Wolverhampton Domestic Homicide Review (DHR02)

Produced for Safer Wolverhampton Partnership

OVERVIEW REPORT

Simon Hill, Independent Domestic Homicide Review Chair and Report Author - July 2015

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1. Introduction and background

1.1 Introduction

This Domestic Homicide Review (DHR) examines the circumstances surrounding the death of a 53-year-old Wolverhampton man. In order to protect identities aliases have been used throughout the report. Police and paramedics were called to Peter 's home address, where Kate reported that he had fallen and suffered an accidental knife wound to the chest whilst peeling vegetables. She was however charged with murder and was subsequently convicted and sentenced to life with a recommendation that she serve a minimum of seventeen years before being eligible for parole.

1.2 Purpose of a Domestic Homicide Review

Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004).[1] This provision came into force on 13th April 2011; responsibility for undertaking domestic homicide reviews lies with the Community Safety Partnership (CSP) within the victim's area of residence. (Where the victim's area of residence is not known, the CSP lead responsibility will relate to the area where the victim was last known to have frequented as a first option and then considered on a case by case basis). In Wolverhampton, the Safer Wolverhampton Partnership (SWP) meets the responsibilities of the CSP.

Domestic Homicide Review (DHR) means:
'A review of the circumstances in which the death of a person aged 16 years or over has, or appears to have resulted from violence, abuse or neglect by –

(a) a person to whom (s)he was related or with whom (s)he was or had been in an intimate personal relationship, or

[1] Home Office Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews- Revised- 1 August 2013

(b) a member of the same household as himself/herself

A review to be held with a view to identifying the lessons to be learned from the death; this may include considering whether appropriate support, procedures resources and interventions were in place and responsive to the needs of the victim'

Intimate personal relationships include relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality. A member of the same household is defined in section 5(4) of the Domestic Violence, Crime & Victims Act [2004] as:

(a) a person is to be regarded as a 'member' of a particular household, even if he does not live in that household, if he visits it so often and for such periods of time that it is reasonable to regard him as a member of it;

(b) where a victim (V) lived in different households at different times, 'the same household as V refers to the household in which V was living at the time of the act that caused V's death.

When victims of domestic homicide are aged between 16 and 18, a child SCR should take precedence over a DHR. However, it is vital that any elements of domestic violence relating to the homicide are addressed fully and the review includes representatives with a thorough understanding of domestic violence.

1.3 Process of the Review

On the 28.10.13 The Public Protection Unit of West Midlands Police notified in writing the Head of Community Safety and Chair of the Safer Wolverhampton Partnership (SWP) of the homicide. An Initial Consultation Group meeting was convened on the 15.11.13 to consider whether the circumstances fulfilled the criteria for a DHR. The group recommended to the Chair that the case did

require a DHR to establish lessons to be learned. The Chair ratified the decision. The Home Office was notified of the intention to conduct a DHR .The SWP chair prepared initial terms of reference within one month of notification to the Home Office of the intention to hold a DHR.

An independent person was appointed to chair the review and to write the overview report. The appropriate representation on the Review Panel was discussed at the Initial Consultation and reviewed at the First panel meeting.

The Home Office guidance requires that the Overview Report should be completed within a further six months of the date of the decision to proceed. However once Safer Wolverhampton Partnership had received the initial scoping submissions, it became evident that some agencies had had many hundreds of contacts with the victim and perpetrator. It was the panel's view that the DHR would be involved and complex and that an extension may be required from the Home Office. Delays in presentation of some agencies' IMRs made this approach necessary. This request was sent in June 2014 and it was hoped that submission of the DHR could be achieved by September 2014. However delays with crucial IMRs from West Midlands Police and Crown Prosecution Service (CPS) required the Review to be extended.

The police in particular, made it clear from the outset that their IMR would require a time extension. Two extensions were requested before submission of a first draft on the 28.04.14 and after consideration of that first draft IMR, further questions were asked of police. Due to operational reasons, the police were not able to return a final IMR submission until mid-September 2014.

CPS had been approached at the outset of the process to engage with the DHR. However CPS reported to the chair that a decision on their participation could only be taken post trial (May 2014). Thereafter the DHR panel made several additional approaches for key information from CPS; however a final report was not received until mid-October 2014.

The Review Panel felt that with such a complex series of events and such extensive involvement by several agencies, during the period under review, it would be appropriate to adopt some features of current best practice from Serious Case Reviews. Two learning events were held.

The first was with IMR authors, after the submission of revised IMRs. The intention was to share the timeline and the key themes with authors, and

consider whether strategic and agency recommendations would help to improve safeguarding outcomes in future complex domestic abuse cases. Some agencies sought to refine and improve their recommendations having gained a significantly better insight into the case. This was felt by the panel to be a very positive outcome.

The second event, with agency managers, allowed the same discussion of the case, but concentrated on a consideration of the strategic recommendations and the actions required to improve practice.

1.4 The Domestic Homicide Review Panel and Independent Chair

The panel was formed with the following representation:

- Head of Wolverhampton Community Safety (WCC)
- Director of Public Health (Commissioning – WCC)
- Head of Safeguarding (Adult and Child - WCC)
- Director of Nursing and Quality (Clinical Commissioning Group)
- Safeguarding manager Quality assurance (Adults - WCC)
- Strategy and General Manager (Wolverhampton Domestic Violence Forum)
- Head of Probation (Walsall & Wolverhampton)
- Detective Chief Inspector (West Midlands Police Public Protection)

A Joint commissioner (Mental Health) attended a panel meeting to discuss mental health issues, but was not a member of the DHR panel.

The independent panel chair and author is a retired police public protection investigator with twelve years' experience of child and adult safeguarding and investigations. Prior to leaving the police service, he managed the Public Protection Review team, responsible for writing the force's IMR and contributing to over thirty DHRs and child and adult SCRs. He has had no involvement with the case subject of this DHR.

1.5 Parallel proceedings

The panel was aware of the on-going criminal proceedings and therefore the terms of reference were shared with the SIO, to ensure there were no disclosure issues raised. The panel commenced in advance of criminal proceedings having been concluded and for that reason the Crown Prosecution Service informed the chair that they would not be able to contribute a written report until after the trial was completed.

1.6 Scoping the Review

The process began with an initial scoping exercise prior to the first panel meeting, to identify agencies that had had involvement with the victim and perpetrator prior to the homicide. Where there was no involvement or insignificant involvement, agencies advised accordingly.

All agencies were asked to provide a chronology of involvement from which a merged chronology was created, allowing the Review panel to commence consideration of the circumstances of the case in anticipation of the IMRs

1.7 Time period

Agencies were asked to focus on events from September 2009 leading up to the date of death on 27 October 2013, unless it became apparent to the Panel that the timescale in relation to some aspects of the review should be extended. The Review also considered relevant information relating to agencies contact with the victim and perpetrator outside the time frame as it impacted on the assessments in relation to this case.

1.8 Individual Management Reviews

An Independent Management Review (IMR) and comprehensive chronology was received from the following agencies;

- Anti-Social Behaviour Team (Wolverhampton Homes)
- Black Country Partnership Foundation Trust (Penn Hospital & Healthy Minds)
- Adult and Community Emergency Duty Team (WCC)
- General Practitioners (Wolverhampton Clinical Commissioning Group)

- The Haven- Wolverhampton (domestic abuse support services women, girls and children)
- Housing Options Team/Housing Support Division/Communities Directorate/WCC
- Housing Outreach team/Housing Support/Communities Directorate/WCC
- Learning Disability Team (WCC)
- Adult Mental health & Emergency duty team (WCC)
- NACRO / Recovery Near You (Substance Misuse Services)
- New Cross Hospital – Royal Wolverhampton NHS Trust
- Older Person's Services (WCC) – (Incorporating initial assessment team and South West Locality Team)
- P3 (Wolverhampton homelessness accommodation and support services)
- Staffordshire and West Midlands Probation Service (From 01.06.14 National Probation Service (Midland Division)
- West Midlands Ambulance Service NHS Trust
- West Midlands Police
- Wolverhampton Domestic Violence Forum
- Wolverhampton Homes

The Crown Prosecution Service (CPS) are not an agency that the Secretary of State can require to participate in a DHR under section 9(4) of the Domestic Violence, Crime and Victims Act 2004.

Due to the nature of the case, the panel requested CPS involvement at the start of the review. CPS informed the panel they were unable to consider participation before the trial process concluded in May 2014. It was therefore decided by the panel that rather than request an IMR, a list of questions to CPS should be agreed and submitted for consideration at that time. Thereafter the Chief Operating Officer authorised a report, which was submitted to the panel by the Chief Crown Prosecutor (CPS West Midlands) on 13.10.14.

Reports were also received from HMP Prisons, Avon & Somerset Police, Bedfordshire Police and SERCO.

1.9 Subjects of the review

The subjects of the review were the victim, Peter the perpetrator Kate and her daughter Louise.

The victim Peter (28.04.60) had a previous partner, Rachel with whom he had one child, Rebecca (22 years old)

The perpetrator, Kate (10.08.64) had a previous relationship and had two children; Jane was born in 1989 and Andrew 1988. She was then married to Brian and had a daughter, Louise born in 1996.

1.10 The area and community context

Wolverhampton is an ethnically diverse city which has experienced a great deal of change over the past decade as the city's population has increased by 6% to just under 250,000 people since 2001 alongside increased levels of overcrowding and deprivation.

The city is ranked in the Indices of Deprivation 2010 as the 20th most deprived nationally and is now one of the 10% most deprived local authorities in England. The area of Wolverhampton, where Kate and Peter lived during much of the period under review is ranked amongst the top 5% deprived local areas in the country.

The majority of jobs in Wolverhampton have historically been in manufacturing, but recently service sector jobs have increased significantly. As a legacy of industrialisation, Wolverhampton is one of the most densely populated local authority areas in England, with a population density of 36 people per hectare based on the 2011 Census.

Safer Wolverhampton Partnership (SWP) comprises a range of partners committed to working together to tackle issues of crime and community safety in a coordinated way to deliver a collective response. As a statutory body and the City's Community Safety Partnership (CSP), SWP performs statutory functions that it delivers to fulfil its legal obligations.

In Wolverhampton a range of agencies deliver services to tackle domestic violence; increasingly both adults and children's Safeguarding Boards are involved in addressing safeguarding concerns that arise from domestic violence.

The Domestic Violence Forum (WDVF), being one of the key services in the City, has been instrumental in setting up a co-located multi-agency team that facilitates earlier intervention and risk reduction for adult and child victims. Wolverhampton Police, Housing and Independent Domestic Violence Advisers

from WDVF and the Haven- Wolverhampton meet three times a week to assess and take action for the highest risk adult referrals, enhancing fortnightly full Multi-Agency Risk Assessment meetings (MARAC) into a business as usual model. In addition, daily meetings are held between Police and Social Care to assess and take action in respect of risks to children using the Barnardos Assessment Tool and Health partners contribute to this weekly. This screening system has been adopted across the West Midlands.

WDVF leads on the development of the City's Domestic Violence Strategy. WDVF has approximately 50 member organisations and provides forum meetings, training events and participates in promotional activities on a local and citywide level. WDVF also provides an independent service to victims of domestic violence pursuing a case through the civil or criminal justice process.

1.11 Terms of reference (brief summary)

Initial terms of reference were agreed by the consultation group and were reviewed and updated by the chair and panel at the first Review Panel meeting of 17.12.13 and underwent minor amendments in January/February 2014 as information considered relevant emerged, or it became clear that additional IMRs or reports were required.

The panel were clear that agencies should be encouraged to analyse safeguarding in its' widest context, since it was evident that not only the victim, but also the perpetrator, had suffered significant domestic abuse. It was the view of the panel that agencies should also consider the impact of domestic abuse upon the perpetrator's daughter, who was a child during the entire timeframe and had previously been the subject of a child protection plan and was known to have had contact from the Domestic Violence Forum when she pursued a criminal justice domestic violence case against her mother, Kate.

The intention of the terms of reference (supported by an IMR training event for IMR authors and managers held on the 18.12.13) was to encourage agencies not to concentrate exclusively upon chronicling individual events. Rather to give detailed consideration and analysis of **why** decisions were taken (or not) by professionals and supervisors, and the impact these had upon the safeguarding of anyone who should have been seen to be at risk.

The full terms of reference are included as Appendix 6.4.

In addition to the generic requirement to identify learning described below, all agencies completing an IMR were instructed to;

- identify a definitive timeline of events leading to the homicide for the victim and the alleged perpetrator
- establish whether failings occurred in the assessment, care or treatment of all family members
- identify whether there were any mental health or capacity issues at the time of the homicide for the victim of the alleged perpetrator identify whether safeguarding arrangements had been considered or were effectively in place for all family members
- establish how recurrence – if appropriate – may be reduced or eliminated
- formulate recommendations and an Action Plan
- provide a report as a record of the investigation process
- provide a means of sharing learning from the incident
- provide a report to enable the SWP to meet its responsibilities under its Domestic Homicide Review Procedures.(section 9 Domestic Violence Crimes & Victims Act 2004)

Domestic Homicide Reviews are not inquiries into how a victim died or who is to blame. These are matters for Coroners and criminal courts. Neither are they part of any disciplinary process.

The purpose of a Domestic Homicide Review 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.

1.12 Individual needs

Home Office Guidance requires consideration of individual needs and specifically: *'were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary?'*

Section 149 of the Equality Act 2010 introduced a public sector duty which is incumbent upon all organisations participating in the review, namely to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The review gave due consideration to all the protected characteristics under the Act. In particular the review took into account the victim's gender to identify any gender bias in the access to and provision of services relating to domestic abuse and to identify whether professionals responded differently, when a male suffered domestic abuse.

Although the perpetrator was recorded as disabled, and identified the victim as her carer, the review found little evidence that this impacted upon her access to services or her ability to carry out her everyday activities. There was evidence that some agencies felt at various points that the perpetrator's mental health affected her mental capacity but

also her ability to make appropriate decisions in relation to safeguarding herself. This is developed in detail within the report.

1.13 Family Involvement

As far as possible the family and friends of the victim and perpetrator were given the opportunity to contribute to the review. The panel discussed with the senior investigating officer and family liaison officers (FLOs), the timing of the review panel's introduction to family/friends, which was achieved by contact on the panel's behalf by the FLOs, followed by an introductory letter. Meetings with members of the family were sensitive to the on-going criminal proceedings.

The Independent chair met with the victim's brother and sisters, who had consulted extended family to collate any questions the extended family may have had and undertook to feedback to the family after the meeting. On a separate occasion the independent chair met with the former husband of the perpetrator, and their daughter.

1.14 Perpetrator Involvement

The Independent chair contacted the perpetrator Kate by letter, following her conviction for murder, encouraging her to contribute to the DHR. At present there has been no indication of her willingness to engage with the review.

2. Contextual information

1. In understanding why Kate and Peter embarked on a relationship that seemed so self-destructive, it is important to acknowledge that they both had established patterns of alcohol abuse and related relationship problems, well before they first met in 2009.
2. Peter was a Wolverhampton man with seven siblings, who had worked in road construction, had been employed by the City Council but had also been a relief manager in several local pubs. Peter had a daughter, Rebecca, from whom he was estranged. His family indicated that his abuse of alcohol correlated to earlier unsuccessful relationships; the

ending of one of which led to Peter taking an overdose. Peter had told his GP at various points between 1995 and 1998 that he had had a temper ' all his life' which was affected by his use of alcohol. He was advised to seek psychiatric help.

3. Although known to police from 1993, for drink driving offences and other offending relating to dishonesty, damage and alcohol abuse, Peter had no convictions relating to domestic abuse until 2002, when he was sentenced to a term of nine months' imprisonment for an attempted rape of a former girlfriend. The attack also apparently involved strangulation.

4. Peter's family believe that Peter's alcohol abuse worsened following the death of his mother in 2006 and his work in pubs with constant access to alcohol heightened the problem.

5. Kate had four children. D, from whom she was estranged, from an earlier relationship. She then had two children, Jane (born 1989), and Andrew (born 1988) with Steve. She met Brian in 1993 at a newspaper where they both worked, and started a relationship, which prompted her to leave Steve and move in with Brian in 1994. They married in 1995 and Louise was born in 1996. At various times Jane and Andrew lived with, or visited Kate Brian and Louise.

6. According to Brian, Kate experienced considerable anxiety about her children, Jane and Andrew, who suffered emotionally from their parent's break-up. By 2002, Kate had been involved in drink/drive offending, and was reporting depression to her GP.

7. According to Brian, Kate had met a man with whom she had an affair in 2001 and it was during this period she began to 'binge drink' in response to anxieties caused by concern for Andrew and Jane and difficulties in her relationship with Brian. The couple separated in 2001 and Kate lived in a caravan for a period. They were however reconciled in 2002.

8. It was Brian 's view that even whilst living in Bristol, Kate had already established a pattern of behaviour that was to become a distinct feature of her life in WV; repeated calls to support agencies such as police and GP surgeries. Indeed Brian explained to the DHR author that Kate had

been prosecuted by Avon & Somerset police for wasting police time; making fifty calls to their control room in one day.

9. The family moved to WV in April 2003 in an attempt to start afresh. This apparently required Brian to give up his well-paid position in Bristol and by his own admission he was never able to find similarly remunerated employment. This caused family tensions.

10. It is apparent that Kate 's continuing alcohol abuse was known to her GP and led to domestic incidents in 2003, which in turn led to social services involvement due to concerns for Louise

11. In January 2004, Kate made a drunken allegation that Brian had stabbed her in the arm, although she later retracted this claim and Brian was not subject to a police investigation. Then in September 2004, concerns were again raised for Louise, after Kate apparently threatened Brian with a knife, in Louise's presence. The domestic incidents involving Brian and Kate reported between 2004 and 2006 were considered of sufficient gravity that Louise was placed on the child protection register under the category of emotional abuse.

12. Kate was employed at ASDA for a period in 2005 to 2007 but as her alcohol dependency worsened she was unable to continue. During this period she spent some time in a privately funded alcohol rehabilitation programme, which was unsuccessful. After a period with no reported incidents in 2007 and 2009, Kate was reported missing by Brian in March 2009, whilst Kate herself reported to police that she was suicidal and was driving around having taken pills. When she was eventually located she was suspected to be drunk driving and was charged with the offence.

13. Peter and Kate first met in 2009 whilst Kate was walking her dog along canals close to her home. Peter had been spending time with a friend on a canal boat, but had also been sleeping rough under canal bridges. Although still married to Brian, a relationship started between the two and in January 2010, Kate and Brian separated and Kate moved out of the family home. She remained in close contact with Brian (her address was in reasonably close proximity to the former family home) often calling upon him for help when incidents occurred between her and

Peter (Apart from a brief period in 2011 following a severe head injury, Kate never returned to the family home.)

3. Summary of Significant Events

3.1 Key themes identified in the review

1. This section is not intended to reproduce the integrated Chronology or Timeline, which were used in the review process by the DHR Panel and during 'Learning events' with both IMR authors and senior managers of the agencies contributing to the DHR. They enabled the Review to cross-reference the interactions by the different agencies and professionals in order to determine what actions and contacts there had been with Peter and Kate as well as between the professionals themselves.
2. From 2010, until the murder of Peter in October 2013, Peter and Kate formed a relationship in which their abuse of alcohol was a defining and sustained feature. They exhibited many of the mental health concerns commonly linked to alcohol addiction. It appeared that Kate might have also suffered from an unidentified personality disorder. In addition, as a consequence of a significant head injury in February 2011, Kate believed both her behaviour and memory had been adversely affected.
3. The couple were well known to the police services of both Bristol and Wolverhampton during the period under review, through the almost unbroken chain of requests for assistance, made in the greater part by Kate. She was therefore generally identified by services as the primary victim and Peter as the primary offender.
4. However both Kate and Peter suffered significant injuries at each other's hands and both spent periods on remand, albeit that few of the incidents ultimately resulted in prosecution or conviction. Peter (and for a period Kate) were on bail with conditions that failed to prevent Peter's repeat offending, or encourage Kate to keep Peter away.
5. The credibility of Kate and Peter as witnesses was significantly undermined by their refusal to co-operate with police enquiries and their

frequent retraction of allegations or statements of complaint. This appeared to lead to some risk assessments and responses to incidents by police, which did not comply with force domestic abuse policy or with risk assessment guidance. Kate and Peter's lack of credibility also apparently influenced CPS in their decision-making concerning prosecutions.

6. The high level of risk the couple posed to each other was recognised by their listing at the Multi Agency Risk Assessment Conference (MARAC), fifteen times between August 2011 and October 2013.

7. The Marac's role is to share information relating to risk and play a central role in co-ordinating the safeguarding responses of all agencies engaging with the couple. In addition it was required to identify key actions for agencies that contributed to an identified safety plan and offender management strategy.

8. Hospitals and GPs had very frequent contact with the couple presenting with both injuries and physical and mental health concerns, which appeared to be the consequence of alcohol and domestic abuse. The response of primary and secondary care to suspected domestic abuse; GP and A&E engagement with safeguarding, and the extent of professional curiosity exhibited by professionals became a key feature of this review.

9. The personalities of both Kate and Peter appeared to be central to their almost complete refusal to engage meaningfully with alcohol and mental health services and highlighted the need in the face of difficult clients, for or an escalation policy for not only the MARAC, but also every agency with a safeguarding duty.

3.2 Significant events

The following extracts from the integrated Chronology and Timeline are the Independent Overview Report writer's view of significant information and events that illustrate the themes described above.

3.2.1 The pre MARAC incidents (2010 to August 2011)

1. In February 2010, Peter was admitted to the Emergency Assessment Unit at HOS1 following an alleged self-harm incident involving an 'overdose with alcohol' and prescription drugs. He was referred for a mental health assessment with a view to being taken on by the Crisis Resolution Team/ Home Treatment. He described depression and stress caused by being unemployed. He sought help in reducing his alcohol intake and managing anger. However he was not considered suicidal and was referred back to his GP who suggested he contact Aquarius, a third sector organisation that at this time, provided alcohol dependency services in Wolverhampton.

2. The first incident involving Kate and Peter was in March 2010; (Brian and Kate had separated some six weeks before) an alleged criminal damage to a window and assault by Peter on Kate for which he was arrested. Peter was subject to a further mental health assessment in custody by an Approved Mental Health Professional (AMHP). The AMHP; '*found no evidence of suicidal ideation or evidence of self-harm'* and concluded that Peter may have *'an alcohol induced behavioural disorder'.* Peter was referred back to his GP in order to facilitate counselling for anger management and to attend appropriate alcohol abuse treatment.

3. Peter was sentenced in May 2010, in relation to the earlier assault and damage. He was given a Community order of 24 months with supervision, Integrated Domestic Abuse Programme (IDAP) and an alcohol treatment requirement (ATR). Some months later, after failing to appear at court, his community order was varied and he was required to undergo the Low Intensity Alcohol Programme (LIAP). (Following imprisonment for offences in November 2010, Peter's community order was replaced with a custodial sentence .It appears Peter was never required to undertake the IDAP and alcohol treatment to which he had been sentenced.)

3.2.2 Early incidents in Bristol and first suspected stabbing of Peter by Kate

4. Peter spent much of the period between May and October 2010 in Bristol. On the 01.06.10 on the M4 a car driven by Kate crashed into the embankment. Peter subsequently drove the vehicle on the hard shoulder. Both were suspected of excess alcohol and arrested. (In July 2010, Kate was found to have driven whilst disqualified and with no insurance and with excess alcohol and she received eight weeks in custody. Peter was sentenced in January 2011 having failed to appear previously. He received a 12-month sentence with a conditional discharge.)

5. On the 30.06.10 police were called by ambulance control to an incident at Jane's (Kate's adult daughter) home address in Bristol. It was alleged that Kate had stabbed Peter in the stomach and arms. Kate denied the offence and Peter claimed he had accidentally stabbed himself whilst trying to open a can of beer with a knife. Kate corroborated the account but was still arrested. In interview she described Peter as having self- harmed earlier in the day, claiming her daughter and her boyfriend had witnessed this.

6. In July 2010 Kate was sentenced to eight weeks in custody for breach of her community order and resisting arrest. However, she had been released by the 16.08.10, and was in a Bristol sheltered accommodation for single, homeless or ex-offenders with support needs in relation to alcohol/drugs abuse. Peter was alleged to have climbed through her window and punched her repeatedly in the face. However, Kate would not pursue the allegation claiming she had not been hurt, and would not accept medical attention. Faced with an apparent lack of evidence the matter was not taken further. Later the same day, Kate was evicted from the sheltered accommodation for apparently abusing the shelter staff.

7. On the 24.08.10, Kate called police, alleging that Peter had become jealous of another male at the address (a Bristol Housing Project property) and had attempted to strangle her. Peter was arrested. A

witness described Kate shouting at Peter and calling him '*useless*'. He ventured the opinion that Kate was often the aggressor. Kate for her part would not pursue the original allegation, despite 'numerous' attempts to encourage her to do so by the police. The Crown Prosecution Service (CPS) was consulted and they decided the matter should be recorded as 'no further action' (NFA ed.)

3.2.3 The second suspected stabbing of Peter by Kate

8. On the 10.09.10, police were called to the same address as the incident on the 24.08. The same witness told police that Peter had stated that Kate had stabbed him in the abdomen. Peter had two abdominal injuries. The knife was recovered from a dressing gown. Kate was arrested on suspicion of grievous bodily harm. However, Peter then changed his initial account insisting that the injury was self-inflicted. Kate was bailed to an address in Wolverhampton. This serious alleged offence was later recorded as no further action (NFA) by police after a Home Office pathologist advised that the injury could have been self-inflicted.

9. On the 02.10.10, police were called to a premises operated by the Bristol Family Homeless Trust. Kate alleged that she had been dragged from her bed by Peter and punched in the head until she lost consciousness. Peter had left upon arrival of police. Kate was admitted to hospital overnight. It does not appear that police took into account that Kate was herself on bail for the GBH incident on the 10.09.10.

10. It was not until March 2011 that the warrant in relation to this offence was executed and not until April 2011 that Peter was convicted for this incident, receiving a custodial sentence.

11. In early November 2010, Peter was arrested for being wanted on warrant. He would remain in custody until early February 2011. In the absence of Peter, Kate appeared unable to cope. There were numerous incidents of damage, drunkenness reported in December

and January 2011 that illustrated Kate's vulnerability when separated from Peter.

3.2.4 Kate's life-threatening head injury (Feb 2011)

12. In February 2011, Peter was released from custody and by the 28.02.11 Kate suffered a serious life threatening head injury. The circumstances surrounding the injury were confusing, linking several incidents and potential suspects. Apparently during the day, Peter and Kate had been drinking both at home and around town. They went shopping for an engagement ring and Peter proposed marriage to Kate in a town centre pub.

13. Whilst there, Kate had an argument with another woman who punched her in the mouth causing a cut lip. Kate and Peter continued drinking at another pub, where Kate was pushed in a renewed confrontation with the woman who had punched her earlier. That push apparently caused Kate to fall backwards into a door striking her back and head. Later that evening, Kate was forcibly ejected from the pub by the landlord, fell down two steps, and landed on her back. At this point witnesses suggested that she was still conscious. A short while later, Peter apparently tried to lift Kate up from the floor, lost his grip on her resulting in her head striking the floor.

14. Kate was taken to A&E having suffered a subdural haematoma and presented with bruising to both upper arms, the right side of her lower back and buttocks. She was transferred to a Neurological Unit where she underwent surgery and thereafter was kept in a medically induced coma for a number of days.

15. The landlord who had ejected Kate from his pub, the woman who had twice assaulted Kate and Peter were all arrested and interviewed. CPS reviewed the facts, but a lack of clarity as to what had occurred was not helped by poor CCTV .The varying accounts by witnesses meant that, in the lawyer's opinion, a prosecution could not be justified. Police consulted the expert opinion of a neurosurgeon, who postulated that the most probable cause of the injury would have

been one of the punches thrown by the woman. However she was believed to have a strong claim to self-defence. Peter and the landlord's criminal responsibility were also unclear. All three of the suspects, who had been bailed, were eventually refused charged.

3.2.5 Kate's post–injury mental health and capacity assessments

16. Kate spent the first three weeks of March 2011 in hospital. Upon discharge she was advised by the hospital to have 24 hour care for two weeks. Brian, her former husband, took on this responsibility in so far as he could. She was then under the care of her GP. Despite suffering double vision, she would not follow her GPs advice nor accept support offered to her. She developed chest pains but again did not present for the treatment she was advised to seek.

17. She was later admitted to hospital, via A&E, with a pulmonary embolus (blood clot in the lung). Almost immediately following her discharge, on the 18.04.11, Kate called the GP complaining of chest pains, but refused to return to the hospital which had treated her, stating she would go to a local hospital. The next day, Brian informed the GP that she had refused to go and that furthermore he was due to go on holiday and would not be available to care for her.

18. The GP made a home visit that evening because of growing concerns about Kate's mental state, but Kate refused to open the door, telling him to go away. Later in the evening the GP re-attended with an AHMP after consultation with a duty psychiatrist who advised a mental capacity assessment was required. Again, Kate would only speak through the closed door. It was decided that the Mental Health team would attend the following day for what the GP hoped would be a Mental Health Assessment (MHA). However they declined to undertake an MHA without a preliminary capacity decision. The GP therefore returned that afternoon, but Kate was found to have taken too many painkillers for a full assessment. However she was judged to have capacity. Consequently the GP was unable to secure a Mental Health Assessment.

19. Some days later, Kate was admitted to hospital with abdominal pain and after a few days tried to self-discharge prompting a call from the hospital to the GPs. She was allowed to return home for a night but returned intoxicated and refused a CT scan. She was aggressive with staff necessitating security to be called. She subsequently informed the surgery that she did not want to see either of the GP she had had recent dealings with. This was entered on her records. These also show that in June she missed rehabilitation treatments and other clinic appointments. The surgery had contacted the Primary Care Trust (PCT) to have her removed from their list due to her abuse of staff, and Kate herself stated she intended to change surgeries, which she did.

20. In May 2011, Peter was due for release from prison, (having served a sentence for assault upon Kate) and a detective called Kate to discuss safeguarding. She would not engage and hung up. The officer recorded; "*The only conclusion I can draw from her reaction is that she does not want assistance from PPU … her referrals show this pattern of behaviour."*

21. On 16.06.11 Kate called police and alleged that Peter had raped her the evening before. She was taken to the Sexual Abuse Referral Centre (SARC) by Brian, having refused to be taken there in a police car. The police report recorded that once there, she became abusive to officers, and although she made a brief statement, she would not agree to a medical examination. Police recovered clothing in an attempt to secure some forensic evidence, but Kate would not co-operate further. Brian claimed that Kate had been experiencing mood swings since her head injury. Officers noted she smelled of alcoholic drink.

22. Several hours after the initial report, Peter returned to the flat, and was arrested and later interviewed. He denied rape and described his sexual relations with Kate as 'healthy'. There had then been a row, where Kate threatened that unless Peter got his own flat she would '*get him sent away for years'.* He had left the flat to *'let off steam'*. Officers made a further attempt to persuade Kate to provide fuller

evidence but she refused saying she did not care what happened to Peter an inspector reviewed the case whilst Peter was in custody and concluded it was highly likely the rape did not happen. Peter was released without charge and the matter filed. The incident was subject to a DASH and graded as a standard risk.

23. The period from July 2011 to December 2011 saw an increase in the frequency of calls to police from Kate and the first assessment of her as a high-risk case, which was taken to the Multi Agency Risk Assessment Conference (MARAC).

24. On the 29.07.11 Brian called police claiming Kate was too scared to call police, but that Peter had broken into her flat some three hours earlier and was refusing to leave. Kate herself then called saying she had been strangled and was in '*extreme danger'*. Police attended and Peter was immediately arrested. Officers remained to take a statement from Kate who had no apparent injuries. She then became abusive towards officers, refused to give further details and told them to leave. She called police a further two times, claiming to have heard a female officer saying, 'I don't believe a thing she is saying' and complaining at police refusal to take a statement. No statement was taken or crime recorded, as officers did not believe an assault had occurred. Peter was released without charge.

25. On the 12.08.11 Kate was attacked by Peter. She suffered lacerations to the bridge of the nose and bruising to the left side of the face and left eye after Peter grabbed her by the throat and punched her three times. Brian and her daughter Louise came to her home in response to her call for help. Apparently both Kate and Peter had been drinking heavily. In interview Peter described being taunted by Kate. He also disclosed being assaulted by her in the past with golf clubs and bottles and being stabbed. He alleged Kate had punched him first. He was charged and remanded in custody and remained in prison between the 13.08 and 26.08. (A Court liaison mental health assessment carried out by a community psychiatric nurse (CPN) in custody concluded that Peter currently had no thoughts of suicide or self-harm.) The incident was recorded as

medium-risk by the reporting officers but increased to high-risk by the Public Protection Unit (PPU) and prompted the first listing at MARAC. The counter allegations made by Peter were not investigated.

26. The police IMR described Kate as '*deliberately sabotaging*' the prosecution of Peter. What is evident is that she was not prepared to continue with a prosecution and claimed her memory of events was poor due to her head injury. She denied police access to her medical records reinforcing this by informing her GP surgery on the 17.08 that she did not want her medical records released to police. In a conversation with the investigating officer she asked where Peter was in prison so that a non-molestation order could be obtained, yet did not want the officer to prevent calls from Peter in prison.

27. On the 24.08 saying she loved Peter and intended to marry him, she became abusive with the investigating DC when told there was no-one available to take an immediate retraction statement. CPS was informed of Kate's retraction on the 25.08 and it would appear Peter was immediately released.

28. It is of note that Kate underwent an assessment with the occupational therapist as part of the rehabilitation team's work post her head injury on the 28.08. Kate claimed it had been caused by Peter pushing her down a flight of stairs. She described being recently assaulted by Peter. She complained of '*mood fluctuations and behavioural changes'* and was recommended to undergo a cognitive assessment.

3.2.6 The first MARAC (August 2011)

29. The first MARAC where Peter and Kate were considered was held on 31.08.11. The meeting considered the risk to Kate posed in the light of her recent retraction of her allegation against Peter Other than information sharing and establishing that addiction services had no on-going engagement with either party, there were no tangible actions listed on the minutes.

30. A new incident occurred on the 01.09.11, just five days after Peter's release from custody and the day after the MARAC. Kate called

police in fear stating that Peter had broken into her flat and stolen tobacco and a small amount of money and she had fled in fear. When police arrived Peter was not present and Kate was extremely abusive. It was only after they returned three times, that Kate could be persuaded to make a statement. The incident was described as a high-risk domestic burglary on the police log. Police contacted Older Persons Services Emergency Duty Team and a temporary room in a hotel in Walsall was arranged for Kate that night.

31. Yet the same day, her doctor's surgery received a call from her 'carer' Peter stating Kate would be late for an appointment. She then rang and said that in fact she was unable to get out of bed and needed a home visit. Later Peter came to the surgery to apologise for Kate's mood swings. He had blood on his head he explained was from an injury caused by Kate but was still apparently looking after her. The GP's IMRreveals that no note was made on Peter's records and no action was taken.

