an answer at the door.	Officers attended Adult B's address but could not hear any noise. They spoke to a drunk female (presumably Adult B but this is not recorded in the URN) and gave her advice about the reported noise. They did not go to the caller's house as he had requested that this did not happen. Later the next day PCSO C1 attended the caller's house and completed an Anti-Social Behaviour (ASB) Risk Assessment Matrix which was assessed as standard risk. Completing the ASB matrix was the correct procedure. It is correct that the officers went to the address to speak to the occupiers and that they did not go to the caller's address at their request.	Thames Valley Police IMR
URN 49	The incident was classed as a 'neighbourhood dispute' and no	Thames Valley Police IMR

Adult A's brother called TVP to report that Adult B had threatened to punch their mother "in the nose".	offences were recorded. Uniformed Patrol Officers attended and updated the control room that this was an argument over money and not a domestic incident. Adult A's mother and Adult B are, in effect, 'common law' mother-in-law and daughter-in-law and therefore this should have been classified as a domestic incident. They were neighbours which is why this could be seen as a neighbourhood dispute. Adult A and Adult B were not married and Adult B did not live in the same house as his mother so although a domestic related CEDAR report should have been created and a Domestic Abuse Risk Assessment Form completed, this review can understand why this was not seen as a domestic incident.	

Adult B - Face to face consultation	Medication review, ran out of medication, 1 week prescription and arranged phone review	NHS Oxfordshire CCG Individual Management Review for General Practitioners
Tried to telephone patient as arranged x2, no answer - Adult B	Failed phone encounter	NHS Oxfordshire CCG Individual Management Review for General Practitioners
Adult B - Phone consultation	Review of depression Plan for review 1 week, patient had found more sertraline so no prescription issued	NHS Oxfordshire CCG Individual Management Review for General Practitioners
Adult B - Safeguarding Adults Issues. Email received from TVP attaching police report raising safeguarding concerns, safeguarding alert raised and sent to ASC (Vale) as advised by PS Carly Weller.		Adult Social Care Vale Team Individual Management Review
Adult B - Safeguarding Adults Issues. T/c to police contact who had referred case, SW checked if the information had been forwarded to Adult B's GP. Agreed action the police	As incident recorded above- police matter, dealt with by the police. Therefore NFA needed by Vale ASCT at present.	Adult Social Care Vale Team Individual Management Review

would liaise directly with her GP as necessary. Incident summary, Adult B rang 999 yesterday she had been threatening to injure herself. Police carried out a welfare check and taking any further action, plus no crime was committed. Client independent.		
URN 1631 This was another noise complaint from a neighbour of Adult B's.	The caller was passed the contact details for the out of hours Environmental Health office. The information was also passed to the local Neighbourhood Policing Team. Given the ongoing nature of the complaints an ASB matrix should have been completed with the caller.	Thames Valley Police IMR
URN 6 This was a call from Adult B when she sounded very drunk. It was initially stated in the URN that something may have occurred between her 18 year old son and his girlfriend but Adult B was not answering any questions or making much sense. A neighbour then called at 00:19 hours and said that he had heard arguing coming from Adult B's house for the last hour and in the last	The next update was at 00:32 stating that this was not a domestic incident and that Adult B was 'hammered' but happy as she had a new boyfriend. Her son and his girlfriend were staying there with a puppy and they had disagreed about raising it. They said that the comments were in relation to the dog. This should have been recorded as a domestic incident and a CEDAR	Thames Valley Police IMR

10 minutes it had escalated. He had heard someone say, “Get your hands off my throat”.	report created and a Domestic Abuse Risk Assessment Form completed. This should have included the information that a witness had heard someone say “Get your hands off my throat”. Although it may have been difficult to identify the offender/s and victim/s, the information should have been formally recorded. The officers involved have been spoken to (Police Constables P1 & P2) and they did not class this as a domestic incident as the argument was between Adult B and her son’s girlfriend. The officers are now aware that this should have been treated as such.	
URN 407 This was a call from Adult B reporting issues with her neighbours. She said that she had been threatened by the father of one of them but was currently safe at home.	Uniformed Patrol Officers went to see her and she complained about being woken up early in the morning by her neighbour’s children. She said that she went to bed at around 04:00 hours and the sound of the children would wake her early. The attending officer noted that they would speak to the Housing Officer about the situation.	Thames Valley Police IMR

	The attending officer (a Neighbourhood PCSO – C1) took the initiative to refer the case to the housing officer which was positive action.	
URN 616 This was a call from Adult B reporting that a male had threatened her partner, Adult A, via Facebook. She was worried that this male thought that Adult A was a drug dealer and that there was cannabis in the house and so he would set fire to it.	Attempts were made to speak to her but she was very drunk and it was not possible. It was eventually established that the threats were made against Adult A who did not want any action taking. The URN was then closed. As the threats were not fully established and neither Adult B nor Adult A was engaging it is understandable that this did not progress.	Thames Valley Police IMR
URN 1067 Adult A called TVP to report that Adult B would not answer the door to him and he was concerned as she had harmed herself in the past. He said that they had argued that day about money and she had thrown him out. He also said that there were people in Faringdon (not known who) that were out to get him.	Uniformed Patrol Officers attended and spoke to Adult B who said that she just wanted some space and had asked Adult A to stay at his mother's house for the night. The officers updated that she did not smell of alcohol and did not show any signs of harming herself. The URN was closed.	Thames Valley Police IMR

	It is positive that officers attended but they should have completed an ASB matrix with the caller	
URN 1421 This was another call from Adult B's neighbour complaining about loud music being played and waking their children up. Adult B banged on the wall and shouted abuse which also woke the children.	Uniformed Patrol Officers attended a short while later but could not hear anything so no further action was taken. This was graded as a standard risk ASB incident and the caller said they would speak to the council in the morning. An ASB matrix was not completed. It is positive that officers attended but they should have completed an ASB matrix with the caller.	Thames Valley Police IMR
Adult B - Face to face consultation	1.Request for sickness certificate issued for 3 months 2.request for more medication, restarted, asked to see usual GP to change from acute to repeat 3. bruised coccyx 4. asthma medication	NHS Oxfordshire CCG Individual Management Review for General Practitioners
MC4239590/13 - Assault ABH Adult B walked into her sister-in-law's (Adult A's sister) house and asked her about some money owed to her. She said she did not have	Adult B was arrested and interviewed but said that she acted in self-defence. With no other evidence available no further action was taken and the case was filed.	Thames Valley Police IMR

any money so Adult B got angry and grabbed her hair and punched her three times to her left eye.	As with the earlier incident involving Adult A's mother, this should have been dealt with as a domestic incident and A Domestic Abuse Risk Assessment Form completed and the CEDAR crime report flagged as being as Domestic Abuse related.	
MC4239989/13 -Assault Occasioning ABH Adult A was a witness to an incident where Adult B was assaulted by two females. Adult B was owed £10 by one of these women and she had been to the woman's house the previous day to demand the money back. The woman who owed her the money was not in so Adult B spoke to her 17 year old daughter. The woman and her daughter went to Adult B's house, let themselves in via an insecure door and went upstairs where one of them pinned Adult B to the bed by her throat and the other woman hit Adult B in the face. They were told to leave, which they did, and an hour later, Adult A called TVP. Adult B had slight bruising to her face however had been involved in an incident the previous day which resulted in some minor facial injuries.	Witness statements were taken from Adult A and another witness but Adult B was too intoxicated to provide her own statement. The two women were arrested and one was given a Police caution and the other was charged with assault. Two days later Adult A called to say he wished to retract his statement. This investigation was proportionate and resulted in one offender being cautioned and another charged.	Thames Valley Police IMR
URN 19	Officers attended and found that she was intoxicated and reporting	Thames Valley Police IMR

Adult B called TVP to say that she had taken an overdose.	that she had taken Diazepan and Co-codamol. An ambulance was called and took her to hospital. No further action was taken by TVP. It was the correct action to attend and ensure that an ambulance was called for Paramedics to care for Adult B. A CEDAR report was not created and the Vulnerable Adult Co-ordinator was not informed. No referrals were made to Adult Social Care or to the Mental Health Team by TVP and these should have been considered with Adult B's consent.	
Adult B - Assessed at the Barnes Unit following presentation to A&E o/D of cocodamol. Sertraline and Diazepam.	Reported Police arrested her two days previously for assault on her partner's sister, on release from custody reported that 3 women broke into her home and attempted to strangle her whilst she was in bed. Also Grandmother's funeral scheduled and the uncle who abused her would be present. Stated that overdose was in response to a belief that her home was being broken into and being	Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report

	informed by Police that she was not on a 'witness protection programme'. Police responded to her original call. Denied suicidal thoughts, plans or intent.	
Adult B - Telephone call from Barnes Unit (John Radcliffe Psychiatric Liaison)	Information that patient had taken overdose of paracetamol, sertraline and alcohol.	NHS Oxfordshire CCG Individual Management Review for General Practitioners
MC4242121/13 – Adult Protection (non crime incident) Adult B was said to be an agoraphobic alcoholic who had decided to go for a walk in an attempt to conquer her condition. Another female made comments towards her and allowed her dog out to run towards Adult B who then returned home, distressed.	A referral was made to her GP by the Vulnerable Adult Co-ordinator via an information sharing report. It was good practice that a referral was made to Adult B's GP. This had the effect of sharing the information about Adult B's alcoholism and agoraphobia with professionals who could help her.	Thames Valley Police IMR
URN 975 Adult A called to say that his ex-partner, Adult B, was causing problems and he wanted to retract a statement that he had made.	An appointment had been made for him to do this the next day. Patrols were conducted and he was found to be all in order. The URN was closed. It was not established what the nature of these problems were nor was it treated as a domestic incident. He should have been asked to complete a Domestic	Thames Valley Police IMR

	Abuse Risk Assessment Form and a CEDAR report should have been created for a Domestic Incident (non crime).	
Adult B - Vulnerable Adult info-share report from TVP. She has decided to go for a walk to attempt to conquer her agoraphobia and alcoholism when she passed her neighbours door an incident occurred, comments were made and Adult B was frightened by the neighbour's dog. Adult B intoxicated. Noted as non- crime domestic Incident. Also logged on this report historic incidents involving Adult B including assault occasioning actual bodily harm (Sec 47) (historic)	Referral to ASC and GP checks made.	Adult Social Care Vale Team Individual Management Review
Alert from police/SCAS to Adult Safeguarding Team regarding welfare concerns for Adult B as she is an agoraphobic, alcoholic and there had been a recent discussion with a neighbour regarding a neighbour letting her dog to run towards Adult B, this particular incident had led to Adult B becoming distressed and her level of drink dependency was not helping the situation.	No further action taken by Adult Safeguarding Team at this time	Oxfordshire County Council Adult Social Care DHR Chronology
MC4243830/13 – Adult Protection (non crime) Adult A attempted to kill himself by taking 16 Paracetamol and throwing himself down the stairs.	No referral was made as it was deemed that Adult A's actions did not fit with the definition.	Thames Valley Police IMR

	It is not explained as to why this did not fit the definition and the officer who wrote this (Detective Constable P3) cannot now recall.	
Adult B - Adult Protection info-share report – Adult B suffering from agoraphobia and alcoholism and receiving support from Elmore team in Oxford. She made a further call later in the evening of 29-30th detailing in a drunken state that she wished for the help of the Elmore team and couldn't wait any longer and felt like harming herself with knives or others. As Adult B had made an attempt on her life last week, police attended for a welfare check. She reported she had been drinking and 4-5 knives were found in her bedroom. These and medications taken and handed to her son. Paramedics who attended confirmed no physical issues and she had mental capacity. A call to the Ashurst and the Warneford to establish that if she would leave the house voluntarily would they accept her as she had been drinking. No beds were available and no admission to JR/11 as she was suffering from agoraphobia. All weapons and meds, taken away and son (17) will look after her, plans are in place for caller to be seen tomorrow after	Adult protection review - checks please & referral to mental health team and general practice.	Adult Social Care Vale Team Individual Management Review

she has had some sleep and reduced her alcohol intake.		
MC4245283/13 – Adult Protection (non crime incident) Adult B was suffering from agoraphobia and alcoholism. She was having support from the Elmore Team in Oxford and she had made threats to harm herself.	Officers attended and spoke to Adult A and the other occupants at the address. An ambulance was called to check her over and Mental Health professionals were consulted and confirmed that she could stay at home. Knives were removed from the house. A referral was made to the Mental Health Team and her GP. It is positive that a referral was made to Adult B's GP but it does not state in CEDAR whether consent was gained from Adult B.	Thames Valley Police IMR
Assessed by CMHT following Police referral to Oxon CAS after Adult B called them expressing thoughts of harming someone with a knife.	Precipitating factors as above. Adult B called Police after making cuts to her stomach whilst intoxicated	Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
MD4251550/13 – Drunk and Disorderly PND CRI Adult B was making a commotion outside. She was abusive and rude to an officer.	Adult B was arrested for being drunk and disorderly. She was convicted and given a conditional discharge.	Thames Valley Police IMR
URN 54	Adult B was located by Adult A but not seen by Police officers. This was dealt with as a 'fear for welfare'	Thames Valley Police IMR

