SAFER STRONGER DONCASTER PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

'Ruth'

Date of death – Autumn 2019

OVERVIEW REPORT

September 2022

Chair and Author - Carol Ellwood-Clarke QPM
Supported by - Ged McManus

CONTENTS

1. INTRODUCTION

1.1 The panel offers its sincere condolences to Ruth's family.

1.2 This report of a domestic homicide review (DHR) examines how agencies responded to, and supported, Ruth, a resident of Doncaster, prior to her death in Autumn 2019.

1.3 Home Office Domestic Homicide Review statutory guidance (2016)[1] states:

'Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable'.

1.4 In addition to agency involvement the review also examines the past to identify any relevant background or trail of abuse, and whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.5 Ruth had been in a relationship with John, for approximately 12 months prior to her death. The couple first came to police attention in July 2019, when Ruth was assaulted by John. Ruth was the victim of a further incident of domestic abuse with John in September 2019.

1.6 The circumstances of Ruth's death were treated by the Police as suspicious. John was arrested on suspicion of her murder. After a lengthy investigation and consultation with the Crown Prosecution Service no criminal charges were brought. Toxicology and histology revealed high levels of substances and alcohol present in Ruth's system and from the findings, the pathologist could not rule out completely either overdose or suicide. Neither could the presentation of facial injuries be attributed to her death.

1.7 The intention of the review is to ensure agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with the aim of avoiding future incidents of domestic homicide, violence and abuse. Reviews should assess whether agencies have sufficient and robust procedures and protocols in place, and that they are understood and adhered to by their employees.

[1] www.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

1.8 It is not the purpose of this DHR to enquire into how Ruth died. This is determined through other processes.

1.9 An inquest held on 28 April 2021, concluded that the cause of Ruth's death was undetermined.

2. TIMESCALES

2.1 Following Ruth's death, formal notification was sent to Safer Stronger Doncaster Partnership by South Yorkshire Police on 14 October 2019. A meeting was held on 15 October 2019 where it was agreed to conduct a Domestic Homicide Review. On 17 October 2019 the Home Office were notified of the decision.

2.2 The first meeting of the review panel took place on 19 December 2019. Subsequent panel meetings were held virtually during the Covid-19 pandemic and contact was maintained with the panel via email and telephone calls. In total the panel met six times.

2.3 The DHR covers the period from 1 November 2018 to 13 October 2019. The start date was chosen as it was identified that this was the start of the relationship between Ruth and John. All agencies were asked to consider and analyse any significant contacts prior to these dates, and this has been included within the review where relevant.

2.4 The domestic homicide review was presented to Safer Stronger Doncaster on 30th September 2021 and concluded on 10th December 2021 when it was sent to the Home Office.

3. CONFIDENTIALITY

3.1 Until the report is published it is marked: Official Sensitive Government Security Classifications May 2018.

3.2 The names of any key professionals involved in the review are disguised using an agreed pseudonym. The report uses pseudonyms for the victim, and her partner. The pseudonyms were selected by the panel.

3.3 This table shows the age and ethnicity of the subjects of the review. No other key individuals were identified as being relevant for the review.

Name	Relationship	Age	Ethnicity
Ruth	Victim	38	White British female
John	Partner	62	White British male

4. TERMS OF REFERENCE

4.1 The Panel settled on the following terms of reference at its second meeting on 22 September 2020.

4.2 The DHR panel set the period of review from 1 November 2018 (start of relationship) to 13 October 2019.

4.3 **The purpose of a DHR is to**:

- establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
- prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
- contribute to a better understanding of the nature of domestic violence and abuse; and
- highlight good practice.

[Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2016] Section 2 Paragraph 7]

4.4 **Subjects of the DHR**

Deceased: Ruth 38yrs

Partner of deceased: John 62yrs

4.5 **Specific Terms**

1. What indicators of domestic abuse, including coercive and controlling behaviour, did your agency have that could have identified Ruth as a victim of domestic abuse and what was your response.
2. What risk assessments did your agency undertake for Ruth; what was the outcome and if you provided services were they fit for purpose?

3. What was your agency's knowledge of any barriers faced by Ruth that might have prevented her reporting domestic abuse and what did it do to overcome them?

4. What knowledge did your agency have of Ruth and John's physical and mental health needs and what services did you provide?

5. What knowledge or concerns did the victim's family, friends, colleagues and wider community have about Ruth's victimisation and did they know what to do with it?

6. What knowledge did your agency have that indicated John might be a perpetrator of domestic abuse and what was the response, including any referrals to a Multi-Agency Risk Assessment Conference [MARAC]?

7. Was there sufficient focus on reducing the impact of John's alleged abusive behaviour towards the victim by applying an appropriate mix of sanctions (arrest/charge) and treatment interventions?

8. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Ruth and John?

9. Did your agency follow its domestic abuse policy and procedures, and the multi-agency ones?

10. Were there issues in relation to capacity or resources in your agency that impacted on its ability to provide services to Ruth and John, or on your agency's ability to work effectively with other agencies?

11. What learning has emerged for your agency?

12. Are there any examples of outstanding or innovative practice arising from this case?

13. Does the learning in this review appear in other Domestic Homicide Reviews commissioned by Safer Stronger Doncaster Partnership?

5. METHOD

5.1 On date 22 November 2019 Carol Ellwood-Clarke was appointed as the Independent Chair and Author. The Chair was supported in the role by Ged McManus.

5.2 The first meeting of the DHR panel determined the period the review would cover. The review panel determined which agencies were required to submit written information and in what format. Those agencies with substantial contact were asked to produce individual management reviews and the others, short reports. The Chair provided training to Individual Management Review (IMR)[2] Authors to assist in the completion of the written reports.

5.3 Some agencies interviewed staff involved in the case to gain a better understanding of how and why decisions were made. The written material produced was distributed to panel members and used to inform their deliberations. During these deliberations additional queries were identified and auxiliary information sought.

5.4 A decision was made at the first panel meeting to suspend the DHR process until the criminal investigation had been concluded. This decision was made to ensure that there was no conflict of interest in the DHR process and no risk of jeopardising the criminal investigation. Following the conclusion of the criminal investigation, the DHR process re-commenced with the second panel meeting taking place on 22 September 2020.

5.5 A request was made to Doncaster Clinical Commissioning Group to complete an IMR and chronology. The CCG queried the legality of sharing information without the consent being obtained from the subjects of the review. The Chair advised the CCG panel member of the relevant guidance contained within the Home Office Statutory Guidance. An initial decision was made by the CCG not to complete an IMR, due to other demands and requirements for completion of the reports for ongoing safeguarding reviews. In April 2021, the CCG provided the review with an IMR.

[2] Individual Management Review: a templated document setting out the agency's involvement with the subjects of the review

5.6 The DHR Chair liaised with the panel members to identify family members or friends to help inform the DHR process. The Police provided access to information gathered in the criminal investigation. This is covered in Section 6.

5.7 The Chair wrote to John to invite him to contribute to the review. The Chair received no response from the request. During the review it was established that John had moved address. The Chair wrote again to John. No response was received.