32. On the 05.09 Kate called police to say that Peter had 'hit himself over the head with numerous objects' and was bleeding. A male and female could be heard arguing. Police attended and Peter was arrested for the burglary. He was not charged because Kate retracted her allegation saying she had found the money and tobacco and that her confusion was a result of the blood clot on the brain. The incident was not recorded as domestic abuse. It is worthy of note that whilst in custody, Peter was subject to mandatory drugs testing (MDT) and he tested positive for heroin. (This was later overturned because he had taken co-codemol which is known to interfere with drugs testing.)

33. During the remainder of September Kate called police a further three times, on one occasion raising concerns that Peter had a knife and intended to kill himself. Although he was found safe and well a referral was made to EDT, which in turn was passed to Peter's GP. He was offered counselling by the GP in early October, which he refused.

34. On the 20.10.11 Peter was taken to hospital by ambulance with an injury to his face having overdosed on drugs and alcohol. In the same

month, police received several calls from Kate making allegations against Peter of assault on one occasion and theft of a bank card on another. On one occasion, Kate made as many as five successive calls to police, saying Peter was breaking in to her flat. She berated controllers when police did not arrive, but then proceed to insult them when they did. Peter was found in the flat and was taken once more to his brother's home.

35. Controllers were becoming so used to Kate that decisions not to send officers, (in apparent breach of domestic abuse policy) were reviewed by duty inspectors. On the 19.11.10, Kate alleged Peter had threatened her with a knife. This was recorded as non-crime.

36. A second MARAC was held on the 05.12.11 Kate had told the domestic abuse officer reporting to MARAC, of her dissatisfaction with police responses and her intention of making a formal complaint. They discussed the possibility of non-molestation orders and Kate'said she would consider them but did not require any other police service. The officer recorded that Peter was present during the phone conversation.

37. *{DHR author's note: It seems inappropriate that potential enforcement measures to be taken against Peter were discussed on the phone with Kate knowing the frequency of their violent arguments.}*

3.2.7 The third suspected stabbing of Peter by Kate December 2011

38. On the 09.12.11 Kate called police saying a male (Peter) had a stab wound and blood was 'squirting' from his chest. Both Kate and Peter maintained that four men had attacked them. However officers noticed there was significant amounts of blood in the house, recovered a knife and consequently arrested Kate .Peter was taken to hospital and required sutures for lacerations to the chest and wrist. Kate was interviewed and was placed on bail. She was to reside at a stated address, and not let Peter into the address. She was also subject to a curfew. Kate remained on bail from 09.12.11 until 23.04.12, whilst the case was prepared for a CPS decision.

39. Despite Kate and Peter's denials, the incident was identified as high-risk domestic abuse and listed for a MARAC on the 05.01.12 with Peter as the victim.

40. On the 17.12.11, Kate called police stating that Peter had broken into her flat, stayed several hours and assaulted her. When police arrived Peter was arrested and charged with criminal damage following a CPS decision. However Kate now denied an assault and would not co-operate with a DASH assessment. Officers concluded she was at medium risk.

41. In his interview, Peter admitted causing damage but stated it was not through forcing entry. In his account he stated that Kate had allowed him in and they had drunk together. She had admitted sleeping with another man, which made Peter angry and he had kicked the door causing the damage. He told officers Kate had indeed stabbed him and showed them his wounds. The police IMRauthor found the account of the incident offered by Peter to be *'more credible than that of Kate.'*

42. In January 2012 Kate was discharged back to the care of her GP, having missed two mental health outpatient appointments and having declined a third.

43. The MARAC on the 05.01.12 related to Peter and was an information sharing exercise, where all present acknowledged that alcohol abuse was at the heart of Kate and Peter's problems but they would not engage with addiction services. Police undertook to ensure breaches of bail were acted upon.

44. On the 09.01.12 Kate presented at hospital with 'lacerations *to right ear, bruised and lacerated right thumb and laceration to side of left eye.*' She was aggressive at hospital and would not allow a proper examination and self-discharged against medical advice. Two days later she returned to the hospital where she was given painkillers. Kate explained the injuries were from a fall down stairs.

45. On the 02.02.12, Kate called police and claimed Peter had come to the door three times and had eventually broken in and head-butted Kate causing a laceration on her nose. There was no sign of damage

to anything but a picture frame; however the matter was recorded as a wounding. Kate would not give a statement and was uncooperative. Although officers found Peter in the street, and he had a cut to the head, he explained it was caused not head-butting Kate but a picture frame.

46. The following day a PPU detective sergeant recognised the poor practice and the need for active attempts to arrest Peter PPU staff were able to persuade Kate to give a more detailed account of the incident. In consultation with a uniformed inspector an arrest strategy was agreed which included victimless prosecution, which CPS authorised. Peter was finally arrested at Kate's flat on the 07.02.12 and remanded to court, where bail conditions were imposed. However on the 09.02.12 officers visited Kate and Peter was found there. He was arrested for breach of the court bail conditions and put before the court but released again on bail. Police recorded impressing upon the prosecutor the complexities of the case and the need for remand in custody but this application was unsuccessful.

47. On the 14.02.12 Kate called police saying Peter had assaulted her causing reddening to her eye. In the event Peter was arrested for assault and Kate for a breach of the peace. Neither was charged, but Peter was sent for a third time before magistrates for breach of bail. He was again released.

48. On the 16.02.12 Peter was arrested for breaching his bail conditions and was remanded in custody. He spent the period from 17.02.12 to 03.04.12 in prison. During this period agencies made concerted efforts to engage with Kate the same day that Peter was remanded in custody, Kate suffered a house fire and was consequently homeless. She was taken into A&E suffering from shortage of breath but according to A&E records, 'stormed out after arguing with relatives'. Adult social care (EDT) was contacted for assistance in finding her accommodation and a B&B was arranged over the weekend, although she would remain there some time.

49. The police PPU actively encouraged Kate to contact Aquarius and Haven-Wolverhampton; specialist third sector providers of alcohol

and domestic abuse services. Although Kate did not think there was 'any point' in attending Alcoholics Anonymous (AA), they overcame her reluctance and agreed with an AA representative that she would be collected and taken to a meeting. (The AA felt that this might be a better option for Kate since Aquarius tolerated moderate drinking, whilst AA called for total abstinence.)

50. PPU had asked for Kate's GP details, which she refused. However they traced the GP's surgery only to be told that Kate had actively forbidden them from divulging her records to the police. The GPs recorded the words of the officer, 'Police *officer has grave concerns for Kate … she fears one of them will end up dead.*' Immediately after this Adult Safeguarding team wrote to the surgery and also asked for disclosure about Kate a high-risk domestic violence victim whom they also had grave concerns about. The surgery wrote to Kate for permission to disclose.

51. Housing Outreach interviewed Kate on 20.02.12 as potentially homeless and fleeing domestic abuse. Police PPU supported her application on this basis. It was not successful.

52. It appeared Kate would not accept that she be characterised as fleeing domestic abuse by police, housing or any other agency. On the same day that she called Housing, the 23.02; Peter was due in court for a remand application. Kate phoned the PPU safeguarding team saying police had 'lied' and that she was not fleeing domestic violence. She began to swear at officers and hung up. Some hours later, CPS called to say she had made the same claim to them. CPS however were not swayed, and Peter remained in custody.

53. When Kate was discussed at the MARAC on 27.02.12 she had been listed for support from the Independent Domestic Violence Advisors (IDVAs) at Haven-Wolverhampton, but had not yet been seen. The only help Kate accepted was from Aquarius because she conceded alcohol was the cause of hers' and Peter's' problems.

54. In March 2012 there was very considerable efforts made by Adult Services to provide an assessment of Kate's needs for support with care. Her temporary accommodation at the B&B ended because Kate

kept breaching the smoking policy and she was required to leave. Kate refused help from Haven-Wolverhampton and did not attend an appointment with the Community Mental Health Team that had been arranged by her consultant psychiatrist. By the end of the week it was clear that no B&B could be found locally. Kate refused to move from the area because she wanted to be near Peter and became abusive on the phone. Despite repeated calls, she could not be contacted for several days. Kate later disclosed she had spent a night wandering around the city centre.

55. Kate moved to a new flat, the location of which was not known to Peter Yet, the day after Peter was released from prison, and Kate called police, at about 19:00. Peter was apparently drunk and aggressive outside the location. Kate was abusive to the operator who dispatched officers. They concluded both Peter and Kate were drunk and that there were no offences and removed Peter to his brother's address that was a few miles away.

56. Shortly after midnight police were called back to Kate's flat. Peter had returned and broken in, dragged Kate out of bed and hit her over the head with a lamp causing a head injury; Kate even had some of the ceramic imbedded in her forehead. A police search located Peter nearby and he was arrested and charged with assault. He was kept in custody between the 07.04.12 and the 18.04.12.

57. Almost immediately after Peter was arrested, Kate began to be un co-operative. She claimed that she had memory problems and her statement should not have been taken. She now provided a new version of the events, which she had not given on the night, saying that Peter had broken in and dragged her out of bed, but only after finding her with another man had provoked Peter the two men had apparently fought. When it was pointed out that Peter was still guilty of assault in those circumstances she said she would not go to court. (When Kate went to her GP for outpatient care on the 10.04 she recounted this story to the GP, but said both men were in prison.)

58. CPS faced with Kate's lack of co-operation, and her apparent unreliability, concluded that the prosecution should be discontinued.

59. In May 2012 the pattern of Kate's repeated calls to police continued. She called on five different days but on some of those she made multiple calls. She rang PPU to say that she was a high-risk domestic abuse victim who needed support but then abused the officer who tried to engage with her. On some days she would phone claiming Peter was standing on her window ledge, or had climbed into her garden, then she would call to say he had left. Minutes later she would call to say he was back. On several occasions police found Peter outside, drunk but amenable and sent him away. On another occasion he was outside in the garden asleep in a chair. Most of the incidents were recorded as either standard or medium risk. It was not until the 28.05 that response officers chose to arrest Peter for a breach of the peace, which was graded as high risk. Peter refused to be bound over, and the matter was listed for trial in June.

60. On the 10.05.12, a fifth MARAC occurred but there were few actions other than continued attempts to persuade Kate to engage with Aquarius alcohol services and the placing 'weapons' warning markers on the address. In fact Kate consistently refused to engage with alcohol services, and by 11.06 they reported to the MARAC lead that Kate's case had been closed for lack of response.

61. On the 18.06.12 a sixth MARAC addressed Kate and Peter It is evident from the IMRfrom Older Persons Services that a new approach to Kate was considered at the meeting.

62. It was suggested that Kate's head injury in 2011 may have caused injuries which impacted upon her mental capacity and mental health. It was argued that this made her a vulnerable adult, regardless of the additional risk from domestic abuse, and that a mental capacity assessment was needed. A public protection officer discussed this with a Safeguarding Manager from Older Peoples' Services and it was considered a worthwhile approach to obtain additional support. Police therefore submitted an SA1 (the local safeguarding adult referral document) to Access and Initial Assessment Team (AIAT). However when a deputy team manager received the referral, it was discussed with the police. It was the manager's view that MARAC

was managing Kate and that there was nothing further that could be offered by Older Person's Services. The referral was deemed 'inappropriate' and closed and the team manager endorsed this. The decision was taken not to discuss the referral with the subject Kate.

63. On the 23.06.12 Kate went to a neighbour who called police on her behalf because Peter had damaged her phone. Kate alleged that she had been assaulted by Peter and had reddening to her neck caused by being grabbed. However when officers returned she said she had not been assaulted and the reddening was a rash caused by the menopause. The matter was however recorded and assessed as high risk.

64. Peter was arrested on the 25.06.12. In interview he provided the same explanation as Kate for the reddening. However he acknowledged their potential for causing each other serious harm when drunk. He made counter-allegations showing the officers 'serious burns to his chest' caused some weeks earlier when Kate had poured boiling water over him. Immediately out of interview, Peter said he had 'fallen into the water' and refused to allow his injuries to be photographed. Nonetheless the incident was recorded as a crime and assessed as high risk. Kate was arrested on the 26.06.12, interviewed in relation to the incident, and said that the injuries were birth- marks.

65. An acting police sergeant in PPU reviewed the allegation against Kate and felt that it did not pass the evidential threshold and could be filed. Kate was released without charge and without referral to CPS. The case against Peter was however reviewed by CPS, who concluded there was insufficient to charge, and he was released. Both were offered safeguarding advice and help, which they declined.

66. Two separate Detective Sergeants summarised the position in relation to Kate and Peter a few days later. The police IMR records the following observations;

67. '*This couple are constantly being referred to safeguarding. Neither of them will engage nor take up offer supported to them. However, referrals will continue to be made in the hope one of them may accept*

assistance. The couple have/will also be made subject to the T[T]CG [Tactical Tasking Coordination Group] process to the LPU.'

68. The second sergeant recorded;

69. '*It is generally agreed by all parties that the safeguarding measures implemented and offered thus far are reaching a point where little else is available. In spite of this I have asked that the entire menu of support offered and tried thus far is put under review at the next MARAC to see if gaps exist*.'

70. July 2012 continued the pattern of Kate's drunken calls to police to have Peter removed, followed by denial of any complaint. Police logs increasingly made reference to Kate's perceived false allegations.

71. Other agencies also had contacts in July. Peter presented at A&E with lacerations to his right arm after allegedly falling on to glass. This was reported to the GP. There is nothing to suggest that either the hospital or GP actively considered this could be an inflicted injury, despite Peter's history.

72. On the 16.07.12 a further MARAC took place and police proposed to concentrate on offending behaviour with targeted offender management. Peter had been assessed as 'medium' risk on the offender management system (IOM). He was also recognised as a potential victim. His management plan involved at least two contacts with Peter a week, (which could include police call outs) and an offender manager was identified. The police IMR was honest about the level of engagement this strategy generated. Between the 22.06.12 and his death, the IOM system records 24 attempts to see Peter but only identified 8 occasions when he was seen. The IMR author offers the view, ' *it is difficult to identify any positive changes to his(Peter 's) behaviour' The offender manager tried to interest Peter in the "Steps to Change " programme run by RELATE, and tried yet again to persuade Peter to engage with alcohol services. He recorded engaging with Peter around his cycle of abuse.'*

73. *{DHR author's note: the 'Steps to Change' programme would not have been suitable for Peter because of his alcohol abuse and high-risk offending.}*

74. On the 07.08.12, Peter was arrested for an assault on Kate Information in the IMR of Older Person's Services suggested that EDT were told Peter was threatening to harm himself and wanted to be 'sectioned.' The following day an AMHP concluded that Peter was responding appropriately and that he was not suicidal and was not detainable under the Mental Health Act and should be referred back to his GP in relation to alcohol abuse and depression.

3.2.8 Peter and Kate attempt to tackle their alcohol abuse (Aug-Oct 2012)

75. There followed a period between August and October 2012, which the police described in their IMRas a 'period of relative calm'. It is significant because it appears to the DHR panel to have been the only time when both Peter and Kate had common purpose to tackle their alcohol abuse. Agency contacts with the couple were supportive, around health needs. The couple moved to a new GP surgery on the 20.08.12, and unusually their medical notes were received within ten days, therefore the extensive history of concerns was known.

76. Louise, (Kate's daughter) in conversation with the DHR author, recollected very well the period of August 2012. It was her sixteenth birthday on the 02.08.12 and around that time, she, Kate and Peter enjoyed a rare happy and harmonious day. The three went to a local zoo as a treat, and she went to Peter and Kate's for dinner. Louise remembered that Kate and Peter both promised her that they had decided to try and tackle their alcohol abuse. She made it a condition of continuing contact with them. It was evidently an emotional and highly charged evening. At one moment, Kate offered Louise a drink to celebrate and the incongruity of the offer, next to what they had promised, apparently struck Kate and reinforced her in her determination to change.

77. After a MARAC on 13.08.12, PPU staff conducted a joint visit with Aquarius. They met with Kate and Peter on the 21.08. The two claimed to have been sober for a week and engaged in a constructive

way. They recognised the potential they had for harming each other when drunk. They were offered individual appointments with Aquarius.

78. The GPs surgery undertook alcohol assessments with Kate and Peter and both were identified as high risk requiring advice from the practice's specialist nurse. During this period Kate phoned the surgery simply to talk about the stress her concerns for her son and daughter (Jane and Andrew) caused her. She claimed to have a '*very supportive'* partner. It was suggested that she have an appointment with the Healthy Minds team, which she took up.

79. It is also of note that Peter had a wide-ranging consultation with a GP on the 30.08 in which he acknowledged years of alcohol abuse but pointed to the fact he was engaging with Aquarius and was about to start with AA. Importantly, this was the only time a GP recorded on noted that Peter was a victim of domestic abuse.

80. In September, Aquarius had several home visits with Kate but little constructive progress was made and Kate and Peter were unreliable in relation to appointments saying they did not want help. By the end of the month, despite attempts to achieve engagement with both Kate and Peter he had disengaged saying he would use AA. Kate had never accepted Aquarius' support, saying she would work with 'Healthy Minds.' Her file was closed on the 05.10. However at a MARAC in November, Aquarius revealed important information regarding Peter's withdrawal from the service and the injuries that had been overlooked.

81. Kate made the first request for police help since August 2012, on the 17.10.12. A few days later, Brian and Louise reported to police that Peter had threatened to burn their house down and that Kate had told them she had been assaulted and Peter had caused damage. When officers spoke to Kate she was no longer making any complaints. Peter was noted to have injuries to his arms that looked to officers to be self-harm. The Police IMR speculated that these could have been inflicted injuries given the history between Kate and Peter Kate herself stated if Peter went to his brother's he would return, so he

was taken to the station so he could get a train to visit a friend. None of the multiple allegations were recorded as crimes.

82. On the 31.10.12 Kate made around sixteen calls to police in one day. On each occasion she added new elements to an allegation that included assault, forced entry (criminal damage) by Peter who came and went to the address but was never found there by police. Officers saw damage and arrangements were made for it to be boarded up, only for Peter to return and allegedly cause more damage. When Kate reported that Peter had returned the log was downgraded because officers had been out twice and he had not been present. Kate then called the PPU direct at around 10am and consequently a PPU DS raised the profile of the incident by pointing out that this was a high profile domestic abuse case that the couple were going to be considered at the LPU Tactical Tasking & Coordination Group, (TTCG) and every opportunity for victimless prosecution should be taken. Peter was not in fact arrested for the damage and assaults until the 02.11. Released on bail he immediately breached his conditions by contacting Kate by text. The officer in the case was not in a position to charge Peter so no action was taken.

83. On the 05.11.12 Kate was listed at MARAC for the ninth time.

84. Aquarius reported their last meeting with Peter *'he presented with a scar across the left side of his nose and later revealed a deep cut to the left hand, which should have been stitched, and stab wounds to the left arm and chest area. He stated he had not received any formal medical attention. He says the wounds are about three weeks old'.* Peter would not openly accuse Kate of the injuries but he described that in his view she needed help not prison and that she would allege they were self-inflicted. Peter said he did want to engage with Aquarius but Kate had pressured him into not coming. The minutes listed all the measures and support refused by Kate bleep alarms, Haven referrals, referral to alcohol services, Cocoon watch, and Police watch. It also described an attempt to serve a 'threat to life' Osman warning on Kate on the 25.10. She had refused to sign.

85. *{DHR author's note: Osman warnings (named after the case of the same name) are a warning of a 'real and immediate' risk of serious harm or death given to a potential victim who is provided with details of protective measures proposed by police.}*

86. Aquarius were still trying to assist Kate and Peter. Peter was now homeless, and supported by Aquarius and police, started to be referred to P3, who provided temporary accommodation and support for socially isolated homeless males aged 18 to 65 in the city. Peter was to have two periods in the hostel as a response to crises or arrests.

87. P3 tried to engage with Peter who they described as a 'very *proud man who struggled with asking for help*'. They reported a lack of progress in engaging with Peter in part due to his frequent abuse of alcohol and his unexplained absences. He was *'unable to manage his lifestyle*'. Although Peter recognised the mutually abusive nature of his relationship with Kate he gave the impression that he did not intend to return to it. Yet his plans were fluid and unclear, leading P3 to conclude in their IMR, '*We found it very difficult to establish a meaningful relationship and effective plan of support as a consequence.*'

88. Peter moved into the hostel on the 02.11.12. Kate still made frequent allegations against Peter Evidently Kate was often letting Kate into her flat and Peter was often absent from the hostel. PPU were increasingly frustrated by Kate's persistent calls to their office but her refusal to take out a non-molestation order against Peter

89. On the 30.11.12, Peter told the hostel he was moving out to *'live with a friend'* against their advice. The next day he returned but his room had been allocated. Peter was told he would need to go to the Homeless Unit to find accommodation. Instead, he went again to Kate's flat. Kate called to say Peter was threatening to kill her and was in possession of a gun. She phoned again and repeated that Peter was outside with a gun. Police knew this was malicious because Peter was with them, being taken back to his hostel and was not in possession of a gun.

90. *{DHR author's note: The period in mid to late November saw Kate at her most argumentative and the growing frustration of both PPU and frontline officers was evident.}*

91. On the 03.12.12 Kate was listed at the tenth MARAC. The Acting inspector pointed out that Peter was no longer in the hostel and a domestic abuse officer said Kate had 'point blank' refused a non-molestation order. Other agencies such as the Domestic Violence Forum, reported that Kate had been abusive when their staff called to give Kate feedback from Peter's most recent court appearance. Yet again the Aquarius representative was asked to try and locate Peter and ask him to re-engage as well as set up a new referral for Kate the same actions requiring warning makers to be place against Kate's address, required at the November MARAC, re-appeared on the December MARAC actions. Kate was removed from the panel.

92. On the 03.12.12 at 16:00, a call was received from a neighbour reporting an incident between Kate and Peter This in itself was unusual since calls usually came from Kate He reported real concerns for the safety of Peter He had heard Kate shout, ' *Now I'm going to kill you*' and heard Peter say, '*you're dangerous you are*.' Significantly, he said that Kate was often the aggressor. Police attended but concluded that this was a drunken argument and warned the couple that if they were called again one or other would be arrested. They recorded that it was an *'everyday occurrence*' for them to speak this way.

93. At 17:40 Kate called twice saying that Peter had hurt her throat strangling her and had left leaving her flat looking like 'Armageddon'. Police did not arrive until 20:55. Kate did not answer the door. Officers waited twenty minutes to ensure that all was quiet and then left. Neither incident was recorded as a domestic incident or a crime. It is unclear whether the informant was spoken to.

3.2.9 The fourth suspected stabbing of Peter by Kate

94. On the 08.12.12, Peter called police saying that Kate had slashed his arm with a knife and knocked his teeth out with an axe. Peter had 4 inch lacerations to his arm, and muscle damage requiring stitching, and missing teeth from an incident a few days before. Peter said that Kate had pushed him out of the flat after the incident and told him she would never see him again if he informed police. Kate was arrested at the scene saying she done nothing and Peter had come home like that.

95. Peter was put into emergency accommodation after hospital treatment. By the next day Peter was calling police to retract his statement saying they had '*got the wrong person'*.

96. Kate in interview alleged that he had slashed his own arm and that Peter had said '*if I can't have you I'll send you to prison'*. This contradicted her claim that Peter had arrived home in that condition. She was charged and kept in custody. Police and CPS opposed bail and Magistrates remanded Kate in custody until 04.03.12

97. The neighbour who had reported the incident of the 05.12.12 gave a statement, which described Kate as a *'bully'*. He had heard Kate make frequent violent threats and in contrast he described Peter as '*defensive and apologetic'*. In the days before the wounding he heard Kate say; '*now I'm going to kill'* and on another occasion, '*go ahead and leave, you're nothing, you'll be dead'*. Finally on the day of the wounding, he heard Kate '*shout like a maniac'* and Peter say '*please, I'm sorry, no more'* and at 1611 hours, Peter shouted '*stab me again, it's not my fault'*. The neighbour and his family expressed their concerns that Peter would be killed.

98. On the 10.12.12 Peter returned to the hostel run by P3 as emergency housing. His second stay at the hostel was not without problems; he was recorded as swearing at staff and drinking with other residents.

99. On the 12.12.12, Peter was offered support by the Domestic Violence Forum but he was already asking to retract his complaint. On the

same day, apparently unaware that Kate was in custody, Aquarius re-opened their file on Kate.

100. Peter made numerous contacts through his solicitor and police to try to retract his original allegation and in a second statement he claimed to have inflicted the injury himself trying to cut out a "Kate tattoo. He withdrew support for the prosecution on the 28.12.12, but CPS and police apparently remained committed to a victimless prosecution.

101. A MARAC was convened on the 07.01.13 where Peter was discussed as a high- risk victim. WDVF contacted Peter who expressed his regret at Kate's imprisonment. He said that he had made his statement when he was '*high*' on drugs and alcohol and police had been abusive to him saying they wanted to get either him or '*Kate locked up*.' The WDVF offered support to Peter should he be required to attend court. The only contact WDVF had with Peter thereafter was by letter.

102. In January 2013 Kate was scored under the Integrated Offender Management (IOM) matrix as low risk. The police IMR pointed out that although Kate had been suspected of stabbing Peter before, these had not led to convictions. However the police IMR concluded in assessing Kate '*Although she had not been convicted she was certainly a violent person and posed a significant risk to Peter if not to others*.'

103. In April 2013 CPS discontinued the prosecution of Kate According to Brian, when Kate was released from prison she met Peter the same day in a city centre pub, where they got drunk.

104. Kate called police on the 29.04.13, saying she had been beaten by Peter and had a head injury, which was '*bleeding all over the place'*. She was taken to A & E but self-discharged after twenty minutes. When police attended they found it to not be a particularly serious injury and Kate was saying the incident had occurred a week before. Later the same day Kate called and said Peter had assaulted her again since police attendance. Controllers judged this was in fact the same incident and did not send officers. Having had no response,

Kate called and said Peter had broken into her flat and raped her. She then attended the police station to report the claim.

105. Kate was extremely drunk upon arrival at the station where a female inspector attempted to engage with her. Even by Kate's standards, the level of personal abuse directed at the officer was crude and sexualised. A sergeant and PPU staff tried to speak to Kate but she continued to abuse officers and left the station. Later that evening, she was found collapsed drunk in the street. The next morning Specially Trained Officers (STOs) tried to engage with Kate but she would not co-operate, saying her rape allegation was dismissed the evening before. The matter was written off on the police log without being recorded as a crime allegation.

106. On the 21.05.13, police were required to investigate an allegation of assault made by Kate and a counter-allegation of assault by Peter It stemmed from an incident that was alcohol fuelled and very typical of the interactions between Kate and Peter over the years. Apparently Kate had ordered a taxi to deliver 24 bottles of Lambrini wine to her flat and tipped the driver £20. Kate and Peter argued over this and Kate alleged that Peter had strangled her, punched her to the head and thrown her to the floor and kicked her. She had no visible injuries, but said she was in pain. Neighbours had heard Kate '*shouting*' and Peter responding at '*talking volume'*. Peter was arrested and brought into custody.

107. Whilst in custody, Peter showed officers a number of old scars on his arms and a more recent, one inch long scar, which he said had been caused by Kate In interview Peter refused to elaborate on the cause of his own injuries but he did deny assaulting Kate Peter did accept that he was an alcoholic but considered himself better able to handle the consequences than Kate.

108. PPU officers visited Kate the following day offering advice and support. She was advised that if she moved away from the area she might be able to make a fresh start away from Peter the officers said that they would be prepared to write a letter of support to the housing department in any area she chose. Kate said that she wanted to stay

at her current address but had decided not to reconcile with Peter Kate expressed a desire to take out a non-molestation order and so a referral was made to The Haven-Wolverhampton.

109. This willingness to engage lasted until 11:00am, when Kate made a statement of retraction of her allegation against Peter At 13:35 she was arrested for the injuries she was suspected of causing Peter. She denied the allegation, saying that Peter had caused them falling out of a tree. Both Peter and Kate were released on bail with conditions not to contact each other, to live at their own addresses and not go the other's address.

110. The police IMR identified that through the Tasking process and Daily Management Meetings, the LPU managers were very aware of the problem posed by Kate and Peter In May 2013, the LPU Superintendent therefore decided to take control of the strategy in relation to Kate and Peter and called a professionals meeting outside of the MARAC process. It was set for the 17.06.13.

111. The period 29.05.13 to the end of July 2013 was perhaps the most challenging for all agencies, but particularly the police, in the entire history of the relationship. Kate and Peter had been on bail since the 21.05 and would remain so until 01.08, but persistently would spend time together, in breach of bail. Once they were drunk, Kate would make allegations, many of which were strewn with contradictions and inconsistencies to the point where it was impossible to separate the truth from exaggerations or proven untruths. Although Kate alleged frequent assaults, she rarely was seen with injuries consistent with the kinds of assault alleged, or she refused medical examinations. She seemed incapable of keeping Peter away and the lack of damage after alleged forced entries made it seem more likely that she was allowing Peter access. Her credibility as a witness was further seriously undermined by her frequent claim to suffer memory loss; a consequence of her head injury in February 2011.

112. The MARAC on the 03.06.13 recognised that some of the same people who attended MARAC would attend the professionals meeting but also identified the GP as an important 'stakeholder'. It is of note

that the officers investigating the most recent assaults were asked to request a restraining order if charged. This was the only occasion that the panel found any mention in MARAC minutes of restraining orders being considered and they were not mentioned again at the repeat MARAC of the 17.06.

113. On the same day as the MARAC, Kate made several calls to police. In the early hours she alleged being assaulted by Peter but was asleep when officers arrived and would not discuss the matter. In the afternoon, she alleged Peter had gained entry to her flat, thrown water over her and kicked her about the body whilst she was on the floor. Peter was present and therefore was arrested. He was bailed whilst further enquiries were completed. His bail address was now with his sister on the Welsh coast.

114. On the 05.06, Peter was arrested for breaching bail conditions. He was brought into custody at 02:00 and re-bailed at 02:34. At 02:39 Kate called police saying Peter had been at the flat shouting at her for getting him arrested. Police could prove this was untrue because he had been in custody. Officers therefore attended Kate's and issued a fixed penalty notice for wasting police time.

115. Over the next few days, Kate engaged with professionals who offered help whilst trying to convince her GP to prescribe Librium the brand name of a drug chlordiazepoxide hydrochloride. This medicine has application for the treatment of anxiety. 'NHS choices' explain it makes people feel less agitated and less tense. Chlordiazepoxide hydrochloride may also be used to treat muscle spasms or the symptoms of alcohol withdrawal. When used in alcohol withdrawal it is important not to drink alcohol while taking Chlordiazepoxide hydrochloride.'}

116. On the 09.06 Kate called ambulance control saying she felt suicidal but refused to go to hospital and was advised to speak to her GP. The callout was notified to the GP surgery. The next day, Kate called the surgery and abused staff when she could not speak to a GP. Later that day during a home visit, PPU, Haven and housing offered Kate a panic alarm, and support with housing issues, which she

accepted. She wanted police to talk to the GPs about her alcohol issues, which they did, asking for the GP to come to the multi-agency meeting planned for the 17.06. The GP undertook to have representation at the meeting because he was committed to a surgery of patient appointments.

117. Later the same day a different GP conducted a home visit and explained that Librium could not be prescribed without detoxification, which would require alcohol services. Kate insisted she did not want that, just the prescription. She said she was drinking 2.5 litres of Lambrini a day, and was drinking during the consultation. When the GP declined to prescribe, she told him to leave saying he was "*a useless doctor from a useless surgery with a ludicrous appointment system*" .Within ten minutes she had called the surgery describing Aquarius as '*rubbish*' and complaining about the GP.

118. The next morning Kate called police and said she was going to hang herself. Officers arrived promptly and called an ambulance. Kate explained it was a cry for help because she needed Librium to control the 'shakes'. She made it clear she would carry on calling police until she got what she needed. Police offered to make referrals but could not pressurize the GP. The ambulance crew assured Kate a notification would be made to the GP for a home visit.

119. The same day a GP made a home visit, and Kate persuaded a GP to prescribe Librium. She said that she had been prescribed it in prison and she was,' *the best she had ever been'*. The GP explained it was usually prescribed as part of a programme with Aquarius, but he would prescribe it just once, if Kate were genuine in her desire to stop abusing alcohol. She undertook not to drink for a week. She asked the GP to contact police, which he did, describing her as being on a 'programme' to come off alcohol. He explained it was unlikely that a GP could attend the multi-agency meeting, so he arranged a report to be submitted.

120. {*DHR author's note: Librium could only be a short- term relief in those circumstances. It is a concern that it was a prescribed when the surgery knew that Kate was still drinking excessively. Kate's*

commitment to change was selective; when Wolverhampton-Haven called that day to offer support Kate hung up. The next day, when police investigated a breach of bail, she had clearly been drinking.}

121. On the 12.06.13 an off-duty officer saw Peter going into Kate's flat in breach of bail. When officers arrived, Kate said she had not seen Peter for a few days. However he was found hidden by the side of the bed. Both were arrested; Kate for obstructing police and Peter for breach of bail. Kate was charged with the offence and subsequently convicted. Peter was again bailed.

122. On the 15.06.13 police were called to a hotel within the force area, but not Louise and Peter's home area. Kate was found to have a fairly deep cut on her forehead. The ambulance crew felt it looked to have been caused by an object. Kate said Peter had come to her door and punched her when she opened it. He had left the scene. Officers soon established that Kate and Peter had checked in together two days before, and two people had used the room.

123. Kate went to hospital in an ambulance, but discharged herself before being treated. When she returned to the hotel she became abusive when she found the room being treated as a crime scene. She refused to give a statement unless she was given a drink, and then removed her bandage causing renewed bleeding. She left in a taxi and it was established she had asked to go to her home. Officers went to her address in the early hours but Kate would not let them in. They forced entry to check she was safe.

124. On the 17.06 Kate changed her account, informing police that having had a shower, she had tripped on a towel and hit her head on a wardrobe. She demanded that the bleep alarm in her home be removed. Officers attended to remove the alarm, whereupon Peter arrived in taxi, in breach of his bail conditions. He was arrested for the suspected assault and was interviewed, but made no comment. Officers apparently made strenuous attempts to persuade CPS to charge Peter and remand him in custody to prevent further offences, however CPS pointed out that the threshold test to charge had not been met. The fact that police had so recently issued fixed penalty for

wasting police time was cited as evidence of Kate's tendency to lie to police. Her refusal to make a statement and her new version of the allegation, which tallied with the type of injury suffered, made a charge impossible.

125. Whilst in custody Peter met with the Aquarius/NACRO worker, who was present for the MARAC and professionals meeting. Peter said he could not continue this way and wanted to get away from the fighting. He said Kate would not be happy '*until he was behind bars'*.