Adult A called TVP to say that he did not know where Adult B was and he was worried about her.	rather than Adult B being a Missing Person. The time between Adult A making the phone call and then him seeing Adult B was less than 20 minutes so it seems appropriate that she was not dealt with as a Missing Person.	
MC4255467/13 – Domestic Incident (non crime incident) This was a verbal argument between Adult B and her 19 year old son. Both parties were calm upon Police arrival and no offences were disclosed. Adult B was said to be very drunk.	The Domestic Abuse Risk Assessment Form was refused and the incident was classed as standard risk. This review has no issue with the actions taken as a Domestic Abuse Risk Assessment Form was attempted and a CEDAR report created	Thames Valley Police IMR
Adult B - Face to face consultation	Double appointment for review after overdose (arranged at request from psychiatric team) Antidepressant prescription Request for diazepam prescription – declined Patient not ready to discuss alcohol issues	NHS Oxfordshire CCG Individual Management Review for General Practitioners
Child 1 called the Police after being 'slapped' around the face by his mother. Adult B was arrested and Child 1 returned to live at his	No further action/Case Closed	Children's Social Care Summary of Involvement

father's. Child 1 viewed as being safe and therefore case closed.		
MC4259988/13 – Assault without injury Adult B returned home from a friend's house drunk, and began an argument with her 14 year old son about money. She then started arguing with her 19 year old son and slapped him on both sides of his face. No injuries were caused.	Adult B's 14 year old son was classed as being at standard risk of Domestic Abuse. The CEDAR report stated that the victim was aged 14 (therefore did not fit the definition) but it was treated as a domestic incident for risk management purposes. There was also a 19 year old son involved too however which would classify the incident as Domestic Abuse. Both the Domestic Abuse and Child Abuse flags were added to the CEDAR report which would highlight this to the PVP Referral Centre. The CPS made the decision that no further action was to be taken. This was actually Child Abuse and Domestic Abuse (given that there was a child and an adult son involved). The CEDAR report was flagged for Domestic Abuse and	Thames Valley Police IMR

	Child Abuse and Social Services were informed. There are no issues with this incident.	
MC4270555/13 – Public Order Act offences Adult B was yelling and banging on the front door of a female's house. She was asked to leave and Adult A took a swing at the female but no contact was made. The female then struck Adult B once to the face who continued to shout and swear.	Police were called and Adult B was arrested and later charged. She was 'bound over' for 12 months.	Thames Valley Police IMR
URN 1440 This was another noise complaint from a neighbour of Adult B.	Officers attended and found that the music was very loud and Adult B was very drunk. They turned the very loud music down, closed the windows and took two knives away from Adult B who was threatening to harm herself. Her son was due home soon and the neighbours were also spoken to at length and advised about calling Police. The URN noted that this was being dealt with by the Neighbourhood Policing Team. Although this started as a noise complaint, Adult B was threatening to harm herself when the officers arrived at the scene. Knives were	Thames Valley Police IMR

	taken away from her but no Adult Protection report was created nor referrals made. Adult B's permission would need to have been obtained. An ASB matrix was not completed and should have been.	
URN 91 This was another call from the same neighbour as above.	Officers attended and an ASB matrix was completed with the caller.	Thames Valley Police IMR
URN 1215 This was an anonymous call reporting that Adult B was drunk and was sat on her driveway.	Uniformed patrol officers attended and found Adult B drunk but in good spirits.	Thames Valley Police IMR
MC4285740/13 – Domestic Incident (non crime incident) Adult B's 19 year old son's girlfriend called TVP to report that Adult B was very drunk and was beating her son up. They had taken a knife from her and restrained her.	Officers attended and spoke to those present who said that they had tried to restrain Adult B to stop her drinking any more. She had lost a court case that day. It was written that her screaming and shouting was due to frustration. A Domestic Abuse Risk Assessment Form was not completed at the time but officers were asked to do this and later did complete a form. The risk assessor agreed that the incident should be graded as standard risk.	Thames Valley Police IMR

	The initial caller stated that Adult B had a knife and had to be restrained. This is not noted as a risk factor in the risk assessment which this review believes it should have been and potentially increased the risk grading to medium risk. The attending officer (Police Constable P4) has said that he was not told about the knife. In his view it was a disorder and not a Domestic incident.	
URN 1694 Adult B called to say she was having problems with two females who were verbally abusing her.	Uniformed Patrol officers attended the next day and completed the ASB Risk Matrix with Adult B who was assessed as standard risk. There were no offences recorded.	Thames Valley Police IMR
MC4290133/13 – Domestic Incident (non crime incident) Police attended a report of loud music from a third party. All parties were spoken to and Adult B was very drunk. One of her sons (aged 19) and his girlfriend who was pregnant were living at the house and confirmed they had been involved a verbal argument.	This was flagged for Adult Protection due to Adult B's ongoing alcohol problem. The information was not shared with agencies as consent was not obtained. The information was to be shared with Child Social Care though due to Adult B's son's girlfriend being pregnant.	Thames Valley Police IMR

	The Domestic Abuse Risk Assessment Form was completed and assessed as standard risk. It is positive that this was flagged as an Adult Protection incident and correct that the information was not shared due to lack of consent. The attending officer (Police Constable P5) should have documented asking her for consent. He could not recall but said that at the time he would record such information on CEDAR however now he would record this agreement in his PNB and ask the person to sign it. It is also positive that information was shared with Children's Social Care.	
URN 1808 This was another noise complaint from the neighbours about loud music coming from Adult B's house and waking up their children.	Officers attended and the noise had stopped. The neighbour called Police again because of Adult B turning the music up again as soon as officers left. Officers returned to the location 40 minutes later but the noise had ceased by this time. An ASB Matrix should have been completed.	Thames Valley Police IMR
MC4294711/13 – Domestic Incident (non crime incident)	An email was sent to the local Neighbourhood Policing Team	Thames Valley Police IMR

Adult B rang TVP in a drunken state requesting her 19 year old son's partner be removed but could not explain why. Adult B left the house and when she returned she argued with her son about his girlfriend still being there. Adult B also threw some of her own belongings around, damaging them. The neighbours also reported this incident due to the noise being made. Adult B's 14 year old son was also present.	about Adult B's drink problem which was affecting the neighbours. The Domestic Abuse Risk Assessment Form was completed and assessed as standard risk. Her 19 year old son informed the officer completing the form that Adult B had once (many years before) almost stabbed him when he had tried to take a knife from her because she was trying to stab herself. He said that she had tried to strangle him the previous year. Adult B's son's girlfriend was pregnant and the unborn child was listed on the CEDAR report. It is the opinion of this review that this could have been graded as medium risk due to the previous incidents involving a knife and attempted strangulation. The Domestic Abuse Risk Indication Form also indicates that she had threatened to kill him and that the situation was escalating. The previous Domestic Abuse incident between Adult B and this son was graded as medium risk the previous	

	September. It is positive that the Neighbourhood Policing Team was informed. Children's Social Care should also have been informed due to the age of Adult B's youngest child who was 14 at the time. A referral should have been made to Children's Social Care as Adult B's son's girlfriend was pregnant.	
Domestic Violence report from Police. Argument between Adult B and Partner of Child 2 (aged 18). She confirmed that Child 1 no longer lived at the house and therefore case closed.	No further action/Case closed	Children's Social Care Summary of Involvement
Adult B - Telephone call to reception from patient	Request for further sick note to duty doctor, advised to make routine appointment	NHS Oxfordshire CCG Individual Management Review for General Practitioners
Adult B - Face to face consultation	1. Depression, request for antidepressants, 2.Agoraphobia,request for diazepam, 3. Request for sickness certificate, 4. Request for referral to mental health team 5. Medication request for back pain 6. Medication request for cystitis. Medications prescribed after discussion, GP phoned CMHT to	NHS Oxfordshire CCG Individual Management Review for General Practitioners

	ask about option of home assessment	
Re-referral to CMHT from GP to address agoraphobia. States that Adult B now keen to have CMHT input.		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
URN 16 Adult B's 19 year old son called TVP to report that he was not at home but had heard from a friend (his brother's girlfriend) that his mother was really angry and had threatened to "smash up" his belongings and cut his dog's throat. He said that he would not go back and would stay with his pregnant girlfriend.	Officers attended and spoke to Adult B's son who said that this was not a domestic incident; it was third hand information that Adult B was drunk and wanted to damage his property. There was no-one at Adult B's house and no further action was taken. This was still a domestic incident and as such a CEDAR report for a Domestic Incident (non crime) should have been created and a Domestic Abuse Risk Assessment Form completed with Adult B's son.	Thames Valley Police IMR
Adult A - Assessment	Assessment by Mental Health liaison within Emergency department, following impulsive overdose of x 10 Co-codamol tablets 30/500. Adult A reported drinking quite heavily prior to overdose and recent difficulties including arguing with his girlfriend	AWP Individual Management Review

	and concern over his Nan who was unwell.	
URN 1371 This was a call from Adult B reporting that her 19 year old son was refusing to leave the house.	A Uniformed Patrol officer attended and updated that this was a case of Adult B wanting him to move out but he had nowhere to go to. He said he was looking for somewhere else to live and all was calm at the house. This was deemed not to be a domestic incident but rather one of Adult B's 'usual drunken calls'. No further action was taken. As a dispute between Adult B and her son this should have been dealt with as a domestic incident with a CEDAR report for a Domestic Incident (non crime) being created and a Domestic Abuse Risk Assessment Form completed.	Thames Valley Police IMR
URN 1665 The Ambulance Service called to report that Adult A had run away from Adult B's house after taking an overdose.	Uniformed Patrol officers attended and located Adult A. He was taken voluntarily to hospital in the ambulance. No CEDAR report was created nor referrals considered. An Adult Protection CEDAR report should have been created and	Thames Valley Police IMR

	consideration given to making referrals to Adult Social Care.	
Adult A - Assessment	Assessment by Mental Health liaison within Emergency department, following impulsive overdose of Co-codamol	AWP Individual Management Review
Adult A - Face to face Consultation	Discussion of recent self-harm. Sickness certificate issued 1 month	NHS Oxfordshire CCG Individual Management Review for General Practitioners
URN 1538 Adult B called to report that Adult A was trying to overdose on his medication and had tried to do this before.	An ambulance was called and a Uniformed Patrol officer attended. It was established that there was no overdose taken and Adult B and Adult A were fine. No further action was taken. This has been discussed with a Vulnerable Adult Co-ordinator and the expectation is that a CEDAR / NICHE report should still be created as this would make the MASH aware of the incident. Although they may not make any referrals if there was not an actual overdose, with subjects like Adult A and Adult B who were known to Police and	Thames Valley Police IMR

	services, the MASH staff may want to make the other services aware.	
URN 49 Adult B called to say that Adult A had taken an overdose.	Uniformed patrol officers and an ambulance attended and he was cared for by the Paramedics. An Adult Protection CEDAR report should have been created and consideration given to making referrals to Adult Social Care.	Thames Valley Police IMR
URN 20 Adult B called TVP sounding very intoxicated and saying that her 19 year old son's girlfriend had lost a baby. She said that she was worried about Adult A as he kept taking overdoses but said that he had not taken an overdose on this occasion. There was however a concern that Adult B had taken an overdose herself.	An ambulance was called for Adult B as the call taker was concerned that she may have taken an overdose. Uniformed patrol officers and an ambulance attended and also found that Adult B had picked at some scabs on her wrist causing bleeding. She was also thought to have taken some tablets and went willingly to hospital. Adult A had not taken an overdose on this occasion. In relation to the overdose an Adult Protection CEDAR report should have been created and consideration given to making referrals to Adult Social Care.	Thames Valley Police IMR