5.8 The Chair of the Community Safety Partnership agreed for an extension of the timeframe for the DHR to be completed as a result of delays due to the criminal investigation and the Covid-19 pandemic. The Home Office were notified of the extension.

5.9 Thereafter a draft overview report was produced which was discussed and refined at panel meetings before being agreed. The draft report was shared with Ruth's family who were invited to make any additional contributions or corrections.

6. INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS AND THE WIDER COMMUNITY.

6.1 The Chair wrote to Ruth's family to inform them of the review and included the Home Office Domestic Homicide Review leaflet for families and the Advocacy After Fatal Domestic Abuse leaflet (AAFDA)[3]. The letter was delivered by the Police Family Liaison Officer who explained the Domestic Homicide Review process. The family informed the Police that they did not want to be involved in the review.

6.2 The Chair contacted the National Homicide Service to try to establish contact; however, the family had declined to engage with the service after the death of their daughter.

6.3 The Chair enquired with panel members and wider agencies in the Community Safety Partnership to establish a point of contact which could facilitate engagement with the family. No agencies were actively engaged with the family.

6.4 In May 2021, after the inquest, the Police made a further approach to the family regarding the DHR. The family reaffirmed their view that they did not want to be involved in the review process but agreed for the Chair to contact them via telephone.

6.5 The Chair spoke to the family and discussed the purpose of the review, including family engagement. The family informed the Chair that they did not wish to participate in the review but appreciated that the review was taking place. The family stated that now the inquest had concluded, and the upset and difficulties they have had since Ruth's death, it was their decision to not to be involved. The family agreed for a copy of the report to be shared with them and confirmed that they would contact the Chair if they wished to raise any questions or seek clarification on the contents.

6.6 The Chair requested access to any statements from other family members or friends that had been gathered during the criminal investigation, to inform the review and enable contact from the Chair. The Chair was informed that the family were unable to provide the Police with details of family and friends. The Chair was provided with a copy of the antecedent statement completed by the Police Family Liaison Officer with information provided by the family. The family had agreed to the content of the statement. Details from the statement have been included within the

[3] https://aafda.org.uk/

report as necessary. The Police were unable to identify any additional friends and family members.

6.7 Ruth was not in employment and therefore it was not possible to progress contact with an employer.

7. CONTRIBUTORS TO THE REVIEW

7.1 This table show the agencies who provided information to the review.

Agency	IMR	Chronology	Report
Aspire		✓	✓
Department for Work and Pensions			✓
Doncaster and Bassetlaw Teaching Hospitals Foundation Trust (DBTHFT)	✓	✓	
Doncaster Children's Services Trust		✓	✓
Doncaster Clinical Commissioning Group	✓	✓	
Doncaster Council Adult Social Care		✓	✓
Doncaster Council IDVA Service	✓	✓	
Lincolnshire Police			✓
Riverside		✓	
Rotherham and Doncaster South Humber NHS Foundation Trust (RDaSH)	✓	✓	
South Yorkshire Police	✓	✓	

7.2 The IMR's contained a declaration of independence by their authors and the style and content of the material indicated an open and self-analytical approach together with a willingness to learn. All the authors explained they had no management of the case or direct managerial responsibility for the staff involved with this case.

7.3 Below is a summary of contributors to the review.

7.3.1 **Aspire (Drug and Alcohol services)**

Aspire is a partnership between Alcohol and Drug Services (ADS) and RDASH to provide assessment and treatment for patients who have drug and/or alcohol problems, helping them on the road to recovery. The staffing complement is made up of nurses from RDaSH, and case managers and community staff from ADS. Access to the service is via professional referral or self-referral and is purely voluntary. The exception to this is the Criminal Justice route via a court order which is an alternative to a custodial sentence. Following an assessment of need, the patient is offered the appropriate treatment/recovery pathway. New Beginnings provides a specialist inpatient detoxification accessed through a formal pathway. For further information: https://www.aspire.community

7.3.2 **Doncaster and Bassetlaw Teaching Hospitals Foundation Trust**
DBTHFT is a provider of acute Health Care serving the population of Doncaster, Bassetlaw, and the surrounding areas. It has a total of over 700 inpatient beds over 3 hospital sites and provides outpatient services over several sites across the area. The Trust provides inpatient care, outpatient services, and has a minor injuries department and 2 emergency Departments with 24hr care provision.

7.3.3 **Doncaster Children's Services Trust**
Provide social care and support services to children, young people and families in Doncaster. The Trust was set up in October 2014 as an innovative way to provide these services following an agreement with national government and the local authority, and we're the first kind in the country.

They have a very clear focus and believe that every child and young person in the borough deserves the best start in life and support when they need it to reach their full potential. The Trust support all children and young people who need help in the borough, at times of need or crisis in their lives. At the heart of the business is a team of young people who have experience of care, our Young Advisors. They advise the Chief Executive on how to run the Trust and how services can be improved for other children and young people. Driving all this work forward is a team of some 500 staff at the Trust, led by the Chief Executive and a board of local and professional people with expertise in social care and safeguarding within and outside of the borough.

7.3.4 **Doncaster Council Adult Social Care**
Adult Social Care is about providing personal and practical support to help people live their lives. It's about supporting individuals to maintain their independence and dignity. There is a shared commitment by the Government, local councils and providers of services to make sure that people who need care and support have the choice, flexibility and control to live their lives as they wish.

7.3.5 **Doncaster Council IDVA Service**
The Doncaster Domestic Abuse Service Independent Domestic Violence Advocate (IDVA) team is a Doncaster Local Authority support service for victims of domestic abuse, aged 16 and over, who are assessed as being at high risk of harm from domestic abuse. The IDVA service provides support and assistance in a number of ways, offering practical advice and assistance around safety planning, supporting clients with legal applications

through criminal and civil court proceedings, supporting clients in liaison with other services that offer assistance in relation to housing, health and wellbeing and a variety of other support services in Doncaster and sometimes beyond. The IDVA's support clients with referrals to therapeutic support provided by other services and, if appropriate, applications to refuge and safe housing away from the perpetrator. The role of the IDVA is to support clients to reduce risk from domestic abuse. The IDVA is the voice of the victim at the Multi Agency Risk Assessment Conference (MARAC), The Doncaster Domestic Abuse team is not a statutory service.

7.3.6 **Doncaster Clinical Commissioning Group**

Comprises 39 member GP practices based in Doncaster, with responsibility for commissioning (buying and organising) healthcare services for around 320,000 patients in Doncaster. The 39 Member Practices are grouped into four localities and monthly locality meetings led by locality leads and attended by nominated practice representatives are held in each locality to ensure effective engagement of member practices in the work of their governing body.

7.3.7 **Lincolnshire Police**

Lincolnshire Police is the territorial police force covering the non-metropolitan county of Lincolnshire in the East Midlands of England. In terms of geographic area, the force is one of the largest in the England and Wales covering 2,284 square miles.

7.3.8 **Riverside**

Doncaster Homeless Floating Support is a community-based service, providing tenancy support if you are homeless or at risk of losing your home. Who help single people or families in their own homes and offer practical and emotional support, as well as assistance and advice to help people maintain their tenancy.