3.2.10 The Emergency MARAC 17.06.13

126. It was against this backdrop that a Chief Inspector chaired the professional's meeting on 17.06, to discuss both Kate and Peter Representatives from the City Council Housing, DV Forum, Mental Health, Aquarius NACRO/RNY, the ASB team, BCPFT (psychiatric nurse), the Haven-Wolverhampton, Partnerships, police Offender Managers, Police Safeguarding, LPU Neighbourhood police, attended. Apologies were received from the GP and Probation.

127. Kate's urgent need for accommodation was an important consideration. The Haven- Wolverhampton made it clear that accommodating her would put other service users at risk. Police had previously supported Kate in a move away from the area, but had now changed their position and did not want to '*move the problem to another area.* '

128. It is evident that all present at this meeting viewed alcohol as the central reason for both Peter and Kate's behaviour. Alcohol services had been unsuccessful in persuading Kate and Peter to engage voluntarily. They raised the possibility of an Alcohol Treatment Requirement being attached to any future conviction of Kate or Peter Police did submit information to Staffordshire and West Midlands Probation trust to support an application for an ATR when Kate was later convicted of wasting police time and resisting a constable, but no ATR was requested at either conviction.

129. During the meeting police made it clear that they would seek criminal charges through CPS when an opportunity arose and would not use the fixed penalty process; an email was to be sent to all officers.

130. The chair and PPU staff considered Kate's mental health a significant factor in accounting for her behaviour. Kate had not, in the view of professionals, been subject to an assessment and it was agreed that this was necessary and should be done as a matter of urgency.

131. A police ASB coordinator and a PPU safeguarding DS prepared a detailed document; "Review of police intervention regarding the case of Kate and Peter – Professionals meeting" which was considered at the meeting. The document was discussed at the professionals meeting and became a source document for the review conducted by a solicitor from City Council legal services.

132. The document included a case summary, overview of crime reports, an arrest history and a list of possible civil interventions. The interventions that were discussed in the document included antisocial behaviour contracts (ABC), fixed penalty notices for wasting police time, injunctions for public place nuisance, ASBIs, civil injunctions (non- molestation order, occupation or common law), ASBOs, restorative justice and drinks banning orders. Ultimately none of the interventions appeared appropriate for a variety of reasons and the legal representative from city legal services undertook to review the application of ASBOS or ASBIs in this case. The next day he gave written confirmation that he did not believe these measure to be applicable.

133. Feedback was to be sought in two weeks, from all present; however the police IMR author could find no indication on any records that this had been received.

134. The new approach was put to use twice in the next few days. On 18.06, Kate called police claiming Peter had forced his way into Kate's property and verbally abused her before leaving. Officers investigated the claim and concluded it was false and malicious. She

was arrested for wasting police time. However she was not charged, but was given a fixed penalty ticket. Whilst in custody she was seen by staff from Aquarius/NACRO and agreed to engage with the service.

135. On the 21.06, Kate alleged that a neighbour had punched her. The attending officers formed the opinion that this also was a false and malicious call, because the neighbour could prove she was elsewhere at the relevant time, and because Kate had no injuries. She was arrested and on CPS advice, Kate was charged with wasting police time. Kate maintained her innocence, but was convicted at the end of September.

136. It is of note that she also was seen by her GP on the 21.06, who noted, "*Healing cut right eyebrow; bruise below right eye and on right arm. Punched by abusive partner (Peter) whilst in Birmingham 13.6.13'."*

137. *{DHR author's note: This was a further occasions where either Kate or Peter reverted to their original allegation when speaking to GPs about apparent assault injuries. Common to many of Kate's claims of assault, was the lack of visible injuries, coupled with a refusal to be examined. This examination by the GP suggests that injuries were indeed present and that an accidental explanation was not credible.}*

138. Kate was arrested for breaching her bail conditions on the 25.06, and the opportunity was taken to conduct a mental health assessment. According to the BCPFT IMR, Kate described her head injury and alcohol abuse having an effect upon her memory. Kate attributed the domestic violence to Peter's jealousy, and '*played down'* any part she had in violence. She gave *'a good account of herself and her situation'* and did not demonstrate low mood or depression. She was not detainable and did not need referral to the Crisis Home Treatment Team. She was to be referred back to her GP for neurological support in relation to her head injury. Police pointedly removed all warning markers 'suicidal', mental'; 'self-harm' and left in place the *'alcohol'* marker.

139. On the 27.06 a GP from surgery 5's walk-in centre, saw Kate and Peter in the GP's view, Kate '*shouted at and humiliated him in front of me'* .He formed the view that she had '*psychiatric'* issues. The GP's IMR conceded that this did not apparently lead to any referral or action and remained simply an observation.

140. On 11 .07.13, Kate wrote a letter to the safeguarding team.

141. "*To the inspector of safeguarding, I have spoken to DC LG today who has suggested I should write in. I feel as if I'm being hounded by the police safeguarding team, they turn up at my address and break in at 1-20pm just because my lounge curtains are drawn when I was out. They break in at 3 & 4 in the morning & shine torches in my eyes when I'm fast asleep in bed alone! That's happened twice now! Now the inspector is ringing the flats management company, which is only serving to make them want to evict me THIS HAS TO STOP. I'm perfectly well and safe. If I need you I will call you. Please put a stop to this immediately. Yours faithfully Kate* "

142. From the end of June to mid-July it was the GP and NACRO/Aquarius who had the most contact with Kate and Peter Kate was theoretically engaged with Aquarius/NACRO, but it appeared the engagement was simply to satisfy her desire for Librium. Her alcohol consumption appeared to have continued unabated. The GP surgery and Aquarius/ NACRO, now received the brunt of her abuse, which was sufficiently severe to lead the surgery to seek to remove Kate from their list.

143. In her discussion with her GP Kate admitted to drinking 6 – 8 litres of Lambrini a day and suffering stomach problems as a consequence. Despite repeated abuse, the GP tried to make Kate understand that she needed to engage with Aquarius/NACRO, since detoxification and the prescription of Librium was never done without an assessment. When the required assessment was organized, Kate refused to attend and swore repeatedly at professionals.

144. The GP identified that Kate had abnormal liver function, from alcohol abuse. Over the next few days Kate's symptoms of vomiting an abdominal pain continued, and she also swore at staff every time

she called the surgery to ask for medication, and was refused. Kate was admitted to hospital for three days where she was given vitamins and Librium and felt '*much better*.'

145. On the 09.07, Aquarius/NACRO contacted Kate about her hospital admission and she declined all support or home visits. On the 12.07 Peter did not attend his appointment and his case was closed. On the same day, he did attend his GP, where he had an in-depth consultation with a junior (foundation year 2) doctor. The notes he took were comprehensive and were overseen by a senior GP in the practice. The doctor noted the presence of a lot of scars from injuries inflicted by his partner '*years ago'* and Peter said he was *'on the edge of a nervous breakdown'*. He said he would never leave Kate but just wanted her to get better. He claimed to still be going to Aquarius '*occasionally*', which helped.

146. In the first few weeks of July although Kate still made some calls to police, complaining about her neighbours, the calls did not generally relate to Peter this is not to say that she was not demanding; on the 21.07 she made around seven drunken calls in one day and a similar number on the 24.07. These were logged as anti-social behaviour and great store was put upon her imminent eviction to resolve the problem.

147. On the 01.08.13, Kate and Peter were released from all bail conditions after CPS decisions in relation to all outstanding cases against them concluded there was insufficient evidence to proceed to charge.

148. On the 12.08 at 20:59 a call was received from a hotel; in the background a man could be heard to say *'you stab me again and I'll kill you, you fucking stabbing bastard.'* It took an hour to establish this was Kate and Peter Officers attended and confirmed that Kate and Peter had been staying there but had left. It took several more hours for officers to find Peter's address and secure entry. It was not until 05:18 that a log was placed on the system that Kate and Peter were seen, unharmed. They said they had been in a pub where men had been fighting. Officers accepted this explanation.

149. On the 16.08.13 Peter presented at hospital with a laceration of the right shin allegedly caused when gardening. This was not questioned by the hospital or by the GP when notified.

150. On the 19.08, Kate phoned police, after Peter had apparently threatened to kill her. He apparently had taken exception to the visit that day from an anti-social behaviour officer. Peter had been warned about anti-social behaviour and was served a notice of seeking possession (a final warning letter). Kate would not give a statement.

151. On the 26.08 Kate and Peter were considered again at MARAC. It does appear that there was an action to establish which Probation Officer was completing a pre-sentence report (PSR) on Kate so that a request could be made for an ATR. The Probation Service IMR made it clear that the request for an ATR together with supporting information was received, but the ATR was not applied for.

152. The updates from the Safeguarding officer were entirely negative; Kate was refusing engagement of any sort and was angry when contacted on the saying that she had already submitted a complaint about police harassment. The same officer made a further call, after the incident reported on 19.08, but Kate remained adamant that she wanted to be left alone. There is nothing to indicate in the minutes that Peter was considered as a potential victim, and the incident of the 12.08 is not mentioned. With hindsight this seemed to be a serious oversight.

153. On the 05.09, Peter presented at A&E with lacerations allegedly from a fall onto a boulder whilst out walking. The injuries were noted as, '*Deep Laceration to middle aspect of left shoulder, 2 lacerations to left arm. Deep laceration to right upper arm. Wounds described as clean lacerations which may have been ca. all wounds required stitching.*' There is nothing on the hospital or GP records to suggest that the account was challenged. The police safeguarding team would have been unaware of this incident.

154. According to Housing/ASB IMR, on the 10.09 the ASB worker received a call from a resident saying that there was blood in the communal area, which they believed could be Peter's or Kate's. The

worker visited the next day and emailed police on the 18.09 to see if police knew of any incident, which could account for the blood.

155. On the 16.09.13 Peter attended the GP's surgery for his wounds to be cleaned and re-bandaged. No discussion of how they were caused occurred. This was the last contact Peter had with the Health service before his homicide.

156. On the 20.09.13 at 00:06, Kate called police from her new address and the operator heard a male say 'you *stabbed me last week'*. Officers attended and reported there was no disorder, just drunken behaviour. No domestic abuse record was taken, and the identity of the caller and the male was not noted. Inexplicably there was no investigation of what had been heard. Later the same night (02:56) Kate called to say Peter was refusing to leave. A disorder could be heard. Officers recorded this as an argument with no violence, and took Peter back to his flat. They emailed the Safeguarding team to inform them of the incident. A further call was made at 16:28 from Kate's flat. A disturbance could be heard in the background. Kate wanted Peter removed again. When police arrived he had already left. The incident was added to the earlier logs as a standard risk.

157. On the 06.10 police received a call from Kate's flat and Kate asked police to keep the line open. A male could be heard saying *'why are you wasting police time?'* and '*did you tell them you punched me in the face three times today?*' The duty inspector recorded on the log that this was a high-risk domestic violence case, being fully supported by the Safeguarding team and that the senior leadership team at the daily management meeting required that robust action be taken. Peter was consequently arrested for breach of the peace and kept in custody overnight. The potential allegations he had made earlier were apparently not investigated.

158. On the 17.10 Kate and Peter registered at a new surgery. Kate was apparently '*rude and aggressive'* and shouted at her *'husband'*, who '*never spoke, or tried to calm her down*.'

159. On the 27.10.13, at 13:40, police were called by Kate's to her address, as were ambulance control, to a man '*who had collapsed*

whilst peeling vegetables and fallen on to his knife.' Peter had been stabbed through the heart, went into cardiac arrest and died at the scene.

160. Kate was arrested on suspicion of murder and in interview maintained that Peter had collapsed and fallen on his knife. She was charged with murder on the 28.10 and remanded in custody. On the 13.05, Kate was convicted of murder and sentenced to life imprisonment with a recommendation she serve a minimum of seventeen years before being eligible for parole. The Judge concluded in sentencing Kate that he was satisfied that she had stabbed Peter on '*four previous occasions between 2010 and 2012.'*

4. Analysis of agency involvement and Lessons learnt

1. It is an acknowledged feature of domestic abuse that a great deal goes unreported, before a victim discloses their abuse to friends, family or protective agencies. This did not appear to be the case with Kate and Peter whose abusive relationship seemed to be played out 'in full view'.

2. Peter and Kate became well known to many agencies responsible for providing care and protection in their community. The DHR chronology and the primary care (GP) and Police IMRs demonstrate that those two agencies, had by far the most significant number of engagements with Kate and Peter From 2010, until Peter's homicide in October 2013, two police services recorded an almost unbroken chain of domestic abuse incidents. Health services, particularly GPs and two A&Es had well over two hundred contacts with Kate and Peter.

3. This case therefore places an even greater burden than usual upon the contributing agencies and the DHR chair and panel to answer the question; why was it that with the high risk known and documented for more than three years, and a fatal outcome for one or other of Kate and Peter being predicted by both professionals and family, that those agencies were apparently powerless to prevent it?

4. A central feature of this DHR was the personalities and perceptions of Peter and Kate A refusal to engage with the available services offered made safeguarding almost impossible and led to a constant cycle of abuse. Neither Kate nor Peter demonstrated any interest in being cast in the role of domestic abuse victim when it did not suit their purpose; most of the time it apparently did not. That professionals routinely encountered aggression and abuse from Kate does not appear to have deflected them from their professional purpose and there are examples of good practice in spite of Kate's demeanour.

5. Many contributors to the DHR process used similar terminology in describing the case, 'we did everything we could', 'what do you do when people keep refusing any help?' or 'they just wouldn't engage with services'. If as was documented at the Professionals' meeting in June 2013, there was no civil or criminal law measures capable of keeping Peter and Kate from self-destruction, and all possible avenues had indeed been exhausted, was it appropriate public policy to wait for the outcome, whatever that might be? Clearly that is wholly unacceptable to society and indeed was to the agencies involved, which right until the end, repeated many of the processes and responses, which they recognised had been unsuccessful so far, in the hope of a breakthrough. It seemed, however, that weariness set in amongst some agencies.

6. Before attempting to analyse where opportunities were missed and how outcomes may have changed, it is important to summarise the key areas of engagement with Kate and Peter and the problems encountered.

7. Both Peter and Kate had their own tenancies for large periods of the time under review. However as Peter and Kate's domestic and alcohol abuse became increasingly entrenched, they experienced evictions and homelessness brought about by their anti-social behaviour. This tended to bring them together in their remaining flat, frustrating bail conditions and increasing the likelihood of more abusive incidents.

8. The IMRs of all the agencies charged with providing support and care for Peter and Kate had many common elements. However a recurrent

theme was that Kate and Peter 'did not attend' (DNA). They missed appointments with consultants, with alcohol and mental health services. Time after time agencies reported a failure to persuade Kate and Peter to engage with the services being offered.

9. The character and personality of Kate appeared to have a significant impact upon outcomes. Almost every call for services originated from Kate. Often there would be repeated calls where the allegations against Peter were added to, or changed. Very frequently they related to Peter gaining or attempting to gain entry, or refusing to leave, with resultant criminal damage and assaults. Most were made when Kate was under the influence of alcohol. If Kate did not achieve the outcome she wanted from police she would become aggressive and insulting. What officers consistently recorded was that Kate was uncooperative and verbally abusive.

10. Kate invariably refused to pursue an allegation against Peter or would seek to retract any statement she had made, once Peter had left or was in custody. There were few examples of allegations that led to prosecution of Peter and no occasion at which Peter was convicted based upon Kate's evidence.

11. As time went by, police were able to prove that Kate was making malicious allegations or was wasting police time with such calls and this led to fixed penalties being imposed or prosecutions. It appeared that this was a police tactic designed to reduce calls on the service rather than to improve the safeguarding of Kate and Peter.

12. This in turn led to Kate's credibility as a witness being seriously undermined. Whilst a protocol existed between police and the Crown Prosecution Service to continue with domestic abuse prosecutions even when faced with a victim who is unable or unwilling to give evidence, none of Kate's allegations resulted in victimless prosecutions. Police in their IMR, described Kate as 'sabotaging' prosecutions. Convictions for obstructing police or wasting police time did not enhance Kate's credibility as a witness.

13. With hindsight it is clear that between 2010 and his homicide in October 2013, Peter suffered at least four stabbings, allegedly inflicted by Kate.

There were other presentations at A&E, which the panel felt might indicate inflicted injury. Kate however never claimed to have inflicted these injuries in self-defence, during assaults by Peter. She alleged they were self-inflicted, accidental, or inflicted by third parties. This pattern was continued even after the homicide, with Kate claiming the fatal stab wound to the heart was caused by Peter falling on his knife whilst peeling vegetables. Peter was complicit in protecting Kate from prosecution, claiming injuries were indeed accidental. Like Kate Peter was never called upon to give evidence against Kate because he would have refused or withdrawn his allegation.

14. The charging decisions in some cases relating to Kate and Peter and decisions relating to withdrawal of prosecutions fell to the Crown Prosecution Service (CPS). They required the application of a threshold judgement and in reaching these decisions CPS needed to be given the very best evidence possible drawn from every source other than the victim. Although victimless prosecutions were considered, and in one case actively commenced (December 2012) none reached trial.

15. Both Kate and Peter spent some time in custody awaiting trial for offences against each other. Kate's daughter was very clear in conversation with the DHR chair that custody was positive for her mother, enforcing detoxification by properly supervised withdrawal. She spoke movingly of her memories of a telephone conversation with her mother whilst she was in prison. It was the first time she had sounded her 'old self' in her recent memory. Even Kate described herself as the best she had been in a long time when in custody. Removal of risk by incarceration therefore had a benefit in so far as it prevented re-offending and allowed an imposed detoxification that could not apparently be achieved with the consent of either Kate or Peter.

16. The alternative to custody was police and court bail and both parties were subject to bail conditions on numerous occasions. Between May and August 2013 both Peter and Kate were subject to bail conditions, which they breached. Peter was brought before the court for breaches and re-bailed three times during that period. The effectiveness of bail in preventing re-offending in this case is clearly a key theme. Peter 's

brother was used repeatedly as a 'safe' place to leave Peter after an incident, without being entrusted by officers with sufficient information to understand the risk posed by his brother and with no ability to ensure he did not return to Kate

17. If police and partners knew of the high risk the couple posed to each other, so did their families. Even if in conversation with the DHR author, the respective families put the 'blame' for what happened on the other party; they all recognised that Kate and Peter's relationship was toxic. They tried to persuade them as individuals and as a couple to go their separate ways.

4.1 What can we learn about DASH risk assessment and risk assessment tools?

4.1.1 Domestic Abuse Stalking and Harassment (DASH)

1. A widely recognised weakness in the multi-agency response to domestic abuse was in early identification, intervention and prevention.

2. Police used the Domestic Abuse Stalking and Harassment (DASH) risk indicator tool to assess the nature of the domestic abuse. It is a tool which was designed to be used by all agencies but is used almost exclusively by the police. Similar CAADA-DASH risk indicator checklists are used by WDVF and the Haven-Wolverhampton. It is the DHR panels' view that as early as 2010, it was evident from the serious assaults between Peter and Kate that both were at high risk. Yet the police IMRis full of examples of incidents being graded as high risk, to be followed by an incident that was graded as a standard risk, or not even risk assessed. The threshold for a Multi-Agency Risk Assessment Conference (MARAC) required a high-risk incident (at least 14 affirmative ticks on the DASH or professional judgement) in order for Kate and Peter to be listed for consideration. It is this incident-specific approach which will need to be closely examined to answer the question 'why could this happen?'

3. In his work on coercive control, Evan Stark described an attitude to domestic abuse risk which has great resonance for this case;

4. ‘ *A prior assault predicts subsequent assault better than all other risk factors combined and the near certainty that abusers will reoffend is the basis … safety planning, the issuance of protective orders, batterer intervention programmes (BIPs), and numerous other interventions. Because this predictable course of conduct is framed as recidivism, however, the justice and helping systems treat each individual de novo, an approach that trivialises, and confounds what is actually happening… The absurdity of the incident-specific approach is illustrated in communities where police assess an offender’s risk by judging the severity of each incident, as they do in a number of English communities, identifying the same man as high risk on Monday and low risk a week later*.’[2]
5. The introduction of (DASH 2009)[3] Risk Identification, Assessment and Management Model meant that for the first time all police services and a large number of partner agencies across the UK were using a common checklist for identifying and assessing risk. It’s’ aim was to create one standardised practical tool to share information and manage risk effectively by identifying high risk cases of domestic abuse, stalking and honour based violence, and dangerous and serial perpetrators.
6. Through proper use of the tool, agencies would be able to make defensible decisions based on the evidence from extensive research of cases, including domestic homicides, ‘near misses’ and lower level incidents.
7. DASH was designed to help to decide which cases should be referred to MARAC and what other support was required. All agencies that are part of the MARAC process have a common risk assessment tool that provided a shared understanding of risk in relation to domestic abuse, stalking and harassment and ‘honour’-based violence.

[2] Coercive Control: How Men entrap women in Personal Life. Evan Stark . Oxford page 99

[3] The DASH model was developed by Laura Richards, BSc, MSc, FRSA on behalf of the association of Chief Police Officers (ACPO) and in partnership with Co-ordinated Action Against Domestic Abuse (CAADA)

8. The ACPO Council accredited the DASH (2009) Model to be implemented across all police services in the UK from March 2009. West Midlands Police used a risk assessment tool, Domestic Abuse Risk indicator Model (DARIM) 2007 and then DASH 2009 to allow frontline officers to make an early identification of risk through the use of the questions to victims based upon these known risk elements. The completion of a DASH was compulsory at every domestic abuse incident, until Jan 2011.

9. At that time the force issued new guidelines[4] and officers were given more discretion when to complete a DASH risk assessment. If a crime was reported, DASH was still mandatory. For all other domestic abuse incidents, which did not involve crimes, the officers had discretion as to when to fill out a DASH. However in a case with the kind of domestic abuse history of Kate and Peter the expectation would be that a DASH would be completed. The evidence of this DHR would suggest that officers sometimes failed to take this into account (or did not know) the history of Kate and Peter well enough.

10. The HMIC review of 2013: 'West Midlands Police's approach to Tackling Domestic Abuse' was critical of the impact of the use of discretion in relation to DASH; '*The officer is expected to make a judgement in all other circumstances on whether or not to complete a DASH risk assessment. HMIC found that this causes confusion and leads to inconsistences. A formal risk rating from a DASH risk assessment triggers involvement of partner agencies and specialist support to victims. There is no robust quality assurance process in place to monitor whether they are consistently making the right decision. The force cannot be confident that all victims are consistently receiving appropriate services from either the police or partners.*[5]'

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[4] A Practical Guide for frontline staff (DASH policy) and Domestic Abuse, Stalking and Harassment and honour-based Violence

[5] HMIC: West Midlands Police's approach to tackling domestic abuse 2013

11. The police IMR acknowledged the organisational vulnerability relating in the first instance to the failure to complete a DASH, but also around the accuracy of 'standard' grading of incidents. Unlike 'medium' or 'high' assessments that are reviewed by specialist domestic abuse officers, 'standard' assessments are generally filed without further scrutiny. Although a first line manager should review all DASH assessments, the police IMR expressed concern about the depth of understanding of DASH across frontline officers and supervisors.

12. The HMIC report of 2013 recommended that the force should implement a robust quality assurance process that provides consistent reviews of "standard" risk assessments.

13. The police IMR identified a systemic weakness in the requirement that every incident should have a crime or non-crime number completed before the end of the reporting officer's tour of duty. The IMR pointed out that whilst this may be appropriate for non-domestic abuse cases, it was in part the explanation for the absence of, or poor completion of DASH. Before a domestic abuse crime number is generated, the risk assessment has to be declared. Without any ability to conduct the necessary checks on the street, officers are obliged to rely upon whatever checks the Crime Service Team (CST) have time to complete, which are then used to inform the DASH assessment. At the end of the tour of duty, with officers attempting to record their day's reports, the capacity of the CST is apparently stretched and the quality of checks may be further compromised.

14. The IMR author was frank in expressing concerns in relation to this vulnerability; '*It is the function of service desks to provide information to officers on the street but they have competing priorities of quality and volume. The author would not be confident that the quality of checks that a service desk member of staff might provide would equal to that which an officer would do for themselves. Effectively an officer*

generating a crime report would be putting their name to a risk assessment based on research which they had no control over the quality because it was completed by another person….the marginal improvement in service to a victim, providing them with an early reference number is outweighed by the realistic possibility that the risk assessment might not be properly considered. It seems appropriate for domestic abuse cases to be defined as one of the "exceptional circumstances" when policy allows for crime numbers to be created when officers have left the scene of an incident.'

15. The force has addressed the systemic weakness in their crime recording and DASH policy in two agency specific recommendations.

16. There is evidence that the force was particularly vulnerable in the immediate aftermath of the introduction of the officer discretion policy. In the period between August 2011, the first MARAC and the second in December 2011, the chronology reveals that at least seven call outs were not subject to DASH assessments, based on officer judgement of incidents viewed in isolation, leading to a long period without MARAC intervention, even though nothing had occurred which reduced risk either at MARAC, or in the lives of Kate and Peter.

17. The chronology in this case has shown some good practice, where several medium risk incidents subject to DASH assessments, which were re-graded as high following a full assessment by PPU. Risk assessments are dynamic and ideally would all require oversight by safeguarding/domestic abuse officers who would have access to more detailed relevant information such as MARAC feedback. Professional judgement is a crucial part of the risk assessment process and it was always the intention that the actuarial element could be enhanced by the experience and knowledge of professionals.

18. The chronology reveals that around eight incidents were assessed as medium risk during the period under review. These were in the midst of repeated high-risk MARACs. It is the DHR panel's view that even if the incidents were correctly assessed; the PPU and MARAC had to view them as evidence of ongoing high risk, and the grading was almost irrelevant.

19. The rape allegation of 16.06.11 was an example of a questionable risk assessment. The credibility of Kate as a witness, her perceived lack of co-operation with officers, and her tendency to retract allegations no doubt had an influence on decision making. The police IMR author correctly questioned the risk assessment of a serious offence such as a rape in a domestic context being considered 'standard'. Peter had, it should be noted, served a prison sentence for sexual assault in a domestic context in a previous relationship. Kate had, unusually, not retracted her allegation and the crime was classed as 'undetected'; the allegation was simply not proven. The DASH assessment can be seen as one of many such examples in this case where a previous history of serious domestic incidents (including those in Bristol) had no tangible impact on the assessment of the incident reported.

20. It is reasonable to assume that persuading Kate (and Peter) to engage with the detailed questions on DASH would have posed a challenge, particularly since they were often drunk when officers attended. There is no clear indication of how many questions the respondents refused to answer, or with hindsight how many were answered honestly.

21. There were also numerous incidents (like that of 29.07.10) where police made it quite clear they did not believe Kate This would communicate itself directly to Kate who would then become abusive, which in turn appeared to entrench positions being taken by all parties. The incident would therefore not be recorded as domestic abuse and no DASH would be completed.

22. If consideration is given to the DASH questions based upon the MARACs knowledge of Kate and Peter it is evident that a large number of the known risk factors remained entirely relevant for the duration of agencies involvement with Kate and Peter Viewed simply through the prism of Kate as a victim, the risk remained constantly high. In the view of the DHR panel, the fact that the dynamic of the abusive situation led Kate to respond with, or even initiate violence, heightened the risk to them both. Only when one or other of Kate or Peter was removed, because of being imprisoned, did the risk to them both lessen.

23. By the time a second MARAC was held in December 2011, the known history already included many of the proven risk factors that form the basis of a 'high' risk assessment.

24. These were; 1. Use of weapons or objects to hurt Kate 2. Threats to kill which are believed, 3. Strangulation or choking, 4. Hurting someone from a previous relationship, 5. Criminal history of domestic violence and sexual violence, 6. Threatened or attempted suicide. 7. Doing or saying things of a sexual nature which make the victim feel bad or physically hurt them (rape allegations). 8. Problems with mental health and alcohol abuse. 9. Increase in frequency and severity. 10 Problems with child contact.

25. Whether officers had been given truthful or complete answers, every fresh incident should have been viewed by PPU as having as many eight affirmative risk factors, but probably considerably more. For example, two questions required subjective judgements from the victim; *'is the abuse happening more often?'* and *'Is the abuse getting worse?'* It is known how Kate and Peter responded to these questions during the period under review. However, it is the DHR panels' view that whilst officers attending may not have had access to a sufficiently clear understanding of the couple's history, (for the reasons described above) the PPU clearly did have; constant and serious abuse had occurred without any significant break for the duration of the period under review.

26. DASH risk assessment is designed to provide early identification of risk, and it could be argued with some justification, that early on in the case, that all the high risk factors in relation to Kate and Peter were known. To some degree this argument is advanced in the police IMR;

27. *'The failure by front line response officers to record some incidents of domestic abuse correctly, in addition to the inconsistent completion of DASH assessments; did lead to an incomplete corporate understanding of the situation between Peter and Kate. Also it appears that some officers who were dealing with individual incidents might not have appreciated how their handling of that particular incident might affect the couples' overall pattern of behaviour…. Whatever the reason for*

incorrect completion of risk assessments… the number of calls was so great that little additional benefit would have resulted from correct adherence to policy.'

28. Whilst the DHR has demonstrated that there were indeed many significant risk elements known and recorded from early on in the engagement with Kate and Peter there were times when the severity of risk altered.

29. Some elements of risk heightened at different stages; Kate's depression or suicidal thoughts, Peter's alleged jealousy, the fear of violence after an assault, the risk posed by breaches of bail, the couple's financial issues. It was these subtle changes, which the completion of a DASH would have brought to MARAC attention (provided of course Kate and Peter were open and honest.)

30. DASH was supposed to give all agencies encountering domestic abuse in their client group a shared language of agreed risk factors. Modified risk indicator checklists (RIC), which are similar to DASH, are available to agencies to use. CAADA emphasises the need for primary and secondary care health services, housing providers, alcohol and mental health service providers to be familiar with the use of RICs and have an understanding of the threshold for referral to MARAC. This DHR has highlighted occasions where the failure to use an agreed RIC have led to identified domestic abuse risk not being shared or referred.

31. Several agencies contributing to this DHR have recommended training their staff in the use of DASH, acknowledging that it represents an important aid to identifying domestic abuse early and improving inter agency working.

32. There is evidence that some of the perceived errors by police officers completing the DASH assessments in this case, or deciding a DASH was not required, may have been due to an insufficient understanding of the purpose of the DASH assessment. When it was introduced the developers of the system gave this warning; *'Training is crucial to understanding the DASH Risk Model. Without effective training, the same mistakes will continue to be made and questions will be asked*

about the DASH (2009) implementation process and what training professionals received.'

33. It is the view of the DHR panel that a wider implementation of DASH across agencies would lead to an earlier and more consistent identification of risk in cases such as the one under review. However the panel is clear that in the light of the findings of the DHR, WMP should review the quality and scope of the training its' frontline staff have received and consider how understanding of DASH could be enhanced.

DASH and the use of risk assessment tools- what can we learn?

1. **That DASH and RICs derived from it could provide a shared language for all agencies coming into contact with victims of domestic abuse.**
2. **That the use of DASH and RICs should not be restricted to police and all agencies should seek to train sufficient staff to be able to include RICs as part of a domestic abuse assessment.**
3. **That using DASH and RICs without quality training can lead to poor assessments or a failure to identify risk; agencies using DASH should review the training of their staff**
4. **That the removal by police of mandatory DASH at all domestic abuse incidents has undermined domestic abuse safeguarding and should be reviewed in line with HMIC recommendations**
5. **That the known history of abuse is a crucial part of risk assessment. Police should review procedures relating to crime recording that are leading to hurried or poorly researched and therefore unhelpful DASH assessments.**

4.1.1.1 Key Learning Points- DASH and risk assessment tools.

4.1.2 What can we learn about adult safeguarding risk and 'trigger alerts?"

1. During the course of the review, the panel was struck by the number and variety of incidents that were known to agencies and individual practitioners, yet which did not feed into a greater assessment of risk, but could be described as multiple triggers of concern.
2. Examples would include failures to attend crucial mental health or medical appointments, refusal to engage with support workers, moving surgeries when challenged by GPs, neighbour disputes, repeat presentations at A & E, evictions, evidence of financial hardship. These were factors which taken together would have raised concern, but in isolation did not appear to require to be shared with partners.
3. It is clearly important, where factors such as alcohol abuse and mental health are present, that triggers of concern are identified to support domestic abuse risk assessment. Wolverhampton Adult and Child safeguarding are currently working to identify a broader cohort of vulnerability trigger factors for early intervention. Engagement with this work by the Community Safety Partnership is an action from strategic recommendation 3 (see section six)

4.2 What can we learn about the Multi Agency Risk Assessment Conference (MARAC)?

4.2.1 MARAC structure and management

1. In order to understand how the WV MARAC responded to the case of Peter and Kate it is useful to summarise from MARAC guidance issued by CAADA. The operating principles that represent best practice and

which should be reflected in locally agreed working protocols and information sharing protocols.

2. Co-ordinated Action Against Domestic Abuse (CAADA) is a national charity supporting a multi-agency and risk-led response to domestic abuse. CAADA provides practical help to support professionals and organisations working with domestic abuse victims. They have a central role in supporting MARACs and defining and describing best practice. CAADA describes the working assumption behind MARAC; '*that no single agency or individual can see the complete picture of the life of a victim, but all may have insights that are crucial to their safety.'*
3. A MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Abuse Advisors (IDVAs) and other specialists from the statutory and voluntary sectors.
4. Any agency could refer a high-risk victim to MARAC, using the Domestic Abuse, Stalking and Harassment (DASH) assessment to establish whether a victim has passed the referral threshold for MARAC. In WV police account for the vast majority of referrals into MARAC, although IDVAs and health professionals also make occasional referrals.
5. It is the responsibility of the representatives to have researched the cases listed at MARAC and to be able to bring to the meeting relevant information about both the perpetrator and the victim, in order to assist the chair and other representatives to identify risk.
6. The actions focused upon the perpetrator, which form an element of the safety plan, fall into four main headings; Divert, Manage, Disrupt, Prosecute
7. Accountability is crucial to a successful MARAC. Representatives must account for the actions they propose and agree to, and must communicate the safety plan and actions within their agency.
8. Since the victim is not present at MARAC, it is usually the IDVAs who share the safety plan with the victim and represent the voice of the victim at MARAC. Obviously engagement with the IDVAs is crucial for

the success of MARAC. Without it there is little prospect of measures being effective.