Adult B - Assessed by Barnes Unit, A&E at JRH following overdose of Naproxen and Diazepam, in the context of relationship issues and financial problems.		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
Domestic Violence report from the Police. Adult B has allegedly hit Adult A around the left cheekbone with a curtain rod. Adult B claimed self defence and Adult A refused to co-operate with the investigation. Child 1 not present at incident and does not live at the address, therefore case closed	No further action/Case closed	Children's Social Care Summary of Involvement
MC4309429/13 – Assault Without Injury During an argument Adult B hit Adult A with a metal curtain rod. No injuries were caused and Adult B was arrested.	The Domestic Abuse Risk Assessment Form stated that there were no previous incidents between Adult A and Adult B. The incident was graded as standard risk which seems appropriate given the information available. Adult B was arrested and interviewed and claimed that she was acting in self-defence and Adult A would not co-operate with Police so no further action was taken. Positive action was taken with this in the form of an arrest. It was incorrect that there had not been	Thames Valley Police IMR

	any previous incidents between them. There had but these had not been properly recorded (on CEDAR). The attending officers would not have known that as they would not be expected to conduct the level of research in order to find the URNs, only for CEDAR or NICHE reports.	
Adult A - Telephone call	patient requested duplicate sickness certificate	NHS Oxfordshire CCG Individual Management Review for General Practitioners
MC4311046/13 – Public Order Offences Adult A was witnessed to be shouting and swearing in the street.	He was arrested for breach of the peace and public order. He was taken directly to hospital A & E in an ambulance as he stated he had taken drugs and was incoherent and aggressive. Two Uniformed Patrol officers travelled with him due to his demeanour. He was refused treatment at hospital due to his violent nature and given a doctor's note and taken to Abingdon custody. He was	Thames Valley Police IMR

	accepted into custody and later charged with a public order offence. Police Constable P7 has been consulted about his response to this incident which is deemed to have been appropriate. Adult A's welfare was prioritised before dealing with him for the Public Order offence.	
URN 103 Adult B called to say that she was an alcoholic and a self-harmer and although she was agoraphobic, she had been out that day. She said that she would like to be in a Police cell as she felt safe and looked after. She said that she would not self-harm and had no medication to overdose on.	She was given the phone number for the Samaritans and she said that she would speak to her support worker the next morning. Adult B was not saying that she was going to harm herself and was not informing TVP of anything not already known, i.e. that she was a self-harmer, agoraphobic and alcoholic. Therefore this action seems appropriate.	Thames Valley Police IMR
Adult A - Face to face consultation	Emotional problem. Given forms for Talking Space referral. Chest examination.	NHS Oxfordshire CCG Individual Management Review for General Practitioners

Adult B - Telephone consultation	Request for further medication, prescription given	NHS Oxfordshire CCG Individual Management Review for General Practitioners
URN 55 This was a call from the Ambulance Service at 00:48 hours reporting that a male, Adult A, had taken an overdose and they were holding back from going to the house as they did not know if he may be violent.	Uniformed Patrol officers attended and found the house in darkness. When they gained entry at 01:05 hours, Adult A spoke with the officers and Paramedics and although he was talking about taking Paracetamol, he refused medical treatment and walked away. The officers updated that there was no reason to stop Adult A from walking away. The Paramedics said that there was no need to treat him and no further action was taken. The URN was closed at 01:27 hours. This was a judgement call by the officers (Police Constables P8 and P9). The Police can use Section 136 of the Mental Health Act to take a person to a place of safety when in a public place. They can do this if they think they have	Thames Valley Police IMR

	a mental illness and are in need of care. A place of safety can be a hospital or a Police station. If it was considered that Adult A lacked the capacity to make the correct decision in relation to his health after taking an overdose, then the Mental Capacity Act could have been invoked. This has been discussed with a Vulnerable Adult Co-ordinator and the expectation is that a CEDAR / NICHE report should still be created as this would make the MASH aware of the incident. Although they may not make any referrals if there was not an actual overdose, with subjects like Adult A and Adult B who were known to Police and services, the MASH staff may want to make services aware.	
URN 121 Adult A's brother also called at 02:09 hours about Adult A having taken an overdose and was locked out of the house.	This relates to the incident on the 30/08/13 00:48 hours	Thames Valley Police IMR
URN 160	No officers were available to attend and at 03:49 hours the Ambulance	Thames Valley Police IMR

This was a further call from the Ambulance Service at 02:54 hours asking for Police officers to attend whilst they treated Adult A for taking an overdose of 30 Co-codamol. They had been called by Adult B who had intimated to them that she may be violent to Adult A.	Service called and informed TVP that Adult A had been taken to hospital. This relates to the above incidents. No officers were available to attend this call however Adult A was already being cared for by Paramedics. More enquiries should have been made about the possible violence towards Adult A. An Adult Protection CEDAR report should also have been created.	
Adult A - Assessment	Assessment by Mental Health liaison within Emergency department, following impulsive overdose of x 30 Co-codamol tablets 30/500, x 2 Fluoxetine 20mgs and possibly heroin, crack cocaine. Girlfriend, Adult B, was present and was intoxicated. He described recent difficulties which included, his Grandmother's recent death, a relationship breakup with his girlfriend, has a court appearance date on the 09/09/2013 following arrest and charge for being drunk and disorderly.	AWP Individual Management Review

URN 351 A neighbour of Adult B's called TVP to report screaming coming from the address.	Uniformed patrol officers attended and found only Adult B's son and his girlfriend there who said there had not been an argument. There were no signs of injuries and Adult B's son had been asleep. No further action was taken. Other enquiries, such as speaking to the initial caller, should have been conducted prior to closing this URN.	Thames Valley Police IMR
MC4316354/13 - Domestic Incident (non crime) Adult B reported that she had been assaulted by Adult A. She was outside Faringdon Police station at the time. They had both gone out together for some drinks.	Adult B and Adult A were spoken to and no offences were disclosed. The Domestic Abuse Risk Assessment Form questions were refused and Adult B was assessed as being at standard risk of Domestic Abuse. Adult A had taken an overdose and was taken to hospital, accompanied by Adult B. This was one of many incidents where either Adult A or Adult B would call TVP reporting having been assaulted by the other but then when officers attended, saying that nothing happened. Police	Thames Valley Police IMR

	Constable P10 has been consulted in relation to his attendance to this incident. He cannot recall why he let Adult A and Adult B go in the ambulance together but presumes that they would have wanted to. He cannot remember anything else about the incident and was working alone at the time. A CEDAR report was not created for Adult Protection nor was the Domestic Incident CEDAR report flagged for Adult protection. One of these should have been done to highlight the incident to the Vulnerable Adult Co-ordinator and consider referrals to other agencies.	
MC4316883/13 - Adult Protection (non crime) Adult A called for an ambulance saying he had taken a large quantity of Paracetamol.	He was detained under the Mental Capacity Act for him to receive treatment. This was the correct action for dealing with Adult A. He gave consent for referrals to be made however this did not happen and a review on the CEDAR report stated that this was not necessary as he was under the care of	Thames Valley Police IMR

	professionals. TVP should still make referrals and not presume that the other agencies would do this or would already know the information.	
Adult B - DNA'd Appointment with SW CMHT. Further appointment agreed for 16.9.2013		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
Adult A - Assessment	Assessment by Mental Health liaison within Emergency department, following impulsive overdose of x 24 Paracetamol tablets. He described recent difficulties which included, on-going relationship difficulties with his girlfriend, Adult B, worries regarding his court appearance 09/09/2013, and his Grandmother's funeral.	AWP Individual Management Review
MC4317528/13 - Domestic Incident (non crime) Adult B reported that after they had separated, Adult A had walked into her property to collect belongings. They had a verbal argument and he left.	No offences were disclosed. Adult B answered the questions on the Domestic Abuse Risk Assessment Form and it was assessed as being standard risk. It was not dip checked so the risk assessment was not reviewed or changed by PVP Referral Centre staff.	Thames Valley Police IMR

	The questions which Adult B answered yes to were that he had previously grabbed her throat, escalation, mental health, depression and afraid of further violence. It is the opinion of this review that this information would indicate the risk to be higher than standard risk. Medium risk would be more appropriate in this case.	
Adult A - Face to face consultation	Emotional problem, helped complete Talking Space form	NHS Oxfordshire CCG Individual Management Review for General Practitioners
URN 49 This was another call from the Ambulance Service at 01:06 hours asking for Police to assist as Adult A had taken an overdose and then run away from Paramedics.	The incident was managed as Adult A being a Missing Person with intelligence checks being completed and a search commenced. He was found by officers at 01:44 hours and taken to hospital. When the medical staff were happy that Adult A was receiving treatment the officers left the hospital at 06:00 hours.	Thames Valley Police IMR

	An Adult Protection CEDAR report should have been created and consideration given to making referrals to Adult Social Care.	
MC4320477/13 – Criminal Damage to Vehicles Adult A was alleged to have 'keyed' the car of T.	Enquiries were carried out but due to insufficient evidence the case was filed.	Thames Valley Police IMR
Domestic Violence report from Police. Adult B has shouted verbal abuse at Adult A in the street outside the house. Child 1 is still not living at the property therefore case closed.	No Further Action/Case Closed	Children's Social Care Summary of Involvement
MC4321017/13 - Domestic Incident (non crime) This was a verbal argument involving Adult A telling another person not to damage T's car. Adult A had recently been accused of causing damage to it.	No offences were disclosed and this was assessed as being a standard risk domestic incident. Adult A refused to answer any questions from the Domestic Abuse Risk Assessment Form. Police Constables P11 and P12 have been spoken to and there are no issues with this incident.	Thames Valley Police IMR
URN 1486 Adult B called TVP but the line was so poor it could not be established what she was saying.	Officers attended and she was drunk and abusive. They left and no further action was taken.	Thames Valley Police IMR

URN 1614 Adult B called TVP very drunk and, in relation to Adult A, said that she wished that she could "get wankered and slit his throat". She said that there were lots of issues and that she would like to kill Adult A for doing these things.	She was advised not to and to go to bed and sleep it off. Officers did not attend and no further action was taken. This has been reviewed by a control room inspector who has listened to the call and said that Adult B sounded very drunk and initially said that she would kill her boyfriend but then changed to say she would hurt him. The call taker advises Adult B not to take matters into her own hands but to speak to her solicitor. Adult B agrees to do this and also agrees to go to bed when they call ends. The Inspector agrees with the decision not to attend as officers had been to the address 2 hours prior and Adult A was not present, only Adult B's son and his girlfriend. No operational learning has been identified.	Thames Valley Police IMR
URN 1241 Adult A's mother called TVP to report that T had attended the home address of Adult A and	Officers updated that there were no offences and the URN was closed.	Thames Valley Police IMR

threatened him. This was the day after T's car had been damaged.		
Adult A - Face to face consultation	Emotional problem. Medication change	NHS Oxfordshire CCG Individual Management Review for General Practitioners
Adult B - Assessment with CMHT.		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
MC4326560/13 – Public Order Act offences Adult B was verbally abusive to her neighbours.	She was arrested for a Public Order offence. She was given medical treatment and taken to hospital as she said that she had taken an overdose. She was de-arrested and was due to be reported for the offences. Due to a delay in submitting the paperwork to court, Adult B was not reported and no further action was taken. There are no issues with this incident. The paperwork went missing and because she had been to court and been arrested for other offences before it was found it was	Thames Valley Police IMR

	considered that to report her at a later stage could be viewed as an abuse of process.	
Adult B - Assessment	Seen and assessed at GWH by the Mental health Liaison Team, following an overdose of x 14 naproxen tablets and 10 pints of lager.	AWP Individual Management Review
URN 85 This was an anonymous call from a neighbour reporting screaming and shouting from Adult B. He said that she did not sound in distress and was also laughing.	Officers did not attend as it was not known who the caller was. This should have been attended as without officers going to the address it could not be known for certain that no-one needed help.	Thames Valley Police IMR
MC4331296/13 – Affray Adult B was under the influence of alcohol when she became involved in an argument with her 19 year old son. He pushed her away and she threw a bottle at him which hit his door. She then used a knife to stab his bedroom door.	A Domestic Abuse Risk Assessment Form was completed with Adult B's son and he was assessed as being at medium risk of Domestic Abuse. Adult B was later charged with common assault. This was later dismissed as no evidence was offered. Risk management was not carried out with Adult B's son and the CEDAR report stated that this was because he had moved out of the	Thames Valley Police IMR

	property to a location that Adult B did not know of and therefore the risk was lower. A flag was still placed on the address even though the risk level was downgraded to standard risk.	
URN 1587 Adult A called to say that T had threatened to stab him. Adult A said that his ex-partner Adult B had lied to him and then her new partner T had threatened him. Adult A then said that he was going to kill himself.	Uniformed Patrol officers attended and established that there were no actual offences and Adult A had taken heroin that day. There was bad feeling between Adult A and T because of Adult B. Officers monitored to ensure that there was no breach of the peace and the Neighbourhood Policing team were notified. Several officers attended this incident and spoke to both Adult A and to T to establish that there were no offences. They also monitored the situation to prevent escalation and there were no further issues or offences.	Thames Valley Police IMR
Adult A - Face to face consultation	Discussion re drug misuse. Sickness certificate 2 months	NHS Oxfordshire CCG Individual Management