7.3.9 **Rotherham and South Humber NHS Foundation Trust**

RDaSH employs approximately 3700 staff who provide a wide range of clinical and non-clinical services from 240 locations across Rotherham, Doncaster, and North Lincolnshire. During 2018/19 115,000 people accessed Trust services. The services provided by the Trust include:

- Adult Mental Health services.
- Memory services
- Older Peoples Mental Health.
- Community Integrated services.

- Drug and Alcohol services[4].
- Forensic services.
- Psychological services.
- Learning Disability services.
- Children, young people and family services.
- St John`s Hospice.

7.3.10 **South Yorkshire Police**

South Yorkshire Police is the territorial police force responsible for policing South Yorkshire in England.

7.4 Nil returns were received from –

Doncaster Council – Complex Lives
Doncaster Council – Public Health
National Probation Service (Historical info from 2005 deleted)
Phoenix Women's Aid
South Yorkshire CRC
South Yorkshire SARC

8. THE REVIEW PANEL MEMBERS

[4] Provided by Aspire.

8.1 This table shows the review panel members.

Review Panel Members		
Name	**Job Title**	**Organisation**
James Axe*	Senior Investigating Officer	South Yorkshire Police
Ian Boldy	Designated Nurse Safeguarding Adults & Head of Individual Placements	Doncaster Clinical Commissioning Group
Charlie Cottam[5]	Lead Professional Safeguarding Adults	Rotherham Doncaster and South Humber NHS Foundation Trust
Carol Ellwood-Clarke	Independent Chair and Author	
Jayne Grice	Head of Service	Doncaster Children's Services Trust
Kim Goddard	Lead Professional Safeguarding Adults	Rotherham Doncaster and South Humber NHS Foundation Trust
Andrea Hamshaw	DHR Co-ordinator	Doncaster Council
Pat Johnson	Lead Professional, Safeguarding Adults	Doncaster and Bassetlaw NHS Foundation Trust
Emma Jones*		Doncaster Clinical Commissioning Group
Griff Jones*	Removed	Adult Safeguarding, Doncaster Council
Cal Lacey	IDVA Manager	Doncaster Council
Suzanne Kirby	GP	Doncaster Clinical Commissioning Group
Robert Maginnis*	Head of Patient Safety	Rotherham, Doncaster and South Humberside NHS Trust
Ged McManus	Independent Reviewer	
Andrew Miller	Detective Sergeant	South Yorkshire Police

[5] During the process Charlie Cottam was replaced by Kim Goddard.

Jane Mundin*	Drug and Alcohol Commissioner	Public Health, Doncaster Council
Jenny Rayner		Doncaster Clinical Commissioning Group
Vesta Ryng	Managing Director	Phoenix Women's Aid
Luke Shepherd*		South Yorkshire Community Rehabilitation Company
Karen Shooter[6]	Domestic and Sexual Abuse Manager	Doncaster Council
Sarah Smith	Health Improvement Co-Ordinator - Suicide Prevention	Doncaster Council
Tim Staniforth	Domestic and Sexual Abuse Theme Manager	Doncaster Council
Louise Stevenson*	Case and Review Policy Officer	South Yorkshire Police
Gary Thompson[7]	Case and Review Policy Officer	South Yorkshire Police
Jo Wade*	Case and Review Policy Officer	South Yorkshire Police

* Attended first meeting only.

8.2 The Chair of Safer Stronger Doncaster Partnership was satisfied that the Panel Chair and author were independent. In turn, the Panel Chair believed there was sufficient independence and expertise on the panel to safely and impartially examine the events and prepare an unbiased report.

8.3 The panel met six times and the circumstances of Ruth's death were considered in detail with matters freely and robustly considered, to ensure all possible learning could be obtained. Due to the Covid-19 pandemic panel meetings met virtually. Outside of the meetings the Chair's queries were answered promptly via email or telephone call and in full.

9. CHAIR AND AUTHOR OF THE OVERVIEW REPORT

[6] Karen Shooter left her post during this undertaking of this DHR and was replaced by Tim Staniforth.
[7] Replaced by DS Andrew Miller

9.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 sets out the requirements for review chairs and authors.

9.2 Carol Ellwood Clarke was appointed as the DHR Independent Chair. She is an independent practitioner who has chaired and written previous DHR's and other safeguarding reviews. Carol retired from public service [British policing] in 2017 after thirty years during which she gained experience of writing independent management reviews, as well as being a panel member for Domestic Homicide Reviews, Child Serious Case Reviews and Safeguarding Adults Reviews. In January 2017 she was awarded the Queens Police Medal (QPM) for her policing services to Safeguarding and Family Liaison. In addition, she is an Associate Trainer for SafeLives[8].

9.3 Ged McManus is an independent practitioner who has chaired and written previous DHRs and Safeguarding Adult Reviews. He has experience as an Independent Chair of a Safeguarding Adult Board. He served for over thirty years in different police services in England. Prior to leaving the police service in 2016 he was a Superintendent with particular responsibility for partnerships including Community Safety Partnership and Safeguarding Boards.

9.4 Between them they have undertaken the following types of reviews: child serious case reviews, safeguarding adult reviews, multi-agency public protection arrangements [MAPPA] serious case reviews, domestic homicide reviews and have completed the Home Office online training for undertaking DHR's.

9.5 Between 1986 and 2005 Ged McManus worked for South Yorkshire Police a contributor to this review, before moving to another police service. The commissioners of the review were satisfied of his independence given the length of time since he had any involvement with South Yorkshire Police. Carol Ellwood Clarke has not worked for any agency providing information to the review. Both have completed one previous DHR for the Safer Stronger Partnership, and are undertaking a further two DHR's, independently.

10. PARALLEL REVIEWS

[8] https://safelives.org.uk/

10.1 HM Coroner for Doncaster opened and adjourned an inquest. The Chair notified Her Majesty's Coroner that a DHR was being undertaken. An inquest was held on 28 April 2021 the outcome concluded that the cause of Ruth's death was undetermined.

10.2 South Yorkshire Police completed a criminal investigation following Ruth's death. There have been no criminal proceedings pursued in relation to the death as the pathology established that the cause of death was due to drugs overdose. A charging decision was also requested in relation to unexplained injuries on Ruth's face. The CPS decided that there was not a realistic prospect of conviction as –

a) it could not be shown that the injuries were received as a result of a criminal act, and
b) who caused them.

10.3 The family requested a meeting with the CPS following the decision not to pursue criminal charges. Whilst arrangements were being made for the meeting to take place, the family contacted the Police to withdraw their request to meet with CPS.

10.4 South Yorkshire Police referred themselves to the Independent Office for Police Conduct[9] (IOPC) following the death of Ruth. The investigation concluded during the completion of the DHR with no adverse findings against any officer.

10.5 The review was not aware of any other investigations that have taken place since Ruth's death.

11. EQUALITY AND DIVERSITY

[9]https://www.policeconduct.gov.uk/
Every time someone has direct or indirect contact with the police when, or shortly before, they are seriously injured or died the police force involved must refer the matter to the Independent Office for Police Conduct (IOPC).