4.2.2 The Role of Independent Domestic Violence Advisors (IDVAs)

1. There was IDVA provision provided by several agencies in Wolverhampton. IDVAs worked as part of the provision by Haven-Wolverhampton, who also provided amongst community services, refuge accommodation in the city and community services, a helpline. The mission statement of the charity states*, 'The Haven-Wolverhampton supports women and dependent children who are vulnerable to domestic violence, homelessness and abuse.*' At the time they would not have worked with men, their service was for women and children affected by domestic abuse and homelessness, however they would have been able to signpost to services for male victims. This strand provided the funding for The Haven-Wolverhampton IDVAs through Housing, as part of the local tenancy sustainment programme. Haven had a high-risk IDVA funded through the Wolverhampton Domestic Violence Forum (WDVF), working with clients listed at MARAC. The high risk IDVA was located with the WDVF criminal justice IDVA.
2. The WDVF has a specialist criminal justice support service co-ordinator IDVA, supporting victims through the specialist domestic violence courts, which had been in place since 2005. The WDVF IMR describes; '*The CJSSC role is further specialised as it supports DV victims of any level of risk, and regardless of gender or sexuality, through the criminal justice system at the Magistrates Court, and aims to reduce the attrition rate of criminal justice cases, to coordinate support needs primarily through the criminal justice process, but also to refer victims to other services to meet their support needs, in order to bring perpetrators to justice. '*
3. A multi-agency Co-located team made up of the police, IDVAs from the Haven- Wolverhampton, the Domestic Violence Forum, and Housing assessed the impact of domestic abuse on adults and children and

offered support and advice as well as making safeguarding referrals between MARACs.

4. The contact that Kate and Peter had with these IDVAs is described in the IMRs of Haven and the Domestic Violence Forum. Although Peter was known by Haven to be a high-risk victim as well as a perpetrator, he was not referred to them and they had no contact with him. The detail of the contact Kate had with Haven and the IDVAs is described in the following terms;

5. *'On six occasions Kate called our helpline service, Kate was offered support, advice and referrals were made to Haven Community Support and Advocacy support service and the IDVA service. On two of these occasions Kate put the phone down and stated on another occasion that she would think about obtaining a non-molestation order. The Haven-Wolverhampton contacted Kate on three occasions via telephone to offer support Kate declined twice and hung up once. Two attempts were made by THW to contact Kate in relation to her hospital attendance, the phone was either disconnected or we had the wrong number. One letter sent to Kate to attend the Options and Guidance appointment at THW, Kate did not attend. One home visit undertaken to offer support with a housing referral out of Wolverhampton Kate accepted. One occasion Kate was supported into Haven offices after an altercation in the street.'*

6. There is no evidence that there was any attempt to engage with Peter as a high-risk victim through the use of IDVAs, after the stabbing incident of December 2011. The DHR panel cannot help but feel that this was evidence of gender bias and a lack of appropriate provision for male victims of domestic abuse. The matter was listed at MARAC in January 2011, but it may be that because Peter so quickly reverted to being a high-risk offender, IDVAs were not considered appropriate. (This can be contrasted with the second occasion when Kate in December 2012 allegedly again stabbed Peter however the extent of IDVA support was a series of letters and one phone call.)

7. An Independent Domestic Violence Advisor [IDVA] has been available within the Hospital Trust, based in the A&E Department since 31.10.12.

Part of the IDVA's role is training and awareness of DV amongst frontline trust staff alongside a referral system and an information website posted on the Trust's intranet.

8. The IDVA can provide advice and support for patients who may have been victims of domestic abuse, and advise staff, who may have concerns around a presentation. For much of the period under review the A&E IDVA was a pilot scheme, and the IDVA was engaging with colleagues within the hospital trust, to break down resistance and barriers where the role was new and not fully understood. The A&E IDVA is dependent upon referrals being received from health staff who must recognise signs of domestic abuse and respond appropriately.

9. Since the appointment of the IDVA, Kate had presented once with assault injuries on the 01.05.13 and was appropriately referred. Peter had presented three times with injuries. After the stabbing incident of the 8.12.12 where Peter was alleging an attack by his partner, Police were in attendance and Kate had been arrested, therefore the IDVAs role would have been to support if necessary. The presentation with a scythe cut to the shin after an alleged gardening accident, appeared to have been taken on face value. Peter presented on the 05.09.13 with multiple lacerations alleged from a fall onto boulders. The examining doctor documented injuries as not consistent with the explanation offered story. There was no evidence of escalation or referral by the doctor or the IDVA.

10. It is fairly evident that throughout the period under review, and despite the best efforts of experienced and well-respected IDVAs, no meaningful engagement was achieved with Kate or indeed Peter. The IDVA role is central to the risk assessment, and action plans because through frequent liaison with the victim, any resistance or fear is overcome.

11. The absence of any significant degree of 'buy in' was probably fatal to the MARACs chance of success with such challenging subjects. Kate and Peter refused to be cast in the role of victims and as a consequence a large number of the usual responses would be ineffective. It is therefore unsurprising that such a heavy reliance was

placed upon alcohol services, because the only remaining opportunity for engagement was represented by tackling what was considered to be the root of all problems, alcohol abuse.

4.2.3 Key operational vulnerabilities in the MARAC

1. During the period from 2011 to 2013, the MARAC in WV was chaired, by a Public Protection Unit Detective Inspector. The DHR panel was informed by the Strategy and General Manager of the Wolverhampton Domestic Violence Forum (a panel representative) that due to a force reorganisation, which created a Safeguarding team within PPU, the Safeguarding inspector had geographical responsibility for safeguarding across four Local Policing Units (LPUs). The inspector was therefore required to manage the four MARACs held on those LPUs. This was the case for the greater part of the time under review. It was common for around 25 cases to be discussed at each meeting of the WV MARAC, and similar numbers at the other three MARACs.

2. The panel, whilst recognising that this organisational issue was not raised in the police IMR, nor apparently alluded to in the conversations held with the detective inspectors, felt this was a significant factor in any shortcomings in the operational effectiveness of the MARAC. The panel understands that this was a situation without precedent. That the inspector was expected to manage four MARACS as well as their other functions was neither operationally sound nor sustainable.

3. It is also of note that for a large part of the timeline, the post of Detective Inspector Safeguarding with MARAC responsibility was being undertaken by a Detective Sergeant acting as inspector. It is the view of the DHR panel that albeit the officer spent eighteen months in post as a substantive inspector, and was expected to developing the skills required of a manager at that rank, the additional workload imposed by the management of four MARACs, may have represented an unreasonable expectation. This DHR has identified that for a period during the timeframe, the PPU in Wolverhampton had no DCI, who would ultimately have been responsible for supervision of the A/DI and

the MARAC. The force has acknowledged that this was an unsustainable position, and has made changes to their management structure that will be discussed later.

4. No deputy chair was identified to share the responsibility of MARAC or cover in the absence of the ADI; this remains the case.

5. This operational weakness was exacerbated by the lack of a MARAC co-ordinator in WV. Although the police IMR identified quite rightly, the poor quality of the MARAC minutes, it did not go on to ascribe this to the absence of a co-ordinator. However it is clear that the absence of a co-ordinator, providing operational support, measuring Wolverhampton's MARAC against CAADA principles, with responsibility for co-ordinating actions plans and action tracking, seeking feedback, attendance monitoring, and providing support to the chair, meant the WV MARAC had a further significant organisational weakness.

6. The PPU DI interviewed explained 'the lack of a MARAC coordinator had made "action tracking" difficult and was a hindrance to the MARAC process. She did however believe that the difficulties that arose were no worse in the Kate and Peter case than in any other case.' It would appear therefore that the deficiencies recognised in the management of Kate and Peter's MARAC involvement would have been replicated with many of the other more complex cases the MARAC considered.

7. In correctly supported MARAC arrangements, the minutes are the responsibility of administration support or the coordinator. The responsibility for the MARAC minutes therefore was devolved to PPU safeguarding officers as an addition to their other duties, and without appropriate training.

8. The DHR panel sought permission from the participating agencies at MARAC for release of the minutes. The protocol for their release was agreed through the Detective Superintendent (Adult Protection & Safeguarding) PPU for the release of the minutes, although not all the minutes during the timeframe were available.

9. The panel has therefore attempted to distinguish the key actions and the safety plan from those documents. Unfortunately the minutes are almost exclusively sketchy summaries of previous history with lists of

actions. The PPU officers used a 'cut and paste' approach to information shared, making it difficult to differentiate between new information and intelligence shared at previous MARACS. The minutes were a significant deviation from the CAADA model. Importantly they did not link risk factors and actions, and feedback and accountability for the actions was not evident. More often than not actions were not accounted for, or were paraphrased, or cut and paste from emails.

10. The inability to discern a clearly recorded, risk-focused safety plan, or actions which are purposeful, with evidence that agencies were required to account for those actions, was a grave concern to the DHR chair and panel.

11. The DHR panel would stress this was not the fault of individual PPU staff charged with this responsibility. The absence of a co-ordinator and the consequent impact upon the minutes and the action plan tracking was a governance issue that should have been addressed by the chair and the steering group for MARAC.

12. It is a concern that funding was available for a Co-ordinator for the WV MARAC and had been released to the PPU Detective Superintendent so that an interview process could be arranged and the post filled. Although a MARAC co-ordinator was appointed, the successful candidate remained in post for only a week before leaving. The post was not re-advertised or filled.

13. A joint case management system, Modus-Paloma with access licences and funding for two servers had also been agreed, but again was never implemented. It seems to the Review panel that these were opportunities to improve the effectiveness of MARAC and should be reconsidered urgently.

14. At the same time a CAADA compliant MARAC protocol had been created by the PPU detective inspector, for use on the four MARAC areas that were that inspector's responsibility. The protocol was considered to be suitable for roll out force wide. However the protracted consultation period this required meant the protocol for WV was only recently finally signed off.

15. Changes that have now been implemented to address these shortcomings will be described at the end of this section.

4.2.4 Analysis of the MARACs held in this case

1. The DHR panel has not been provided with any evidence that Kate and Peter were subject to MARACs in Bristol in 2010. It is clear from Avon and Somerset Domestic Incident Protocol (2010) that MARAC existed there for high-risk cases; however DASH had not been implemented across the force area at that time. It is therefore not possible to establish what was considered the threshold for referral. However the gravity of the five serious incidents in Bristol between 30.06.10 and 02.10.10 could not have left any professional doubting that Kate and Peter were both high risk offenders but also both high risk victims. Albeit that neither stabbing incident in June and September 2010 led to charges, the suggestion that Peter was self-harming had very little credibility. In addition there had been two serious assaults alleged against Peter in 08.10 and 10.10 and in the latter Kate had lost consciousness.

2. It seems entirely unsatisfactory that when it became evident to Avon & Somerset police in October 2010, that Kate and Peter were residing in Wolverhampton, apparently no safeguarding referral was made. The behaviour that was to characterise all of their domestic abuse had already been established; serious allegations followed by retractions or a refusal to co-operate. It was already evident that alcohol and reciprocal violence was a feature of the risk. If one force was aware of this intelligence, it should have been shared. The panel have been informed that for their part, when a high risk MARAC subject leaves the force area, WMP do have a system to transfer relevant intelligence to the receiving force.

3. By the time Kate and Peter were listed at MARAC in WV for the first time in August 2011, they were by any standards high risk with eighteen months of serious domestic incidents across two force areas. In fact the DHR panel have found no evidence in West Midlands Police

documents, that this highly significant antecedent history was ever given significant consideration. If it had been, it is arguable that Kate and Peter should have been listed at MARAC earlier; in February 2011, after the serious head injury suffered by Kate or in May 2011 after an alleged assault, (Peter had only recently been released from custody following a conviction for assault upon Kate) or in June 2011 when Kate alleged rape against Peter.

4. In the event the MARAC minutes of the 31.08.11 simply described 'an extensive history of dv between these two parties' and mentions that 'Peter has convictions and custodial sentences for assaults upon Kate There is nothing in the minutes to suggest that enquiries were made to understand the history known to Avon and Somerset police which would have highlighted the true extent of the reciprocal violence between the couple. The minutes described Kate's complete refusal to engage with MARAC.

5. It is evident that even at this early stage in the history of MARAC involvement in relation to Kate and Peter the emphasis was upon the information-sharing element of the process. It is clearly crucial that this occurs, but everything mentioned at the meeting indicated that although Kate had suffered a severe assault at Peter's hands, it was unlikely the prosecution would continue. The only safety element noted was that Peter was currently remanded in custody. It is a measure of the lack of pre-meeting checks that the police were apparently unaware that Peter had been released five days before. (The day after the MARAC, Kate reported a further incident) There were no actions listed on the minutes. Nothing indicated that a safety plan was even considered. No action to liaise with GPs about the victim and perpetrators' domestic abuse or alcohol abuse, no consideration of orders which could be put in place, in fact nothing but a warning marker on Kate's home address. A MARAC at which a subject is considered to be at high risk of serious harm or murder but at which no apparent safety plan is commenced, is evidence of a process with significant organisational flaws. Records of subsequent MARACs fail to address the panel's concerns about the same shortcomings.

6. GPs had crucial information about Kate's mental health, which should have been sought by the MARAC. The significance of her February 2011 head injury should have been considered at this first MARAC and the GP could have been helpful in this regard.

7. A further concerning feature was the inaccuracy of some of the information provided by police to the representatives at MARAC. At the second MARAC held on 05.12.11, police stated there had been two incidents since the first MARAC. The chronology shows there had been nine calls made by Kate albeit only two were of particular concern. With hindsight the fact that Kate had been threatened with a knife by Peter assumes particular resonance, given that just four days later, Kate would be arrested and remanded in custody for stabbing Peter.

8. It is fair to assume that this serious incident, followed closely by two assaults upon Kate by Peter should have brought their case to a tipping point. Here was all the evidence needed that both Kate and Peter were at high risk of serious harm during the regular drunken incidents. However the MARAC of the 05.01.2012 was once again an information sharing exercise where all participants agreed that alcohol was at the root of Kate and Peter's problems.

9. The MARACS that followed from January to August 2012 give little evidence that any meaningful engagement was achieved with Kate even though Peter spent from the 17.04.12 to the 18.04.12 in custody. As has been demonstrated in the summary of facts, the LPU responses to calls at this time give little indication of a coordinated approach to a high-risk couple. The MARAC was fully aware that Kate would not engage with IDVAs, would not keep her new address secret from Peter and would not support prosecutions.

10. When Peter was returned to custody and within a day Kate was changing her account to undermine the case, it was evident that it would not be long before Peter was released, and it was entirely predictable that high-risk incidents would ensue.

11. From a risk management perspective Kate and Peter should have been at the highest possible level by the time Peter was released from custody for the 05.04.12 assault. Peter had assaulted Kate immediately

upon release from prison. Kate had clearly disclosed her new address to him. She had never given evidence against him, despite his multiple assaults against her. Likewise, Peter had not co-operated when he himself suffered serious injury at the hands of Kate Police were unable to keep the couple apart, even when subject to bail conditions.

12. It is the DHR panel's view that the MARAC chair should have convened an emergency MARAC to formulate a strategy that involved the Local Policing Unit senior leadership team, the PPU and partners. Whilst the management of safeguarding and MARACs was very properly the responsibility of the PPU, the frontline response to Kate and Peter was an LPU problem. Kate and Peter already represented an almost constant drain upon resources.

13. Most tellingly, all professionals involved with Kate and Peter recognised the huge risk; a PPU officer seeking disclosure from GPs in February 2012 had said that the police's view was that one or other of them 'will end up dead.' When a threat level reached this severity it was unrealistic for it to remain the responsibility of MARAC. This was an exceptional case requiring exceptional measures.

14. It is the DHR panel's view that the DI with MARAC responsibility needed to acknowledge an emergency meeting at which only Kate and Peter were discussed was required. The MARAC needed to call in a broader range of professionals to include the couple's general practitioners, to consider the implications of the dual diagnosis, and recognise that Kate and Peter required alcohol services and mental health services to be working in tandem.

15. It would allow participants to develop a safety plan and offender management plan that was sufficiently flexible to be applicable to either Peter or Kate Most importantly the plan had to be accessible to all agencies and communicated to those frontline staff likely to come into contact with them: police officers, community mental health teams, GPs surgeries, A&E.

16. The plan needed to be clear that any further criminal activity needed a robust response; every opportunity to prosecute had to be taken. A sufficiently senior investigator (probably the PPU DI) had to take

responsibility for managing all criminal investigations and ensure that the time was taken to prepare a summary of all the known history, which would be submitted to the CPS endorsed by a member of the senior leadership team. The case was so serious that every callout, however trivial, needed to be reviewed by a specified supervisor to ensure that force policy was complied with and that interventions were robust.

17. Had the emergency meeting sought legal advice at this stage, it seems to the DHR author unlikely that the opportunity to apply for a restraining order would have been missed. Furthermore the opportunities for Anti-Social Behaviour Orders (ASBOs) could have been approached at a far earlier stage.

18. Although the possibility of holding emergency MARACs is written into MARAC protocols, it does not appear that they are commonly used. It is possible that the officer responsible for chairing the MARAC was unaware of the possibility of holding such a meeting. If the attendees at MARAC had not previously held an emergency MARAC, they would not perhaps have advanced the possibility to the chair.

19. It is also very possible that an acting DI (ADI) would have been reluctant to escalate the case to a senior PPU manager, if usual practice was to manage MARAC at DI level. If the A /DI was not being routinely supervised in this new role, the officer would not have had the opportunity to discuss Peter and Kate who were already proving to be a significant challenge. The absence of a DCI for a period was clearly a contributory factor.

20. Subsequent MARACs in May and June did not alter the response to Kate and Peter in any significant regard. However MARAC did demonstrate a change of direction, in so far as the meeting formed the view that Kate should be considered a vulnerable adult based upon her alcohol abuse, mental health issues and domestic abuse. What is clear is that a strict interpretation of the vulnerable adult criteria was applied and the view of Adult Social Care managers in closing the referral was that the case was already at MARAC and therefore there was nothing else that could be done. This is an example of agencies seeing MARAC

as a separate entity with separate resources, able to deal with all risks without their input. In fact MARACs need participation from as wide a range of agencies as possible, at a sufficiently senior level to ensure that decisions can be made on behalf of the agency and that undertakings in relation to service delivery can be made.

21. In June 2012 PPU supervisors identified that in their view every available safeguarding measure had been taken and refused. It is at this point that the use of the TTCG process on LPU was formally recognised. What is also evident from the subsequent MARACs, is that there did not appear to be any expectation that the two processes would feedback to each other. There is nothing in MARAC minutes describing steps taken on the LPU to contain the risk to Kate and Peter

22. The MARAC increasingly seemed to rely upon one tactic; to ask alcohol service to engage with Kate and Peter because alcohol was believed to be the cause of all the problems. Aquarius dutifully took every opportunity to approach Kate and Peter and were repeatedly rebuffed by them both. They were offering a non-mandatory service and could not compel engagement. Kate and Peter it seemed, would only engage with agencies on their terms.

23. Faced with this refusal to engage, and a consensus amongst MARAC attendees that every safeguarding measure had been offered, Kate and Peter were often removed from the panel. It seems to the DHR panel quite extraordinary that such a high risk unresolved case could be considered as closed, even if this was simply a technical closure. It is even more surprising that a MARAC minute in June could say; ‘All appropriate safeguarding is in place for this couple.’ When in fact, every safeguarding measure that had been offered had been declined.

24. MARAC cannot force adults with capacity to make wise decisions, nor can it make adults engage if they have no inclination to do so. However police have a duty to prevent crime and therefore offering help could only be a part of their strategy. Beyond MARAC there needed to be a robust crime prevention strategy linked to a robust prosecution policy because the reality was that almost the only time Kate and Peter could be considered safe, was when one or other of them was in custody. It

took far too long for MARAC and the police service to recognise this reality.

25. Between August and October 2012 there was a brief period of relative calm which was not it seems, due to the interventions of MARAC, but was in fact due to a positive intervention by Louise. For a rare moment both Kate and Peter showed some desire to break the cycle of alcohol abuse and offending. When however, this short 'truce' ended, there is no evidence that MARAC asked' why have we not heard from Kate and Peter for two months?' This was in part a failing of a system that was reactive; Peter and Kate would only be discussed as a consequence of new high-risk incidents.

26. It is a measure of how lacking in direction MARAC had become, that at the November 2012 MARAC, a clear allegation of serious assault against Kate made by Peter and reported to Aquarius did not become a police action requiring investigation. Instead the Aquarius representative was asked to encourage Peter to report the matter. This was not only poor practice, but demonstrated a disregard for the safety of Peter and ignored the very real risk of further serious harm. It is all the more ironic that on the 25.10, police had attempted to persuade Kate to sign an Osman warning; a notification by police that a victim is considered to be at risk of serious harm/homicide outlining the protective measures being offered or refused.

27. It seems to the DHR panel, that after repeated failures to secure the engagement of Kate and Peter with alcohol services, it should have been acknowledged that despite their very professional efforts, alcohol services could not provide a solution. Whilst a pathway to the service needed to remain open, it was no longer an effective principal strategy to hope that Peter and Kate could both be encouraged to break the cycle of alcohol abuse and domestic abuse. An alternative strategy needed to be identified.

28. It seems to the DHR panel that the MARAC process simply could not respond in a case where both Kate and Peter were capable of inflicting serious harm upon each other and often did. The absence of a detailed analysis of the causes of their behaviour and detailed identification of

risk led to an over reliance upon the work of a voluntary sector organisation; namely alcohol services.

29. The incident of the 03.12.12 was a criminal allegation against Peter but offered strong independent evidence that Kate was the aggressor. The case was once more removed from the panel. Five days later on Kate had allegedly stabbed Peter and was in custody on remand.

30. Not for the first time, the principal victim had become the offender and Peter was listed as a high-risk victim. MARAC was once again presented with a safeguarding opportunity to work with Peter with the other party removed from the scene. It does not appear to the DHR author that these 'windows of opportunity' were recognised for what they were. It is hard to define the control that Kate and Peter apparently exerted over each other or the loyalty that led them to retract their original allegations but what is clear is that contact with them as victims needed to be intense and focused during these periods when they were forcibly separated.

31. A MARAC was apparently held in January 2013 but the minutes have not been made available to the DHR panel. The subsequent MARAC was in June 2013. The minutes of that meeting have updates from agencies relating to the December 2012 MARAC, six months before. This is illustrative of the lack of coordinated, pre-emptive MARAC engagement.

32. It is the DHR author's view that there is a fundamental flaw in the MARAC arrangements that allows the process to be almost entirely reactive. A MARAC is held in response to a crisis, and then the case is 'removed' from the list. At precisely the time when Peter may have been responsive to intensive supporting activity, no properly coordinated MARAC action was occurring. P3 support workers from the hostel in which Peter lived were actively trying to find him new accommodation and community care grants and persuade him to engage with alcohol services and counselling.

33. In their IMR they explain that they were persuaded by Peter that he had left Kate and was not intending to go back to her. Furthermore even though he was the high-risk victim of a stabbing, the hostel support

workers did not know he was listed at MARAC and had no contact with anyone in relation to it.

34. It is the DHR panel's view that MARAC should identify a lead worker for every high-risk victim. This would be the person with the most developed relationship with the victim, probably the IDVAs or the professional from the agency currently addressing that victim's most pressing need; alcohol, homelessness, adult social care, mental health. They would be responsible for coordinating the work of other agencies between MARACs and ensuring that relevant developments are shared so that work being undertaken is complimentary. They would work in tandem with the MARAC coordinator. They would not end this level of engagement until clear protective factors could be described which genuinely reduced the risk to the victim. The IDVAs would continue to engage with these high-risk victims because a refusal to accept a safety plan would not be grounds for removing a victim's name from MARAC, unless properly identified protective factors existed. It may be that the emphasis would change from victim support to offender management; however there should be no hiatus in agencies' actions merely because the victim refuses to acknowledge risk or makes poor choices.

35. From March 2010 until October 2013 MARACs were held on around fifteen occasions. It is the view of the DHR panel that although the risk factors were not properly recorded, they were well known. Actions taken were rarely successful and the only protective factors ever listed were periods that Peter and Kate spent in custody. That either Peter or Kate could be considered removed from MARAC co-ordination at any time in this period is unfortunate and is a fault of the system.

36. However it is also inappropriate that the safety plan for both Kate and Peter could have been so imprecise. It appeared that police simply waited for the next severe incident, at which point the injured party would be relisted for MARAC and the usual participants would be reminded of the case so far and asked to suggest actions. As has been described at length, these were generally the same actions, for the same agencies with no increased chance of success.

37. In this case it took until June 2013, for the senior leadership team from the LPU to play an active part in the management of the case, even though it had apparently been a regular subject of TTCG since the year before. TTCG is a monthly meeting on LPUs where priority arrests, suspects, and crime problems are addressed. Daily tasking meetings complement this.

38. Taking high risk domestic abuse cases to tasking has been a core police task since the Multi Agency DV Strategy (2008-11) In the case of Kate and Peter had featured on the TTCG since June 2012 and it would be reasonable to have expected that it should not have required PPU intervention to have prompted a robust intervention in line with domestic abuse policy.

39. The minutes from the professional's meeting have not been kept and could not be produced for the police IMR author or DHR panel. However from available evidence, (notes taken by attendees) it does not appear that any consideration was given to managing Kate or Peter under MAPPA arrangements or as potentially dangerous persons (PDPs). The police IMR stated that neither Kate nor Peter met the criteria for MAPPA listing. It was true that neither had recent convictions that met the criteria for listing at MAPPA (although Peter had an Actually Bodily Harm and Indecent Assault conviction from 2002). The DHR panel would however argue that both Kate and Peter met the criteria for being managed as potentially dangerous persons,[6] which could have led to a far clearer offender management strategy.

40. Albeit PDPs are not managed under a statutory duty, it has been recognised that cases where there is a high risk of harm from domestic abuse, but no relevant convictions allowing MAPPA management, require offender management that is targeted and robust.

41. If Kate and Peter had been submitted for consideration as PDPs, an initial assessment would have checked whether they met MAPPA

[6] Guidance on Protecting the Public: Managing Sexual Offenders and Violent Offenders, Second edition Section 5.1 ACPO

criteria. Upon confirmation that they could not be managed at MAPPA they would have been further assessed and if ratified as PDPs, Kate and Peter could have been subject to many of the offender management techniques used by MAPPA. These include PDP meetings, appointing a senior investigating officer (SIO), reviews of unsuccessful investigations and reviews of the PDP status every 4-6 weeks.

42. By the time the emergency MARAC/Professional's meeting was held it could be argued only very robust offender management could prevent the continuing risk of harm. The failure to consider either Kate or Peter as PDPs seems to the DHR panel to have been a further missed opportunity.

43. The meeting led to renewed commitments to engage with both Kate and Peter. This was probably a positive response. In the police IMR the A D/I with responsibility for MARAC in 2011 and 2012 was frank that she had experienced some level of resistance from participating agencies, 'because *Kate and Peter had constantly refused to accept help and there may have been a sense that "they were as bad as each other" there had been an apparent reluctance to keep offering support. As MARAC chair she said that she regularly reminded agencies that they must persist in offering because there may be a time when Kate and Peter were ready to accept support*.'

44. It also led to an emphasis upon robust use of any available powers to prosecute domestic abuse offences by either party. However it also directed that frontline officers should actively seek to prosecute Kate for wasting police time, or obstructing police, whenever the opportunity arose.

45. As was identified in the summary of facts, advice from the city council legal department suggested to the meeting that there was no suitable legal protective order that could be used. It is the view of the DHR panel that the meeting should have actively considered restraining orders that could have been sought when a case involving either Kate or Peter went to trial, and this will be revisited later in the analysis.

46. The meeting explored the possibility of applying for alcohol treatment requirement (ATR) as part of the sentence for any offence. This was a positive approach given that neither Kate nor Peter would engage with the detoxification process unreservedly. Many present believed that Kate (and probably Peter) had undiagnosed mental health issues and therefore a mental health assessment (either in custody or not) was a priority. This was obtained on the 25.06.13, and will be considered later in the analysis.

47. Whilst the professionals' meeting reinvigorated those agencies that had previously been involved, the criminal justice strategy appeared to have an unforeseen consequence. It is understandable that the LPU were belatedly attempting to reduce the huge volume of demand for help from Kate It is also evident that they had an increasing conviction that a significant amount of the calls were as a result of her drunken state and did not represent real risk. However by any risk assessment, police would have had to acknowledge that Kate had been beaten numerous times by Peter whether she acknowledged this or not. Furthermore, Peter had been stabbed on at least four occasions, as well as suffering other injuries, and although he denied Kate had inflicted them, there was sufficient information known to other agencies, GPs to make it almost certain they were as a result of assaults by Kate .

48. From a safeguarding perspective, any strategy that deterred a victim from reporting incidents was a high risk one. It is not hard to detect the exasperation of professionals after such long and apparently ineffective engagement with Kate and Peter. Neither presented as a 'blameless' victim and both steadfastly refused help. It is probable that the collective view was that, as the A/DI had openly admitted, 'they were both as bad as each other'. This was an exceptional case, in its' intensity and duration and it required perseverance.

49. The Review panel noted the apparent 'short fix' approach of this emergency MARAC. The attendees were in large part the same people who regularly attended MARAC. The LPU Chief Inspector chairing the meeting did not apparently hold a follow up review meeting, and although everyone undertook to feedback the result of their enquiries,

there is no evidence that they were considered at later MARACs. Most importantly the panel concurred with the police IMR on need for a more senior officer to take responsibility for the police strategy and driving it forward. Without this, the meeting had no discernible impact.

50. By August 2013 CPS had reviewed all the outstanding bail cases for Kate and Peter and none were considered to have met the threshold for prosecution. One of the reasons cited was Kate's recent convictions for wasting police time, since this made her an even less credible witness. It is ironic that an approach that was designed to reduce the number of calls to police was seen as a safeguarding tactic, since in reality it made the likelihood of controlling Peter and Kate through domestic abuse criminal prosecutions, even more remote.

51. It seemed to the DHR panel that when agencies said that they felt that they had done all they could in this case, that judgement was probably correct viewed against the limited actions set by the MARAC.

52. The safety plan, such as it was, amounted to going through a selected menu of actions that would usually be effective in most cases allowing some high- risk cases to be removed after one MARAC, whilst others may return several times. A case that was listed at MARAC fifteen times in two years was exceptional, and should have been treated as such.

53. The absence of an escalation plan for MARAC was one reason that the process appeared to be ineffective. Addressing the needs of a couple with such complex problems does not lend itself to being considered as part of the agenda of a busy MARAC.

54. Agencies contributing to and attending MARAC have recognised that where engagement with services offered is voluntary; clients may choose not to engage the frontline workers. Therefore an escalation policy is required which would allow a senior manager to review the case. If as a result of such a review, a service concluded they were unable to take a MARAC action forward, this should be reported to MARAC and would require a re-evaluation. If as in Kate and Peter's case in relation to referral to voluntary alcohol services, the action was the centrepiece of the safety plan, the in-house escalation and manager

contact with MARAC would possibly be a prompt for escalation of the MARAC itself.

55. The police knew that prosecutions of either Peter or Kate necessitated the best possible available evidence and would need to be victimless because neither Kate nor Peter was likely to cooperate. This required a properly communicated tactical strategy shared between frontline officers and PPU staff.

56. The DHR has shown that if the TTCG and PPU had such a clear strategy, it was apparently not communicated effectively to the frontline officers. Whilst there is some evidence of more intrusive supervision of the case after the meeting of June 2013, there was little evidence that officers treated this as a high profile case before that date. There are multiple examples throughout this case of missed opportunities to act robustly in line with force domestic abuse policy. The cumulative impact of domestic abuse was ignored and DASH risk assessments, the trigger for MARAC were not completed. Basic investigations were sometimes incomplete and evidence was not gathered. This is one of the key areas of learning and will receive separate consideration in the analysis.

57. The police IMR makes it clear that a system that could have improved communication between PPU, TTCG and LPU already existed. The CORVUS briefing system would have allowed up to date briefings in relation to both Kate and Peter to be attached to their record. This could have been a comprehensive safety plan and offender management strategy, had these been properly recorded. Alternatively CAADA compliant minutes could have been made available to officers. That WMP have not yet used the capabilities of their own intelligence system is key learning from this DHR, which the force should address as a priority.

58. The force needs to consider how the new Safeguarding and Domestic abuse teams will manage MARAC and identify a senior officer who would be responsible for chairing MARACs, which have been identified as having reached an impasse with the identified risk factors unresolved. The trigger for this should be a combination of the

frequency of listing of a case as high risk, combined with a checklist of areas in which little progress has been achieved in securing the safety plan or managing the offender.

59. Although both Peter and Kate were listed as high risk, and were often considered together, it is evident that Kate was more often considered the primary victim. This was probably because she made the vast majority of the calls for service. The most frequent allegation she made apart from assault, was that Peter was either refusing to leave, or attempting to break in, or had forced his way into the property. It was therefore likely that she would be considered in need of protective measures. However from very early on it was evident that she would not support the kind of protective measures such as non-molestation orders that a victim making so many calls for help would normally require.

60. In fact Peter had suffered significant injuries himself, and some third party evidence, gathered by police in Bristol and WV, suggested Kate was frequently the aggressor. The IMRs of the agencies that had significant contact with the couple are full of examples of Kate's abusive behaviour directed at Peter but also professionals who would not engage with Kate on her terms. There are very few examples of Peter being aggressive with officers attending call outs, but numerous examples of Kate's anger management problems. This needed to be balanced against Peter's self -confessed anger management issues, recorded by GPs as early as the 1990s. It was evident that when drunk Kate and Peter could lose control and attack each other in almost equal measure. When interviewed Peter described in vivid detail the taunting and assaults that led to his own violent responses. The DHR panel has been told that when Peter did make statements of complaint, they were detailed and described Kate as someone quite capable of initiating and controlling a violent episode. It is clear this may have been self-serving.

61. However the totality of the evidence available to the DHR panel from chronologies and IMRs has led the panel to the view that the case of Kate and Peter was an example of a relationship without a significant power imbalance. There is little to suggest that Kate was subject to

coercive control by Peter although jealousy and accusations of infidelity are the most frequent pretexts for violence and Kate often pointed to Peter's jealousy as a catalyst for violence. It also should not be overlooked that Peter had a conviction for sexual assault with strangulation and violence against a former partner, and was twice accused of rape by Kate.

62. If then Kate and Peter were in a mutually destructive relationship and were both at risk of reciprocal violence, the MARAC needed to identify how the parties could be diverted, the risk managed, their behaviour disrupted, and criminal activities prosecuted. Actions set needed to be considered in the context that the victim today could very probably be the offender tomorrow. The presence of offender managers at MARAC under the PPU re-organisation could be a positive improvement, which would be further enhanced by LPU representation at MARAC.

63. If health services were the key in relation to the mental health and alcohol abuse of Kate and Peter and access to services was through the GP, then given that both Kate and Peter were patients at the same surgeries, GPs needed to be fully briefed after each MARAC, even if it was not practical for them to attend the MARAC. (However with the widespread availability of free video conferencing services, it should be possible to allow hard-pressed professionals to be present on a video link)

64. The MARAC agencies made genuine and well intentioned efforts to adapt its' usual processes and responses to a very unusual case. There is evidence of significant and protracted efforts by Aquarius/NACRO, PPU staff and supervisors and IDVAs to build crucial relationships with Kate and Peter. The MARAC was however hampered by systemic and organisational weaknesses, due to poor governance and the absence of administrative support. The managers chairing the MARAC were insufficiently supported by their SLT, who gave them an unsustainable workload. They were inexperienced in PPU safeguarding or were acting inspectors. For a period the PPU had no DCI. That fifteen MARACs could be held without a senior PPU manager intervening reflects more on the isolation of the chair than on the work

being done by the MARAC. There was no escalation policy for a MARAC which had in the words of the DI MARAC chair, "*exhausted all possibilities"* for Peter and Kate.