		Review for General Practitioners
MC4337239/13 - Domestic Incident (non crime) This was a verbal argument between Adult A and Adult B as she had a new partner.	No offences were disclosed and the incident was classed as a standard risk Domestic Abuse incident. Adult B refused to complete the Domestic Abuse Risk Assessment Form.	Thames Valley Police IMR
Adult B - Referral to complex needs service made by CMHT		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
Adult B - No details available	Details not available	NHS Oxfordshire CCG Individual Management Review for General Practitioners
URN 1363 A neighbour called to report that Adult B could be heard arguing with another female at the address.	Uniformed patrol officers attended and found that she was not happy about bail conditions put on her but there were no offences. No further action was taken. There is no record of other enquiries having been completed to establish the facts with the	Thames Valley Police IMR

	exception of speaking to Adult B. The attending officers (Police Constable P1, Police Sergeant P13, Police Constable P14, Police Constable P15 and Police Sergeant P16) cannot recall what happened or what actions were taken.	
MC4342023/13 – Adult Protection (non crime incident) Adult B called TVP stating she had a head injury. Upon arrival officers established that she had fallen over in the back garden and sustained a cut to her head.	Adult B had a cut to her head but refused to go to hospital. An ambulance did attend, speak to Adult B and give medical treatment. The officer believes that she signed a form with them to say she didn't want to go to hospital. Her son was in the house with his girlfriend upstairs and was aware of the situation so the paramedics were happy to leave her at the house. An Adult Protection review from Niche stated that from 17/10/13 Adult B had weekly appointments with MH Team. This information was shared with the Community Mental Health Team. This is an appropriate response in relation to the referrals being made	Thames Valley Police IMR

	and the treatment received by Adult B.	
Adult B - Telephone consultation	Request for medication, prescriptions renewed	NHS Oxfordshire CCG Individual Management Review for General Practitioners
MC4343068/13 – Domestic Incident (non crime incident) Adult B reported somebody had broken into her garage she felt it was her boyfriend T. Adult B had become jealous that her boyfriend was not drinking and instead was spending time with her son. Out of spite he removed some fuses switching off the TV and some lights.	Officers attended the address and the fuses were found and there were no offences. The risk assessment was that she was at standard risk of Domestic Abuse.	Thames Valley Police IMR
Adult B - Safeguarding report sent to CMHT following police concerns about regular calls the Adult B's address, and her intoxication.		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
Adult B - TVP report received, sent to GP at The White Horse Medical Centre and CMHT South West.		Adult Social Care Vale Team Individual Management Review
MC4349391/13 – Domestic Incident (non crime)	When officers attended it was found to be a loud party and there were no	Thames Valley Police IMR

This was a third party report of a domestic incident.	signs of a dispute. The call was received from neighbours who had made previous noise complaints. A CEDAR Crime Related Incident Report for a Domestic Incident (non crime) was created by the Control Room when the call first came in. The attending officers then deemed that it was not a Domestic Incident. None of the names of the people at Adult B's house were recorded. The names of the occupants should have been recorded and a Domestic Abuse Risk Assessment Form completed with whoever the officers deemed as being the victim. The CEDAR report documents that the officers did not do this as they did not believe that a Domestic Incident had occurred.	
URN 46 This was another noise complaint from the neighbours about Adult B.	Adult B was contacted by TVP and asked to turn the music down. An ASB Matrix was not completed but, given the ongoing nature of the ASB, should have been.	Thames Valley Police IMR
URN 1807	Uniformed Patrol officers attended the address at 00:06 hours and	Thames Valley Police IMR

This was a call from Adult B's neighbour at 21:55 hours reporting an ongoing domestic incident where a male and female he believed to be Adult B and Adult A, were shouting and screaming at each other.	reported that the people in the house were highly intoxicated. They were given verbal abuse by Adult B and no-one would explain what had happened. A Domestic Abuse Risk Assessment Form was not completed and a CEDAR report was not created. As there was a suspicion that there had been a domestic incident (due to the information from the caller) a CEDAR report should have been created and the officers should have attempted to complete a Domestic Abuse Risk Assessment Form.	
MC4350980/13 – Anti-Social Behaviour (ASB) non-crime Adult B had been banging on walls making a general nuisance which went on throughout the evening. She was shouting out 'I hope I have woken your fucking kids up.'	This incident was classed as medium risk ASB and sound equipment was installed by the EHO. The ongoing problems were eventually resolved by way of a property swap.	Thames Valley Police IMR
URN 1163 Adult A called to say that Adult B had hit him on the head with a shoe. He said that Adult B	Uniformed Patrol officers attended and updated that there were no offences disclosed and that their Pocket Note Books (PNBs) had	Thames Valley Police IMR

was intoxicated and that he himself was under the Mental Health Team as he was a recovering heroin addict. He said that Adult B's other partner, T, was also there but not causing any problems. The URN also mentions Adult B being suicidal.	been signed accordingly. House to house enquiries were conducted and neighbours told the officers that shouting was usual from the address and there was nothing out of the ordinary this night. Adult A and Adult B were spoken to separately and Adult A refused to complete the Domestic Abuse Risk Assessment Form. Although upon Police attendance Adult A did not disclose any offences, a CEDAR Crime Related Incident Report should have been created for a Domestic Incident (non crime). The attending officer (Police Constable P17) has said that, in retrospect, a CEDAR report should have been created.	
URN 1271 This was a call from T reporting that he had been sent a text message advising him that Adult A was coming for him with a gun. He was with Adult A and Adult B at the time so did not think that it was from them.	He was spoken to but did not take the threat seriously and thought that it was someone trying to split him and Adult B up. Checks were conducted on the mobile phone number and there was no intelligence linked to it. The URN was closed with no further action.	Thames Valley Police IMR

	Those involved were debriefed and did not have any concerns about the message. There is no evidence that the property was searched for weapons; however there were no further problems and Adult A, Adult B and T had all been together at the time of the text.	
URN 1046 This was a call from Adult B reporting that her ex-partner, T, was in her house and there was a risk to Adult A but she did not say what. She was intoxicated and the call taker could not get any further information. Adult A also called and they were talking about the previous incident from URN 1271 – 05/11/13 (Incident 86). It appeared that T, Adult B and Adult A were all at the same address and did not want to be seen.	As it could not be established what they were saying, the URN was closed. This should have been attended to clarify what was happening, particularly as there had been previous incidents involving the parties.	Thames Valley Police IMR
URN 1156 Adult A called TVP to report that he wanted to kill himself and was fed up of people accusing him of things such as being a heroin addict. He said he was not taking his medication and had not seen his GP for 2 weeks. He said that he wanted to be admitted for treatment and was very distressed.	The call taker spoke to Adult B about the situation but she sounded very intoxicated and was not making much sense. Officers attended the address, as did an ambulance and Adult A said that he was suffering from the effects of withdrawing from heroin. The Paramedics could not help him and	Thames Valley Police IMR

	Adult A said that he was not going to harm himself but wanted something to help with the effects. He went to his mother's house where there were people to look after him. The URN was closed stating that there was no further action to be taken at that time. It appears proportionate that the attending officers clarified that he did not intend to take an overdose and placed him in the safety of his family who would help to protect him. A referral could have been made to a drugs agency or GP to give Adult A help with the withdrawal effects. This could have been done with his permission if a CEDAR report was created for Adult Protection.	
Adult A - Telephone third party	Phone call from ambulance crew Susan requesting GP attendance as patient withdrawing from heroin. Duty doctor advised she was unable to help at this time and ambulance crew advised to contact OOH service if required (patient	NHS Oxfordshire CCG Individual Management Review for General Practitioners

	subsequently taken to Emergency Dept GWH)	
Adult A - Telephone third party	Phone call from paramedic to OOH. As above. Prescribed 10mg diazepam	NHS Oxfordshire CCG Individual Management Review for General Practitioners
MC4354821/13 - Domestic Incident (non crime) Adult B called Police to say that Adult A was destroying the house.	Police attended and no offences were disclosed but rather a verbal argument. The officers saw a broken Sky box which Adult A said was his and was damaged prior to the incident. Adult B refused to complete a Domestic Abuse Risk Assessment Form. This was classified as a standard risk domestic incident. There are no issues with this incident. No offences were apparent and a CEDAR report was created and the officers attempted to complete a Domestic Abuse Risk Assessment Form.	Thames Valley Police IMR
URN 306 Adult B called TVP to complain that a PCSO had told Adult A that she was a 'drunken piece of shit' and a 'piss head'.	A sergeant phoned Adult B but she was intoxicated and not making much sense. Efforts were made to contact her again when she was sober but she did not engage.	Thames Valley Police IMR

	The sergeant followed protocol by attempting to make contact with Adult B to take further details of her complaint. As she refused, and considering the low level nature of the complaint, it seems proportionate to have closed the URN.	
MC4354851/13 – Adult Protection (non crime) During a verbal argument with his partner, Adult A took an overdose.	Adult A was taken to hospital and left in the care of the staff. The Adult Protection Co-ordinator noted in the CEDAR report that no referrals were required due to Adult A having been taken to hospital and left in the care of the medical staff. No further Police action was taken. The Adult Protection Co-ordinator should not presume that referrals would be made by the hospital staff and this should have been actioned by TVP, even if it was later duplicated by medical professionals. It was also not established what the argument was about and the Domestic element was not dealt with.	Thames Valley Police IMR
Adult A - Admission to GWH following overdose	Discharged by medics, not seen by Mental Health liaison Service.	AWP Individual Management Review

URN 128 Adult B called TVP to say that she wanted one of her ex-boyfriends (she gave a name that was not Adult A or T) removed from the address. She then said that it was Adult A.	Uniformed patrol officers attended. When they arrived they were told that there were no issues and Adult B wanted Adult A to be left at the address as he had not done anything wrong. No further action was taken. It was not clarified why Adult B wanted him removed in the first place but if, upon Police attendance, Adult B did not want him to go and there were no suspected offences then the officers would not have the power to remove him. The officers should have treated this as a Domestic related incident however and created a CEDAR report and completed a Domestic Abuse Risk Assessment Form.	Thames Valley Police IMR
MC4356201/13 – Public Order Offences Adult A received a text message from T. Adult A later saw T in person who then threatened to shoot him.	Police were called and the suspect was arrested and later cautioned for a Public Order offence.	Thames Valley Police IMR
Adult B - No details available from OOH Practitioner	Details not available	NHS Oxfordshire CCG Individual Management

		Review for General Practitioners
MC4358106/13 – Domestic Incident (non crime incident) A neighbour called TVP after hearing loud music and sounds of a verbal argument.	Upon Police arrival no arguing could be heard. Adult B stated the police had woken her. Both parties (Adult B and T) had been asleep but appeared to be very intoxicated. Only Adult B was spoken to (T was in bed asleep). A Domestic Abuse Risk Assessment Form was submitted and the incident was classified as a standard risk. Police Constable P5 has been spoken to and said that although he cannot exactly recall he would usually speak to neighbours after this type of call, unless the noise had stopped and it was an unsociable hour as he would not want to wake the neighbours again.	Thames Valley Police IMR
Adult B - Fax -from South Central Ambulance Service Safeguarding Adult/Child Form		Adult Social Care Vale Team Individual Management Review