11.1 Section 4 of the Equality Act 2010 defines protected characteristics as:

- **age** [for example an age group would include “over fifties” or twenty-one-year-olds. A person aged twenty-one does not share the same characteristic of age with “people in their forties”. However, a person aged twenty-one and people in their forties can share the characteristic of being in the “under fifty” age range].
- **disability** [for example a man works in a warehouse, loading and unloading heavy stock. He develops a long-term heart condition and no longer has the ability to lift or move heavy items of stock at work. Lifting and moving such heavy items is not a normal day-to-day activity. However, he is also unable to lift, carry or move moderately heavy everyday objects such as chairs, at work or around the home. This is an adverse effect on a normal day-to-day activity. He is likely to be considered a disabled person for the purposes of the Act].
- **gender reassignment** [for example a person who was born physically female decides to spend the rest of her life as a man. He starts and continues to live as a man. He decides not to seek medical advice as he successfully ‘passes’ as a man without the need for any medical intervention. He would have the protected characteristic of gender reassignment for the purposes of the Act].
- **marriage and civil partnership** [for example a person who is engaged to be married is not married and therefore does not have this protected characteristic. A divorcee or a person whose civil partnership has been dissolved is not married or in a civil partnership and therefore does not have this protected characteristic].
- **pregnancy and maternity**
- **race** [for example colour includes being black or white. Nationality includes being a British, Australian or Swiss citizen. Ethnic or national origins include being from a Roma background or of Chinese heritage. A racial group could be “black Britons” which would encompass those people who are both black and who are British citizens].
- **religion or belief** [for example the Baha’i faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism are all religions for the purposes of this provision. Beliefs such as humanism and atheism would be beliefs for the purposes of this provision but adherence to a particular football team would not be].
- **sex**
- **sexual orientation** [for example a man who experiences sexual attraction towards both men and women is “bisexual” in terms of sexual orientation even if he has only had relationships with women. A man and a woman who are both attracted only to people of the opposite sex from them share a sexual orientation. A man who is

attracted only to other men is a gay man. A woman who is attracted only to other women is a lesbian. So, a gay man and a lesbian share a sexual orientation].

11.2 Section 6 of the Act defines 'disability' as:

[1] A person [P] has a disability if —

[a] P has a physical or mental impairment, and

[b] The impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities[10]

11.3 Neither subjects of the review had any known protected characteristics that would have fallen within Section 4 of the Equality Act 2010. Professionals applied the principle of Mental Capacity Act 2005:

'A person must be assumed to have capacity unless it is established that he lacks capacity'.

11.4 John had contact with Adult Social Care in relation to a medical condition. John had a series of illness including a medical history of Ischaemic Heart Disease, Calf pain due to Peripheral Vascular Disease, High Blood pressure, Glaucoma, Asthma and Bronchiectasis. He was under close regular follow up by the hospital respiratory clinic for management of his asthma.

11.5 In September 2019 John was prescribed antidepressants after presenting to his GP with low mood. A suicide risk assessment stated that suicidal ideation was present. "

11.6 Ruth had been diagnosed with Chronic obstructive pulmonary disease (COPD)[11] and had several hospital admissions due to breathing problems and was known to the asthma clinic. Ruth had contact with Adult Social Care due to her mobility and following an assessment in 2017 her property was adapted with equipment to help her with entering the property, climbing stairs and bathing.

11.7 Ruth had alcohol dependency and had been an in-patient to help reduce her alcohol intake, in addition, Ruth was referred into drug and alcohol services. Ruth was known to suffer with anxiety and depression and was on a repeat prescription for codeine, sertraline[12] (stopped May 2019),

[10] Addiction/Dependency to alcohol or illegal drugs are excluded from the definition of disability.

[11] https://www.nhs.uk/conditions/chronic-obstructive-pulmonary-disease-copd/

[12] https://www.nhs.uk/medicines/sertraline/

diazepam[13] and propranolol[14]. In June 2019 Ruth commenced a prescription of Fluoxetine[15].

11.8 Ruth had a history of self-harm, overdose, and suicide attempts. Between 2016 and 2019 Ruth had attempted to take her own life on ten occasions. It was confirmed that there were incised wounds over her old scars when she was found deceased, which were deemed consistent with self-harm.

11.9 The Equality Act 2010 (Disability) Regulations 2010 (SI 2010/2128) states that addiction to alcohol, nicotine or any other substance (except where the addiction originally resulted from the administration of medically prescribed drugs) is to be treated as not amounting to an impairment for the purposes of the Equality Act 2010. Alcohol addiction is not, therefore, covered by the Act. It should be noted that although addiction to alcohol, nicotine and drugs is excluded from The Equality Act 2010, addiction to alcohol and drugs should be taken into account when a Care Act 2014 (care and support) assessment is completed.

11.10 All subjects of the review are white British. There is no evidence arising from the review of any negative or positive bias on the delivery of services to the subjects of the review.

11.11 There is nothing in agency records that indicated that any subjects of the review lacked capacity[16] in accordance with Mental Capacity Act 2005.

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[13] https://www.nhs.uk/medicines/diazepam/
[14] https://www.nhs.uk/medicines/propranolol/
[15] https://www.nhs.uk/medicines/fluoxetine-prozac/

[16] The Mental Capacity Act 2005 established the following principles;
Principle 1 [A presumption of capacity] states "you should always start from the assumption that the person has the capacity to make the decision in question".

Principle 2 [Individuals being supported to make their own decisions] "you should also be able to show that you have made every effort to encourage and support the person to make the decision themselves".

Principle 3, [Unwise decisions] "you must also remember that if a person makes a decision which you consider eccentric or unwise this does not necessarily mean that the person lacks capacity to make the decision".

Principles 1 – 3 will support the process before or at the point of determined whether someone lacks capacity.

Principles 4 [Best Interest] "Anything done for or on behalf of a person who lacks mental capacity must be done in their best interest".

Principle 5 [Less Restrictive Option], "Someone making a decision or acting on behalf of a person who lacks capacity must consider whether it is possible to decide or act in a way that

11.12 Domestic homicide, and domestic abuse in particular, are predominantly a crime affecting women, with women by far making up the majority of victims, and by far the vast majority of perpetrators being male. A detailed breakdown of homicides reveals substantial gender differences. Female victims tend to be killed by partners/ex-partners. For example, in 2018 the Office of National Statistics homicide report stated:

'There were large differences in the victim-suspect relationship between men and women. A third of women were killed by their partner or ex-partner (33%, 63 homicides) in the year ending March 2018. In contrast, only 1% of male victims aged 16 years or over were killed by their partner or ex-partner'.

'Men were most likely to be killed by a stranger, with over one in three (35%, 166 victims) killed by a stranger in the year ending March 2018. Women were less likely to be killed by a stranger (17%, 33 victims)'.

'Among homicide victims, one in four men (25%, 115 men) were killed by friends or social acquaintances, compared with around one in fourteen women (7%, 13 women)'.