65. The MARAC was working in isolation; although the PPU safeguarding sergeants took the problem to TTCG and DMM, no clear strategy emerged which was linked into MARAC minutes. There is a strong sense that Kate and Peter were not considered a shared problem by the LPU and PPU. Furthermore frontline officers could neither obtain a current safety plan nor an offender management strategy from a single intelligence system even though systems existed which had this capacity. MARAC minutes were not made available to frontline officers on a searchable system.

66. This DHR illustrated the need for a greater depth of health involvement at MARAC. The lack of consistent information sharing between GPs and MARAC meant that primary care had no clear understanding of the strategy being followed in relation to either Kate or Peter's domestic abuse. MARAC did not fully appreciate the steps being taken by GPs to address alcohol abuse and mental health concerns. Pathways to both services were unclear. There were A & E presentations by both Kate and Peter that were not placed in the context of the history due to poor information sharing.

67. It is hard to avoid the conclusion that the MARAC manifestly failed over a period of two years. It could not divert Kate and Peter from domestic abuse, nor could it manage their behaviours. It could not disrupt the offending behaviour, which continued unabated despite the efforts of MARAC. There were few prosecutions and convictions despite the countless allegations. It failed to put in place any of the protective orders that could have diverted the couple from their reciprocal behaviour. There was no evidence of engagement with local neighbourhood officers to target Kate and Peter for proactive interventions. Most worryingly, although MARAC recognised it had reached an impasse, it continued to repeat processes, which had been shown to be ineffective, both before the professional's meeting in June 2013, and to some extent after.

68. The Wolverhampton Domestic Violence Forum has been able to appoint a Co-ordinator during the course of this DHR and the panel recognised this as an important improvement, which is essential to an effective MARAC. However this remains one of the actions for strategic recommendation 1, since there remain doubts around the funding of the post. Sustainability is crucial to this effort to improve practice. The reorganisation of PPU has led to an enhancement of domestic abuse investigation and safeguarding which should have a positive impact on safety planning at MARAC. The role of the detective inspector for domestic abuse and safeguarding has been enhanced and it is this officer who will now chair MARAC, but in two boroughs not four, which this DHR had identified as an operationally unsustainable model. This change is helpful. However for the management of MARAC to be robust, a deputy chair must be identified as a priority to assure continuity. That the first strategic recommendation for the DHR concerns MARAC, (and so many of the agencies at the learning event chose to make greater MARAC involvement and awareness an agency recommendation) is a measure of the importance of a MARAC which is CAADA compliant. Safer Wolverhampton Partnership will ensure that a learning event is held for all those staff working in domestic abuse provision and within MARAC in Wolverhampton, so that the learning from this case leads to change in practice.

4.2.4.1 Key Learning points- MARAC

MARAC- what can we learn?

1. **MARAC is not a separate entity, but is the sum of all participating agencies and requires full involvement in safety planning.**
2. **The MARAC management structure has to be sustainable and supported, with a chair and identified deputy.**
3. **A sustainably funded MARAC co-ordinator is essential.**
4. **Agencies that become aware that a high risk MARAC subject has moved area should share intelligence with the receiving MARAC.**
5. **Broader representation of Health services at MARAC is vital.**
6. **MARACs must have a clear safety plan in every case, supported by actions that are detailed in CAADA-compliant minutes, which are accessible and shared with frontline practitioners.**
7. **MARAC should identify cases of reciprocal violence and adapt responses to meet the identified risks.**
8. **MARAC and all contributing agencies should have escalation policies when actions, interventions or safety plans are deemed ineffective.**
9. **MARAC should use special/emergency meetings for complex cases.**
10. **MARAC should identify a key worker (IDVA, support worker or professional) in complex cases**
11. **Where there are no identified protective factors, a high-risk case should not be closed when support is refused.**
12. **GPs have a key role in safeguarding and should be more closely linked in with MARAC**
13. **An accurate and reliable summary of history and intelligence in complex high risk cases should be maintained and shared where appropriate with professionals and CPS**

4.3 What can we learn about supporting both victims and perpetrators of domestic abuse?

4.3.1 The role of families in safeguarding victims and perpetrators of domestic abuse

1. The families supporting victims and perpetrators in the safeguarding process are often placed at risk by the presence of a domestic abuse victim (or perpetrator) in their home. The chronology revealed numerous examples of incidents where family members were present during violent episodes; (Jane, Kate's daughter during the stabbing incident of 30.06.10) Peter made direct threats to Brian (and by extension to a child Louise); threatening violence, arson. Peter's sister spoke of a violent row and attack upon Peter when Kate came to Wales, when Peter's bail address was their home.

2. Peter's brother expressed his real frustration that Peter was so frequently brought to his home after an incident but officers refused to explain the circumstances of the incident, citing confidentiality constraints upon disclosure. He was therefore expected to 'police' Peter's behaviour, without the necessary information to assess the risk. Peter himself recognised the risk he posed to his brother simply by his presence, and apparently often left almost immediately.

3. Peter's sister was several times used as a bail address after serious violent incidents. It could be argued that this was inappropriate given Peter's unrelenting alcohol abuse and unresolved mental health and behavioural problems.

4. Inevitably, through loyalty and love, families find themselves taking sides. In conversations with the DHR author it was clear that neither family disputed that Kate and Peter were capable of abusive or violent behaviour. However viewed from their perspectives, the catalyst for the descent into alcohol abuse and violence was the other party.

5. The behaviours; alcohol abuse, domestic violence cannot be changed without the individual taking full responsibility for their actions. Families that validate or accept the excuses used to justify violence or abuse are unwittingly colluding with it and preventing real change occurring.

6. It is the panel's view that when families are asked, or find they are supporting victims and perpetrators, they must firstly be safe and not be put at risk by the actions of agencies with safeguarding responsibility. They should be encouraged to do it in a way that does not allow perpetrators to minimise the harm they do, or their responsibility for their actions. They should be asked to look for signs of real motivation for change and know how to signpost loved ones to appropriate services (MARAC, IDVAs and other support services)

7. Brian was recognised by the MARAC as a source of information about Kate but the presence of Brian and Louise as a support and influence over Kate and even to some extent Peter was apparently not explored in any meaningful way.

8. The DHR has highlighted a brief moment (August to October 2012) in an almost unrelenting cycle of abuse when for a both Kate and Peter had expressed a desire to change. It is sad to reflect that the resolve which led Kate and Peter to promise change Louise seemed to dissolve very quickly for Kate and lasted only a few weeks longer for Peter None of the agencies appeared to know the pivotal influence of Louise , a mature and reflective young woman, on both Kate and Peter It is the DHR panel's view that more attention should have been given to the positive (or negative impacts) of the extended family in producing change in domestic abusers or victims and perpetrators with substance abuse problems.

4.3.1.1 Key Learning points- the role of families in safeguarding victims and perpetrators of domestic abuse

The role of families in safeguarding victims and perpetrators of domestic abuse- what can we learn?

1. **The safety of families of domestic abuse victims and perpetrators should be a paramount consideration**
2. **Decisions to place perpetrators of domestic abuse with their families or friends whilst on bail, or as a safe address after a breach of the peace, requires that they be provided with full disclosure of the circumstances to allow informed decision making and contingency plans securing their safety.**
4. **Families of both perpetrators and victims should be provided with information around positive interventions that support the desire for change and access to appropriate signposting**

4.3.2 The role of link or support workers

1. In a case that was characterised by a persistent and resolute refusal by either Kate or Peter to engage with support workers and IDVAs in any meaningful way, the DHR panel nevertheless remains committed to the belief that forming relationships with victims and perpetrators is a key to changed behaviour and long-term recovery.

2. The panel would tentatively suggest that whilst huge efforts were put into offering help, understanding of why it was refused was not evident in the IMR submitted to the review. The broadly held view appeared to be ‘you cannot make an adult who doesn’t want help accept it.”

3. The DHR has commented on the central part Aquarius was expected to play in the safety plan of MARAC. Very few of the multiple MARACs did not have as an action that Aquarius try again to re-engage with either Peter or Kate The panel would agree that the door to the service had to remain constantly open. It is no criticism of the individual workers that

they never succeeded in gaining the level of engagement required.

4. The IMR for NACRO/Recovery Near You was able to assess the work of Aquarius, who provided alcohol services at this time and NACRO/RNY, who took over provision in April 2013, because most of the staff remained in post during the transition.

5. ' *Staff spent time attempting to engage the couple and persuade them into treatment for their alcohol addictions but were unsuccessful. The nature of addictions is such that people have to reach a point whereby they are sufficiently motivated to stop drinking and change their patterns of behaviour*.' This is no doubt accurate. This agency recognised the need for an escalation policy in such difficult cases, and it forms one of their recommendations.

6. However it is possible that had conversations been had with Kate's near family, a clearer understanding of her character would have provided a 'way in' to professionals.

7. On one occasion, after a 'routine' attendance by officers, Kate complained that she had not got an individual officer to talk to rather than the 'hundreds' of officers who attended. This appeared to be a rare constructive observation from Kate

8. Whilst in custody on the 14.02.12, Kate allowed a safeguarding officer an insight into her mind-set saying that when Peter was in custody "*he is looked after with his meals and other people to talk to and I am left at home in the bedsit with no one to talk to so he comes out better off".* This was echoed by Brian and Louise in conversation with the DHR chair. They felt that Kate accepted Peter's mistreatment because the alternative was loneliness, which she feared more than anything else. Kate also complained that '*she had never been offered any support from social care or any other agency other than being sent a letter stating that she should refer herself to Aquarius*.'

9. Whilst the police IMR points to very persistent engagement with both Kate and Peter by the officers charged with MARAC and domestic abuse co-ordination, there is no evidence that any local neighbourhood officer was tasked with monitoring and engaging with Kate. The panel acknowledges this may have been a potentially dispiriting and

thankless task.

10. However, Brian in conversation with the DHR author was very clear that what Kate wanted most was someone to talk to. Unbeknown to them, police controllers fulfilled that role. Brian described Kate as unable to cope without company. It was his belief that repeated calls to agencies was Kate's way of getting attention. (She had a conviction in Bristol for wasting police time, after making approximately 50 calls in one day.)

11. Clearly emergency service call handlers cannot fulfil a support role. The panel were struck by the approach taken by the West Midlands Ambulance service explained at the learning event. A pilot has been undertaken whereby the service's most persistent 'nuisance' callers were identified and pre-emptive welfare calls were made to them. Apart from the positive impact this had on troubled individuals, it appeared to substantially reduce their level of problem calls. This is an example of thinking outside the box that may have application in the case of a persistent caller for service such as Kate

12. However her case required a professional (ideally a fully trained support worker) who formed a relationship that encouraged Kate to view her problems holistically; alcohol abuse, mental health, domestic abuse as victim and perpetrator, housing and welfare. The possibility of a single professional helping vulnerable and troubled individuals with each of the obstacles in their life has been piloted in other areas of England and it may have an application with hard to engage people like Peter and Kate.

13. Many at the learning event were struck by the positive impact of projects run by P3 both in surrounding authorities (Sandwell Complex Needs Service) and around the country. The assertion that Kate and Peter would represent very typical profiles of P3's client base was seen as an indication of a possible gap in service provision. A particular feature of the way they work would appear to be to partner with the public sector in order to deal more effectively with the problems that the public sector finds it hard to tackle alone. The social return for one of their local projects would suggest that for each £1 invested, savings of

around £9 are achieved.[7]

14. Some on the panel felt that whilst such additional provision may have application, properly funded IDVAs could fulfil this role, and were already doing so.

15. The All Party Parliamentary Group on Domestic and Sexual Violence enquiry into the changing landscape of domestic and sexual violence services looked at the funding and commissioning of provision for the victims of domestic abuse. CAADA in their response to the APPG[8] described funding and commissioning decisions made in a non-strategic way without comprehensive needs assessments. They argued that they 'routinely identify potentially dangerous gaps in provision of IDVA and MARAC interventions for high-risk victims. (Caseloads of 75 to 150 for IDVAS.)

16. CAADA believes that areas should commission larger community-based teams of IDVAs and/or other specialist practitioners to support medium and high-risk victims of domestic abuse. These teams may be divided into smaller operational teams but should be managed and supervised under one structure. They need to be responsive to the range of client needs, with specialisms across the team in the criminal justice system, family courts, substance use, mental health, young people, safeguarding, sexual violence, housing, and BME and male victims.

17. The DHR panel are in agreement that this would be an appropriate aspiration. Service provision of IDVAs within Wolverhampton was recently re-organised and therefore one of the panel's strategic recommendations includes an action to ensure that current IDVA provision could meet the needs of future high-risk case such as this one.

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[7] P3 Sandwell Complex Needs Service Social return On Investment Analysis (SROI UK Assured)

[8] CAADA Response to the APPG on domestic and sexual violence enquiry into the changing landscape of domestic and sexual violence services

4.3.2.1 Key Learning points- the role of support/link workers

The role of support/link workers- what can we learn?

1. **That where IDVAs and support workers experience difficulties achieving engagement this should be escalated to managers through an established escalation process.**
2. **That in the face of refusal to engage, repeatedly offering the service without analysing the reason behind that refusal, may not be effective.**
3. **That MARAC recognises that an understanding of a victim or perpetrators' needs can be drawn from many sources and is a key to effective support work.**
4. **That properly supported, the best professional to work with a victim or perpetrator as a key worker, is the one who has formed a relationship**
5. **That support provision should be holistic and be able to support victims and perpetrators through a range of services and needs.**

4.4 What can we learn about gender bias in domestic abuse?

1. Peter was a victim of domestic abuse as well as a significant perpetrator. This was recognised at several MARACs. The DHR has acknowledged the challenge to safeguarding this case posed, where it was hard to identify a principal offender and a principal victim. However, reaching this level of clarity is advised by CAADA[9] to be a precursor to dealing with counter-allegations in relationships which

[9] Professor Marianne Hester University of Bristol School for Policy Studies

appear to demonstrate reciprocal violence;

2. '*MARACs should watch out for a victim using defensive or retaliatory violence. While these may be subject to sanctions, including prosecution, the context of any violence or abuse must be understood to identify a primary aggressor or victim and manage risk to all parties appropriately*.' [10]
3. We have few insights into the feelings of Peter about the violence he suffered at Kate's hands. In interviews in relation to his own offending, he followed the self-justification followed by many perpetrators; that he was provoked, insulted, 'that Kate made him do it.' Although he did report violence against himself, it was often in the form of counter-allegation, which in some regards undermined its' credibility, albeit that police did generally arrest and interview Kate.
4. He shared with Kate a reluctance to be characterised as a victim, repeatedly colluding with Kate to cover up their offending against each other. In a relationship where the victim is female this is often seen as evidence of the coercive control exerted by men over women.
5. There is parallel evidence that women who go on to murder men are often retaliating violently after repeated abuse at the hands of men. There is some evidence that the use of weapons by women is a response to the frequent imbalance between the physicality of the parties.
6. A study by Professor Marianne Hester in 2009 described apparent reciprocal domestic abuse in these terms; *'Men's violence tended to create a "context of fear and control", whereas women were more likely to use verbal abuse or some physical violence. But women were more likely to use a weapon, although this was often to stop further violence from their partners… Both men and women can be violent, but there are significant differences in the way men and women use violence and*

[10] CAADA eNews - March/April 2012: Responding to counter-allegations. (CAADA Quality Assurance Manager James Rowlands)

abuse against their partners and also the impact of such behaviour. This needs to be taken into account if we want to ensure greater safety for individuals.'

7. Whilst the DHR panel would accept Professor Hester and CAADAs analysis that female offending is often a response to longstanding coercive domestic abuse from a male, the panel would struggle to state this analysis had complete relevance to this case.

8. The witness evidence that existed when Peter was a victim of domestic violence clearly indicated that witnesses saw Kate as the principal offender. The DHR review has noted that right up to and including at her eventual trial for murder, Kate never raised self- defence as an explanation for alleged stabbing injuries.

9. The chronology is full of hundreds of calls for help made by Kate. Within those are a significant number of incidents that resulted in clear physical injury. It was therefore not unreasonable for Kate to be viewed by MARAC as the primary victim.

10. The DHR has however described four occasions (although there may well have been others which never reached investigation) when it was suspected that Kate had stabbed Peter After the incident of the 09.12.11, Peter received no IDVA support. This was because there was at the time no IDVA for male victims. He would have been referred to St. George's Hub a centre providing support services for vulnerable and socially excluded people, or The Mankind Initiative a national helpline for male victims.

11. The Mankind Initiative themselves point to the lack of appropriate support services for men at local level as evidence of inequality of treatment. There is no evidence that Peter actually asked for such help. However a female victim who repeatedly denied that the suspected offender was responsible, would it is suggested, receive a more intense effort to provide support.

12. Peter did however receive support from the Criminal Justice IDVA after the stabbing in December 2012, as a service to support criminal justice prosecutions at the Specialist Domestic violence Court had been put in place.

13. Although Peter was later made subject of MARACs there is a sense that the Police felt uncomfortable seeing him as a victim. These serious incidents were lost amongst the history of other allegations against him. Even when he was found to have previously unreported injuries and Kate was arrested and interviewed, there is little sense from MARAC minutes that he was seen as being at the same level of risk as Kate It is a matter of speculation as to whether a female victim with a similar history would have been treated the same way.

14. The Home Office definition of domestic violence is gender neutral. The police service and the CPS would argue their domestic violence policies are similarly, gender neutral. They would argue that if there is sufficient evidence to pass the evidential and public interest tests, offenders will be prosecuted regardless of gender.

15. The Mankind Initiative, the leading male support service for male victims would disagree. They describe a lack of recognition by statutory authorities such as CPS creating a 'justice gap'. They point to the CPS' Domestic Violence Strategy as not gender-neutral, if it falls under the remit of the CPS' Violence against Women Strategy. Their domestic violence victims and witnesses page apparently makes no reference at all to male victims. They further point out that the Domestic Violence policy consultation document has just one line in the whole document concerning men.

16. In their report to the DHR, commenting on the charging decision relating to the alleged stabbing of Peter by Kate in December 2012, CPS provided a significantly inaccurate one-paragraph account of Peter as a victim, with no acknowledgement of Kate's offending history. They provided ten paragraphs justifying their decision not to proceed, including stating that Kate was 'clearly a high risk victim of domestic abuse at all times' creating the impression that this in itself prevented Peter being considered a victim.

17. The DHR author has pointed out the apparent gender inequalities in guidance offered to GPs around domestic abuse. Although CAADA has more recently provided gender-neutral guidance (4.7.3.paragraphs 1-4).

18. Male victims of domestic abuse are suspected of failing to report domestic abuse for many of the same reasons that historically, female victims have; fear of not being believed, anxiety about entering the criminal justice system. There are gender specific features inhibiting men reporting domestic abuse; stereotypical perceptions around gender identity and role, and society's view on female violence against men. If policy documents do not appear to see men as genuinely at risk of domestic abuse, it is not hard to conclude that it might inhibit males from reporting offences.

19. The DHR review has been provided some evidence that Peter was the victim of gender bias. The GP IMR suggested that GPs do not have sufficient awareness of men as victims of domestic abuse. It could be argued however that evidence of a lack of awareness can be seen across all patients, regardless of gender.

20. On one occasion Kate and Peter's GP became aware of an apparent assault by Kate on Peter when he arrived at the surgery with a head injury caused by Kate but took no action. The GPs IMR author observed in relation to this and other failures to record suspected domestic abuse of Peter that; *'this discrepancy was even more obvious when it was clear that Peter was a victim. When he attended with blood on his head having been hit by Kate nothing was recorded on his notes, and he does not appear to have been told to go to the police. Had a woman presented having been hit by her male partner, I suspect the response would have been different.'*

21. It is true that on several occasions, even when an injury was known to be an assault, and even where a history of domestic abuse was known, no questions were asked of Peter to identify if he was receiving support. The GP IMR recorded that Peter was only recorded as a victim of domestic abuse once. Even when a junior doctor (supervised by a senior practitioner) carried out an excellent exploration of Peter's multiple and complex problems (including significant injuries from domestic abuse) no on-going support or referral was offered.

22. Although the domestic abuse support to both Kate and Peter offered by GPs was seen to be lacking, the DHR panel would tend to concur with

the IMR author's judgement on gender bias.

23. When in September 2013, Probation failed to request an Alcohol Treatment Requirement upon conviction for Kate the Probation IMR attributed this failure to gender and a failure by the Probation Service Officer to appreciate the risk Kate posed based on her history, which had been provided.

24. In The probation IMR the author stated, ' *in my opinion gender was significant in the offender manager's (OM's) response. This disclosure did not appear to be taken as seriously as it would have been with a female client. There is no evidence of Peter being referred to support agencies or given specific advice as the victim of domestic violence*

4.4.1.1 Key Learning points- Gender bias

Gender bias in domestic abuse-what can we learn?

1. **That work is required to ensure a better understanding of male victimisation, so that it can be put in context, and assist in cases where there appears to be reciprocal violence**
2. **That the gender neutrality in the Home Office definition of domestic violence has not yet led to gender neutral policy, practice, or guidance in some agencies.**
3. **That MARACs should show greater awareness of male victims**
4. **That GPs need more awareness of male victims of domestic abuse**

4.5 What can we learn about police responses to domestic abuse?

4.5.1 The key features of Kate and Peter's relationship and the apparent impact upon investigations

1. There is no doubt that Kate and Peter represented a significant challenge to police officers investigating the almost constant stream of

allegations made (in large part by Kate). At almost every incident police attended, one or other or both of Kate and Peter would be under the influence of drink.

2. The consistent feature of the vast majority of allegations was that they would not be substantiated, or if statements were given (as was sometimes the case, more with Peter as a victim, than Kate) they would be retracted. It was a recurrent feature of Kate and Peter's relationship that allegations and counter-allegations would be made (usually by Kate), some of which had substance whilst other appeared to be malicious. Frequently further calls would be received which added strands of allegation and counter allegation. Often Kate would make these calls whilst sounding drunk.

3. Police Domestic Abuse policy required robust police action based upon correct recording and thorough initial investigation of domestic abuse crimes and non-crime incidents.

4. There were periods of intense police activity by frontline officers on the Local Policing Unit (LPU) whilst MARAC was the responsibility of the Public Protection Unit safeguarding team and was chaired by a PPU detective inspector. Frontline uniformed officers investigated many of the allegations, whilst the more serious injuries and allegations fell to the PPU to investigate. There were frequent examples of incidents where officers failed to gather evidence, which may have built a robust case. This was in part due to the pattern of behaviour exhibited by Kate.

5. However it was also because the high priority that the LPU and PPU placed upon breaking the cycle of offending and abusive behaviour was apparently not communicated effectively to the frontline officers who would come into contact with Kate and Peter.

6. It is not however unusual for victims of domestic abuse to chose not to pursue an allegation for a variety of reasons. They may genuinely want to give an offender a second chance, or intend to be reconciled with them. They may not want to go through the stress of appearing in court, and in such instances CPS policy and police Domestic Abuse policy include a raft of measures designed to support and protect a reluctant

victim. Sometimes a previous experience of criminal proceedings has made the victim wary of further exposure to the judicial process. In these cases victim and witness support is available.

7. Some victims are genuinely fearful of reprisal, or believe that prosecuting the offender will make matters worse. In those cases, CPS and police domestic abuse policy requires careful scrutiny of the circumstances before it is considered in the public interest to drop a prosecution. The possibility of proceeding with an evidence-led prosecution must always be considered.

8. Kate as a victim of domestic abuse did not fit comfortably in any of these descriptions, leaving the dichotomy between frequent call for help, and refusal of that help when it arrived.

9. That Kate made hundreds of calls over the years, would suggest that she was extremely vulnerable. However the DHR has shown that she was herself quite capable of extreme violence. Peter reported numerous stabbings and other assaults. It is recognised that female victims of severe and repeated domestic abuse sometimes resort to knives as the only way to protect themselves from being physically overwhelmed, after repeated experience of physical abuse. Certainly there is strong evidence that Kate suffered many incidents of severe physical abuse inflicted by Peter.

10. Yet despite this domestic violence, Kate never answered any allegation of violence against Peter by claiming self -defence. Even at her murder trial she persisted with the defence that the injury was accidental. With other alleged stabbings of Peter she claimed that they were either self -inflicted or the result of attacks by third parties. She was assisted in this by Peter who himself would retract or repeat Kate's defence. In fact Kate appeared to refuse to acknowledge herself as a victim of abuse, which she clearly frequently was.

11. The DHR has noted Kate's ex-husband's view, that calls to any agency were a way that Kate coped with stress and anxiety and the need to have contact with someone, whoever it was. The DHR has noted reliance upon Peter as a carer and her apparent deterioration mentally, when Peter was in custody.

12. It seems therefore that when Kate had had enough of Peter, she knew that a call to police alleging domestic abuse would, at the very least usually lead to the removal of Peter. That he was often found together with Kate hours later, is an illustration of the complex nature of their relationship and the problem the couple posed police.

13. The police responses to the incidents reported are too numerous to analyse individually, but some can be grouped together because it seems that there were common elements to the type or level of response afforded.

14. A significant number of cases started with allegations of assault or a domestic disturbance, but upon arrival, police reported there was no evidence of injury or on-going disturbances. Frequently Kate wanted Peter removed, and generally he was neither threatening nor aggressive (which could not be said for Kate). The police IMR described the duty placed upon officers;

15. '*The 2005 WMP domestic abuse policy required officers to take positive action when attending domestic abuse incidents. Despite revisions and additions to domestic abuse practice this remains the case to date. Policy also evolved in line with Home Office counting rules and the need to replace a paper recording with computerised records. Attending officers are expected to generate a crime or non-crime number at every domestic incident.'*

16. The duty of officers to record the incident as domestic abuse with either a crime or non-crime entry was sufficiently frequently not complied with for it to be acknowledged in the police IMR and was frank in analysing why this occurred; '*There were cases where there were no specific offences, where Kate refused to cooperate, where Kate was very abusive to the attending officers and others where Kate may actually have lied. There appears to have been a tendency to close a proportion of these C&C logs with phrases such as "Not domestic incident – no problems" or "no police offences". The author speculates whether there had actually not been a recordable incident or whether there had been an element of complacency or apathy on the part of the officers. The*

reality of provable lies in the past might have served as a convenient excuse for officers to not engage as thoroughly as might be expected.'

17. The IMR author identified the same mind-set being applied when officers considered the completion of the Domestic Abuse, Stalking and Harassment (DASH) risk assessment forms, which from being mandatory at every domestic abuse incident had become discretionary. (This will be considered elsewhere in the analysis)

18. The DHR panel cannot agree with the Police IMR analysis of the impact of this failure to record domestic abuse incidents correctly. The IMR concluded*; 'Whatever the reason for incorrect completion of risk assessments and non- crime reports the number of calls was so great that little additional benefit would have resulted from correct adherence to policy. The purpose of the non-crime reports was to record incidents and ensure specialist PPU officer were in a position to analyse the relationship with Kate and Peter and offer specialist support. It was undeniable that PPU staff, C&C staff, uniformed officers and senior management on the WV LPU were very aware of Kate and Peter. The failure to make proper reports meant that some opportunities to refer to external agencies might have been missed but Kate and Peter had already been offered third sector advice, such as Aquarius and Haven, on numerous occasions*.'

19. The DHR panel would argue that the attitude of frontline officers would communicate itself to Kate and Peter. If incidents were treated as being of little consequence, it encouraged Kate to see the police as a 'taxi service', removing Peter when she did not want him around and trivialising the domestic incidents that had preceded calls. Most importantly, if officers were not 'doing the basics right' because they judged the matter trivial, and were 'apathetic ' or 'complacent', it would have served to make Kate or Peter feel invulnerable when they were perpetrators. If police made no effort to find out what had happened in these apparently minor cases, Kate and Peter were learning at first-hand how best to conceal evidence in more serious cases. It could also be argued that complacent officers probably missed more serious incidents, precisely because of their complacency.

20. It also does not seem a tenable proposition that police already knew enough about Kate and Peter for there to be no appreciable impact from inaccurate recording. The police IMR and DHR have identified occasions when MARAC was not given accurate information concerning the number of domestic abuse incidents involving Kate and Peter since the last meeting. This may have reduced the sense of urgency around the case.

21. The police IMR did censure a practice, which occurred on numerous occasions in this case, which was a symptom of officers taking a pragmatic approach. The IMR stated;

22. '*there were numerous occasions in the period of review when Kate called the police to allege that Peter had assaulted her or had refused to leave. Generally officers acted appropriately but on occasions he was taken to another address, often his brother's from where he would return several hours later. In almost all of these cases an arrest for an offence or breach of the peace would have been a legal and proportionate resolution. It is generally not appropriate in domestic abuse incidents to take the suspected offender away from the property and leave them at another place if an arrest was possible. WMP policy requires "positive action" by attending officers. This resolution to a domestic incident means that suspects are not properly held responsible for their actions in any meaningful way and runs the real risk of them returning and reviving trouble.*'

23. There was at least one occasion when apparently this practice led to a serious assault. On the 04.04.12, police removed a drunken Peter from Kate's flat after an alleged disturbance. Rather than arresting to prevent a breach of the peace he was taken to his brother's home. By midnight (five hours later) he had returned and seriously assaulted Kate. He was kept in custody for ten days thereafter. Had the officer's 'done the basics right' he would have been detained until such time as it became clear there would be no reoccurrence; (often when offenders are sober). In Peter's case, there would always be a high level of risk of re-occurrence so he could have been placed before the magistrates' court

to be bound over. This apparently pragmatic approach can be seen to have had serious consequences for Kate.

24. The police IMR suggests that in the face of Kate's frequent aggression, officers felt a degree of sympathy with Peter.Officers have all received domestic abuse training throughout their careers and should have been well aware that they had a responsibility to take robust action in domestic abuse incidents. WMP expects officers to make an arrest where an offence has been committed. It is highly likely that the domestic situation between Kate and Peter was well known to the majority of LPU officers. The panel suspects that incidents where arrests were not made was not a case of officer neglect but perhaps highlights an element of sympathy for Peter over Kate who was believed to exaggerate her claims and was almost always very abusive to the officers who attended.

25. It is a feature of some domestic abusers that they are able to present a reasonable, even likeable, persona to police and other agencies, which they know will contrast with the demeanour of their victim. As the victim sees the officers becoming drawn in, they become increasingly frustrated and appear aggressive. It is possible that there was an element of this with Kate and Peter although it must be acknowledged that many professionals experienced Kate's aggression when she did not get what she wanted. When she was drunk abusive behaviour and language was common, apparently without any provocation.

26. There was another unanticipated consequence of the use of Peter's brother's as a 'drop off for Peter In conversations with the DHR author, he was clearly angry that he and his family were put at risk having to deal with Peter. His greatest frustration was that officers used confidentiality to refuse to tell him why police had become involved with Peter. He therefore could not anticipate the likelihood of Peter returning to Kate. Since police should not have been using Peter 's brother, they never agreed a contingency plan should Peter leave. In reality he never stayed long, according to Peter 's brother, because Peter was very conscious that he did not want Kate harassing his brother and his family

27. The DHR panel recognised that since the events described in this DHR, WMP have put in place structural changes within PPU that are intended to have an impact upon the response to safeguarding and domestic abuse investigation.

28. The PPU will be responsible for investigating vulnerable adult abuse, child abuse (sexual, physical and emotional), adult sexual abuse and domestic abuse. The PPU commander who is a Detective Chief Superintendent will manage a detective superintendent (Adult) who in turn will be responsible for 5 detective chief inspectors.

29. Each DCI will be responsible a geographical area and in the case of domestic abuse one of the DCI's will cover the Wolverhampton and Walsall boroughs. A detective Inspector will manage each borough, with responsibility for a domestic abuse investigation team and a domestic abuse protection (safeguarding) team.

30. The Domestic Abuse Teams (DAT) will be responsible investigating all domestic abuse incidents regardless of crime type or risk grading. Within the DAT there will be an Investigation Team (DAIT) and a Domestic Abuse Protection Team (DAPT).

31. The DAPT will comprise of DA Offender Managers responsible for the offender management of a cohort of DA offenders (up to 20), and DA safeguarding officers responsible for medium and high-risk DA victims. In their IMR the police hoped that this will lead to a more robust management of bail in domestic abuse cases and more importantly professionalise the quality of police objections to bail presented to CPS

32. In addition to safeguarding officers attending MARAC meetings to discuss victims of domestic abuse, where appropriate offender managers will also attend to discuss the offenders.

33. Each LPU will continue to provide an initial response and conduct the primary investigation prior to being transferred to the DAT. All officers regardless of their role will have a safeguarding responsibility and will work to provide the most efficient and effective service to victims in line with the statutory obligation to comply with the Victims Code (December 2013).

34. The geographical DA Detective Inspector will attend TTCG and LPU

DMM.

35. The DHR panel are aware that the IOM system was not developed to manage domestic abuse offenders, and consequently an offender of Peter's magnitude could be identified as 'medium risk,' and Kate as 'low risk'. In addition, police offender managers were rarely tasked to manage domestic abuse offenders. The police IMR identifies that although WMP's domestic abuse lead, a detective inspector, was to initiate training relating to domestic abuse offenders for offender managers in 2013, at the time the work started with Peter this was a relatively untested strategy. The IOM system is currently being redesigned to place risk from domestic abuse offending centrally in the matrix. This has support from the Senior Leadership Team and has a Superintendent as its lead. The DHR panel noted that progress on this work has been slow and would seek reassurance from West Midlands Police that this remains a priority in the management of domestic abuse offenders.

4.5.1.1 Key Learning points- police responses to domestic abuse

Police responses to domestic abuse – what can we learn?