Adult B - SCAS report received- forwarded to client's GP and saved in records. NFA. RQ SCSA		Adult Social Care Vale Team Individual Management Review
URN 1536 Adult B called to say that she wanted Police to leave her alone.	No action was taken. There were no offences or concerns so it is reasonable that officers did not attend.	Thames Valley Police IMR
Adult A - Telephone consultation	Heroin withdrawal. Advised to contact GP practice within 24 hours	NHS Oxfordshire CCG Individual Management Review for General Practitioners
URN 1132 Adult B called TVP to say that her neighbour may call to report her as Adult B had been involved in a loud conversation with her friend.	The call taker checked that Adult B was fine and then the URN was closed. This is a reasonable response where nothing seems to have actually happened.	Thames Valley Police IMR
URN 1421 Adult B called TVP to report that she believed her sons (aged 15 and 19) were stealing from her and wanted her keys and Sky box back. She sounded slurred and was getting confused during the call. It was noted that during a call to TVP on a previous occasion she had said that her ex-partner (Adult A) had thrown the Sky box out of the window. When	An officer spoke with Adult B the next day and the URN was closed as being a civil matter and no further action taken. Adult B believed that her sons had stolen from her and as one of them was over the age of 16 this should have been classified as a domestic incident. A CEDAR report should	Thames Valley Police IMR

asked about this she said she had more than one. She was swearing and referring to someone as a “bitch” but it was not known who. The only items that she could confirm that had been stolen were gravy granules and a cheese grater.	have been created and a Domestic Abuse Risk Assessment Form completed with Adult B. Even if it transpired that there was no actual theft, this should have still been recorded.	
URN 1197 This was another call from Adult B who had been drinking and told the call taker about how, a year prior, Police had let her soon to be ex-husband take the fridge freezer.	The call taker tried to advise her but Adult B ended the call. This is a proportionate response to this call as she was not disclosing anything new.	Thames Valley Police IMR
Adult B - DNA’d information session at Complex needs Service. Adult B had phoned the service to say she was unable to travel to the service due to agoraphobia.		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
Letter to GP discharging Adult B from the CMHT as she had not been able to engage with the agreed treatment plan due to intoxication on a number of occasions.		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
MC4369430/13 – Domestic Incident (non crime incident) Adult B rang TVP whilst drunk stating that her son was spreading rumours that she had inherited some money from her grandmother. She said she would like to smack her son if he carried this on and “smash him up”. She was	The call was originally to be resourced as ‘urgent attendance’ but then downgraded as a Neighbourhood sergeant noted that she was a habitual caller. A Neighbourhood officer attended as they had knowledge of the family. Adult B’s son was spoken to who	Thames Valley Police IMR

not allowed contact with her son's girlfriend due to bail conditions. Her son said that he was not concerned by the comments.	was not concerned about her comments. Adult B refused to answer the questions on the Domestic Abuse Risk Assessment Form and the incident was assessed as being standard risk. This review does not agree with downgrading the attendance resourcing due to Adult B being a regular caller. It does not mean that on this occasion that an urgent or immediate attendance might have been required. There are no issues with the actions of the attending officer.	
MC4371488/13 – Assault without injury Adult B had called Police and said that she needed an ambulance as she had been stabbing her left wrist with cut glass. She also said that she had been restraining her son (aged 15) to take some tobacco from his hand. She pinned him on the bed and during the struggle his foot connected with her head. Adult A also called TVP to complain that Police were not doing anything.	Officers attended and Adult B told them to 'Fuck off' out of her house. An ambulance took Adult B to hospital. This was not classed as a domestic incident as her son was 15 years old. Although this did not fit within the definition (due to her son's age), some of the incidents between them have been treated as domestic incidents regardless,	Thames Valley Police IMR

	therefore enabling risk management. Although the officers had not acted inappropriately, had this had been classed as a domestic incident then risk management could have been considered. There is also the Adult Protection element as Adult B was taken to hospital for self-harming. The CEDAR report was flagged for Adult Protection which is positive although there is no record of any referrals having been made.	
Adult A - Telephone consultation	Vomiting, possibly related to heroin withdrawal. Given health advice	NHS Oxfordshire CCG Individual Management Review for General Practitioners
Adult B - Assessment	Seen and assessed at GWH by the Mental health Liaison Team, following self-harm, laceration, whilst intoxicated of alcohol.	AWP Individual Management Review
MC4373360/13 - Domestic Incident (non crime) Adult A called Police to say that Adult B had hit him in the face and they had only just got back together.	On Police attendance Adult A was spoken to at length and he did not repeat this allegation. He said there had been a verbal argument but nothing more. Adult A refused to	Thames Valley Police IMR

	answer the questions on the Domestic Abuse Risk Assessment Form and the incident was graded as being standard risk DV. If Adult A did not have any injuries and denied that an assault took place then it would be difficult for the officers to deal with Adult B for an offence. However, further enquiries could have been conducted, for example, house to house with the neighbours and listening to the original call to TVP.	
Adult A - Telephone consultation	Drowsy, sick, had ingested heroin. Advised attend ED or OOH base, patient declined	NHS Oxfordshire CCG Individual Management Review for General Practitioners
MC4373895/13 - Domestic Incident (non crime) Adult B reported that Adult A had just left the address taking the key and she did not want him back as he was on heroin.	Six attempts were made to speak to Adult B which were unsuccessful and then the case was filed. The incident was graded as a standard risk domestic incident. TVP made several attempts to contact Adult B without success. As there were no reports of violence and there was an incident the next	Thames Valley Police IMR

	day where noise could be heard from Adult B's house, it seems reasonable to file this report.	
URN 48 This was a call from Adult B's neighbour complaining about the noise.	The ASB matrix was completed and assessed as standard risk.	Thames Valley Police IMR
Adult B - No details available from OOH Practitioner	Details not available	NHS Oxfordshire CCG Individual Management Review for General Practitioners
Domestic Violence Report from Police. Adult B complaining that Child 2 Elderfield (son) has posted abusive comments about her on Facebook.	No Further Action/Case Closed	Childrens Social Care Summary of Involvement
MC4376826/13 – Domestic Incident (non crime incident) This was an argument between Adult B and her 15 and 19 year old sons about abusive comments on Facebook.	Adult B refused to complete the Domestic Abuse Risk Assessment Form and was graded as being at standard risk of Domestic Abuse. A Risk Assessor in the PVP Referral Centre wrote that as there were children recorded therefore a Single Incident Review was required to comply with the 10% dip check policy. The Single Incident Review assessed the risk as standard.	Thames Valley Police IMR

	This was 'dip checked' as per the policy of checking 10% of standard risk Domestic Abuse incidents. The Single Incident Review assessed the risk as standard.	
URN 332 Adult B called TVP whilst drunk but did not know why she was calling. She seemed to think that the call taker would know why she was calling.	The URN was closed pending any further updates. Adult B would often call when drunk, sometimes because she was involved in an incident (often domestic related) and sometimes because she was intoxicated, as with this call. Although she is a repeat Domestic Abuse victim/suspect the Police resources do not allow for officers to attend every call when nothing is actually disclosed other than her being drunk.	Thames Valley Police IMR
MC4381806/13 - Domestic Incident (non crime) Adult B contacted a friend and asked them to call Police as Adult A had picked up a knife.	Officers attended and spoke to Adult B and asked her about the knife. No disclosures were made and she would not engage with Police. She was assessed as being at standard risk of Domestic Abuse. There is no record of the friend having been spoken to establish	Thames Valley Police IMR

	exactly what had been disclosed and how, i.e. by text message. It was confirmed that Adult A was staying at his home address rather than with Adult B which reduced the risk to her.	
URN 190 Adult B called to say that she had her music on at home and should her neighbours call to complain, she wanted TVP staff to know that it was not loud.	The call taker noted that the music did sound loud and asked her to turn it down which she refused. The URN was then closed.	Thames Valley Police IMR
URN 393 & URN 571 Adult B called to say that Adult A had a £700 phone bill and was concerned that he may be distressed enough to take an overdose. She sounded very drunk. She called back shortly afterwards to say that he was with her and that everything was ok.	It was decided by a sergeant that Police attendance would inflame the situation as Adult B was drunk so officers did not attend. This is fair considering that Adult B had called Police when she was concerned that Adult A may take an overdose and certainly had called on other occasions when he had done this. As he was with her and she was saying that he was fine, there would be no reason to attend.	Thames Valley Police IMR
URN 1416	The call taker had concerns for Adult B's welfare and Uniformed Patrol officers were sent to her	Thames Valley Police IMR

Adult B called TVP intoxicated and very upset, apologising for an incident the previous Saturday.	address to check on her. Upon their arrival she could not recall having phoned TVP that evening. She and Adult A were in bed and no further action was taken. If the attending officers did not have any cause for concern then there was no further action to be taken. It was good intervention by the call taker to ask for officers to attend Adult B's address.	
URN 1570 Adult B called to say that she had taken an overdose and had called an ambulance.	It was ensured that an ambulance attended and the URN was then closed with no further action being taken. An Adult Protection CEDAR report should have been created and consideration given to referrals being made. Adult B's permission would need to have been sought.	Thames Valley Police IMR
Adult B - Assessment	Seen and assessed at GWH by the Mental health Liaison Team, following an overdose of x 12 Sertraline 100mgs tablets and a bottle of Lambrini.	AWP Individual Management Review

MC4386376/14 – Domestic Incident (non crime) Adult B called TVP to ask that Adult A be removed from her house. Upon arrival officers were informed that this was a verbal argument and Adult A left the premises. He stated that he had taken an overdose.	Medical attention was sought and it was deemed that he had mental capacity and was not at risk. Adult B refused to answer the questions of the Domestic Abuse Risk Assessment Form and she was deemed as being at standard risk of Domestic Abuse. The officers were correct in their actions creating a CEDAR report for a Domestic Incident (non crime) and attempting to complete a Domestic Abuse Risk Assessment Form with Adult B. They also flagged the Domestic Incident report for Adult Protection.	Thames Valley Police IMR
URN 1528 Adult B's ex-husband called TVP at 21:22 hours to report their youngest son (aged 15 at the time) missing.	He was found at 22:00 hours at his mother's (Adult B's) house and it was agreed that he would stay there for the night. Intelligence checks were conducted on Adult B and her son was visited by officers. The URN notes that Adult B sounded intoxicated but officers attended the address and were happy to leave her son there. The	Thames Valley Police IMR

	attending officer (Police Constable P18) has said that she cannot recall this incident although she had visited the family on several occasions. She said that she would have checked that it was suitable to leave him at the house for the night.	
URN 132 The Ambulance Service called to ask for assistance dealing with their patient, Adult B, who had fallen down four flights of stairs whilst intoxicated. She was being abusive to the responder who was with her.	There were two children (the URN does not say who they were) at the address who were removed and taken to their older brother's house. Adult B was then taken to hospital. The action taken was appropriate for this incident and the safety of the children was prioritised by taking them to a place of safety. A Child Protection CEDAR report should have been created and a referral made to Social Services.	Thames Valley Police IMR
Ambulance Report. Adult B taken to hospital (reason not given). Child 1 was missing from his brother's and returned to his father's address.	No Further Action/Case Closed	Children's Social Care Summary of Involvement
URN 1031 Adult B called TVP to say that she had opened a letter addressed to her 19 year old son. She demanded that Police attend to collect the letter.	She was told to get the post redirected or send it back. The URN was closed with no further action taken.	Thames Valley Police IMR

URN 1075 Adult B called TVP whilst extremely intoxicated and during the conversation threatened to hurt one of her children (not known which one). She was talking about the letter mentioned in URN 1031 – 13/01/14 again (Incident 118).	Uniformed patrol officers attended and confirmed that only her youngest son (aged 15) was in the house and he was fine. He was advised to call if there were any problems. The URN was closed and no further action was taken. If Adult B was threatening to hurt one of her children then consideration should have been given to removing him from the care of his mother to either another family member or to Children's Social Care via a Police Protection Order. Certainly a Child Protection CEDAR report should have been created and sent to Children's Social Care.	Thames Valley Police IMR
Adult B - No details available from OOH Practitioner	Details not available	NHS Oxfordshire CCG Individual Management Review for General Practitioners
Complex needs service closed file due to no contact from Adult B, letter copies to GP and CMHT.		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report