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would interfere less with the persons rights and freedoms of action, or whether there is a need to decide or act at all. Any interventions should be weighed up in particular circumstances of the case".
[Mental Capacity Act Guidance, Social Care Institute for Excellence]

12. DISSEMMINATION

12.1 The following organisations/people will receive a copy of the report after any amendment following the Home Office's quality assurance process.

- The Family
- Safer Stronger Doncaster Partnership
- All agencies that contributed to the review
- South Yorkshire Police and Crime Commissioner
- Domestic Abuse Commissioner

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13. BACKGROUND, OVERVIEW AND CHRONOLOGY

This part of the report combines the Background, Overview and Chronology sections of the Home Office DHR Guidance overview report template. This was done to avoid duplication of information and to recognise that the review was looking at events over an extended period of time. The narrative is told chronologically. It is built on the lives of the subjects of the review and punctuated by subheadings to aid understanding. The information is drawn from documents provided by agencies, and material gathered by the police during their investigations.

13.1 Ruth

13.1.1 Ruth had two children from a previous relationship. In 2016, when the children, were 9 and 13 years of age, Ruth was involved with DCST due to mental health and alcohol use and the impact that this had on the children. In 2017 a Child & Family Assessment was completed which identified domestic abuse in Ruth's relationship with an ex-partner. In November 2017, a Child Arrangement Order was granted, and the children went to live with their Father. Ruth had no further contact with DCST.

13.1.2 Ruth had a long history of low mood and anxiety, self-reported going back since she was 19 when a previous partner of Ruth's died unexpectedly whilst she was pregnant; Ruth lost this baby.

13.1.3 During the timescales of this review, Ruth lived between her parents' address and John's flat. The panel were unable to determine any further information known about Ruth from agencies involved in the review.

13.2 John

13.2.1 John was known to agencies due to domestic abuse in previous relationships. Below is a summary of those incidents and agency involvement.

13..2.2 In 2005 John received a caution for an offence of criminal damage which had occurred at an ex-partner's address. John then committed several offences of harassment against his ex-partner and was subsequently convicted in accordance with Section 2 Protection from Harassment Act 1997. John was supervised by the National Probation Service; however, records no longer exist from this time.

13.2.3 In 2010 John became known to the Police for five incidents of domestic abuse. These related to verbal arguments, minor damage, and an assault. No criminal charges were pursued. In 2011 it was reported that John had assaulted his female partner. When the Police attended the partner denied she had been assaulted. A few days later the Police responded to an argument between the couple. Advice was given.

13.2.4 In 2012 the Police responded to an argument between John and his partner. Damage had been caused inside the property. There were no complaints. Later in the year the Police were called by an ex-partner of John's who stated she had been assaulted. John was interviewed but released without any criminal charges.

13.3 Events prior to November 2018 (start of the relationship)

13.3.1 Ruth was known to Doncaster Children Services Trust (DCST) due to her mental health and alcohol abuse and the impact that this had on her children. DCST were involved with the family in accordance with statutory requirements in place between 2016 and 2018.

13.3.2 In 2016 Ruth attended hospital after having taken an overdose of illicit and prescribed medication and alcohol. Ruth was admitted as an inpatient for a short period of time. Ruth was allocated a named keyworker and offered 12 appointments. Ruth attended six appointments and was discharged from the service towards the middle of the year. Later that year Ruth received a caution for an offence of battery, whereby she had assaulted a member of the public as they had tried to help her whilst she attempted to drown herself in a hot tub.

13.3.3 Towards the end of 2016 Ruth was admitted to hospital having taken an overdose and self-harming. Referrals were made to DCST and safeguarding measures were implemented. It was intimated that Ruth was in an abusive relationship with her current partner at this time, but this was denied by Ruth.

13.3.4 In 2017 the Police attended two incidents of domestic abuse. These were reported as arguments involving Ruth and an ex-partner. No offences were identified.

13.3.5 In January 2018, Ruth self-referred to RDaSH for support to remain alcohol abstinent. Ruth was allocated a named keyworker with one-to-one sessions, and offered eight appointments, of which she attended two.

Ruth was discharged from the service in March 2018 due to disengagement.

13.3.6 In 2018, prior to the relationship starting between Ruth and John, there were six incidents of domestic abuse with Ruth. All of the incidents involved Ruth's ex-partner, and at a time when both parties were under the influence of alcohol. Ruth was the victim in all of these incidents. Three of the incidents were risk assessed as medium and three as standard. There was no referral to MARAC. On two of the occasions Ruth was physically assaulted; however, it was on the last incident in July 2018 that resulted in the offender being summonsed to court. Ruth was referred into the IDVA service on three occasions and attempts were made to engage with Ruth, but these were unsuccessful.

13.3.7 During 2018, there was repeated entries in GP records of unsuccessful contacts with Ruth. It was also recorded that Ruth had been issued with a fit note[17] in relation to her ability not to work and that this had been a recurring fit note since January 2017. Her ability not to work was due to her mental health.

13.3.8 On 4 September Ruth was seen by a GP in relation to her mental health. Ruth reported having suicidal thoughts and that she had tried to hang herself a few days earlier; however, she had been stopped by her Mother. Ruth was noted to have fresh cut wrist wounds. A referral was made to the Community Mental Health Team.

13.4 November 2018 – October 2019

13.4.1 The DHR panel were informed that the relationship between Ruth and John started around November 2018. Ruth's family informed the Police the relationship stared in December 2018.

13.4.2 In March 2019 Ruth attended hospital having taken a mixed overdose of codeine, diazepam and alcohol. Ruth told staff that she had little or no family support. Ruth was seen by the Crisis Team and a FACE[18] risk assessment completed. It was recorded that Ruth had low mood due to a partner dying unexpectedly, when she was 19 years old, and that she was currently homeless. Ruth was referred to the Home Treatment Team. Ruth did not attend two appointments and several calls were made to Ruth

[17] https://www.gov.uk/government/collections/fit-note

[18] https://imosphere.com/care-and-support-tools/adult-risk-assessment/

to re-arrange but there was no answer to her phone on each occasion. A letter was sent to Ruth's GP offering Ruth further support should she wish to engage. Ruth was discharged from the Home Treatment Team at the beginning of April.

13.4.3 On 5 April 2019 John's GP provided a letter for a Personal Independent Payment application. This included information on John's medical history. Ruth and John were both in receipt of Employment and Support Allowance (ESA).

13.4.4 On 24 April, Ruth was admitted to hospital having taken an overdose of sertraline. On admission she was noted to be in alcohol withdrawal, she had self-harm marks on her wrists and told staff that she had intentionally tried to take her own life. Ruth remained in hospital, where she received de-tox therapy. On 1 May 2019, Ruth was seen by a Mental Health Practitioner, Ruth stated she did not want a referral to secondary mental health services but agreed that she would like a referral to Aspire, and this referral was made. Ruth was discharged. A letter was sent to her GP which detailed the circumstances, treatment and ongoing care needs.