1. **Police domestic abuse policy and Home Office Counting rules must be followed in the recording of incidents of domestic abuse and in the assessment of risk**
2. **That rigorous recording practices ensure accuracy of domestic abuse intelligence and identifies heightened domestic abuse risk**
3. **That close supervision of high risk domestic abuse investigations leads to better outcomes**
4. **That police should normally use their powers of arrest at domestic abuse incidents where a power exists. On the rare occasions where this is not done a rationale must be recorded.**
5. **Where police consider removing a perpetrator to another location as a risk reduction strategy, it should be subject to a robust risk assessment around the likelihood of renewed DA.**
6. **That police domestic abuse training should alert officers to the techniques used by repeat offenders to manipulate and influence professionals in order to isolate the victim**

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4.5.2 The role of Police and the Crown Prosecution Service in charging decisions and 'evidence-led prosecutions'

1. That police officers often judged allegations to be malicious led to substantial under-reporting of offences and a failure to record crimes in line with Home Office Counting rules. However a significant number of incidents did lead to crimes being recorded and arrests made. Investigators then had to deal with the tendency of Kate and Peter to refuse to proceed, or to retract allegations.
2. The gathering of best evidence therefore became crucial. However it is evident that sometimes Kate and Peter's known history and their apparent lack of credibility did not have a positive influence on the investigation. Given their status as high-risk MARAC victims and offenders from August 2011, the relatively few charges laid against both parties and the even smaller number of convictions is a concern.
3. CPS was asked by the review panel to comment on a range of issues. To assist them and with the agreement of West Midlands Police, they were given access to the police chronology. The review requested confirmation of the number of occasions police sought a decision in relation to charging Kate or Peter and incidents that may have merited a referral to CPS, where none appeared to have been made.
4. CPS guidance states that '*when police have reasonable suspicion that a suspect has committed an offence involving domestic violence, they must refer that case to a prosecutor, who will make a decision whether to charge. Prosecutors are therefore involved at an early stage in advising on a case of domestic violence*.' [11]
5. The Crown Prosecution Service however acknowledged in their report to the Review that police could make a decision about not proceeding in a domestic abuse case based upon a lack of evidence without reference to CPS (the evidential test) but not on public interest which would still need to go to them for a decision.

[11] CPS policy for prosecuting cases of domestic violence

6. Statistic available to the panel suggested a 60% reduction in the number of domestic abuse cases being referred to CPS for pre-charge advice since 2011. This appears to be a concerning development.

7. The review panel was informed by CPS in their response that their retention policy (for both paper and electronic documents) meant that they were unable to review most of the charging decisions. However they were aware that '*both parties have been arrested numerous times and not charged without any reference to CPS.'* CPS could not however comment on whether those decisions were made on evidential and/or public interest grounds, nor whether they were appropriate.

8. What is clear to the Review Panel is that either because of their record keeping or retention policy, CPS are unaware of several incidents where they were consulted and apparently recommended charge (for example, 07.02.12). There are also examples of charges being brought where it is not possible to tell whether they were authorised by CPS.

9. This appears to the Review Panel to be an unsatisfactory situation. If the application of the charging/reviewing policy is as inconsistent in relation to domestic abuse, as this case would tend to suggest, it is an area that needs to be addressed by both agencies.

10. Even in the face of a reluctant victim, or one who refuses to be involved, consideration should be given to pursuing a victimless prosecution. This would rely on officer observations, medical evidence and evidence from professionals, photographic evidence from the scene, tape recordings of the allegations made on 999 calls, witness evidence of neighbours, friends and family, hearsay evidence; things said by the victim or offender, and bad character evidence.

11. In many cases the police would argue, there was no evidence to gather. Kate would provide an entirely different account to responding officers to that given to call handlers, and would become abusive if officers continued to challenge her new version. It probably did not help that she was often drunk when police arrived and therefore no statement could be taken. In contrast, when Peter did make a complaint, his statement was detailed and provided a compelling account.

12. Retraction of an allegation of domestic abuse, post charge, has to be investigated to ensure that the decision is in the interests of the victim. A case is not dropped automatically. Police are asked to take a statement from the victim describing the reasons for requesting the case be dropped. CPS need to be sure that there is no coercion or fear, particularly if the information comes from the defendant. They will seek the views of police and in reaching a decision will want detailed background information. There may be sufficient evidence to proceed without the victim's testimony, or in some cases the victim could be summoned to give evidence, sometimes against their wishes.

13. For a case to proceed it must pass the evidential stage; there must be sufficient evidence to provide a realistic prospect of conviction against the defendant on each charge. That means that a magistrate or jury properly directed in accordance with the law is more likely than not to convict the defendant of the charge. If the case does not pass the evidential stage it does not go ahead, no matter how important or serious it may be.

14. Once this stage is passed prosecution will usually go ahead unless *'there are public interest factors tending against prosecution which clearly outweigh those tending in favour*.' CPS will take into account amongst other factors, the consequences for the victim or the victim's family, the seriousness of the offence, if the defendant used a weapon, the chances of the defendant offending again, the history of the relationship, particularly if there has been violence in the past, and the continuing threat to the health and safety of the victim.

15. There were several examples where victimless prosecutions were commenced in the face of Kate's or Peter's reluctance or refusal to co-operate. One related to the alleged stabbing of Peter on 08.12.12, another was the 02.02.12 assault upon Kate There were also numerous cases where CPS had to make a charging decision; the stabbing of Peter in December 2011, and also a series of offences for which Peter and Kate were on bail in May and June 2013.

16. An example of a successful victimless prosecution was the 02.02.12 head butting and assault of Kate outlined in detail within the summary

of facts. This victimless prosecution of Peter was being pursued at the same time that CPS was considering Peter's stabbing case. There were some distinct differences between the two incidents. Here, robust supervision within the PPU had corrected initial poor practice by officers and ensured that when Kate retracted her allegation, sufficient representations had been made to CPS for a victimless prosecution to continue. Significantly, in interview, Peter had admitted the head-butting. Furthermore, Peter committed repeated breaches of bail after the initial arrest, before he was finally remanded in custody and convicted on the 03.04.12. This behaviour probably served to stiffen CPS's resolve.

17. This decision can be contrasted with the stabbing of Peter in December 2012, a significant example of a potential opportunity for a victimless prosecution. The DHR panel has not had sight of the details of the criminal investigation. However it is reasonable to suggest, there would have been medical evidence relating to the injury and the likelihood of it being self-inflicted. There was the probability of some forensic evidence gathered from a crime scene. There was evidence of a previous incident during which Peter claimed to have had teeth knocked out.

18. Having claimed upon arrest that Peter had returned injured, Kate had contradicted herself in interview, claiming the injuries were self-inflicted. Most crucially, there was some independent evidence from a neighbour who had heard threats by Kate and had overheard Peter accusing her of stabbing him and pleading for her to stop.

19. Peter very quickly indicated he wanted the prosecution to end, withdrawing his statement and then providing the explanation that the injury was self-inflicted; an attempt to remove a tattoo of Kate's name. He claimed to an IDVA that the original statement had been taken whilst he was drunk and 'high' and police had coerced him into his accusation against Kate.

20. It is understandable that where a victim of crime is so vehement in expressing their view that the prosecution should end, CPS must be sure that it is in the public interest and that of the victim, to continue with the case. Police should have been able to present compelling

evidence that Peter needed to be protected from Kate All the known history demonstrated that despite the couple inflicting serious injuries upon each other, and the imposition of bail conditions, nothing kept Kate and Peter apart except custody.

21. The DHR panel has not had access to the full CPS decision and must rely on the police IMR and CPS report for a summary of the reasons for discontinuance.

22. The fact that Kate had been a high risk domestic violence victim at Peter's hands for so long was cited as a reason that the jury might speculate that Peter's allegation was revenge for the allegations made by Kate If Kate had been a committed witness in numerous attempted prosecutions this may have had some credibility. In truth she repeatedly refused to prosecute Peter and there was absolutely no evidence that this was revenge. In any event his insistence that the case be dropped completely undermined this argument. The only time Peter ever complained to police about Kate was the allegation related to being stabbed, which occurred on four occasions at least.

23. The fact that Kate had reported over 30 'various acts of violence' by Peter between June 2010 and October 2012 was cited by CPS as evidence that she was 'quite clearly considered by the police as a high risk victim of domestic abuse at all times.' There is no explanation of why this is relevant in judging the quality of evidence against her, particularly since she was not claiming self-defence.

24. CPS felt that the history of alleged self-harm might make the jury believe that the tattoo was cut out. The DHR panel are not aware if expert evidence was sought to consider whether the injuries were consistent with this. However it is telling that it was Kate who had defended herself against two previous stabbing charges by claiming they were self- inflicted. No independent witness corroborated this.

25. There was no recorded consideration of factors that would support prosecution; the neighbours had provided graphic accounts that appeared to be compelling. According to police Kate had altered her account; CPS claimed the defendant was consistent in her version throughout. The description of Peter's history of complaints was

inaccurate and summarised in one paragraph. It is hard to avoid the conclusion that CPS had little interest in sustaining the case.

26. The conference to review this decision was attended by the officer in the case, the advocate and reviewing lawyer. It is not possible to tell how much of the previous history of Kate and Peter was presented to CPS. It is the DHR panel's view that PPU should have prepared a comprehensive review of the history of Kate and Peter to support this case (and any subsequent allegation involving Kate and Peter.) A supervisor or manager should have been present from the police, given the high profile of the victim and suspected perpetrator.

27. Had this been done, the CPS may have become aware that only in November 2012, a professional at Aquarius had reported to MARAC having seen multiple injuries on Peter which had probably been inflicted by Kate. Somewhat prophetically, Peter had said that 'Kate needed help not prison' and that if he reported the injury Kate would say it was self-inflicted. Police would quite justifiably have been subject to criticism for not following up this information, as they could have investigated the potential offence with a view to additional charges being brought Kate

28. CPS in their report to the DHR panel pointed out that they have no record of any formal request by the police for review of any charging decisions made in relation to Kate and Peter (An officer of the rank of inspector or above may authorise such a request that would lead to a review by a 'lawyer manager.') It is the DHR panel's view that police believed Kate had stabbed Peter and could have done more to influence CPS' decision.

29. It was undeniable that Peter remained at risk from Kate and that she was also at risk from him. The only time that harm could be prevented for certain was when one or other of them was in custody. It is not possible to make a definitive judgement on this single incident, but it certainly appears to have been a significant missed opportunity.

30. There were periods of time during the domestic abuse history of Kate and Peter that the offending seemed to be constant. Bail conditions imposed upon both Kate and Peter appeared to be totally ineffective. (This aspect will be considered elsewhere) Police were anxious to

convict one or other of the parties, because only then did offending stop.

31. In May and June 2013 offending reached a new peak. Kate was on bail for two offences; Peter had been bailed on three separate occasions for a variety of assaults and other offences. The presentation of a compelling case to CPS became crucial.

32. On the 01.08.2013, a CPS Lawyer determined that there was insufficient evidence to justify charging Peter for the offences which occurred on 21 .05. 2013, (the allegation of assault in a row over a taxi called to deliver Kate's Lambrini, at which Peter made counter allegations), 29 .05. 2013(where Kate alleged Peter had gained entry by removing a window in the door, and had strangled her), 3 .06. 2013, (an assault by Peter) and 15 .06. 2013, (The assault upon Kate in a hotel).

33. The central argument for discontinuance was the complete lack of credibility of Kate as a witness, and the lack of sufficient evidence to continue without her testimony. It is clear from the CPS decision that Kate being on bail for offences which all related to wasting police time or obstructing police in relation to malicious allegations, would have made her a very unreliable witness. If the cases were to proceed as victimless prosecutions, there would need to be reliable third party evidence, or CCTV, to pass the evidential test. In a detailed summary of the cases, the CPS lawyer demonstrated that there was insufficient evidence in any of them. CPS were saying that as a witness, Kate 's credibility was so compromised that even if she was giving testimony, third party evidence would be crucial.

34. The police IMR reported that at a management level the CPS decision was accepted; 'the author has spoken to the MARAC chair, the PPU DI and she has confirmed that she read the CPS response and did not disagree with the conclusion. Therefore WMP accepted the CPS decision.'

35. A change in approach which emphasises evidence-led investigation of domestic abuse could significantly improve the chance of successful prosecution of domestic abuse offenders; an important element of the

safety plan of MARAC. It will require closer co-operation between police and CPS and a much closer involvement of CPS in directing evidence gathering.

36. The Crown Prosecution Service issued a consultation document in May 2014' The Prosecution of Domestic Violence[12]. It places a greater emphasis upon evidence-led prosecutions and starts with the premise; *'The starting point* should be to build cases in which the prosecution does not need to rely on the victim..... *all cases should always be based on and constructed using evidence, other than that of the victim.'*

37. The CPS believe that both prosecutors and police should actively use the joint ACPO and CPS Joint Evidence Checklist to ensure that the maximum amount of evidence is gathered. The list (attached as an appendix) would help to direct both frontline officers, domestic abuse teams and CPS. It is the view of the DHR panel that if the new policy statement is adopted it could improve the quality of investigations particularly in cases such as this one, where there was such reluctance to substantiate allegations.

38. Importantly the CPS would encourage an early consultation between police and CPS where is there insufficient evidence, to identify lines of enquiry using the checklist;*' Where the initial background information is inadequate, prosecutors should proactively request further information from the police. Early consultations with the police may take place in any case where the early involvement of a prosecutor would assist in the gathering of relevant evidence, the questions to be asked of suspects, any pre- charge court procedures and any strategy for a likely prosecution. A brief written record of the consultation should be made on the case file.'* It is the view of the DHR panel that if this policy is adopted it could improve the liaison between the new police DATs and frontline officers, leading to more successful domestic abuse prosecutions.

[12] Crown Prosecution Service: The Prosecution of Domestic Violence page 10,11

39. CPS will adopt flagging domestic abuse files as 'vulnerable/intimidated victim' on their Case Management System (CMS). They say that domestic abuse court files should have a different coloured jacket/sticker.

40. In answer to the DHR's question; '*In what way can CPS introduce into court the high-risk level that agencies had identified the two parties posed to each other? (an example would be the fact that one or both parties had been identified as high risk and discussed at fifteen MARAC meetings.)*' CPS in their report replied; ' *The CPS would not necessarily introduce the 'high risk' status at court… the high risk status determined by MARAC is unlikely in itself to be relevant to the Court's decision-making but the evidence of previous incidents informing this risk-rating would be relevant.'*

41. The review is aware that during MARAC awareness training Magistrates explained that they only find out about the MARAC risk assessments if the CPS Prosecutor puts it to them. It is apparently now local practice for CPS to mark the risk assessment in the inside covers of the file.

42. The Review panel can see no reason why it would be inappropriate to inform the court of the listing of the offender and victim at successive MARACs and strongly believe that this should be accompanied by a detailed chronology of past incidents and logs prepared by either DATs and or MARAC Co-ordinators. The panel would propose that this measure is formalised locally, given that it appears to compliment the direction being taken in the CPS consultation document.

43. The CPS' report demonstrated that their retention policy appears to leave them unable to tell whether they were involved in charging decisions or bail applications in cases. This does not seem to the review panel to be a satisfactory position, placing reliance upon police records. The panel would propose that this is subject to review by CPS particularly in the light of the growing number of DHRs where CPS will be asked for disclosure of their role

4.5.2.1 Key Learning points- role of police and CPS in DA Charging decisions.

Role of police and CPS in domestic abuse charging decision and victimless prosecutions- what can we learn?

1. **Police should treat every domestic abuse case as a 'victimless' prosecution, by adopting the evidence-led approach**
2. **Police should take every opportunity to seek pre-charge advice in domestic abuse cases and be mindful not to resort too quickly to the evidential insufficiency criteria for not referring to CPS**
3. **Police should ensure that their new Domestic Abuse Teams that are now responsible for all domestic abuse investigations develop a firm understanding with CPS how the pre-charge advice protocol is applied.**
4. **Reliable statistics on the number of cases recorded and the number referred for advice should be maintained by both agencies**
5. **The CPS retention policy prevents later scrutiny of charging decisions and should be reviewed**

44. It appeared increasingly the case that the only prosecutions where police had any prospect of success were those where there where witnesses against Kate in 'police' offences; for obstruction, wasting police time or breach of the peace. It is probably not a coincidence that there was only one further arrest of Peter for breach of the peace (which did not require Kate's evidence) before his death. This was after a supervisory intervention. Other similar incidents were handled by removing Peter to his brother's address, (a poor practice analysed above).

4.5.3 The final weeks and the last calls to Kate and Peter

45. On two occasions in the weeks before the homicide, the police were called to incidents that are significant because of what a male voice was heard to say. With hindsight they seem to assume even greater resonance; 'you stab me again and I'll kill you, you fucking stabbing bastard' (12.08.13) and, 'you stabbed me last week' (20.09.13) These were detailed in the summary of facts.

46. The police IMR concluded,' *The history of abuse including assaults with knives would have been known to officers and C&C staff if they had completed thorough or even cursory intelligence checks. It is the author's opinion that was it was far too convenient to accept Kate's account of unknown people fighting. A non-crime record should have been generated.*'

47. It is very unfortunate that supervisors within PPU or the MARAC, did not review these incidents and subject them to more detailed investigation. What police did not know, but could have been discovered with appropriate enquiries, was that Peter had presented at hospital with lacerations (05.09.13), a fortnight before the second declaration,' you stabbed me last week' was overheard, but not appropriately investigated.

48. At around the same date (18.09), police were told that housing had received reports some days before of large amounts of blood in a communal area used by Kate and Peter It is not clear which department received this information, but intelligence of this kind required to be shared with the PPU safeguarding team. If police had evaluated this combined intelligence, an approach to Peter (whilst away from Kate), could have been made, not because of a callout, but as good safeguarding practice. It is just possible that outside the usual context of police contact, (drunken, confrontational engagements) Peter could have been persuaded to disclose what had really happened.

49. On the 06.10.13, three weeks before his murder, when Kate called police, Peter was heard to say 'did you tell them you punched me three times last week?" It was Peter who was arrested for breach of the

peace, but there is no evidence to suggest he was asked about his allegation.

50. It does seem that warning signs of an impending tragedy were present in the weeks before the murder and with hindsight they assume greater significance. It does not appear they were considered at MARAC, and by the standards of the known history there had been a reduction in the severity of the offences alleged by Kate Whether this was a result of Kate's convictions for wasting police time and obstruction, cannot be answered.

4.6 What can we learn about the effectiveness of civil and criminal justice responses to domestic abuse in this case?

4.6.1 Bail

1. The use of bail was a constant feature in this case. With so many reported crimes, and with both Kate and Peter presenting as such unreliable witnesses, many enquiries required further investigation before a charge. There were some more serious incidents where, despite there still being evidence to gather, it was clear that bail was not suitable. The threshold test can be applied in these cases where there is insufficient evidence to apply the 'full code test- (sufficient evidence/ public interest) if there are reasonable grounds for believing better evidence will be available in a reasonable time, the seriousness of the circumstances justifies the immediate charging decision and there are continuing substantial grounds to object to bail.

2. The police IMR provided a useful description of bail;

3. *'Bail can be granted with or without conditions and those conditions might oblige the suspect to do or not do a specified thing. Examples of bail conditions might be to reside in a particular place, to attend a police station at a particular time, not make contact with a witness or not go to a particular place. Bail in England and Wales is legislated in a number of Acts and codes of practice but the most significant are The Bail Act 1976, Police & Criminal Evidence Act 1984 and Criminal*

Justice & Public Order Act 1994. Three distinct types of bail are of concern to this review. "Police to police" bail, "police to court" and "court to court".

4. *These terms relate to firstly, cases where a suspect is released by police to return to a police station, because an enquiry is incomplete. Secondly a person is charged with an offence and instructed to attend a court at a particular time and date. And thirdly, after a first or subsequent court appearance, a defendant is released by the court to return for a trial or hearing. If a person is arrested because they have been suspected of committing an offence they will be usually released on bail if there is insufficient evidence to charge them. If the investigation is incomplete the suspect can be obliged to return to custody. In addition if a custody sergeant believes that the suspect might fail to surrender, interfere with witnesses, obstruct the course of justice or for the suspects own protection; then bail can be imposed conditionally. However a person who fails to comply with a bail condition does not commit a specific offence. They can be arrested, for their original offence, and brought back into custody at which point the custody sergeant will need to decide whether there is sufficient evidence for CPS to be asked to authorise a charge for the original offence.*

5. *It might be appropriate in such circumstances for CPS to apply the "Threshold Test" rather than the "Full Code Test" when making a decision to charge. If a decision to charge is authorised the custody sergeant may well deny the suspect bail and place them before the next available court. If there is insufficient evidence to approach CPS then the person must be bailed again with the same or new bail conditions.*

6. *On occasion acts which lead to a breach of bail conditions might amount to a separate offence, for instance harassment; and in such cases there may be sufficient evidence to deal with the new offence even if the original offence investigation is still incomplete. However where this is not the case the inability to take decisive action in response to a breach of bail conditions often renders them effectively*

impotent and illustrates an apparent weakness with available bail legislation.

7. *Breaches of bail conditions will be recorded and would be considered by both a custody sergeant and court when determining whether a person should be bailed or remanded into custody in the future.*
8. *When a person has been charged with an offence and bailed to attend court, bail conditions are available and once again breaches of those conditions are not in themselves offences. But if a person fails to attend court, or if they had a reasonable cause failed to attend as soon after as practicable, they do commit a specific offence of absconding under s6 Bail Act 1976. In both the case of a breach of condition or failure to surrender the suspect will be likely to be refused bail and will be brought before magistrates as soon as practicable but in any case within 24 hours.*
9. *At court the magistrate may decide whether or not to remand the person into custody pending a trial or to release them with more bail conditions. Different considerations apply in the case of bail or remand into custody when imposed by a court. When a person appears in front of magistrates accused of an offence there is a presumption in law that he will be granted bail. This is enshrined in S4(1) Bail Act 1976 and Article 5 of the European Convention on Human Rights. However if bail is granted there is provision under the Bail (amendment) Act 1993 for a prosecutor to appeal the matter to a crown court judge. Schedule 1, part 1 to the Bail Act 1976 provides occasions when a court need not grant bail. Bail can be denied for a number of reasons that include "would commit an offence while on bail", "would interfere with witnesses or otherwise obstruct the course of justice..." Once again bail can be granted with bail conditions a breach of which would provide the court with evidence to support the assertion that bail should be denied.*
10. There are at least ten examples within the chronology of Peter breaching either police or court bail, between 2010 and October 2013, and several occasions where Kate breached bail. As has been described above, the breaches sometimes led to a review by the

custody sergeant as to whether there was now sufficient evidence and Peter could be charged; at which point the breaches would be notified to the court which could take a view that Peter should be kept in custody to prevent reoffending.

11. The MARAC held in January 2012 recognised in a specific action that any breaches of bail required to be dealt with whenever they occurred. Almost immediately their resolve was tested, when during a period from 07.02.12 to 16.02.12, Peter was arrested, charged and put before the court for a domestic assault, was allowed bail that he repeatedly breached. Initially an illustration of the judicial system failing to use its' powers to remand in custody, despite the breaches, by the third example, Peter was finally remanded in custody and eventually convicted of assaulting Kate.

12. Peter had been charged on the 07.02 with a domestic assault of Kate that caused injury and put before the court where police made representations to CPS for a remand in custody. The police IMR speculated on the decision to grant bail and concluded, '*The magistrate's decision may well have been influenced by the presence of Kate who had attended court when Peter's case was heard.'*

13. The summary of facts details the incidents in this period but in effect the court granted bail three times, before finally remanding Peter in custody, where he remained until convicted of the original offence.

14. There was a similar chain of events in June 2013, when Peter was arrested for breaching police bail on the 06.06, and released on bail again. He was arrested again for a breach on the 12.06 and released, and for a third time on the 17.06.

15. It is evident that whether police or court imposed bail, it proved ineffective in keeping Kate and Peter apart. If the person benefiting from the protection of a bail condition is complicit in undermining it, as was often the case with Kate then its effectiveness is diminished. Kate's lack of support for the prosecutions was also probably influencing decisions in relation to bail and whether to act upon known breaches of bail. However CPS guidance is clear in these circumstances; '*There are all kinds of reasons why victims sometimes*

do this, but if the defendant responds in such a way as to continue the contact, then the defendant is breaching bail conditions because the police or the court have not released the defendant from the conditions of bail they imposed. It does not matter that the victim has agreed to or initiated the contact; the victim is not subject to the bail conditions, the defendant is. The defendant is responsible for complying with any conditions imposed by the police or the court until released from those conditions by the police or court.'

16. Reviewing the effectiveness of bail in this case led the DHR panel to conclude that the only guarantee against renewed incidents and violence was when one or other of Peter or Kate was in custody. It is evident that high -risk domestic abuse offenders need to be managed closely by police so that even where an incident is investigated by frontline officers, they have at their disposal a prepared and comprehensive history, which provides support for an application to refuse bail.

17. The DHR panel acknowledged that WMP has put in place structural changes within PPU; The Domestic Abuse Teams (DAT) will be responsible for investigating all domestic abuse incidents regardless of crime type or risk grading. Within the DAT there will be an Investigation Team (DAIT) and a Domestic Abuse Protection Team (DAPT). It is hoped that this will lead to a more robust management of bail in domestic abuse cases and more importantly professionalise the quality of police objections to bail presented to CPS.

4.6.1.1 Key Learning points- the use of bail in domestic abuse cases

The use of bail in domestic abuse cases- what can we learn?

1. **Where a victim encourages a breach of bail, the defendant remains in breach and enforcement should still be robust.**
2. **With serial domestic abusers, a very detailed report of previous breaches should be made available to CPS.**
3. **Enforcement of breaches of bail have to be consistent**
4. **Where an offender is persistently breaching bail, investigators should not miss any opportunity to charge offences committed on bail such as harassment**

4.6.2 Restraining orders

1. The two MARAC chairs acknowledged in their discussion with the police IMR author that they did not recollect consideration being given to the use of restraining orders during the period that Kate and Peter were subject to MARAC. The DHR panel have only found one line in MARAC minutes, suggesting that the officer in the case, responsible for investigating the assaults of the 29.05.13 and 03.06.13, was to seek to apply for a restraining order if Peter was charged. (This was not shown as a formal action.) In the event, CPS concluded that there was insufficient evidence in both cases and therefore the opportunity did not arise.
2. It could be argued this was 'too little, too late'. The opportunity to apply for a restraining order was open to police from the first time that a case involving Peter (or indeed Kate) went to court. There were numerous missed opportunities to apply for such an order. This represented a serious omission in the safety plan at MARAC and a missed opportunity to control the repeat offending. Restraining orders are a routine and useful measure in protecting victims of domestic abuse and every effort should have been made by police and IDVAs to persuade Kate to seek one. In their limited contacts with Kate IDVAs would have suggested applying for restraining orders; however Kate refused to engage with them on numerous occasions where an order may have offered protection. This should have been flagged up at MARAC.
3. It also does not appear that the council legal department considered restraining orders in their legal opinion, delivered the day after the emergency MARAC of the 17.06.14.
4. From very early on in the domestic abuse history of Kate and Peter it was evident that they needed to be kept apart. A significant proportion of Kate's calls were to have Peter removed, or to report him trying to gain entry. Kate often alleged that he was either being violent, or putting her in fear of violence. The CPS report to the DHR panel confirms the view held by the DHR panel that no request to make an order was made.

5. Restraining orders originate from section 5 of the Protection from Harassment Act 1997, as amended by Section 12, Domestic Violence Crime and Victims Act 2004 (DVCVA) which was enacted in 2009. Whereas previously the order could be applied for when convicting someone of harassment, the amendment allowed an application to made after a conviction or acquittal for any criminal offence. The guiding principle is that there must be a need for the order to protect a person or persons. A restraining order is therefore preventative, not punitive.

6. Restraining orders can only be made in respect of the defendant (not the victim or any witness), even if evidence in the course of a trial indicates that the behaviour of both the defendant and the victim requires addressing. The order can be for a specified period, or until further order.

7. A breach of the order would be punishable on summary conviction with imprisonment for a term not exceeding six months, or a fine or both, and on indictment, by imprisonment for a term not exceeding five years, or a fine, or both.

8. The test applied by the court is whether it is necessary to protect the person named in it from harassment or the fear of violence. The court looks at the surrounding history and antecedents in making that decision. Given the history of violence, and the frequency with which Kate called police because of harassment or assaults, or threats of harm by Peter it would not have been difficult to obtain an order in this case.

9. They are also applicable upon acquittal to deal with those cases where there is clear evidence that the victim needs protection, but there is insufficient evidence to convict on the particular charges before the court.

10. The views of the victim have to be sought, and CPS will check to see that they have been obtained before applying at court. Whilst Kate may have agreed to an order in the immediate aftermath of an incident, experience suggest she may well have objected to it later. However it is

a decision for the court, so if police and CPS had provided compelling evidence of Kate's high risk, the repeat nature of Peter's offending, and the number of calls made to police when Kate was being subjected to a fear of violence, it is quite possible that the court may have been minded to place a restraining order upon Peter The order being a civil remedy, the court can consider and take into account, previous convictions, hearsay evidence, domestic violence incidents logs, crime reports or statements and intelligence logs.

11. *The CPS guidance[13] explains; 'In some cases a victim may not want a restraining order to be imposed on a defendant: for example, when the victim wishes to continue a relationship with the defendant). In such instances the prosecution should not object to the victims' wishes but inform the court, as ultimately it will be a matter for the court… A situation may also arise where the victim opposes the making of a restraining order, for example where she/he did not support the original prosecution… The final decision to make a restraining order is one for the court, having heard representations from the defence and the prosecution.'*

12. If an order had been granted, which for example prohibited Peter from going to Kate's home, approaching her or contacting her in anyway (routine provisions in non-molestation orders and restraining orders) and she had subsequently asked to have it discharged, she would have needed to convince the court that she was no longer at risk and provide some evidence to support the contention.

4.6.3 Domestic Violence Protection Orders

18. In addition, Domestic Violence Protection Orders (DVPOs) are now available. The DHR panel believes that had they been in operation during the period under review, they would have represented a significant enhancement to the safety of both parties. There are

[13] Restraining orders: Legal Guidance: Crown Prosecution Service

countless occasions where, after an incident, no charges were brought and neither was on bail, but the risk remained real.

19. The DVPO may be served by police on alleged perpetrators of domestic violence, potentially on their release from police custody following an arrest for a domestic violence related incident. The DVPNs are used in circumstances where the police deem that there are no enforceable restrictions that can be placed upon the perpetrator – i.e. where no further action (NFA) will be taken or where the perpetrator receives a caution/reprimand or is bailed without conditions.

20. DVPNs are authorised by a police superintendent in situations where the police have reasonable grounds to believe that the victim-survivor remains at risk.

4.6.4 Community orders

1. There were several occasions where the court imposed community orders that were supposed to address Peter or Kate's offending behaviour through tackling underlying problems. However for differing reasons they were not subject to close enough supervision, and circumstances intervened such as re-offending or prison sentences, which appeared to 'wipe the slate' clean for Brian , (who had in May 2010 been sentenced to both an ATR and IDAP.)

2. Integrated Domestic Abuse Programme (IDAP) was an internationally-accredited, community based group-work programme designed to reduce re-offending by male domestic abuse offenders and run by the Probation Service before its recent replacement by the National Probation Service. It is unfortunate that Peter was never required to complete IDAP; this was a missed opportunity. The re-offending rates of those successfully completing IDAP in the West Midlands was 3% in 2010-11 and the lowest reoffending rates in the West Midlands were in

Wolverhampton (2.4%).[14] The IDAP programme is now closed and no replacement has yet been identified since the re-organisation of Probation

3. The alcohol treatment requirement (ATR) is one of a range of community sentences available to the courts. It is applied to offenders who present serious problems with alcohol and where the alcohol is identified as a significant factor in the person's offending. Once the courts impose an ATR order, the person will have a tailored care-plan, which will involve a range of agencies working together to support the person to reduce their offending and address their alcohol misuse.

4. When Peter had his IDAP and ATR removed, in August 2010, it was replaced with a Low Intensity Alcohol Programme. LIAP is a programme for people with a drinking problem, which may be affecting many areas of their life, not just offending. The programme is for people who drink to excess, but not those who are dependent on alcohol. It is clear to the DHR panel that Peter was alcohol dependent by 2010. It could be argued that this decision was misguided, and that ATR remained the best hope of tackling Peter's problem.

That the ATR could have had a significant impact upon Kate and Peter is clear. The Emergency MARAC Meeting of June 2013, had made it a target to apply for an ATR for Kate upon conviction. This makes the failure by the National Probation Service to make an application, despite having been given supporting evidence by the MARAC a significant missed opportunity.

[14] IDAP completions and reoffending rates (2011/12):An analysis from West Midlands Probation Delivery Units

4.6.4.1 Key Learning points- orders available to the courts

The orders available to the courts - what can we learn?

1. **That when orders are imposed, closer supervision is required to ensure that they are complied with.**
2. **If orders are not completed, probation should seek enforcement**
3. **That orders need to be appropriate to the needs of the person on whom they are imposed**
    a. Ensure that the presence of offender managers at future MARACs leads to SMART offender management actions
4. **That a greater awareness of ATRs is needed at MARAC and in PPU domestic abuse teams where alcohol abuse is a factor in domestic abuse**
5. **That DVPOs will be crucial in separating parties in domestic abuse for a period, allowing IDVAs the opportunity to support victims**

4.7 What can we learn about the response of Health care to domestic abuse?

4.7.1 A&Es and General Practitioners responses to Domestic Abuse

1. Kate and Peter were patients of five different GPs surgeries during the period the subject of the review, and from July 2011 until the homicide, both attended the same three GPs practices. They also presented numerous times with ailments and injuries at two local A&E departments. A tally of simply the entries listed in the chronology relating to health, reveals that over the period under review, Kate and Peter had at least 260 separate contacts with health services either in person, on the phone or by letter.
2. It is reasonable to assume that in these circumstances, Kate and Peter's GPs would have a clear understanding of the complex health needs of both Kate and Peter and would have formed a view on such issues as their alcohol abuse, their mental health, and the frequency and severity of domestic abuse from presentations at the surgeries.
3. If the police service had the most direct engagement with Kate and Peter and had the clearest opportunities to divert, disrupt or manage their offending behaviour and domestic abuse, the health service saw the most significant signs of the consequential harm from domestic abuse, alcohol abuse and mental vulnerability. Primary health services, A&E and GPs saw multiple presentations with injuries by both parties, which were sometimes life- threatening. Some were claimed to be accidental as a result of alcohol abuse, but amongst those, there were injuries allegedly inflicted by Kate and Peter upon each other. With hindsight, it seems clear that even some of the alleged accidental injuries may well also have been inflicted.
4. The A&E department in WV saw presentations of injuries that were known to be domestic abuse related, but this information would not always be explicit in the notification sent to GPs. Some potential domestic assaults were not recognised as such.

5. Kate and Peter were patients at the same surgeries, and they changed practices four times during the period under review. Particularly in relation to safeguarding from domestic abuse, this posed problems when the GPs had as patients both the abuser and the abused and their needs conflicted. It was even more challenging when those patients were in turn both abuser and the abused.

6. The A&E department had a system to notify presentations at the hospital to the patient's GP. According to the IMR relating to the A&E, between January 2010 and September 2013, Kate presented sixteen times to WV A&E, and Peter twelve times (This does not include several presentations each to Bristol and Walsall A&Es). In line with nationally recognised best practice, from September 2012, WV A&E had a full time IDVA to set up referral pathways, evaluate risk and raise awareness.