Adult B - Telephone consultation	Request for medication and sickness certificate both supplied	NHS Oxfordshire CCG Individual Management Review for General Practitioners
MC4395295/14 – Assault without injury Adult A was assaulted by one of Adult B's ex-partners. Adult B was also present and all parties were intoxicated when her ex-partner pushed Adult A and swung at him.	During interview the suspect denied any offences and was not charged due to insufficient evidence.	Thames Valley Police IMR
URN 1698 Adult B called TVP to report that a male had turned up at her address accusing her partner of having stolen his plant pot and iron chairs. She recognised the male but did not know him.	After several attempts were made, officers managed to speak to Adult B and it could not be confirmed if a theft had taken place. The Neighbourhood Policing Team was informed. No further action was taken.	Thames Valley Police IMR
MC4401817/14 - Domestic Incident (non crime) This was an argument between Adult A and Adult B about the dog being allowed on the bed.	Both parties were spoken to and no offences were disclosed. Adult A refused to answer the questions on the Domestic Abuse Risk Assessment Form and he was classed as being at standard risk of Domestic Abuse. The attending officer (Police Constable P12) has been spoken to	Thames Valley Police IMR

	and there are no issues with the response to this incident. A CEDAR report was created and the officers attempted to complete a Domestic Abuse Risk Assessment Form.	
MC4402969/14 – Public Order Offences Adult B called to report that her then 15 year old son had been threatened with a bottle to his neck by males looking for Adult A in connection with a theft of a plant pot. She also reported that they had said that they were not scared of pouring petrol in the house.	Uniformed Patrol officers attended and found out that the males were demanding that Adult A came out of the house. PNB entries were taken from those involved and no assaults were disclosed. A CEDAR report was created with Adult B's youngest son named as the victim. A marked Police vehicle was left outside the house and a URN was set up for all calls to the address to be attended immediately. There were discrepancies in the accounts given by the witnesses and offenders were not identified (although suspects were named in the URN). The allegations about threats made were retracted; and they said that they were not scared by any threats. They were asked to leave the house for safety but refused to do so. The case was reviewed by a supervisor who	Thames Valley Police IMR

	confirmed that there was no CCTV or forensic potential and so it was filed and no further action taken. It is positive that risk management was carried out with the family even though the threats were not substantiated when officers visited them. The officer in the case (Police Constable P19) states that all lines of enquiry were followed but she cannot recall if house to house enquiries were completed.	
URN 1506 This URN was linked to MC4402969/14 (Incident 124) and URN 102 – 09/02/14 (this was to make officers aware to attend all calls as immediate). Adult B called TVP again to report that it was written on Facebook something relating to Adult A taking plant pots.	This information was emailed to the officer dealing with the case. This is linked to the above incident on 08/02/14 and so informing the officer in the case was the correct action.	Thames Valley Police IMR
URN 1692 Adult A called to say that he was having problems with some travellers (see above URNs). He said that Adult B had gone to confront them.	Uniformed Patrol officers attended the address and Adult B was present and said that she would not go out. The URN was closed as there were no concerns. As Adult B did not carry out her initial intention, there was no further action required.	Thames Valley Police IMR

URN 69 Adult A made an anonymous call to Police to say that Adult B had put the television on which was something she did when she was drunk. It was established that the call came from Adult A as he used his own mobile phone which was known to TVP.	Uniformed Patrol officers attended and there was no complaint made and he had a house two doors down that he could stay at if he needed to. No Domestic Abuse Risk Assessment Form was completed nor was a CEDAR Crime Related Incident report created for a Domestic Incident. Although nothing much appears to have happened with this, Adult A did still call Police about an issue with his partner, Adult B. Therefore a CEDAR report should have been created to record what had happened and officers should have attempted to complete a Domestic Abuse Risk Assessment Form.	Thames Valley Police IMR
MC4404541/14 – Child Protection (non crime incident) & MC4404553/14 – Adult Protection (non crime incident) This was a report that Adult B's 15 year old son was not at school. Police attended and found him at home and Adult B was drunk. They were concerned for her ability to look after herself and her son.	Referrals were made to Social Services. It is good practice that referrals were made to Social Services for this matter.	Thames Valley Police IMR

Child 1 reported missing, later found and said he had been at home all day. During search for him officers visited 16 The Lees and reported concerns that Adult B was drunk at 3pm and Adult A 'doesn't seem very involved with aggd.' Child Protection information share due attending police officers concerns about Child 1's support network. Contact record notes that if a return interview is required for Child 1 then the Early Intervention hub will undertake this	No Further Action/Case Closed	Children's Social Care Summary of Involvement
URN 2117 Adult B called to say that she had given Adult A £10 and, when he did not return, she thought that he may have bought cocaine or heroin with it. She said that she had not been able to contact Adult A and asked if the call taker had his phone number, which she did not.	She was advised to call 999 should he turn up and she did not want him there.	Thames Valley Police IMR
URN 80 Adult B called TVP asking to be put through to Swindon A & E saying that she was going to do something stupid.	Uniformed Patrol officers attended and confirmed that she was all in order and just intoxicated. It is positive that officers attended and spoke to Adult B. If, upon their arrival, Adult B retracted this and the officers were happy that she was not going to harm herself then	Thames Valley Police IMR

	it seems reasonable to have closed the URN.	
MC4415927/14 – Adult Protection (non crime incident) TVP were called by the Ambulance Service after Adult B had reported she had taken an overdose, believed to be Paracetamol. She was very drunk and would not confirm how many tablets she had taken.	Adult B was taken to hospital. No referrals were made. Consent should have been sought from Adult B and then referrals made by TVP.	Thames Valley Police IMR
Adult B - Assessment	Seen and assessed at GWH by the Mental health Liaison Team,	AWP Individual Management Review
URN 33 This was an anonymous call reporting shouting coming from Adult B's address. The phone number was known to Police as belonging to Adult A.	Uniformed Patrol officers attended and could hear Adult B singing but no male voice. It was noted that this was usual for the address. They could not get a response at the door and the URN was then closed. The URN really should have been left open to try again at a later time.	Thames Valley Police IMR
URN 1720 This was a call from the Ambulance Service reporting that Adult A had called for an ambulance for Adult B as she had breathing difficulties but also that she had assaulted him.	Uniformed Patrol officers attended and no offences were disclosed. They were told that Adult A had called the ambulance when Adult B was having a panic attack but had then cancelled it when she calmed down. No Domestic Risk	Thames Valley Police IMR

	Assessment Form was completed or CEDAR Crime Related Incident report created. This is one of several incidents where Adult A or Adult B called TVP and said that they had been assaulted by the other, but upon Police attendance, denied any assault. A CEDAR report should have been created and a Domestic Risk Assessment form completed.	
URN 94 Adult B called TVP swearing and saying that she was going out of the window. She was then crying and not speaking to the call taker. Banging could then be heard. When the call taker called her back, Adult B just swore.	The call taker terminated the call and dispatched a Uniformed Patrol officer to the location. The URN was updated that there was no answer at the door. More attempts should have been made to make contact with Adult B and the neighbours should have been spoken to. The attending officer (Police Constable P10) cannot recall whether he went to the neighbour's house but he did attend Adult B's house.	Thames Valley Police IMR
MC4422784/14 - Domestic Incident (non crime)	No offences were disclosed to officers. A Domestic Abuse Risk	Thames Valley Police IMR

Adult A reported that during a verbal argument, Adult B threw a wine bottle which hit the wall and smashed. The bottle did not hit him and he was not in any fear.	Assessment Form was completed with Adult A and he was assessed as being at standard risk of Domestic Abuse.	
Adult B - Attempted to call several times, phone engaged (presumed in response to patient's request for a phone call)	Failed telephone encounter	NHS Oxfordshire CCG Individual Management Review for General Practitioners
Adult B - No details available from OOH Practitioner	Details not available	NHS Oxfordshire CCG Individual Management Review for General Practitioners
URN 1524 Adult A's brother called TVP to complain that Adult B was in their house and being abusive to the occupants. Whilst he was on the phone to Police, Adult B left and Adult A's brother said that there was no need to attend.	The URN was closed. It should really have been treated as a Domestic Abuse incident as, although the incident had ended, it had involved family members.	Thames Valley Police IMR
Domestic Violence report from Police. Adult A reported that Adult B returned home drunk, an argument commenced and Adult B is alleged to have thrown two cabinets down the stairs.	No Further Action/Case Closed	Children's Social Care Summary of Involvement

Adult A left for the night to stay at his mother's house 'two houses away'. Child 1 not present and does not live at this address.		
MC4429570/14 – Domestic Incident (non crime) Adult A reported that Adult B was drunk and had thrown cabinets down the stairs.	Police attended and no offences were disclosed and the parties went their separate ways for the night. This was assessed as being a standard risk Domestic Abuse incident although a Domestic Abuse Risk Assessment Form was not completed, citing that one had been completed the previous week and Adult B being very drunk as the reason. A Domestic Abuse Risk Assessment Form should have been completed with Adult A, whom was identified as the victim in this incident. Even if a Domestic Abuse Risk Assessment Form was completed the previous week then another should have been attempted on this occasion. The attending officer (Police Sergeant P20) has said that at around that	Thames Valley Police IMR

	time the control room sergeant would tell officers that they did not need to complete another if one had been done recently. This has been discussed with the Superintendent in charge of CRED who has said that the Control room do not tell attending officers to do this as it is incorrect and not in their remit.	
MC4443145/14 – Drug Possession – Cannabis Adult A was found in possession of cannabis.	He was reported for the offence.	Thames Valley Police IMR
URN 216 Adult A called TVP to report that he had been woken up by Adult B's loud music and said that she had previously harmed herself when she was drunk.	Uniformed Patrol officers attended the address. The attending officers updated that they had not seen her but did not have any concerns for her stating that this was normal for her. This does seem a proportionate response as Adult B was regularly drunk and Adult A was not stating that she was going to harm herself but rather stating the fact that she had harmed herself in the past. This was already known to TVP. There	Thames Valley Police IMR

	does not appear to have been any dispute which would constitute a domestic incident.	
URN 1790 Adult B called TVP to report that she thought that her son (she would not say which one) had stolen her credit card and wine.	Uniformed Patrol officers attended the next day and she had found her credit card so it was not stolen. As nothing had actually happened, this does appear a proportionate response.	Thames Valley Police IMR
MC4432409/14 – Adult Protection (non crime incident) Adult B was at her home address which she had been evicted from but was living there with no electricity. She had smashed an empty bottle of alcohol and cut her left wrist causing superficial wounds.	She refused to go to hospital and went back to sleep. Referrals were made to Adult Social Care and her GP without consent. Officers and paramedics could have assessed her under the Mental Capacity Act. It is positive that referrals were made to Adult Social Care and to the GP albeit without her consent.	Thames Valley Police IMR
Adult A - Phone call to reception from patient	Sickness certificate issued from 8.4.14 for 1 month requested via reception	NHS Oxfordshire CCG Individual Management Review for General Practitioners

Adult B evicted from housing association property but still living there with no electricity. Adult B smashed an empty bottle of alcohol and cut her left wrist, causing superficial wounds, resulting in paramedics attended and checked/bandaged her wound. Adult B remained at house to sleep off the alcohol. History of 8 previous adult protection concerns and poses a risk to herself.	referral to adult social care and GP without consent.	Adult Social Care Vale Team Individual Management Review
Adult B - TVP Domestic Abuse info-share report shared with AMHP Office Advised client discharged from MH Services 06/12/2013 and referred back to GP Surgery due to non-engagement	t/c made to White Horse Ml C to confirm GP. Advised client under Dr Simon Cartwright.	Adult Social Care Vale Team Individual Management Review
MC4436303/14 – Public Order Act offences This was a report of Adult B being abusive and threatening towards people in the street. There were ten or more young children in the street at the time.	Adult B was arrested but no witnesses would provide a statement. She was released without charge.	Thames Valley Police IMR
URN 1457 A TVP PCSO reported a smashing noise coming from inside Adult B's address. She had been arrested and was in Police custody at the time	A Uniformed Patrol officer attended and confirmed that there were no problems at the address.	Thames Valley Police IMR
MC4437511/14 – Domestic Incident (non crime incident)	What she was reporting was unclear and as she refused to pass	Thames Valley Police IMR

Adult B made several drunken abusive calls to Police. She said that her boyfriend was throwing her clothes out of the address.	her address it was unclear who the suspect was or what the issue was, although the CEDAR report noted that there was possibly some domestic element judging from the URN. The URN does state that Adult B said that her boyfriend (not named who) was throwing her clothes out of the address. Officers attended the address and spoke to Adult B's ex-partner (not named who) and he said that he had not seen her. The CEDAR report was created by the attending officer who added this information to the report. The URN stated that there was a possible domestic element and a Domestic Incident (non crime incident) CEDAR report was created. Further attempts should have been made to speak to Adult B and to complete a Domestic Abuse Risk Assessment Form.	
Adult B - Telephone consultation	Request for medication and sickness certificate, multiple other issues, asked to make appt	NHS Oxfordshire CCG Individual Management

		Review for General Practitioners
URN 769 A neighbour called to report that there were people at Adult B's address after she had been evicted by the mortgage company.	Uniformed Patrol officers attended and confirmed that it was Adult B and Adult A and that there were no problems. They should not have been at the address and the mortgage company could have been informed and they could have been removed, thereby saving the neighbours from more Anti-Social behaviour.	Thames Valley Police IMR
Report from Swindon Accident & Emergency Department. Adult B was admitted to hospital while drunk and alleged that Child 1 had assaulted her. Minor facial injuries noted, but Adult B does not intend to press charges. Assessment team contacted (Addictions Support Worker) who was working with Child 1 around his mother's alcohol use and his own drinking. She agreed to liaise with Early Intervention hub regarding any additional support that Child 1 requires.	Case Closed	Children's Social Care Summary of Involvement