13.4.5 Aspire tried to contact Ruth via telephone and letter, which included sending her information on service support available. On 7 May 2019 the GP practice stopped Ruth's repeat prescription for sertraline. On 21 May 2019, Ruth was discharged from Aspire due to no contact and engagement.

13.4.6 On 13 May 2019, Ruth was seen by her GP. It was recorded that Ruth had stated that she wanted to work with her GP rather than be referred to secondary care community mental health services. Ruth reported that her main symptoms were shakiness, anxiety and panic attacks but that her mood was better, and she was not suicidal. It was documented that Ruth would be moving to stay with a new partner. Follow up appointment was arranged for 15 June 2019 when Ruth had a telephone consultation and was commenced on a prescription of Fluoxetine.

13.4.7 On 16 July 2019 Lincolnshire Police dealt with a domestic abuse incident between Ruth and John during which Ruth was assaulted. This was the first reported domestic abuse incident in their relationship. The couple were visiting Lincolnshire at the time. John was arrested and later released from custody. Ruth declined to support a prosecution. Lincolnshire Police assessed the incident as high risk and referred the case to MARAC in Doncaster and notified South Yorkshire Police of the incident. Ruth

returned to Doncaster to stay with family. A Domestic Violence Disclosure Scheme (DVDS)[19] was initiated. The response to this is covered further in Section 14.

13.4.8 Two days later Ruth's Mother contacted the Police as John had attended at her address wanting to speak with Ruth. John left the address prior to the Police attending. John was spoken to by the Police on the phone and advised not to attend at the address.

13.4.9 The case was assigned to an IDVA who attempted to contact Ruth via telephone. When this was unsuccessful a letter of support was sent to Ruth. At the end of July, the IDVA received a voicemail from a female, understood to be Ruth, who said, 'Fuck Off'. The case was heard at MARAC on 31 July. Ruth was not informed of the outcome of the MARAC.

13.4.10 The Police attempted to contact Ruth to progress the DVDS and left several voicemails for Ruth to arrange contact. The Police closed the DVDS application on 21 August 2019, disclosure had not been given.

13.4.11 On 12 August 2019 John was sent a letter from a Respiratory Consultant with documented concerns regarding home visits. A copy of the letter was sent to John's GP. The letter documented that home visits were not appropriate due to domestic violence and Class A drug use.

13.4.12 On 14 September 2019 the Police attended a domestic abuse incident between Ruth and John during which Ruth was assaulted. The incident was reported by family. John was arrested by Police and later released. Ruth declined to provide a statement but stated she would support an application for a Domestic Violence Protection Notice (DVPN)[20]. This was not progressed. The case was risk assessed as high and a referral was made to MARAC and IDVA services. The Police re-instigated the DVDS from July 2019 but closed the application down without Ruth being contacted.

13.4.13 On 15 September an IDVA telephoned Ruth but received no response. A letter was sent to Ruth at her parents address to inform her about available support. At the beginning of October, the Police tried to telephone Ruth to

[19] https://www.gov.uk/government/publications/domestic-violence-disclosure-scheme-pilot-guidance

[20] https://www.gov.uk/government/publications/domestic-violence-protection-orders/domestic-violence-protection-notices-dvpns-and-domestic-violence-protection-orders-dvpos-guidance-sections-24-33-crime-and-security-act-2010

progress the DVDS, but were unable to make contact. A MARAC was held on 9 October. Ruth was not informed of the outcome.

13.4.14 On 4 October, Ruth returned from a holiday in Scotland and stayed at her parent's house. Ruth described being exhausted from the holiday. Two days later Ruth went to stay with John. On 7 October, Ruth telephoned her Mother and stated she had consumed a bottle of whisky the day before and self-harmed by cutting her wrist. John was heard shouting in the background. Ruth's Mother reported that she was unable to get in contact with Ruth for the following days until she received a text from Ruth declining to meet her for lunch. Ruth stated she was not feeling well.

13.4.15 A few days later Ruth was found deceased.

14. ANALYSIS USING THE TERMS OF REFERENCE

14.1 Term 1

What indicators of domestic abuse, including coercive and controlling behaviour, did your agency have that could have identified Ruth as a victim of domestic abuse and what was your response.

Police

14.1.1 The Police had information that Ruth was a victim of domestic abuse from incidents that had been reported to them. There were 8 incidents of domestic abuse between 2016 and 2018 with a previous partner. The majority of these incidents occurred after the relationship had ended. Ruth was assaulted on two of the incidents. The other incidents identified indicators of verbal abuse, theft, and criminal damage. The last incident, (July 2018), resulted in the perpetrator receiving a summons to court for an offence of assault; however, the case was later dismissed by the courts as no evidence was offered. DASH risk assessments were completed by the attending Officers on all incidents which were reviewed by a Domestic Abuse Risk Assessor (DARA) and shared with partner agencies in accordance with policies in place at that time. These incidents when reviewed against the CPS checklist[21] identified coercive control.

14.1.2 In July 2019, Ruth reported to Lincolnshire Police that she had been assaulted by John and that she had been punched to her face several times. Ruth and John were on holiday at a caravan site in Lincolnshire. During contact with the Police and completion of the DASH Ruth described -

- Previous assaults which were not reported. Abuse was happening more often and that she had been assaulted 3-4 times in the last six months. On one incident 3-4 weeks earlier John had attempted to strangle her with his hands.
- John made threats to kill her Mother and Father and burn their house down.

- John prevented her going to medical appointments. Ruth gave an example that a Doctor had telephoned her the day previously and

[21] https://www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship#:~:text=Taking%20control%20over%20aspects%20of,telling%20them%20they%20are%20worthless

she had to have the phone on loudspeaker so that John could hear and suggested what things to say. This had also occurred when she was contacted by a Doctor to follow up on an overdose a few weeks earlier.

- John takes her phone.
- John often throws her out of his address and keeps her medication.
- Isolation.
- John is harassing her parents by calling them.
- Ruth's Father blocked phone number.
- John was drinking a lot every day.

14.1.3 Ruth provided the following account to the attending Officer – 'On Tuesday 16/07/2019 myself and my partner John (redacted surname) were at (address redacted). I have had 5 pints but I cannot tell how much drink he had. Suddenly he started to be angry with me, he called me a slag. He punched my face, around jaw and mouth area.

His punch knocked me out and lost consciousness. When I came round I saw blood on the wall in the hallway. John (redacted name) said to me: "Come to bed. Come to bed." When I refused he got angry again. I rang my mother and told her what has happened. John was not happy with it and he threw me out from the caravan. I went to the Chinese take away and ordered some food, but I could not eat anything due to the pain in my jaw. The Chinese takeaway is located next to the entrance to the caravan site. I was sitting on the bench outside when the police arrived. Due to having few drinks last night I am willing to provide a full statement when I will be sober."

14.1.4 John was arrested by the Police on suspicion of assault and for coercive and controlling behaviour. At the time of his arrest John was in possession of a bag containing a class A drug. Injury photographs were taken of Ruth's injuries and she attended at hospital. The incident was risk assessed as high and referred to MARAC in Lincolnshire. The MARAC referral was transferred to Doncaster as this is where Ruth and John resided.