7. This DHR has concluded that Kate and Peter were at high risk of serious harm or murder from very early on in their relationship. The formal recognition of this was late, in the view of the DHR panel, since no MARAC was held until August 2011. The critical importance therefore of primary and secondary care's role in establishing domestic abuse care pathways for victims, is well illustrated by this case, since GPs and A&Es were coming into contact with patients, in Peter and Kate who were already experiencing serious harm from June 2010.

8. It is a concern to the DHR panel that the A&E IMR when asked about MARAC, should include the assertion,' *During the time in question the organisation would not have been aware of the presentations to MARAC of this family. The Trust would respond to invitation to attend a MARAC meeting should it's contribution be required.*'

9. It is the DHR panel's view that the presence of the A&E IDVA at MARAC could have significantly impacted upon the understanding of Peter and Kate's domestic abuse history and could have ensured that both GPs and the Mental Health services had a clearer understanding of the concerns raised at MARAC.

10. Since the DHR panel sat, improvements have been made to MARAC (which now meets weekly) and the A&E IDVA sits on the MARAC. This is welcome and effective change.

4.7.2 Domestic abuse: the balance between confidentiality and the duty to disclose, and its' relevance for this case.

1. In considering the professional responses of individual frontline health practitioners to disclosures of domestic abuse, or apparent or suspected signs of abuse, (which it may have been reasonable to expect practitioners to question), it is important to understand the range the advice offered to those practitioners, and establish how helpful it is in practice. The DHR will identify influence of the ethical considerations around disclosure of information upon decisions taken.

2. The Royal College of General Practitioners (RCGP) issued a policy statement in 1998[15], to guide GPs in sensitive questioning of patients and recognising symptoms, which might indicate that they are more likely to be suffering domestic abuse. In common with many such policy documents, it provided a wealth of statistics from the numerous studies which demonstrate the prevalence of some form of domestic abuse in the lives of many women and explained, *'the term domestic violence is used to describe the physical, emotional and mental abuse of women by male partners or ex-partners.*' It could be argued that in 2014, a more nuanced policy statement should be available to GPs, with some recognition that whilst the majority of victims are women, men can also suffer domestic abuse.

3. Subsequently, the RCGP issued guidance with CAADA[16] and with a general practice-based domestic violence training, support and referral

[15] Domestic violence: the general practitioner's role Dr Iona Heath MRCP FRCGP

[16] Commissioning Guidance The IRIS solution-responding to domestic violence and abuse in general practice (2011)

programme for primary care staff; Identification & Referral to Improve Safety (IRIS)[17]

4. The mission statement of IRIS is *'targeted intervention for female patients aged 16 and above experiencing current or former domestic violence and abuse from a partner, ex-partner or adult family member.' It offered 'signposting for male victims and perpetrators*.' In relation to current information provided by the RCGP to primary care staff, the DHR panel would suggest that it does not greatly assist in raising awareness of male victims of domestic violence and abuse. The more recent CAADA document; 'Responding to domestic abuse: Guidance for general practices' is at least gender neutral.
5. The earliest RCGP guidance did encourage GPs to 'consider the possibility' of domestic abuse with a range of well-established risk indicators and encouraged them to 'ask the question'. Viewed against the known risk indicators it seems to the DHR panel clear that GPs should have been 'asking the question' of Kate and Peter.
6. The CAADA guidance to GPs added to the risk indicator list, suggesting GPs should look out for unexplained symptoms/ non-specific symptoms, chronic pain, tiredness, depression, self-harm, genital injuries, delay in injury presentation, frequent attendance at A&E/GP.
7. If the GPs who were in contact with Kate and Peter were to safeguard them effectively, they needed to recognise the risk factors that had been outlined by their professional body. Once some of these factors had been identified they needed to be ready to 'ask the questions' necessary to find out a true picture of the level of violence that the victim was experiencing.
8. The domestic violence guidance from the RCGP described how an assessment of the level of risk should then lead to information to the victim about support and ways of getting away from the abusive relationship. It required the GPs to devise a safety plan. This included

[17] Responding to domestic abuse: Guidance for general practices CAADA/RCGP/IRIS

being able to furnish contacts for women's aid, police, social services and housing.

9. However it also offered the advice;' *No patient should ever be pressurized into following any particular course of action. Only the patient can decide what is right for her in her particular situation. Her individual autonomy, self-esteem and self-determination should be encouraged and respected. Even if the patient decides to return to the violent situation, she is not likely to forget the information and care given and, in time, this may help her to break out of the cycle of abuse.'* It was clear that a patient who might be returning to a violent situation and was potentially at risk of immediate harm, should be allowed to choose that risk without the doctor intervening.

10. The expectation upon GPs was that where domestic abuse was suspected, sensitive and extended discussion would take place and a detailed picture of the risk factors would be established.

11. The CAADA guidance for GPs, issued in 2012 is clear that following a disclosure, if the patient (and any children) are in immediate danger the practitioner should make a call to police and start adult/child safeguarding procedures.

12. This leaves the GP with a series of difficult decisions, since they are aware that information must only be shared with the patient's consent subject to adult safeguarding policy. However the guidance refers to immediate danger.

13. The Department of health issued Practical Guidance called 'Striking the Balance' [18] intended to assist those involved in information sharing between agencies about domestic violence to make decisions. It identifies the underlying ethical considerations so that tension between confidentiality and information sharing may be resolved.

[18] "Striking the Balance" Practical Guidance on the application of Caldicott Guardian Principles to Domestic Violence and MARACS. Christopher Finken. Dept of Health(2011)

14. In relation to sharing information with MARAC, the guidance starts from the 'ground rule', '*all information shared about both victims and perpetrators must be in the context of the normal requirements of information sharing without consent, in this case on the basis of prevention and detection of crime or serious harm*.'

15. The guidance cites the example of attendances at A&E as a result of assaults, as normally disclosed but contrasts this with injuries resulting from falling down stairs whilst under the influence, which might not be disclosed. The DHR panel would contend that where there is evidence (as in the case of Kate and Peter) that suspected domestic assaults were covered up with accidental explanations (for example 09.01.12), then an allegedly accidental injury should be disclosed to allow MARAC to evaluate the risk.

16. In assessing the risk of harm it is probable that '*immediate danger 'should be construed to be physical, sexual abuse or neglect.'*

17. The guidance goes on to suggest '*the severity of harm may be categorised in retrospect but organisations should seek to prevent harm proactively. In terms of proportionality, the more serious the harm the greater the imperative to prevent it and the greater the justification for sharing information without consent.*'

18. Medical professionals can disclose confidential information if they are required to do so by law, or if it is in the public interest; to protect individuals or society from the risk of serious harm such as serious crime. (Clearly physical assaults and sexual abuse would fall within this category.)

19. The General Medical Council guidance[19] states; ' *Personal information may, therefore be disclosed in the public interest, without patients' consent, and in exceptional circumstances where patients have withheld consent, if the benefits to an individual or to society of the disclosure outweigh both the public and the patient's interest in keeping*

[19] Confidentiality guidance : the public interest paragraph 36-39

the information confidential. You must weigh the harms that are likely to arise from non-disclosure of information against the possible harm to both the patient, and to the overall trust between doctors and patients, arising from the release of that information.'

20. The GMC guidance states that once it is established that it is necessary to disclose identifiable information the patient's consent should be sought unless **1/** patient is not competent **2/**you have reason to believe that seeking consent would put you or others at risk of serious harm **3/** seeking consent would be likely to undermine the purpose of the disclosure, for example, by prejudicing the prevention or detection of serious crime.

21. The guidance is clear that patients should be informed of the disclosure even if consent has not been sought…unless it is impractical to do so, or would put the practitioner at risk of serious harm or would prejudice the purpose of the disclosure.

22. The DHR has argued that from 2010 onwards, until the homicide in the October 2013, both Kate and Peter could have been recognised as being at high risk of serious harm, and that risk never diminished. This is evidenced by the repeated MARACs that were held from 2011 onwards. The DHR has concluded that even when Kate or Peter were removed from the MARAC, they remained at high risk because no identifiable protective factors existed which diminished that risk.

23. It would therefore be reasonable to expect that the GPs records would indicate, at the very least, that practitioners were aware that Kate and Peter were being managed at MARAC. If engagement with alcohol services and community mental health was considered for both Kate and Peter to be a crucial step to recovery and reduction of domestic abuse and violence, then this strategy required frequent information sharing between the participating agencies, police safeguarding officers and GPs on the basis that the risk of serious harm was high. Yet there is almost no mention of routine MARAC contact with either Kate or Peter's GPs, throughout the period under review.

24. It seems to the DHR panel noteworthy that the GP's IMR also, makes very little reference to MARAC. Only in June 2013, when the

emergency MARAC/Professionals meeting was held, did the MARAC conclude Kate and Peter's current GP should be asked to attend. In the event the GP was only able to offer a report. This was during a period of intense activity involving the GP and Kate and it related to a crucial issue; detoxification and the prescription of Librium. Kate would only engage if she were given the drugs she wanted, without the assessment. This appears to have been a missed opportunity to co-ordinate the response to Kate's alcohol abuse. If the challenges of detoxification had been discussed and the GP had had a clearer understanding of the efforts of Aquarius to date, progress may have been made.

25. In cases that have reached MARAC, it is the DHR panel's view that the MARAC Co-ordinator should be seeking disclosure of relevant information from GPs in every case. There should be communication of the safety plan to the GP, so that the work of primary care is informed by understanding of the complex needs of the patient. There are numerous examples of interactions between GPs and Kate and Peter which would have perhaps led to information sharing with MARAC, had the GPs appreciated the full extent of the domestic abuse or simply that they were listed at MARAC.

4.7.3 The pre-MARAC opportunities for health professionals to identify domestic abuse (2010 to August 2011)

1. In the period from 2010 until August 2011, Kate and Peter were not yet subject to MARAC. Notwithstanding this, the risks and their vulnerabilities were apparently known to primary and secondary care.

2. In 2010, Peter's surgery (surgery 1) had evidence of his serious alcohol abuse, leading to hospitalisation, after an overdose in February 2010. His GP tried to persuade him to engage with Aquarius, but did not apparently seek help for his self- confessed anger management issues. Peter's mental health assessment in March was after an arrest for domestic abuse of Kate and although delayed, was shared with the GP by April.

3. In June 2010, Peter was stabbed in the abdomen by Kate and spent 18 days in a Bristol hospital. On two different occasions after discharge he saw first a GP and a nurse, at a surgery (surgery 2) in his sister's home-town in Wales. The GP's records make no mention of whether questions were asked of Peter to establish whether this was the consequence of domestic abuse.

4. On the 24.06.12, the same surgery treated Peter for an injury caused by being struck on the kneecap with a golf club. No questions were asked to establish the cause. (However Peter 's sister, in conversation with the author, cited as an example of Kate's volatility, a domestic incident near her home where Kate struck Peter with a golf club.)

5. It is the Panel's view that the professional practice of the surgery 2 in Wales showed a poor appreciation of the risk of domestic abuse and a lack of appropriate professional curiosity.

6. In October 2010, Peter returned to his surgery 1 and saw his GP where he discussed being stabbed by his 'ex'. He was given a four-week sick note and advised to return in a week. When he did not, his notes were marked up as having 'moved out of the area'. This does appear to be another example of a GP being aware of Peter 's significant vulnerabilities (alcohol abuse, mental health, domestic abuse as both offender, and victim of a serious domestic abuse-related crime) yet not considering safeguarding steps when the patient DNA ed.

7. It is the view of the panel that both the surgery 1 and surgery 2, appeared to fail to recognise their safeguarding role, faced with the clear signs of Peter's significant vulnerability. (Surgery 1 apparently had no vulnerable adult policy in place at the time, but has since brought one into use.) Whether assumptions were made, that referrals and support had already been offered, or whether the practitioners were insufficiently alert to the needs of a male victim, cannot be established.

8. Police investigated the significant head injury suffered by Kate in February 2011, but ultimately there was insufficient evidence to charge any of the suspects. (The gravity of the after effects of the head injury led to concerted attempts by Kate's GP at surgery 3, to work with

community mental health services to assess her mental capacity and mental health during April 2011.)

9. In any event it seems inappropriate that such a serious injury was not identified to primary care as potentially a domestic assault in the discharge summary, all the more so since in an occupational therapy appointment in August 2011, Kate claimed it was as a result of an assault by Peter It is clearly important that GPs are aware of significant information concerning domestic abuse risk. (It is of course possible that Kate did ascribe the injury to DV but it was not recorded on her notes, which would in itself be poor practice.)

10. On the 03.07.11, Peter presented at A&E with a laceration and soft tissue damage to the shoulder. The notes in the A&E IMR suggest that Peter claimed it was as a result of a stabbing four days before, although he did not allege Kate was responsible.

11. The GMC issued guidance in relation to suspected gunshot wounds and knife injuries[20] The guidance instructs practitioners,' *You should inform the police quickly whenever a person arrives with a gunshot wound or an injury from an attack with a knife, blade or other sharp instrument. This will enable the police to make an assessment of risk to the patient and others.. .*'

12. The guidance goes on to offer advice in relation to knife injuries, '*The police should also be informed when a person arrives at a hospital with a wound from an attack with a knife, blade or other sharp instrument. The police should not usually be informed if a knife or blade injury is accidental, or a result of self-harm. If you are in doubt about the cause of the injury, you should if possible consult an experienced colleague.* '

13. There is no evidence that this was reported to police or that it was notified to a GP's surgery. Peter had been in custody from March until May and it is possible that he was not registered. However this was the

[20] Confidentiality: reporting gunshot and knife wounds GMC

first of several occasions, where Peter presented at hospital without police being present, with knife wounds or lacerations.

14. This period was one of high risk for both Kate and Peter with frequent contacts with health professionals. It would appear that none considered the need to 'ask the questions' of their patients, offer domestic abuse advice or a safety plan, or seek information sharing from colleagues or other professionals.

4.7.4 MARAC (August 2011 to October 2013): its' impact on information sharing with health professionals

15. In July 2011, Kate and Peter had registered with surgery 4, and by August 2011, Kate had instructed the surgery not to disclose her records to police.

16. The work undertaken around Kate's mental health was relevant information and should have been considered at the first MARAC in August 2011, but because no attempt was made to contact the GPs from either surgery 3 or 4, information that should have informed the safety plan did not feature. (Surgery 4 could not have the same appreciation of Kate's vulnerabilities as the GP at surgery 3, since Kate's notes did not arrive until 30.08.11.) Even this early in the MARAC process there is evidence of relevant information known to GPs but not sought by MARAC.

17. When on the 01.09.11, Peter came to surgery 4 to apologise for Kate 's failure to attend an appointment with a head injury that he said was inflicted by Kate the only record of the incident was made on Kate's notes even though Peter was also a patient at the surgery. The DHR panel has noted the view of the GP IMR author on this omission and it does appear to the DHR panel that Peter was too frequently overlooked as a potential victim. The GP could have found out about the 18-day hospital admission, following a suspected stabbing by Kate by looking at Peter's old records.

18. The offending behaviour between Kate and Peter continued through October to December 2011, and they were listed on the agenda at a

further two MARACs. A new crisis was reached on the 09.12.11, with a further alleged stabbing of Peter by Kate He was discharged from hospital the same day, but it appeared no discharge notes were sent to surgery 4, so they were unaware of the injury and the continuing domestic abuse. Had they known of the December 2011 and the January 2012 MARACs, they may have been more anxious about Kate's presentation at A&E after an alleged fall down stairs. This information was known to health but not to police or the MARAC

19. When police approached surgery 4 in February 2012 asking for information saying they feared *'one or other will end up dead'*, it was not a throw away remark, but was a statement of the level of high risk. That the receptionist noted this in Kate's records, would suggest it was perceived as serious. Here was an example of high risk involving both Kate but also Peter. For the first time the surgery found out Peter had been stabbed by Kate There is no information to suggest a corresponding note was placed on Peter's files, even though he was the victim of a stabbing. The fact that it was now Kate listed at MARAC should not have altered the presentation of the facts to the GP; that both were at equal risk.

20. Whilst the surgery had been told by Kate not to disclose details of her medical information to the police, it is clear that there was public interest in disclosing details without her consent to assist in the detection and prevention of crime and to protect both her and Peter from serious harm. This was borne out by the fact they had already been at MARAC three times.

21. It is the DHR panel's view that writing to Kate ten days later, asking for consent to disclose, and failing to follow up after her lack of response, was poor safeguarding practice. This did not correspond to the degree of urgency that a high risk MARAC case should engender. It is an indication of what appeared to be a lack of understanding of their safeguarding role on the part of the GPs. The GP was aware of Kate's stated view on disclosure to police. However Police were acting in the role of MARAC Co-ordinators (not as part of the criminal justice process) and another reason why a non-police coordinator is essential.

22. Surgery 4 became aware of another injury assault on Kate on the 05.04 and on the 10.04 had an extensive consultation with her around issues including the assault, her flat fire and Peter being in custody. (in fact Peter had been released three days before) On the 18.04 the surgery was informed of a presentation by Peter at A&E with a head injury.

23. The first recorded police contact with surgery 3 was July 2012, which was the next time Kate's record was updated. However from February 2012, there was a constant stream of serious incident between Kate and Peter. The Police IMR suggested that in May police mistakenly believed Kate had left surgery 4 and not re-registered. This error was something that could easily have been corrected with appropriate checks. (At some stage police did become aware that surgery 4 was Kate's doctor, because they emailed the surgery in July.) In June, Peter made a counter allegation to a claim of assault by Kate of having had boiling water thrown over him by Kate her, which led to her arrest and to him being classified a high risk victim.

24. Four MARACs were held, however surgery 4 apparently had almost no contact from the MARAC, and apparently no safety plan was communicated to them. Given that surgery 4 was providing GP services for both Peter and Kate this seems a serious shortcoming.

25. The lack of communication led to a further significant missed opportunity on the 19.07.12. Peter presented at A&E with an incised injury to his forearm. He had already presented at the A&E twice before with stab wounds, therefore it does not seem unreasonable to expect A & E to have questioned whether this was an inflicted injury. The injuries were described as '*Lacerations to right arm requiring stitching. Both wounds described as gaping one described as deep'* Given that the Peter claimed to have fallen onto broken glass whilst gardening, but he did not present at hospital until midnight, should have aroused suspicions. That this did not apparently happen would suggest that the A&E had failed to comply with GMC Guidance on gunshot and knife wounds.

26. A notification was sent to surgery 4. Given that the surgery had been notified of at least one previous stabbing of Peter and knew of the

domestic history, it is disappointing that they did not exhibit more professional curiosity and contact Peter to discuss the injury. This injury was not apparently notified to the police, even though they were in contact with the surgery just a week later in relation to domestic abuse.

27. Police contacted the GP by email to request that Peter be referred to Aquarius. In a consultation with Peter the notes of which are described in the GP IMR as 'very brief', Peter claimed to be already sorting Aquarius and claimed to have 'got rid of his girlfriend' so had no domestic issues. This is one of several occasions where GPs were quick to accept claims that Kate and Peter had broken up, or stopped drinking. If the level of contact between the GP and MARAC had been greater, the GPs would soon have had a clear picture of the continuing and undiminished risk.

28. Peter and Kate left surgery 4, and registered with surgery 5 on the 20.08.12. This coincided with the brief period during which the DHR panel has identified some level of shared commitment by Kate and Peter to break their dependency on alcohol. During his first visit to the GP, Peter described his anger management issues and alcohol problems but claimed that both he and Kate were engaged with alcohol services. As a result of the discussion with the GP, Peter was described as a victim of domestic abuse; this was the only time his medical records described him as such.

29. It is worth noting that Peter and Kate's medical notes were received at the surgery on the same day as Peter's consultation. For the transfer of the notes to take only 10 days is good practice; this meant the surgery had access to the full history of Kate and Peter.

30. Despite this promising start, in December 2012 there was a further example of health services and police failing to ensure that the correct information was known to primary and secondary care, and police.

31. On the 08.12.12 Peter himself called police to allege he had been stabbed by Kate and some days before, had had teeth knocked out by Kate with an axe. He was taken to A&E where the wounds were sufficiently serious to require surgery. The surgery was informed that the injury was a result of an assault the next day but not who was

responsible. Given that they received a request from a prison for Kate's medical records, it is not unreasonable to expect that when he came to see a nurse to have the stitches removed some days later, the practice would have attempted to discuss domestic abuse with him.

32. Peter presented at A & E twice more with serious wounds before the homicide in October 2013.

33. On the 16.08 Peter presented with incisions to the shin caused apparently whilst cutting grass with a scythe. Whilst this was an explanation which seemed credible, and not an injury site which was highly suggestive of inflicted injury, the next presentation was.

34. On the 05.09.13 he presented with wounds described as *'Deep Laceration to middle aspect of left shoulder, 2 lacerations to left arm. Deep laceration to right upper arm. Wounds described as clean lacerations which may have been ca. all wounds required stitching'* The hospital recorded this as the result of a fall onto a boulder whilst out walking. Even a cursory review of Peter's admission history should have raised concerns. Given that the lacerations were deep, requiring stitching, they clearly fell within the category that would require notification to police if it were suspected they were inflicted. The A & E IMR makes it clear the doctor did not think the explanation was consistent, but there is no evidence the case was escalated or referred to police. The discharge letter to the GP made no mention of how the injury was caused.

35. When the letter was received at the GPs it was added to Peter's notes without being placed in the context of Peter and Kate's violent and ongoing domestic abuse.

36. Coming only a month before Peter's homicide, this episode appears to represent a significant missed opportunity to intervene. Peter had presented at the same A & E with lacerations or stab wounds six times since 2011. It is a great concern that an adult presenting at A&E with what potentially were inflicted injuries, does not apparently receive a level of safeguarding scrutiny which would lead to a referral to police or other protective agencies. It demonstrates that even with a specialist IDVA in A&E, there remains significant education for frontline staff in

A&Es and in primary care around domestic abuse, and the need to 'ask the questions'. The GMC guidance on knife wounds/lacerations had again not been followed. This was not an isolated presentation, and there was enough known history for this incident to have raised deep concern.

37. Had the police been informed, they would have been obliged to speak to Peter to establish if any offence had occurred. Whilst it is may not be unreasonable to conclude that Peter was extremely unlikely to accuse Kate of causing the injury, however it should be remembered that on the 20.09.13, Peter was overhead by a police controller to say to Kate 'you stabbed me last week.' Although fifteen days after the original injury it is not beyond the bounds of possibility that Peter was thinking of the injuries of the 05.09.

38.. It seems to the panel highly improbable that the injuries could have been caused in the way Peter described. Serious consideration should have been given to the possibility that he was the victim of domestic abuse. It is a great concern that neither A&E nor the GP surgery, where Peter and Kate's domestic history was well known, apparently considered informing police in line with the General Medical Council Guidance (2009).

39. The relatively frequent change of surgeries over the years of domestic abuse by both Kate and Peter meant that no GP had a long-term understanding of the history of Kate and Peter However there appeared to be a failure to 'ask the questions' around the stab wounds in Peter's case by both A&E and GPs, even though they had been given clear indications that domestic abuse was the most serious risk factor. Given the presence of so many other relevant risk factor; depression, mental health concerns, alcohol abuse, frequent DNAs, it is hard to avoid the judgment that GPs and A&Es are not sufficiently involved in the safeguarding responsibilities arising from domestic abuse.

40. The GP's IMR noted that, '*There is no specific mention in the notes about services being offered to Kate or Peter with regards to support for domestic violence, either as victims or perpetrators. There are several good assessments where stress and relationship problems are*

discussed though, and counselling was offered on many occasions to Kate and Peter (and usually declined).'

41. The Guidance for General Practices issued in 2012 described the need to establish a domestic abuse care pathway. It advised that a designated person be identified; either a specialist domestic abuse practitioner or an internal practice nurse or other health professional who could conduct an initial assessment with a patient and share information where appropriate and provide pathways to other services such as counselling.

42. Identification and Referral to Improve Safety (IRIS) is at the forefront of provision of domestic abuse training and IRIS advocate educators in doctor's surgeries and are being widely adopted across adjacent local authorities. It seems to the DHR panel that had such a professional been available, then the practices would have been able to ensure that the help they offered Kate and Peter complemented the work of other agencies and MARAC.

43. The use of regular practice meetings in surgeries, (good practice which is adopted by some of the surgeries in this case), where the GPs and all other staff can discuss problem cases, would allow receptionist and nurses to share signs of abuse they may have witnessed with the rest of the practice.

44. It appears to the DHR author that one of the consequences of the absence of a full time dedicated coordinator for MARAC was that there was simply not enough contact made with each of the surgeries with which Kate and Peter registered. That the chronology of this case should have so little evidence of contact between GPs and MARAC is a significant concern. The DHR panel has demonstrated that disclosure concerns, that might have inhibited the flow of information from health to the MARAC, were based on questionable ethical judgment around the balance between confidentiality and public interest. In 'Striking the Balance', the Department of Health reminded practitioners' *'It cannot be "ethically" justified if we hold information that we know could prevent serious harm to others and yet knowingly decide not to share it."*

45. There should be no corresponding inhibitions for the MARAC. It is clearly vital that a GP who is likely to encounter a patient who is a high-risk victim (or indeed perpetrator) is aware in the interest of safeguarding, of the current risk and safety plan. Both surgery 4 and 5 knew that Kate and Peter had featured at MARACs. Although there was little feedback from MARAC, it is quite possible that the GPs surgeries would have felt that they could not offer anything not already provided by MARAC. That said, surgery 5 knew of the emergency MARAC, which was of itself evidence that the process was 'stuck'.

46. Since the DHR panel sat, changes to MARAC attendance have been made, and the A&E IDVA now attends all MARACs. This has served to improve the information sharing process with GPs and the IDVA is able to educate colleagues about appropriate information sharing and disclosure into MARAC. The DHR panel notes that this has served to improve the MARAC's links with Health services making the MARAC CAADA/Safe Lives compliant in relation to health representation.

4.7.4.1 Key Learning points- A&E and GP's responses to domestic abuse

Accident & Emergency and General Practitioners' responses to domestic abuse- what can we learn?

1. **Hospital notification to GPs of presentations at A & E must include details of suspected domestic abuse.**
2. **Discharge notes do not always reach a GP, undermining patient safety**
3. **GPs must not assume domestic abuse support is already in place, or a referral has already been made.**
4. **GPs must be more willing to 'ask the questions' where domestic abuse is disclosed or suspected and identify a safety plan**
5. **GPs and staff need to demonstrate greater professional curiosity**
6. **GPs surgeries should identify a domestic abuse specialist within the practice to provide domestic abuse screening and referral, support and advice that follows the CAADA model.**
7. **Practice meetings are a vital forum for identifying the risk to patients from domestic abuse**
8. **There is a need for greater awareness of MARAC and domestic violence amongst healthcare professionals.**
9. **There is a need for healthcare professionals to have a clearer understanding of their ability to disclose information to MARAC**
10. **The A&E IDVA provision is helpful but may not have the capacity to provide the level of coverage required**
11. **A system is needed to identify when a high risk MARAC victim presents at A&E and share that information where appropriate.**
12. **A&E staff need to be reminded of the GMC knife wounds policy**
13. **A&E staff must be prepared to challenge when a patient is suspected to be suffering domestic abuse.**

4.8 What can we learn about the response of primary care, mental health services and substance misuse services to the presence of alcohol abuse and mental health concerns?

4.8.1 The nature of Peter and Kate's mental health and alcohol abuse and available referral pathways.

1. The history of Peter and Kate would indicate that for different reasons, in the years before they first met, they both turned to alcohol to combat depression and anxiety.

2. The widespread acceptance within society of self-medication with alcohol in response to anxiety masks the potential for serious long-term harm, as this coping mechanism becomes self-perpetuating. As alcohol use increases, so neurological changes occur which alter the physiology of the brain, depleting the neurotransmitters it needs to reduce anxiety naturally.

3. Mental health concerns related to depression, anxiety disorders, alleged self-harm and suicidal ideation and concerns around personality disorder/ behavioural disorder, which may have been present before problematic alcohol misuse, are all recognised to be worsened by alcohol addiction. Some new mental health concerns may develop as a result. It is widely accepted that some mental health conditions can lead to alcohol or substance abuse, but conversely, that severe substance abuse or alcohol abuse can lead to significant mental health conditions.

4. By the time Kate and Peter met, they shared these complex interrelated health concerns. Foremost appeared to be alcohol dependency and the related physical illnesses caused by it. In addition physical harm, whether accidental or inflicted was an ever present factor.

5. The presence of both conditions is commonly referred to as the 'dual diagnosis'. It has gained prominence in recent decades because of the increasing prevalence of alcohol and substance misuse.

6. A Social Care Institute for Excellence (SCIE) study in 2009[21] described this relationship in the following terms; *'Research shows that substance use, intoxication, harmful use, withdrawal and dependence may lead to or exacerbate psychiatric or psychological symptoms or syndromes. Conversely, psychological morbidity and psychiatric disorder may lead to substance use, harmful use and dependence (addiction). The most common associations for substance misuse are with depression, anxiety and schizophrenia….memory disorders also occur. Alcohol problems, for example, are often seen with bipolar disorders, schizophrenia, and personality disorders…'*

7. The SCIE study described dual diagnosis as, *'In general, four inter-relationships in dual diagnosis are recognised:*

8. *(i)A primary psychiatric illness may precipitate or lead to substance use, misuse, harmful use, and dependent use, which may also be associated with physical illness and affect social ability.(ii)Substance use, misuse, harmful use and dependent use may exacerbate a mental health problem and physical health problem, e.g. painful conditions, and any associated social functioning. (iii) Substance use e.g. intoxication, misuse, harmful use and dependent use may lead to psychological symptomatology not amounting to a diagnosis, and to social problems. (iv)Substance use, misuse, harmful use and dependent use may lead to psychiatric illnesses, physical illness, and social dysfunction.*

9. For many years mental health services and addiction services were aware of the challenge of a dual diagnosis of mental health concerns and substance abuse. In the face of the potentially huge numbers who

[21] SCIE Research Briefing 30 (2009) The relationship between dual diagnosis; substance misuse and dealing with mental health issues. Illana Crome and Pat Chambers with Roger Bloor, Martin Frisher and Diane Roberts

could fall within the 'SCIE' definition, the government tightened the definition.

10. In 2002, the Department of Health Good Practice Guidance on Dual Diagnosis recognised the need to focus on bringing the care of people with **severe** mental health problems and problematic substance use into the mainstream, through mental health services taking the primary responsibility for their treatment.

11. This was in conjunction with The Care Programme Approach (CPA) (Department of Health 2001) the framework which all services, including drug and alcohol providers, are advised to use for people with severe mental health and substance misuse problems. It provided pathways into secondary mental health services based upon two levels of need; enhanced – for those with severe mental illness with a high level of risk to themselves or others. Standard – the care of those who have lower level mental health problems or needs is coordinated by the primary care team.

12. The limiting definitions of the mental illness and alcohol dependence could mean that individuals are excluded from services. This seems to be true of Peter and Kate who were never recognised as having 'the dual diagnosis'. Although they clearly were both alcohol dependent, the absence of any formal recognition that they had a diagnosable mental health condition, and the fact that they were both judged to have capacity, meant that the orthodoxy was that their mental health presentation was a symptom of alcohol abuse rather than a cause.

13. Consequently there was little evidence of joined-up working by alcohol services and mental health services. This appeared to lead to a disproportionate responsibility being placed by partners upon NACRO/Aquarius. Time after time at MARAC, Aquarius was asked to try and engage with Kate and Peter.

14. For Kate and Peter to gain access to the most appropriate services, a co-ordinated approach was required from substance misuse and addiction services and mental health services. However it is difficult to discern any sense from the GP's notes that mental health and alcohol

abuse were considered in a holistic way or that clear pathways existed between services.

15. The Royal College of Psychiatrists and Royal College of General Practitioners issued guidelines[22] on the competencies of doctors in relation to the psychiatric effects of alcohol abuse stressing the need for a 'whole systems' approach;

16. *'Current thinking on recovery emphasises that freedom from dependence is closely associated not only with better mental and physical health, but also with a range of other positive outcomes such as gaining employment, living in suitable accommodation, a reduction in criminal activity, an improvement in relationships and a fuller participation in the community. Recovery-oriented services therefore need to attend to each individual's needs in all areas of their life, in a coordinated way, adopting a 'whole systems' approach.'*

17. Successive GPs tried to address Kate and Peter's complex needs when they presented with similar conditions; depression and anxiety, suicidal tendencies, possible self-harm, and alcohol abuse. They only ever achieved low levels of engagement with either mental health service, and substance misuse partly because of Kate and Peter's consistent resistance to accepting the services offered.

18. Another factor appeared to be a tendency to address the problems in sequence rather than in tandem, because mental health services assessments did not accept that Kate or Peter had mental health conditions requiring treatment, despite the enduring nature of both Kate's and Peter's reported depression and anxiety, and apparent behavioural disorders and potential personality disorder. Consequently few if any pathways existed from alcohol abuse services to mental health and vice versa.

[22] CR173 Royal College of Psychiatrists and the Royal College of General Practitioners. Delivering Quality Care for drug and alcohol abusers and the roles and competencies of Doctors. A guide for commissioners, providers and clinicians (Sept 2012)

4.8.2 What can we learn about how GPs identified pathways to services that would assist Peter and Kate's recovery?

1. Peter was assessed in hospital following his overdose in February 2010, At this stage it was clear that mental health services considered any signs of mental health concerns to be alcohol induced. The hospital referred Peter back to the GP for anger management and alcohol services. (The BCPFT IMR explained that whilst there are clear referral pathways to alcohol services for patients with mental health concerns, there is no referral pathway to alcohol services where no mental illness is diagnosed.)
2. Peter was also subject to mental health assessments whilst in custody in March 2010 and August 2012. On both occasions the AMHP felt there was no mental health concerns requiring a referral to the CMHT. However both assessments referred Peter back to his own GP for re-referral to services for either anger management or depression. On both assessments Peter was recognised as requiring alcohol services, which was also referred back to the GP. Certainly in relation to depression (and probably anger management) it seems that there should be a referral pathway that does not require further intervention of the GP.
3. The summary of facts described the efforts made by Kate's GP in April 2011, to obtain a mental health assessment of Kate following what seemed to be an ill-advised refusal of treatment following her serious head injury in February 2011. It must also be acknowledged that a significant inhibiting factor in diagnosing the cause of Kate's behaviour was Kate refusal to engage with services on anything but her own terms.
4. The difficulties experienced by the GP were around the need to conduct a mental capacity assessment before any mental health assessment could take place. The practitioners needed to be sure there was no impairment or disturbance of the mind (either temporary or permanent) which would prevent Kate being able to communicate her decision to them, or understand the information about the treatment required and

why, or retain that information. Finally she needed to be able to employ that information to make an effective decision. Kate was apparently sober and lucid. The conclusion of the capacity assessment was that she did have capacity. Her decisions around refusing medical treatment may have been ill advised, but she was entitled to make them.