URN 36 The caller found Adult B with blood on her face and wearing just a nightdress. It was not clear if she had been assaulted or had fallen over. She was with Adult A and she had argued with her son and then run away.	An ambulance was called and she was taken to hospital with minor injuries. She was drunk and so officers spoke to her a few hours later. She said that she could not remember anything but would tell officers if she did. No further action was taken. It is correct that an ambulance was called and that she was taken to hospital. Her consent should have been sought for referrals to be made and an Adult Protection CEDAR report created.	Thames Valley Police IMR
Adult B - Request from patient via reception	Request for medication, asked to make appointment	NHS Oxfordshire CCG Individual Management Review for General Practitioners
43140057725 – Adult Protection Report that Adult B was constantly ringing caller's door buzzer and caller witnessed her being dragged away by a male.	A PVP Referral Centre Review was completed which stated that this was a case of an alcoholic neighbour causing Anti-Social Behaviour and did not see that this fitted the criteria for a referral. Although an alcoholic, there was no	Thames Valley Police IMR

	suggestion of lack of capacity. No consent was given and no referral was made. It should have been established who the male was and whether he was dragging her away as he did not want her to upset the neighbour or whether there was something more to the incident.	
43140067637 – Adult Protection Adult B had fallen down a flight of stairs, banging her head.	Due to her level of intoxication it was unclear whether she had sustained any injury or whether it was due to the alcohol. An ambulance was requested who in turn requested Police assistance due to previous violent behaviour towards medical staff. Adult B was eventually taken away on a spinal board by an ambulance crew to hospital. A separate Adult Protection Referral was not considered necessary as she was taken to hospital. Even though Adult B was taken to hospital, TVP officers and staff should not presume that the	Thames Valley Police IMR

	hospital would make any necessary referrals.	
Adult B - Face to face consultation	Consultation re agoraphobia, letter for housing, social problems. Sickness certificate 1 month. Benefits agency assessed as fit for work	NHS Oxfordshire CCG Individual Management Review for General Practitioners
43140074048 – Domestic Incident (non crime) Adult B called in an intoxicated state to say that if Adult A came to the door she would need Police. She disclosed that Adult A had put his hands around her throat but didn't want to get him into trouble. During the call she said that Adult A was at the door and ended the call.	Police attended and liaised with both parties and advised them to remain in separate properties for the night. No injuries were noted to Adult B and she denied that Adult A had put his hands on her throat. A Domestic Abuse Risk Assessment Form was not completed but Adult B was assessed as being at standard risk of Domestic Abuse. The CEDAR report was flagged as an Adult Protection report but PVP Referral Centre staff could not see why and no referrals were made. The Domestic Abuse Risk Assessment Form was attempted but Adult B refused to answer any questions. She had, however already given out information that	Thames Valley Police IMR

	would enable the attending officer (Police Constable P21) to at least part complete the form, such as during the initial call when she said he had put his hands around her throat. Even if it was later denied, she still said this and therefore the risk assessment of standard was incorrect. There did not appear to be any Adult Protection issues so there is no problem with not making any referrals.	
URN 48 Adult A called TVP as he was concerned about Adult B and had not seen her.	Officers located her and she was fine and Adult A was updated. No further action was taken.	Thames Valley Police IMR
URN 1721 Adult B called TVP sounding intoxicated and said that she was about to break into her house. A male could be heard in the background. She was making very little sense but said that she did not have any keys. Adult A also spoke to a call taker and said that Adult B had taken an overdose and was aggressive.	An ambulance was dispatched but then Adult A called and said that they did not require an ambulance as there was no overdose. The URN was updated that Adult B had not eaten for a few days and needed her blood pressure checking. This has been discussed with a Vulnerable Adult Co-ordinator and the expectation is that a CEDRA /	Thames Valley Police IMR

	NICHE report should still be created as this would make the MASH aware of the incident. Although they may not make any referrals if there was not an actual overdose, with subjects like Adult A and Adult B who were known to Police and services, the MASH staff may want to make the other services aware.	
Adult B - Face to face consultation	Consultation, review alcohol.	NHS Oxfordshire CCG Individual Management Review for General Practitioners
URN 650 This was to make TVP aware that Adult B's house had been repossessed.	No action was taken with this. This is information which would be useful to local officers who were regularly dealing with Adult B.	Thames Valley Police IMR
43140101502 - Domestic Incident (non crime) Adult A had an argument with his brother about people smoking weed in the garden. This was a verbal argument and no offences were disclosed.	Officers attended and completed a Domestic Abuse Risk Assessment Form and Adult A's brother was assessed as being at standard risk of Domestic Abuse.	Thames Valley Police IMR
URN 132	It was decided that as Adult A had been previously violent that	Thames Valley Police IMR

Adult B called TVP, intoxicated and very emotional. Adult A spoke to the call taker and said that she was fine and needed to sleep.	Uniformed Patrol officers should attend. Officers attended the house which was all in darkness and there was no answer at the door. No further action was recorded. Attempts were made to speak to the occupants which were unsuccessful. If there was a concern then further attempts should have been made.	
URN 1899 Adult B had a verbal argument, with someone she said was her landlord.	Officers attended and she stayed elsewhere for the night. This was closed as a dispute with Adult B and her landlord. The address she was staying in was actually Adult A's family home so it was incorrect to close this URN stating that it was not a Domestic incident.	Thames Valley Police IMR
URN 1861 Adult B called TVP from a pub to report that Adult A had threatened to burn her property which was at her previous address from which she had been evicted. A call was then received from the Ambulance Service to report that	Officers then spoke to Adult B on the phone but she would not say where she was. As this involved a dispute involving Adult A and Adult B who were or had been in a relationship, this	Thames Valley Police IMR

Adult A had taken an overdose and had been to the address given but he was not there.	should have been dealt with as a domestic incident. A CEDAR report should have been created and a Domestic Abuse Risk Assessment Form should have been completed with Adult B.	
43140126610 - Domestic Incident (non crime) Adult A reported that Adult B (whom he had spoken to over the phone) had threatened to come and smash his head in after he told her to come and get her property.	It was noted that Adult B was an alcoholic and there were several domestic incidents per week. The parties were several miles away from each other at the time of the incident. Adult A refused to answer the questions on the Domestic Abuse Risk Assessment Form and he was assessed as being at standard risk of Domestic Abuse.	Thames Valley Police IMR
43140138954 - Adult Protection/ S.136 Adult B claimed that Adult A threatened to burn her belongings. They had separated and Adult B was homeless but keeping her belongings at Adult A's address.	A Domestic Abuse Risk Assessment Form was completed with Adult B and graded as standard risk. There is an entry in NICHE to state that information was shared with the MASH. This was added by the sergeant during his review. There is nothing in the report to say that the information was then shared with any other agency.	Thames Valley Police IMR

	This was treated as a Domestic incident but a CEDAR report was not created for a Domestic Incident, only for Adult Protection.	
URN 107 – Fear for Welfare for Adult A This was a call made to TVP by Adult A reporting that he and Adult B had argued as she had told him that she had cheated on him with four men. He said that she was drunk and going to meet a man. He said that he had taken some heroin on Wednesday and she was holding this against him. He made threats to kill himself by overdose. He said he was in a tent near to a car park. He said that he and Adult B were homeless and he had come to be with her. She was believed to be prostituting herself with a taxi driver.	Officers attended the location and established that the fear was for Adult A's welfare. Officers spoke to both Adult A and to Adult B and no issues were identified. Adult B was in a tent and Adult A was then taken to a friend's house. The URN was closed and no further action was taken. Adult A was reporting a domestic incident and as such a Domestic Abuse Risk Assessment Form should have been completed and a CEDAR report created. No action was taken as to any concerns for Adult B prostituting herself. Referrals should have been considered with her consent.	Thames Valley Police IMR
43140143633 - Adult Protection A member of public found Adult A on a tow path by the river near a pub. He stated he had	Uniformed Patrol officers attended and found that Adult A had a number of empty tablet packets in his possession. The attending paramedics conducted initial	Thames Valley Police IMR

taken an overdose. The member of public then called for an ambulance.	checks on Adult A including checking the contents of his vomit which contained no tablets. Paramedics questioned Adult A about whether he had taken tablets or he was attention seeking. Adult A was taken to hospital as a precaution. An Adult Protection Review was conducted and it was stated in the NICHE report that as Adult A had been taken to hospital, the medical professionals would make their own referrals and so there was no further action to be taken by the PVP Referral Centre. Just because a person had been taken to hospital does not mean that TVP can guarantee that the staff will make the necessary referrals to Social Services. Police should make the referral regardless of the hospital visit unless it is clear that the person is already being cared for by the appropriate agencies. This has been brought up in a recent Vulnerable Adult Serious	

	Case Review in September 2014 where a recommendation was made that; '**TVP should make a referral (bearing in mind the issue of consent) unless it is clear that another agency is already dealing with the vulnerable adult and is aware of all the information known to TVP'.**	
Adult A - EPDS SpR assessment	Overdose during argument with girlfriend. Detailed assessment. No intention to die. Living in a tent. Long history of DSH. Forensic history: theft, burglary, assault. Polydrug and alcohol misuse. Not considered to be mentally ill. GP asked to consider ref to CMHT if deterioration.	Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
URN 1721 43140149160 - Missing Person report Adult A reported Adult B missing after she said she was going for a shower at her daughter's house but did not return.	It was noted in the URN that Adult B was an alcoholic and officers checked her daughter's address but Adult B was not there. The occupants said that she had been there and they had no concerns for her. They said that Adult A may	Thames Valley Police IMR

	have been using the Police to try and locate Adult B. Checks were conducted at local pubs and officers attended the tent to complete paperwork with Adult A. At 03:07 hours Adult B was located. It was recorded that she had not been missing but had simply taken longer to get back to her tent.	
Adult B - Information request to the Street Triage service, Adult B had jumped in the Abingdon river, TVP 'fished out', were requesting background information. Adult B was taken to A&E in an ambulance		Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
Adult B - 1st report involving Adult A. Incident at the Nags Head Abingdon involving other male and Adult B living in a tent. Arguments with her boyfriend which culminated in her throwing herself in to river 09/08/14.	Dr Cartwright at White Horse MC is her GP. Shared report with him	Adult Social Care Vale Team Individual Management Review
43140151233 – Missing Person Report & 43140151487 – Adult Protection Adult A called to report Adult B as missing. He reported that Adult B was living in a tent and was an agoraphobic, alcoholic and had had arguments with her boyfriend which culminated in her throwing herself in a river on 09/08/14. On 10/08/14 she befriended an	Adult B seems to have been aware that Police were looking for her as she voluntarily walked into an Oxford Police station. Adult B then asked for a lift to where she wanted to go rather than have to 'commit a crime to get a lift'. The NICHE report made reference to a	Thames Valley Police IMR

unknown male at hospital who paid for a hotel room for her to 'freshen up' and gave her food and drink.	previous Adult Protection referral in May 2014 which was alcohol related. This resulted in Adult B attending hospital where she was assessed by health professionals and it was deemed that there were no concerns for her welfare. A PVP Referral Centre Sergeant added that there was no requirement for further referrals at that time. Even though there were no concerns for Adult B's welfare at the hospital does not mean that TVP did not need to make referrals.	
43140152316 –& 43140152310 – Risk Management Occurrence These were set up for risk management in relation to the above NICHE reports.		Thames Valley Police IMR
Adult B - No details available from OOH Practitioner	Details not available	NHS Oxfordshire CCG Individual Management Review for General Practitioners

URN 1098 - 17/08/14 – 18:25 hours 43140157995 - S.136 MHA Adult A telephoned Police distressed and stated that he wanted to kill himself either by taking pills or by hanging himself with rope from his tent.	Police detained Adult A under S.136. Referrals were made by the Adult Protection Co-ordinator. This was an appropriate response in the sense that he was detained under section 136 of the Mental Health Act. Also referrals were appropriately made.	Thames Valley Police IMR
URN 1098 - 17/08/14 – 18:25 hours 43140157917 – Domestic Incident Adult A reported that his girlfriend Adult B had tried to hit him. Reference was made to numerous comments regarding self-harm on previous occasions. The URN is the same for this and the above incident. Adult A called Police to report the Domestic Incident and during the call said that he wanted to kill himself.	Neither party made any allegation of Domestic Abuse. The NICHE report states that no Domestic Abuse Risk Assessment Form could be completed due to the victim being detained under section 136 of the Mental Health Act. It added that the current risk assessment (standard risk) should remain. The next incident occurred on the same day and they were spoken to then so there are no issues with this incident.	Thames Valley Police IMR
URN 1482 – 17/08/14 – 22:47 hours	Adult B was arrested and charged with Criminal Damage. Adult A refused to answer the questions on	Thames Valley Police IMR