14.1.5 John was interviewed and denied the allegations and claimed self-defence. Ruth was seen the following morning by a Police Officer and declined to provide a further statement. It was recorded that Ruth stated, "I do not want to provide a statement. I was injured by my partner John (surname redacted) during an altercation last night. I am not prepared to attend court over the matter." John was released from custody due to insufficient evidence to charge. Lincolnshire Police stated that the decision to take no further action was based on the lack of independent evidence

coupled with the account of self-defence provided by John, and the number of injuries on John's body compared to those on the victim, which did not result in a realistic prospect of conviction. A DVPN was discussed with Ruth however was not progressed as Ruth had told the Police that she was going to return to Doncaster and stay at her Parents address which would be a different location to John. The Police contacted Ruth's Mother and explained the circumstances to her and safety plans if John arrived at their house. The Police informed the review that safeguarding measures were instigated, Ruth was taken to the train station and it was confirmed that she had caught a train to Doncaster, and therefore a DVPN was not necessary. This is addressed later in the report.

14.1.6 South Yorkshire Police received the MARAC referral on 17 July, which was then referred to DARA (Domestic Abuse Risk Assessors) with a request for a 'Right to Know' DVDS application to be progressed. Following the completion of research, the DVDS was authorised by a Detective Inspector to be progressed with Ruth. A referral was made to the IDVA service and a MARAC was arranged for 31 July.

14.1.7 On 18 July, two days after the assault in Lincolnshire, John attended at Ruth's Mothers house to speak with Ruth. John did not see Ruth; however, she contacted the Police to report the incident. John was contacted via the telephone by the police and advised not to attend at the address. A DASH was completed which graded the risk level as medium, which was attributed to the fact that Ruth was living with her parents and not in contact with John.

14.1.8 The DVDS application was closed on 21 August 2019. Ruth had not been provided with disclosure. The Police have acknowledged in their IMR that more robust attempts should have been instigated to engage with Ruth to progress the DVDS. This is addressed further under Term 9.

14.1.9 The call to the Police from Ruth's Father on 14 September 2019 provided further evidence of domestic abuse. On this occasion Ruth's Mother was outside of an address and could hear a disturbance inside the property. Ruth's Mother provided a statement to the Police in which she stated Ruth had telephoned her, she was crying and had asked her Mother to pick her up. During the call Ruth was heard to say, 'Don't you hit me you horrible bastard'. The Police found Ruth and John inside. Ruth told the Police that they had both been drinking alcohol, and that John had asked Ruth to leave, and take her belongings. John had grabbed her by the wrist, pushed her in the chest and had thrown her to the floor causing bruising to her knees. The incident was risk assessed as high. During the completion of the DASH Ruth stated –

- She had previous injuries which included black eyes, bruising all over body and John had pulled her hair out.
- Emotional abuse in that he tells her that her children hate her.
- They had separated multiple times, only been back together a week before he assaulted me again.
- Called her Mum and Dad to get at me and takes her phone from her.
- Assaults her without warning.
- She suffers with depression and is on medication. She had tried to take her own life in the past, overdosed twice in April 2019 and had tried to hang herself on two occasions.
- Strangled her in Lincolnshire during which she lost consciousness.
- Controlling – by telling her what she can wear, jealous because he is older and thinks she will leave.
- John uses cocaine.

14.1.10 Ruth declined to provide a statement; but agreed to the following entry in the attending Officer's notebook - "I do not wish to provide a statement or attend court in relation to the incident and will not provide officers with a statement. I can confirm that what I have signed in (redacted) notebook is true and accurate. I support a domestic violence protection order. I do not want him to contact me or my family." Ruth's Mother provided the Police with a statement. The review panel have had access to this statement.

14.1.11 John was arrested and during interview he denied assaulting Ruth and stated that the injuries had been sustained when Ruth fell over, whilst in drink as they left a nearby racecourse. John claimed that Ruth had struck him with a coat hanger. John showed the custody nurse injuries from this assault. The case was closed with no further action as there was no complaint from Ruth. A DVPN was considered, but not progressed. The criminal investigation was not progressed further due to the conflicting accounts. This is addressed further under Term 7.

14.1.12 The case was referred to IDVA services and a MARAC set for 9 October 2019. The DVDS application from July 2019 was re-opened, as opposed to a new DVDS application being instigated. The Officer authorising the DVDS to be re-opened noted that Ruth had not been seen by the Police in person in relation to the earlier DVDS and that the DVDS still required progressing; however, the DVDS was closed a short time later, having not been progressed further. This is addressed under Term 9.

14.1.13 The DHR panel considered the legislation, under Section 76 Serious Crime Act 2015, in relation to coercive control which states that coercive control is committed by a perpetrator if:

The Perpetrator repeatedly or continuously engages in behaviour towards the victim, that is controlling or coercive; AND

At the time of the behaviour, the Perpetrator and the Victim are

1. In an intimate personal relationship;
2. They live together and are either members of the same family;
3. They live together having been in an intimate personal relationship with each other; AND

The behaviour will have a 'serious effect' on the victim and the perpetrator knows or ought to know that the behaviour will have a serious effect on the victim.

The legislation describes 'serious effect' being to cause the victim to fear on at least two occasions that violence will be used against them (Sec 76 (4) (a). There is no requirement that violence has to have been used or threatened.

14.1.14 The panel agreed with the Police that Ruth had described evidence of coercive and controlling behaviour in the information provided to the Police in DASH risk assessments and Officer's notebooks. The panel questioned the decision making on both incidents, which determined that the outcome would be to take no further action against John based on Ruth's reluctance to provide a written statement. It was clear to the panel that there was evidence available which should have been used to consider a criminal case which included, detailed DASH information, photographic evidence of injuries and John's previous involvement in domestic abuse, which could have been considered as evidence of bad character. The panel have identified this as an area of learning and made a relevant recommendation. [Recommendation 1]

<u>IDVA</u>

14.1.15 The IDVA service had knowledge that Ruth was a victim of domestic abuse from three previous referrals into Domestic Abuse Caseworker (DAC) service between 2016 and 2018. A DAC supports victims of domestic abuse assessed as standard or medium risk. Support is with consent of the victim. These referrals related to a previous partner of Ruth's. Ruth did not engage with the service during this time and the referrals were subsequently closed in accordance with policy.

14.1.16 In July 2019 the IDVA service received information, via a DASH, assessed as high risk, that Ruth was at risk of domestic abuse and coercive control from John as detailed in 14.1.2. Ruth was allocated an IDVA, and attempts

were made to contact her. The IDVA service also received the DASH, from South Yorkshire Police on 18 July which determined the risk to be medium. The IDVA service were given an action from the MARAC to update Ruth of the MARAC outcome. This was not undertaken. The case was closed to the IDVA service on 20 August 2019. IDVA contact and MARAC actions are analysed under Term 2.

14.1.17 The IDVA service received further information from the Police on 18 September 2019 following the high-risk incident on 16 September. The case was allocated to an IDVA. The information shared identified that Ruth was a victim of domestic abuse and coercive control as detailed at 14.1.9. The IDVA service response to this information and actions from the MARAC are addressed in Term 2.