5. The mental health assessment would take place either with consent, or would require a court order. Kate's ability to talk lucidly and clearly to the AMHP on the phone over the following two days convinced mental health services that there was insufficient evidence of mental illness to apply to a court for an order to enter her home to carry out an assessment, nor was there evidence justifying compulsory hospitalisation for treatment.

6. In January 2012, Kate's consultant physician referred her to the Community Mental Health Team (CMHT). He described there being no mental health history but described the February 2011 incident as being a potential cause of her aggression to her partner. Despite numerous letters and appointments, she DNAed repeatedly. The BCPFT IMR recorded that following information from the GP, the CMHT contacted PPU and were told ' *Kate is indeed well known to the police as having an Acquired Brain Injury and Alcohol related issues, mood swings and could be extremely violent'*. Kate however refused to engage and was discharged from the service in July.

7. The service suggested to the GP that if concerns persisted, a mental health assessment should be considered. It is clear to the DHR panel that Kate would have resisted any mental health assessment. Brian (Kate's ex-husband) told the DHR chair that Kate had told him she would not be assessed because she feared being 'sectioned' under the Mental Health Act.

8. Given that the CMHT were reporting a complete lack of engagement by Kate the DHR panel is left with the sense that mental health services were failing their colleagues in primary care. The service had been told that Kate was dangerous and was exhibiting mood swings and symptoms possibly caused by her head injury.

9. It does not seem unreasonable to assume that within the service there should be an escalation policy for such cases, which had been referred from a consultant neurologist in secondary care. That it should fall to the GP to reassess the complex needs of Kate and 'start again' seems inappropriate.

10. Between May 2012 and January 2013, Kate encouraged by surgery 4, also had some contact with Healthy Minds, a psychological therapies service for people who are experiencing common mental health problems such as depression, anxiety and stress. The wellbeing service is a nurse-led service for people with more complex mental health problems. However the engagement was peripheral and was also characterised by DNAs. (The BCPFT IMR does not indicate that the CMHT were aware of Kate being in contact with Healthy Minds; which appears to be an example of provision that was not co-ordinated.)

11. The GP was left trying to steer a path through a case that required a careful assessment of facts known to the police and MARAC and the partners such as Aquarius. It is evident from the chronology in this case, that Kate's aggression and violence predated any head injury suffered by Kate

12. If the GP, the physician, mental health services, Aquarius and MARAC had shared what was known, a more holistic approach may have resulted, which could have identified whole systems approach and strategy.

13. Indeed if Kate had remained under the care of one surgery, a consistent strategy may have emerged, but this was not the case. In April 2011, it was a GP from surgery 3 who tried to establish whether Kate was in need of mental health services with visits and attendances with AMHPs. In 2012 it was surgery 4 that initiated contact for Kate with Healthy Minds and the CMHT but it was surgery 5 which received the discharge letter from Healthy Minds.

19. It does seem evident that in the absence of the severe mental health diagnosis that the GPs hoped for, the pathway to recovery was unlikely to come from mental health services.

20. Since the DHR panel sat, mental health services through the Black Country Partnership Foundation Trust (BCPFT) have identified a consistent representative to MARAC. This would serve to identify appropriate pathways for high-risk domestic abuse cases where mental health concerns were present.

4.8.3 Substance misuse services

1. The critical pathway into either alcohol misuse services or mental health services is diagnosis and assessment. The GP was the appropriate health professional to conduct initial screening using audit tools such as the Fast Alcohol Screening Test (FAST). However this required honesty from Kate and Peter There were numerous examples in the chronology of Kate and Peter playing down their alcohol consumption. However by September 2012, Peter was acknowledging he drank 7-8 litres of cider a day. In June 2013 Kate stated that she was drinking 7-8 litres of Lambrini daily. Kate's GPs were seeing physical symptoms such as gastro intestinal and liver conditions, which were evidence of alcohol abuse.

2. Kate and Peter's GPs therefore followed a second strand to that of mental health; alcohol abuse. They were only marginally more successful in achieving engagement with alcohol services, than they were with mental health services. (In Kate's case it was probably because she could not get access to the detoxification drug, Librium without showing some slight willingness to engage with services.)

3. Mental health services and alcohol services have evolved in isolation; referrals are often made to one or other with little evidence of the interrelated problems being shared between services. However it is important that GPs recognise when an existing problem requires assessment that is beyond their level of skill. Dealing with complex alcohol dependency is one such area.

4. The National Institute for Clinical Excellence (NICE) published guidelines in 2011 that was to help in the diagnosis and assessment of harmful drinking and alcohol dependence.[23] The guidelines described the effect of alcohol abuse; the description has particular resonance in the case of Kate (and to an extent Peter); *'Comorbid mental health disorders commonly include depression, anxiety disorders and drug misuse, some of which may remit with abstinence from alcohol but others may persist and need specific treatment.'*
5. For the GPs attempting to find a pathway through the comorbid presentation of alcohol abuse and mental health conditions, the NICE guideline offer the following advice; *'For people who misuse alcohol and have comorbid depression or anxiety disorders, treat the alcohol misuse first as this may lead to significant improvement in the depression and anxiety. If depression or anxiety continues after 3 to 4 weeks of abstinence from alcohol, assess the depression or anxiety and consider referral and treatment in line with the relevant NICE guideline for the particular disorder.'*
6. The guidelines go on to recommend that someone with alcohol abuse and 'significant comorbid mental disorder' be referred to a psychiatrist.
7. This recovery approach acknowledges that GPs have sufficient training in dealing with the mental health problems attendant upon alcohol abuse and can advise patients on the range of options open to them, but where they are severe and complex advised;
8. *'All doctors can identify individuals using drugs and alcohol, and can diagnose substance use disorders, but intermediate and specialist doctors can advise on referral pathways. Specialists are needed to advice on which diagnostic tools are to be deployed and how they should be interpreted to set recovery goals. Addiction psychiatrists have the most comprehensive range of competencies regarding*

[23] National Institute for Clinical Excellence (NICE) (clinical guideline 115) Feb 2011 Alcohol –use disorder: diagnosis and assessment and management of harmful drinking and alcohol dependence

substance use disorders including complex prescribing regimens, co-existing mental illness and criminal matters.'

9. When the guidance offered by the RCP and RCGP is applied to the case of Kate it does seem that her needs were both 'severe and complex and would have required the expertise of addiction psychiatry;

10. *'It is not easy to give a definition of what constitutes 'severe' or 'complex', ... A person's level or complexity of need is likely to be greater if they are having difficulty engaging consistently with services or following their chosen recovery care plan, are exhibiting challenging behaviour, or are facing other relevant social and psychological issues such as a lack of emotional stability and support, homelessness … presence or suspicion of a mental illness, behavioural or personality disorder, pregnancy, significant level of risk to self or others significant forensic history complex issues relating to children or family/carers.'*

11. It seems to the DHR panel that the attempts by both MARAC and Kate's GP to persuade (or in the case of the ATR, compel Kate) to detoxify were perhaps the only way that it could be established whether the mental health symptoms which the GPs clearly believed existed, were a symptom of, or cause of Kate's alcohol abuse and this was a treatment plan which if successful may have seen mental health symptoms diminish.

12. There was a period in July 2013 that surgery 5 was dealing with Kate and there ought to have been a degree of clarity about which of her complex needs should be addressed. The BCPFT IMR summarised the mental health assessment of Kate conducted whilst in custody*; 'The Assessment concluded that Kate did not present with any low mood or depression and Kate is noted to give a good account of herself and her situation. There was no reason to detain her or instigate the services of the Crisis Home Treatment Team however it was noted to the Police that another Mental Health Assessment could be requested if further concerns arose. A copy of a letter to Kat 's GP advises the outcome of the assessment concluding that from a Mental Health perspective Kate is not detainable however it also refers to a request being sent to the*

GP to arrange Neurological support as Kate's memory is reported to be affected due to a previous acquired head injury. '

13. There is no evidence from the GP's IMR that the letter concerning the assessment was entered onto Kate's records. In fact two days later, a GP at the walk-in centre of surgery 5 recorded the view that Kate had some issues denies any psychological history but apparently looks like psychiatrically some issues"

14. The period in June and July 2013, where surgery 5 had significant contact with Kate as she was constantly attempting to obtain Librium, is documented in detail in the summary of facts. Having been prescribed the drug in June, after excerpting considerable pressure on the GP, Kate attempted to obtain a repeat prescription in July 2013. The GP dealing with her then was clear, that prescription of Librium required engagement with alcohol services and proper assessment. When the doctor contacted them, she discovered that Kate was known to the service through referrals from police. It is unfortunate that when the GP promised the alcohol team would contact Kate they apparently did not and the GP had to chase them up. They also apparently did not return her call either.

15. For perhaps the first time, the efforts of alcohol services and the GP were co-ordinated. The GP had access to test results, which described abnormal liver function, making the prescription of Librium inappropriate in any case. Aquarius made it clear to Kate that any medication prescribed had to be following an assessment and an assisted withdrawal plan. Faced with this, Kate refused to engage with Aquarius and would not cooperate when challenged about the decision by the GP. When she suffered vomiting and diarhorrea, the result of alcohol dependency, she was admitted to hospital to detox for one day, where rather ironically, she was given the Librium that neither the GP nor Aquarius had felt happy to prescribe. She did not respond to the follow up appointments sent from the GP and had no further contact with the surgery concerning alcohol abuse before she changed surgeries in October 2013.

16. It is unfortunate that when the case reached this impasse, neither the GPs surgery nor alcohol services attempted to refer Kate to an addiction psychiatrist to understand her complex needs. Faced with Kate's constant abuse, surgery 5 had every intention of removing her from their list and perhaps felt that they had done everything they could. That said, there is little evidence that Kate's aggressive and abusive demeanour prevented the GP engaging with Kate in fact she demonstrated great professional commitment. It is the DHR author's view however that without understanding Kate's mental state as a result of her addiction, it was very unlikely that any progress would be made. It is possible that the use of an addiction psychiatrist would have brought a new perspective to the treatment of Kate.

4.8.4 The impact of Kate's Feb. 2011 head injury upon behaviour and memory

1. Even if no diagnosable mental health issues were present, and professionals believed any mental health issues or behavioural issues were caused by alcohol abuse, consideration has to be given to the significant head injury suffered by Kate in Feb 2011. Kate repeatedly claimed memory loss was a consequence of her injury and professionals reported behavioural changes were a possible result of the injury.

2. The Professor of neurosurgery treating Kate wrote a report in response to a request from the DHR panel for information on the likely impact of such an injury. He described the possible short term effects of a serious brain injury upon Kate 's functioning*; "there is little doubt that the initial CT scan showed a life-threatening acute subdural haematoma and these are frequently relieved with a degree of subfrontal and subtemporal damage which can effect cognition, memory and importantly behaviour, particularly judgement, mood and abstract thought.' He concluded that people suffering a head injury such as Kate's frequently suffer some frontal problems,' such as attention deficit…social awareness. They may be quick to anger, and may have*

difficulties with balancing behavioural issues and maintaining insight into their difficulties.'

3. The police IMR described the frequent occasions that Kate had claimed memory loss to allow her to refute her original allegation against Peter It pointed to an occasion in April 2012 where investigators of an allegation against Peter had contacted Kate's physician and been informed that the head injury of February 2011 would probably not cause memory loss. Yet in a submission to CPS in relation to charging decisions in June 2013, a DC stated that there was medical confirmation of memory loss. This DHR has suggested that whilst the head injury may have been a contributory factor to Kate's demeanour, history before the injury would suggest that her behaviour was already frequently volatile and violent.

4.8.4.1 Key learning points- the response of primary care, mental health services and substance misuse services to the presence of alcohol abuse and mental health concerns

The response of primary care, mental health services and substance misuse services to the presence of alcohol abuse and mental health concerns -what can we learn?

1. **That the problems of Kate and Peter were beyond the scope of either service in isolation and that a whole system approach looking at both complex issues in tandem, would have been more effective.**

2. **That patients fitting the widest definition of dual diagnosis, should have clearer pathways to mental health services for support and treatment.**

3. **Referral pathways between services should not necessitate referral back to the originating GP.**

4. **That when a client is subject to MARAC, substance misuse services such as Aquarius /NACRO need to be able to escalate a case when services are repeatedly refused.**

5. **All practitioners need an understanding of the impact of alcohol abuse upon mental health.**

6. **That GPs and alcohol services should consider addiction psychiatry in complex and severe cases and know how to recognise when this level of expertise is required.**

7. **That a failure to engage and frequent DNAs, should be a trigger for heightened concern and not a cue to close a case.**

5. Conclusions and recommendations

5.1 Conclusions

1. Peter and Kate's long history of domestic abuse linked to alcohol misuse was an extreme, but in no way unique, example of the challenges faced by agencies responsible for safeguarding those individuals and the wider community. The case illustrates the difficult balance between support for vulnerable adults, and the use of prosecutions and measures available within the criminal or public justice system, to provide protection even where the persons being protected are opposed.
2. Adults cannot be made to make sensible life choices; they can choose destructive relationships and can place themselves at risk. Yet when they commit offences against one another and cause each other injury, the law can intervene, and society accepts that the decision to intervene is not the victim's alone, but is one that involves the public interest.
3. The personalities and life experiences of Kate and Peter and their alcohol dependency made for a very dangerous relationship; an inter-dependence that they could not and seemingly did not want to break. Kate constantly called upon services; police, health for help, but when it arrived she rebuffed it, or refused to co-operate and abuse was commonplace. There were many professionals who persisted regardless, meeting insults with renewed offers of help. Clearly some professionals concluded their efforts were pointless and the quality of their interventions mirrors this. As some agencies remarked, Kate would only engage on her terms.
4. The DHR has illustrated the almost complete unwillingness of Peter and Kate to engage with the support services, which could have helped them to break their alcohol addictions and then address their domestic abuse. The DHR panel agreed with the often-expressed view that alcohol was at the root of their problems. It is not a cause of domestic abuse, but in some people, it causes aggression, and a loss of self -

control and this was very much the case with both Kate and Peter It was the question of how to address their complex needs which was never answered.

5. By the time Kate and Peter first reached MARAC, their high-risk domestic abuse was already well established and had already gone too long unchallenged. MARAC should have been able define a safety plan with clear accountable actions. Yet significant systemic weaknesses existed within the MARAC that undermined the efforts of the participants and manager to safety plan. The MARAC was police-led and there is little evidence that partners felt able to challenge or address those systemic failings. There was a lack of awareness amongst agencies of what a properly functioning MARAC should look like and some assumed that MARAC was a separate entity able to safety plan on its' own. That apparently no one challenged the fifteen appearances at MARAC (including the PPU responsible for its' management) until June 2013, is evidence of a lack of an escalation policy and management oversight at a sufficiently senior level.
6. Key professionals such as GPs were not brought into in the safety planning for their patients, Kate and Peter even though both were at high risk. Accident and Emergency relied upon their staff and IDVA to identify domestic abuse, but had no communication with MARAC even though Peter and Kate made repeated presentation with domestic abuse injuries.
7. There was little evidence that MARAC significantly influenced the response of frontline officers to Kate and Peter although they were all too familiar to the response teams, called out countless times to their addresses. DASH risk assessments often did not reflect the known risk, due to systemic weaknesses and a lack of access to intelligence that should have been available, and could have been made available using existing systems.
8. Although the LPU management and PPU recognised the risk of this high-risk couple, they worked in parallel rather than in partnership, with few signs that everyone was working to an agreed strategy, communicated effectively. When supervisors intervened some good

outcomes followed, but there is little evidence that the strategy involved the robust supervision of fresh incidents, new crime reports and on-going cases. Police and partners did not sufficiently offender manage Kate and Peter failing to recognise that as Potentially Dangerous Persons they could have been subject to closer supervision with better management oversight.

9. That CPS decisions around important charging decisions were never subject to challenge or review is indicative of a lack of confidence in the hope for a positive outcome. A sense of collective resignation which could be seen in MARAC minutes, in the notes written by PPU staff, manifested itself in the response to calls, and the failure to see warning signs in the last few weeks, which even without hindsight should have caused alarm.
10. The refusal of Kate and Peter to co-operate, their retraction of allegations, their collusion to cover up each other's offending, made them the most unreliable of witnesses. It seems unlikely that Kate and Peter were unaware of how easily they could influence criminal outcomes. The police and CPS commitment to victimless prosecutions was put to the test in this case, and in large part found wanting. It is hard to avoid the conclusion that some investigators anticipated the likely outcome and this impacted upon the crucial evidence gathering stage.
11. When Kate and Peter were before courts, the frequency with which they were bailed despite a history of breaches was a concern. However the apparent lack of clarity demonstrated by CPS concerning introducing bad character and the history of MARAC involvement, into court, may have been a factor. If custody was the only way to secure the safety of Kate and Peter then investigators should have been provided with robust supporting evidence of risk, collated and overseen by a manager.
12. The service that could have addressed Peter's and Kate's alcohol abuse was repeatedly tasked by MARAC to try and engage with them. Despite resolute and persistent efforts they achieved little success. With one notable exception, it appeared that Kate and Peter never

wanted to change at the same time; a unilateral decision to change by one or the other was doomed to failure. NACRO now recognise that an escalation policy was required, so that a manager could review what had been done and propose alternatives.

13. Mental health assessments failed to identify mental health conditions in both Kate and Peter yet no one coming into contact with them could fail to see mental health concerns. Pathways between mental health, adult care, or alcohol services, were ill defined or not established. Successive GPs were left to try and find their way through the services available, where a whole systems approach, could have perhaps pointed to addiction psychiatry as an appropriate response.
14. A tragic outcome in this case was entirely predictable, indeed was recorded as a possibility by professionals in February 2012. That both Peter and Kate were at risk for such a sustained period, mitigated only by periods of detention, is a shocking truth.
15. The DHR panel were told ‘everything that could be done, was done’ and there is no doubt that many professionals worked tirelessly and diligently to try and break the cycle of domestic abuse or to effect change in Peter and Kate’s lives. However it seems that they were repeating responses that had not worked, with little sign of innovation or management oversight within agencies or at MARAC. Without a change of strategy the homicide was not preventable.
16. The actions to improve practice and strategic and agency recommendations, we believe, could change the awareness of professionals in domestic abuses services but also alcohol misuse and mental health services as well as in police and the criminal justice system.
17. Complex high-risk cases, with reciprocal violence and hard to engage subjects, require partnership working in its’ fullest sense, with shared understanding of a safety plan and desired outcomes. All agencies need to recognise their part in identifying domestic abuse and intervening early in the lives of families affected by it.
18. Wolverhampton Domestic Violence Forum responded to learning from DHR1, by consulting with both adult and child safeguarding and partner

agencies to agree an over-arching Domestic Violence Protocol and Guidance, [24] which will shortly be adopted across the city. It will empower practitioners to be able to respond appropriately when domestic violence is disclosed, promoting the use of a common risk assessment tool for domestic violence. Information sharing in high -risk cases and clear referral pathways to MARAC are key elements in the protocol. It is the view of the DHR panel that both the strategic recommendations of this DHR and also the single agency actions identified will complement the protocol and improve the safety planning for victims in the future.

[24] Wolverhampton Over-arching Domestic Violence Protocol and Guidance November 2013

5.2 Strategic recommendations

- Recommendation 1: Addressing the shortcomings of MARAC
- **That an independent review of the Wolverhampton MARAC is undertaken after systemic, organisational and staffing issues have been addressed, to ensure compliance with best practice.**
- **Actions**
  - Escalation policies for both the MARAC and the agencies contributing to it when interventions or safety plans are judged ineffective.
  - Appropriately funded MARAC coordinator
  - Actions to be linked to risk, with agencies to be more accountable for completion of actions and escalation of the case where appropriate
  - Link MARAC protocol with escalation policy
  - Ensure that the presence of offender managers at future MARACs leads to SMART offender management actions
  - Identify a lead practitioner in complex repeat cases
  - Ensure MARAC minutes are CAADA compliant and that they are available to agencies involved in the safety plan.
  - Ensure that in cases with reciprocal violence a different IDVA is available for each party
  - Monitor attendance of agencies with recommendations regarding representation at MARAC
  - Promote use of DASH by all agencies with training where necessary
  - A learning event to be delivered to all attendees at MARAC, coordinator, IDVAs, Support workers and WMP domestic abuse and safeguarding teams, specialist DV teams and agency frontline practitioners across all agencies represented on safeguarding Boards
  - Repeat the CAADA self-assessment to ensure that all outstanding areas for development have been addressed.

- Recommendation 2: IDVAs link worker role for complex DA cases
- **Wolverhampton CSP to highlight the need for sufficient IDVA capacity to be provided by city-wide commissioners in line with CAADA recommendations that IDVA teams should have specialisms across the team in the criminal justice system, family courts, substance use, mental health, young people, safeguarding, sexual violence, housing, and BME and male victims.**

- Recommendation 3: Understanding complex needs and reciprocal violence in domestic abuse
- **Wolverhampton Community Safety Partnership to ensure domestic violence features as part of the Safeguarding Adults and Children Board's development of a multi-agency early alert system**

- **That Wolverhampton Community Safety Partnership highlight gaps in academic research on reciprocal violence where identifying the primary victim/offender is problematic**.

6. Appendices

6.1 ACPO /CPS Joint Evidence checklist

Checklist of information to be provided to CPS at the time of charging decision. This checklist **does not** replace the MG3 - but should complement it.

Early and meaningful case building between Police and CPS in cases of Domestic Violence is crucial to ensure effective prosecutions.

The information listed must be made available to CPS before charge decision in every case of domestic abuse. Prosecutors must consider information before making appropriate charging decisions.

Officer In Case	
Staff Number	
Have you collected **all available evidence**, including material other than the complainant's statement?	
999 Call	
Photographs; of **scene and injuries** (taken over time as injuries develop)	
Admissions	
Medical evidence (if available at the time); signed consent form; medical exhibits i.e. hair	
Victim statement (include reference to previous DV if relevant)	
Other statements – neighbours following house to house enquiries, children, attending Officer (to include visible injuries, signs of struggle, disposition of victim/offender, IDs of other persons present) and other witnesses	

CCTV/head cam footage (if relevant/available)	

Is there relevant information to include from **Police Records?**	
Bail history and any breach orders (including civil)	

Previous Domestic Violence incidents (including against other victims)/call outs/pre-convictions – for defendant and victim/witnesses	
DASH or local equivalent risk identification checklist with outcome (i.e. MARAC case, high risk, standard risk)	
Any civil orders/proceedings and whether there has been previous breaches	
Any previous allegations (with URNs) and how these allegations were concluded (if case did not proceed why not?)	
Information regarding the **victim and/or incident**	
Whether victim has been contacted by suspect/friends/family	
Relationship status and history (to include domestic arrangements), Police view of future relationship and likelihood of recurrence/any threats	
Counter allegations/defense	
Is the victim supported by a specialist DV service?	
Ability/willingness of victim to attend court, give evidence and any special considerations	
Special measures needed? And type (views of victim and IDVA/specialist support service) need to complete an MG2	

Does victim wish to retract? Have they previously retracted? Officers statement on	

retraction and views on witness summons (include victim/IDVA/specialist support service views)	
Safety of victim (victim's views and IDVA/specialist support service views)	
Restraining Order – does the victim want a RO and if so with what terms?	
Victim Personal Statement	

Any location(s) to avoid in bail conditions	
Whether the Bail Amendment Act should be invoked in a custody case	
Information in relation to **children**	
Whereabouts of children during incident (include relation to victim/defendant and age)	
Safety of children (Police and victim's views)	
Child Protection proceedings; include whether referral was made to Children's Services	

CPS Legal Guidance on prosecuting domestic violence is available here

http://www.cps.gov.uk/legal/d_to_g/domestic_violence_aide-memoire/

Police inform CPS of any breach, further offences, submit files to CPS and supply interview record in a timely way.

CPS guidance on charging in DV cases: Prepare your case on the assumption that the **victim may in the end not support**

the prosecution. Consider all information provided by the police (see above).

Ensure that you liaise with **IDVAs, Witness Care Units and specialist support organisations**, to ensure that the victim's needs particularly relating to safety are addressed throughout the life of a case.

Comprehensively endorse **MG3** including addressing any evidential strengths

and weaknesses

Ensure you have information in relation to **aggravating features and defence** Ensure that the Police follow Local Service Level Agreements by **providing all**

relevant material to the Duty Prosecutor. Ensure any action plan you provide the police is **detailed and prioritised** Consider **victim's evidence**

On withdrawal/retraction review see LG
http://www.cps.gov.uk/legal/d_to_g/domestic_violence_aide- memoire/#a2
Ensure specialist support is offered through an IDVA if available. And the case is progressed through SDVC.

Has a Victim Personal Statement been taken and refreshed?

 Have you considered a PTWI? Apply for suitable **bail conditions** to prevent further offences or intimidation but that do not restrict the victim and children

Ensure **special measures** are considered and any application is made in a timely way and results communicated to the victim.

Consider **hearsay/bad character** Prevent unnecessary delay by taking **timely** decisions

Find out details of the **defendant's previous misconduct**, if any, at the earliest opportunity so you can assess whether this evidence could be used as part of your case (If the suspect has committed or is suspected of having committed acts of violence against different victims (a 'serial' perpetrator), as well as considering whether this information can be adduced as bad character evidence you should also consider if these offences have sufficient nexus to be joined in the same indictment (or can be heard as part of the same trial process in the magistrates' court). Consider time limit on summary only offences, and whether there is sufficient nexus

Explore **credibility of defendant's account**

Consider **expert evidence**

Find out whether there are any **concurrent or imminent public law or private law family proceedings or civil proceedings and remedies** involving the complainant and/or accused. Also, find out whether Social Services has been alerted to the violence or involved with the family

6.2 Glossary

AA	Alcoholics Anonymous
ACPO	Association of Chief Police Officers
AIAT	Access and Initial Assessment Team
AMHP	Approved Mental Health Practitioner
ATR	Alcohol Treatment Requirement
BCPFT	Black Country Primary Foundation Trust
CAADA	Co-ordinated action against domestic abuse
CMHT	Community Mental Health Team
CPA	Care Pathway Approach
CPN	Community Psychiatric Nurse
CPS	Crown Prosecution Service
CSP	Community Safety Partnership
DASH	Domestic abuse, Stalking, Harassment (& Honour-based violence)
DHR	Domestic Homicide Review
DNA	Did Not Appear
DV	Domestic violence
DVPO	Domestic Violence Protection Orders
EDT	Emergency Duty Team
FAST	Fast Alcohol Screening Test
FLO	Family liaison Officer
GBH	Grievous bodily harm
GMC	General Medical Council
IDAP	Integrated Domestic Violence Abuse Programme
IDVA	Independent Domestic Violence advisor
IMR	Independent Management Review
IOM	Integrated Offender Management
LIAP	Low intensity Alcohol Programme

MAPPA	Multi Agency protection Arrangements
MARAC	Multi Agency Risk Assessment Conference
MDT	Mandatory Drugs Test
MHA	Mental Health Assessment
NFA	No further action
NICE	National Institute for Health & Care Excellence
OM	Offender manager
PCT	Primary Care Trust
PDP	Potentially Dangerous Persons
PPU	Public Protection Unit
RCGP	Royal College of General Practitioners
RCP	Royal college of Psychiatrists
SARC	Sexual Abuse Referral Centre
SCIE	Social Care Institute for Excellence
SCR	Serious Case Review
SIO	Senior Investigating Officer
SWP	Safer Wolverhampton Partnership
TTCG	Tactical Tasking & Coordination Group
WCC	Wolverhampton City Council

6.3 Bibliography

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31. The DASH model developed by Laura Richards, BSc, MSc, FRSA on behalf of the association of Chief Police Officers (ACPO) and in partnership with Co-ordinated Action Against Domestic Abuse (CAADA)
32. Wolverhampton Over-arching Domestic Violence Protocol and Guidance (November 2013)

6.4 Full terms of reference

Terms of Reference for the case of Peter (DHR/02)

Contents

Legislation

The Domestic Violence, Crime and Victims Act 2004 Section 9 requires the commissioning of a Domestic Homicide Review by the Community Safety Partnership within the victim's area of residence.

A Domestic Homicide Review is defined as:

'A review of the circumstances in which the death of a person aged 16 years or over has, or appears to have resulted from violence, abuse or neglect by –

a) A person to whom (s)he was related or with whom (s)he was or had been in an intimate relationship or
b) a member of the same household as himself/herself

A review to be held with a view to identifying the lessons to be learned from the death; this may include considering whether appropriate support, procedures, resources and interventions were in place and responsive to the needs of the victim'.

Governance and Accountability

The Review will be conducted in accordance with the Safer Wolverhampton Partnership (SWP) Domestic Homicide Review Protocols.

As the Accountable Body responsible for its commissioning, the SWP will receive updates on progress of the Review at scheduled SWP Board meetings.

The Chair of SWP will receive regular briefings from the Review Panel Chair/Author on progress

Administrative support will be provided by the Head of Community Safety, Wolverhampton City Council (WCC).

Family Details

Summary of details of victim, perpetrator and any children.

Party	Name and DOB	DOB
Victim	Peter	28/04/60
Perpetrator	Kate	10/08/64
Child of Perpetrator	Louise	

Incident Summary

West Midlands Ambulance Service received a call on 27 October 2013 from Kate reporting that Peter her partner, had fallen. Police officers arrived at the scene and while paramedics and police were in attendance Peter died. A post mortem was conducted on 28 October 2013 which revealed a single stab wound to the heart. Kate was arrested and charged with causing the death of Peter,

Purpose of the Review

The purpose of having a Domestic Homicide Review is not to reinvestigate or to apportion blame, it 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;
- Prevent domestic violence homicides and improve service responses for all domestic violence victims and their children through improved intra and inter agency working.
- Ensure agencies are responding appropriately to victims of domestic violence by offering and putting in place appropriate support mechanisms, procedures, resources and interventions, responsive to the needs of the victim, with an aim to avoid future incidents of domestic homicide and violence.
- Assess whether agencies have sufficient and robust procedures and protocols in place, which were understood and adhered to by their staff

Additionally, this Review will also consider the services and support provided to both the family and its individual members as they pertain to the homicide to:

- identify a definitive timeline of events leading to the homicide for the victim and the alleged perpetrator
- establish whether failings occurred in the assessment, care or treatment of all family members
- identify whether there were any mental health or capacity issues at the time of the homicide for the victim of the alleged perpetrator
- identify whether safeguarding arrangements had been considered or were effectively in place for all family members
- establish how recurrence – if appropriate – may be reduced or eliminated
- formulate recommendations and an Action Plan

- provide a report as a record of the investigation process
- provide a means of sharing learning from the incident
- provide a report to enable the SWP to meet its responsibilities under its Domestic Homicide Review Procedures

Review Time Period

The review period for the purposes of this Review will be September 2009 – 27 October 2013.

Panel Membership

The Panel will comprise of individuals across a broad spectrum of both statutory and voluntary sector agencies. Representation should be at a sufficient level of seniority within respective organisations to commit to the delivery of resulting recommendations. Further agencies may be asked to join the Panel as the Review progresses and for specific subject expert advice and guidance.

The Panel will be made up of the following core membership:

West Midlands Police
Staffordshire and West Midlands Probation Service
Wolverhampton Domestic Violence Forum
Clinical Commissioning Group / NHS Commissioning Board
Wolverhampton City Council - Community Safety / Public Heath / Mental Health
Wolverhampton City Council – Safeguarding (Adult's and Children's)

Individual Management Reports (IMRs)

In the first instance, IMRs will be requested from the following organisations:

Ambulance Service
Anti-Social Behaviour Team
Black Country partnership (Penn Hospital & Healthy Minds)
CPS
Emergency Duty Team (WCC)
GPs

Haven
Housing Options (WCC)
Housing Outreach (WCC)
Landlord of Kate (to be identified)
Learning Disability Team (WCC)
Mental health (WCC)
NACRO / Addiction Services
New Cross Hospital – RWT
Older Person's Services (WCC) – (Incorporating initial assessment team and South West Locality Team)
P3
Staffordshire and West Midlands Probation Service
West Midlands Police PPU
Wolverhampton Domestic Violence Forum
Wolverhampton Homes

Further agencies may be asked to submit IMRs in the light of the progress of the Review.

Family Liaison

Contact with Kate will be directed through her solicitor. Contact with other family members of both Peter and Kate shall be directed through the appointed Family Liaison Officer from West Midlands Police.

Media Strategy

Media contact concerning the review shall be the responsibility of the Chair of the Safer Wolverhampton Partnership in consultation with the Review Panel Chair/Author and the Head of Community Safety. Overall management will be directed through Wolverhampton City Council (WCC) Communications Team.

Legal Advice

Legal advice will be sought, as appropriate from WCC Legal Department to ensure the review process and final Overview Report maintains a commitment to safeguard all parties.

Liaison with the Police

The Chair of the Review Panel will be responsible for ensuring appropriate liaison with the Crown Prosecution Service and the Police through the Disclosure Officer identified by the West Midlands Police.

Review of Terms of Reference

In the light of information brought to his attention, these Terms of Reference will be subject to review and revision at the discretion of the Independent Chair/Author in consultation with the Review Panel.

6.5 Feedback from Home Office

Public Protection Unit
2 Marsham Street
London
SW1P 4DF

T: 020 7035 4848
www.homeoffice.gov.uk

Linda Sanders
Strategic Director for Wolverhampton City Council
Safer Wolverhampton Partnership
c/o West Midlands Police
2nd Floor, Partnerships team
Bilston Street
Wolverhampton
WV1 3AA

9th June 2015

Dear Ms Sanders

Thank you for submitting the Domestic Homicide Review overview report for Wolverhampton to the Home Office Quality Assurance (QA) Panel. The overview report was considered at the Quality Assurance Panel meeting on 19 May 2015.

The QA Panel would like to thank you for conducting this review and for providing them with the final overview report. In terms of the assessment of reports, the QA Panel judges them as either adequate or inadequate. This was a very clear and well-structured report which, subject to the feedback detailed below being incorporated, the Panel judges to be adequate.

There were some aspects of the report which the Panel felt could be revised, which you may wish to consider incorporating before you publish the final report:

- Please ensure that the report is fully anonymised before publication with particular attention given to the Action Plan;
- Please provide a glossary to reference the acronyms contained within the report;
- Please review some of the findings contained in the Analysis section to ensure that they align with public policy intention. For example, on p116, the report asserts that "the police should always use their powers of arrest at domestic abuse incidents where a power exists and an offender should never be moved to another location as a risk reduction strategy". This statement should be reviewed in line with the findings by Her Majesty's Inspectorate of Constabulary (HMIC) in its report on the police response to domestic abuse published in March 2014;
- The report should assess whether there should be greater representation by health agencies on the Multi-agency Risk Assessment Conference (MARAC).

The Panel does not need to see another version of the report, but I would be grateful if you could include our letter as an appendix to the report.

Yours sincerely

Christian Papaleontiou
Chair of DHR QA Panel