43140158134 - Criminal Damage & 43140158140 – Public Order Later the same day as the above incident, Adult A was released from Littlemore Hospital and Adult B threw his belongings in the river.	the Domestic Abuse Risk Assessment Form which was graded as standard risk. During the incident Adult B was also arrested for a Public Order offence but not charged.	
Adult A - MHAA following 136	Seen by SpR, S12 doc and AMPH. Living in a tent, argument with partner. Suicidal ideas. Not considered to be mentally ill Back to GP and advice given.	Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
43140158309 - Adult Protection/ S.136 Adult A was said to suffer with depression and had threatened to take his life.	He was detained by Police under S.136 MHA and taken to hospital. Referrals were made to Social Services.	Thames Valley Police IMR
Adult B - Telephone call from patient to reception	Now living in Abingdon and had made with doctor at Malthouse surgery. Notes summary faxed to Malthouse Surgery	NHS Oxfordshire CCG Individual Management Review for General Practitioners
URN 1461 Adult A called TVP as he was concerned for Adult B's welfare. She had bail conditions to live in her tent in Abingdon.	One of her sons was spoken to and he said that she was fine and was in the pub.	Thames Valley Police IMR
43140172007 - Domestic Incident (non crime)	Officers attended and searched the area but there was no-one there.	Thames Valley Police IMR

This was a call from Adult B stating "I THINK HE'S GOING TO COME DOWN HERE - HE'S SCARING ME" referring to her boyfriend, Adult A. She was said to be very slurred and rambling. She stated that she had been drinking. She stated that she could hear owl type noises.	There was lots of wildlife around which could have been making the owl type noises. Officers spoke to her and concluded that, as there was nothing to suggest that Adult A was actually involved, this was not a domestic incident. There was a CEDAR report created for a Domestic Incident (non crime) but no Domestic Abuse Risk Assessment Form completed. Adult B's perception was that this was a domestic incident. They had also been involved in a large number of domestic incidents in the past. As such this should have been dealt with as a domestic incident and the risk assessment should have been completed.	
43140180003 –Assault without injury Adult B stated that she had been assaulted by T and was shouting and swearing outside Abingdon Police Station. She said that T had kicked her in the ribs and possibly stamped on her face. She was described as drunk or on drugs and not making much sense and did not	An ambulance was called but Adult B refused to engage with the paramedics. She was deemed to have capacity and she did not go to hospital. T was arrested and interviewed and said that he could not remember what had happened as he had been drunk. He said that	Thames Valley Police IMR

have any injuries other than a slight swelling to her cheek.	he had been in a tent with Adult B and she was drunk. He said that she had bitten him when he tried to leave the tent. He then answered "NO COMMENT" to all further questions. Potential witnesses were spoken to but there was insufficient evidence to charge T so no further Police action was taken. The suspect in this case was an on/off partner of Adult B's but no Domestic Abuse Risk Assessment Form was completed and it is not clearly identified as a Domestic Incident on NICHE.	
Adult B - Seen by mental health practitioner from the Liaison and Diversion Service (Berkshire Healthcare NHS FT) whilst in Police custody.	Arrested for a public order offence after 'hammering on the door' of the Police station whilst intoxicated – reported anger at the Police for apparent inaction following an alleged recent assault by her boyfriend.	Oxford Health NHS Foundation Trust Root Cause Analysis Investigation Report
URN 1552 Adult A called TVP asking when Adult B's bail conditions would be removed as he had nowhere to sleep and wanted to stay with her	The URN was updated that the bail conditions were unlikely to be changed as Adult B was due to attend court in October 2014 for the case.	Thames Valley Police IMR

URNs 1174, 1176, 1164 and 1143 This relates to Adult B calling TVP as a male was trying to get into her tent by the river. A member of the public also complained about Adult B and two others camping by the river and starting fires. Adult B sounded intoxicated.	Officers located Adult B and her friend and no offences were disclosed. The neighbourhood Sergeant was made aware of the incident.	Thames Valley Police IMR
URN 957 This was a call to TVP from Adult A, who was upset about his bail conditions.	Adult A was advised over the phone that these were court imposed bail conditions and could not be changed by TVP.	Thames Valley Police IMR
Adult A - Telephone consultation	Insomnia, homelessness, depression, possible heroin withdrawal. Advised see GP the next day and consult Citizens' Advice Bureau	NHS Oxfordshire CCG Individual Management Review for General Practitioners
43140190777 - Domestic Incident (non crime) This was a Domestic related verbal argument between Adult A and his mother.	Adult A was recorded as the victim but refused to answer the questions on the Domestic Abuse Risk Assessment Form. No offences were disclosed and he was classed as being at standard risk of Domestic Abuse.	Thames Valley Police IMR
URN 1168 Adult B called TVP to report that someone had "trashed" her tent.	Officers attended and Adult B was not sure whether it was her ex-boyfriend who was on bail or whether the rain had caused the	Thames Valley Police IMR

	damage. Either way she had put it back together and it was all fine. No further action was taken.	
URN 1316 This was a complaint from Adult B that T had not been charged and she had not been updated by Police. She threatened to stab T and cut a Police officer.	A sergeant attempted to speak to Adult B and she sounded intoxicated. The URN was closed with no further action being taken. The Police sergeant involved in this incident has been interviewed and stated that he was passed this incident by the Control Room as a complaint against Police. He viewed the incident about which Adult B was complaining and this was not classified as a Domestic Incident. He tried to speak to her on the phone but she was drunk and abusive and it was left with her that she would attend the Police station. He did not dispatch officers because he thought she was attending. She did later attend the Police station and was arrested as she was drunk and abusive. He did not known Adult B as he had only been posted to the area a week prior. He thinks that the URN should not have been closed without a	Thames Valley Police IMR

	result of some kind and he left a 'handover' for the next Sergeant on duty. The Control Room Sergeant who closed the URN has also been asked about this incident. He said that it was not classed as a Domestic Abuse incident but rather a complaint as this is what Adult B called about. Also because of this checks were not completed. It is normal practice to close a URN for a complaint after it has been passed to an area Sergeant. The Control Room Sergeant states that this was classified correctly.	
43140209043 - Public Order Act Offences Adult B was arrested outside a Police station for being abusive.	She was charged with a Public Order offence.	Thames Valley Police IMR
43140214635 - Domestic Incident (non crime) Adult B reported that Adult A had stolen her boat keys (she was now living on a boat on the river in Abingdon).	The attending officer updated that there were no offences. Domestic Abuse Risk Assessment Forms were completed with Adult A and Adult B and both were graded as standard risk.	Thames Valley Police IMR
Adult A - EPDS Nurse assessment	Assaulted by girlfriend. Patient called the Police. He then tried to	Oxford Health NHS Foundation Trust Root

	jump in front of a car but was not hit or injured. Polysubstance misuse noted. Referred back to GP. Given info on Drug and Alcohol Services.	Cause Analysis Investigation Report
43140216815 – Assault without injury Adult A was the victim in a Domestic Abuse incident committed whilst Adult B was on bail. He reported that she punched him to the face but no injuries were caused.	Adult B was arrested and interviewed and denied the offence. The 999 tape was unclear and Adult A refused to support a complaint. A Domestic Abuse Risk Assessment Form was not completed as Adult A refused and was taken to hospital. This was an outstanding action that was never completed as Adult A died prior to being seen by the officer in the case. Even without a Domestic Abuse Risk Assessment Form being completed a risk assessment should still have been carried out on Adult A.	Thames Valley Police IMR
43140217307 –Breach of Bail This relates to Adult B breaching her bail conditions by having contact with Adult A at her home address.	Adult B was further arrested for this offence whilst she was in Police custody for the above assault. She was in breach of bail conditions placed on her on 18/08/14 when she was charged with the criminal	Thames Valley Police IMR

	damage offence committed on 17/08/14 (Incident 172). She had been given bail conditions, one of which was not to have direct or indirect contact with Adult A. She was not charged with the breach of bail. As Adult A would not confirm that the above assault had happened it could not be proved that Adult A and Adult B had been together causing her to be in breach of her bail conditions.	
URN 1410 Adult A called to say that he was trying to walk on a grass verge but was slipping. It was noted that he regularly used Police as a taxi service.	He was located by officers away from the main road.	Thames Valley Police IMR
Emergency Duty Team made aware by Police that Adult B had been arrested for attempted murder. Case Record check undertaken and child protection history noted. Assessment team contacted Child 1's father who confirmed that Child 1 had not had recent contact with Adult B. Written agreement signed to prevent any unsupervised contact between Child 1 and his mother.	Case Closed	Children's Social Care Summary of Involvement

43140219229 - Domestic Incident (non crime) Adult B called Police to report that she was having trouble with her boyfriend.	The call for the next incident was received 18 minutes later.	Thames Valley Police IMR
TVP report Adult B of no fixed abode and she has been staying at times on a boat. Adult B has been arrested this evening for attempted murder and it is likely that this will change for murder. Adult B does not usually have an AA but given that the arrest was for such a serious matter the custody Sargent is requesting that an AA is requested. FWI check undertaken as Adult B is known to the coordinator to have children. Child 1 (16 years). It is also known that Child 1 lives with his father, it is not known if Child 1 has any contact with his mother. Adult B is known to be alcohol dependent and the children were subject to CP planning historically. Child 1's siblings are now adults. Child 1 is not an open case to social care. Barbara charged with murder as the victim died, the victim is her boyfriend. No other details known.	AS Child 1 living with father NFA by ASC.	Adult Social Care Vale Team Individual Management Review
Request from Thames Valley Police Sgt F, who was requesting an Appropriate Adult for Adult B as she had been arrested for the attempted murder of Adult A, who did not	Checks were carried out by Emergency Duty Team; Adult B has children that are known to Oxfordshire County Council.	Oxfordshire County Council Adult Social Care DHR Chronology

normal need an appropriate adult but due to the complexity and seriousness of the charge the police believed it would be in Adult B's best interest. Adult B was known to police as a person with a historic alcohol misuse; problem of no fixed abode		
Request for Appropriate Adult B to assist with PACE interview. Emergency Duty Worker carried out this request. Adult B was charged with murder of Adult A.		Oxfordshire County Council Adult Social Care DHR Chronology
43140220134 - Murder This is the final event which resulted in the death of Adult A.	Officers attended and were on scene within 12 minutes, searching for Adult A. When they located him, CPR was commenced. This is discussed in detail within the main IMR. Police Constables P25 and P26 were interviewed about their involvement and response.	Thames Valley Police IMR
Adult A - Telephone consultation third party	Phone call from Coroner's office, patient died	NHS Oxfordshire CCG Individual Management Review for General Practitioners

EDT Referral **reason** Adult B Arrested on suspicion of the murder of her boyfriend Adult A on 19/10/14. Police requesting an AA as Adult B is presenting as mentally vulnerable. Extended detention until 08:30 on 21/10/14. Drew Cooper SW from ASC Vale attended during the daytime hours and EDT worker attended evening interview. SW liaised with legal representative for Adult B and met with her; he was present during the review by the duty Inspector. Adult B is on cell watch with an officer in attendance outside her cell door at all times due to concern around her vulnerability. At time of her arrest and at subsequent occasions whilst under arrest, Adult B had made unsolicited statements appearing to admitting to stabbing Adult A. Adult B was charged in SW presence at 01:10. She did not want anybody informed of her arrest or of being charged. **Outcome** Barbara was charged with the Murder of Andrew on the 19/10/14. Police will advise receiving prison of her vulnerability/medication. **Follow up** Barbara will be at Oxford Court and will be remanded.	Checked background on Doc Man re Adult B.	Adult Social Care Vale Team Individual Management Review

t/c YOT requesting an approp adult and confirmed seriousness of charge t/c to CMHT who know of Barbara but not open case. AA requested at duty doctor's request.		Adult Social Care Vale Team Individual Management Review
Information logged for any follow up please + for electronic social care records and liaison with manager of Children & Families Assessment Team. NFA for Safeguarding team.		Adult Social Care Vale Team Individual Management Review