Doncaster and Bassetlaw Teaching Hospital NHS Foundation Trust

14.1.18 Ruth had three attendances at the Accident and Emergency Department having taken an overdose. This did not provide an opportunity to ask a 'Routine Enquiry' around domestic abuse. These presentations did not indicate evidence of domestic abuse and coercive and controlling behaviour.

DCST

14.1.19 During the completion of a Child & Family Assessment in 2017 it was identified that there had been domestic abuse in Ruth's relationship with previous partners. This information was used to inform the assessment. Ruth was not in a relationship with these partners at that time.

RDASH

14.1.20 The assessments and contacts undertaken, by specialist practitioners, raised no concerns or indicators of domestic abuse for Ruth within her intimate relationships. In February 2018, Ruth informed a professional that she had 'severed ties with her parents as her father is and always has been controlling and inappropriate towards her'. Ruth further stated that she was working with mental health services to improve her mental health, was in control of her finances and this had empowered her slightly.

14.1.21 Two FACE Risk Assessments were completed by the RDaSH Hospital Liaison worker during the scope of this report. The initial FACE risk assessment completed on 15 March 2019, evidenced that Ruth was asked about domestic/emotional abuse by others within the assessment. Ruth stated that her Father was emotionally abusive. On 1 May 2019 a review of the initial FACE risk assessment was carried out. Ruth was asked about domestic abuse and disclosed continued emotional abuse from her Father

but stated that she would not be continuing to reside with him following discharge from hospital and that she was going to stay with a friend, whom she identified as John. There was no evidence to suggest that Ruth was asked any questions around her relationship status. Whilst the staff acknowledged that Ruth disclosed her relationship with her father had been abusive, it was deemed that as she was not returning to his home, there was no risk to her at that time. RDaSH have identified this as an area of learning in relation to awareness of domestic abuse in familial relationships and have made a relevant recommendation.

Doncaster Clinical Commissioning Group

14.1.22 The following indicators of domestic abuse were recorded in Ruth's medical notes - anxiety, depression, self-harm, overdose, suicidal thoughts, substance and alcohol misuse, pregnancy, and miscarriage. These presentations provided opportunities for routine enquiry to be asked of Ruth in relation to domestic abuse. This did not take place. This has been identified as learning by the CCG.

14.1.23 On 22 July 2019 an alert was added to System One regarding MARAC involvement. This alert was added by Drug and Alcohol Services and not the GP practice as the GP practice did not receive notification of the MARAC. This has been identified as learning by the CCG who have made a relevant recommendation. There was no previous record of domestic abuse in primary care records.

14.2 Term 2

What risk assessments did your agency undertake for Ruth; what was the outcome and if you provided services were they fit for purpose?

Police

14.2.1 Police Forces across the country utilise the nationally agreed Domestic Abuse, Stalking and Harassment and Honour Based Violence Risk Identification and Management Model in the form of the DASH question sets. The DASH form and evaluation was developed by Laura Richards (BSc, MSc, MBPsS) in conjunction with the National Police Chief's Council and Safelives.

14.2.2 Within South Yorkshire Police the Officer attending an incident of domestic abuse, completes a DASH and provides an initial risk level which is reviewed by a DARA, who then provide the specialist risk assessment having provided a holistic review and research in relation to the case. The

DARA has received specialist training designed by Laura Richards training and also by DARA Manager, who has extensive domestic abuse knowledge and is a qualified trainer in DASH, Stalking, honour based abuse and a trainer for Safelives. The risk level is determined as follows -

Standard Risk – Current evidence does not indicate the likelihood of serious harm.

Medium Risk – Identified indicators of risk or serious harm, offender has potential to cause serious harm but unlikely to do so unless change in circumstances.

High Risk – Identified indicators of imminent serious harm that could happen at any time and impact would be serious.

All domestic abuse cases, whether crime or non-crime, where there are children within the family, whether they were present or not, are referred to Children's Social Care. Pregnant victims and perpetrators are referred to Children's Social Care and Pregnancy Services. All high risk cases are referred to IDVA's and MARAC. Where care needs are identified for adults these would be referred to Adult Social Care.

Medium and standard risk cases are referred to DA services with victim consent. Some examples of support services victims can be referred to with their consent -

Karma Nirvana[22]

Ashiana[23]

Project Nova[24]

Paladin[25]

Men Standing up[26]

14.2.3 The Police had completed DASH risk assessments as a result of incidents of domestic abuse between Ruth and previous partners. These matters had either been assessed as standard or medium. Ruth had been referred into the IDVA service on three previous occasions.

[22] https://karmanirvana.org.uk/

[23] http://www.ashianasheffield.org/

[24] https://www.rfea.org.uk/our-programmes-partnerships/project-nova/contact-project-nova/

[25] https://paladinservice.co.uk/

[26] http://www.bradfordcyrenians.org.uk/men-standing-up/

14.2.4 Ruth was assessed as being at high risk of domestic abuse in July 2019, which resulted in the Police referring Ruth to the IDVA service and MARAC due to the level of risk. In addition, the Police ensured "tags" were assigned to telephone numbers, names and addresses on the case which alerted the Forces call handlers and Officers to previous domestic abuse incidents in the event of further calls.

14.2.5 The high-risk assessment in September 2019 recognised that Ruth was at risk of serious harm if safeguarding measures were not implemented. The assessment acknowledged that the relationship had resumed, and that Ruth had been assaulted and therefore the risk level was accurate. In accordance with policies the case was referred to the IDVA service and MARAC. DVDS applications were instigated in July and September 2019 and these are addressed under Term 6.

IDVA

14.2.6 No risk assessments were completed with Ruth by the IDVA. Following the receipt of the Police referral in July 2019 phone contact was attempted with Ruth. Ruth did not answer any calls and therefore the IDVA sent a text message and a letter to Ruth. The letter was sent to the address provided by Lincolnshire and South Yorkshire Police, which was recorded as being different to John's. The letter outlined that independent support was available for Ruth and that she was subject to MARAC on 31 July 2019. The letter also contained a leaflet with information about the IDVA service and MARAC and what support could be accessed. On 29 July 2019 a voicemail was received by the IDVA from a female using Ruth's phone. The message was "Fuck Off".

14.2.7 The IDVA received a further DASH in September 2019 from South Yorkshire Police. Telephone contact was again attempted but calls were not answered by Ruth and a further letter of support was sent to Ruth. The letter was sent to her parent's address.

14.2.8 As the IDVA was unable to make contact with Ruth there was no IDVA risk assessment completed and therefore no opportunity to discuss and provide safeguarding options and the case was closed. The panel have had access to the IDVA policy on case closure which states the following –

Non-engaging clients:

It is inevitable some clients will never or disengage with support or resume a relationship with the perpetrator. In such case the IDVA must ensure:

- All methods of safe contact have been attempted.

- Known agencies working with the victim have been contacted and attempts to engage with them have been made and documented.
- The referrer is informed.
- Safeguarding are alerted.
- GP is informed.

14.2.9 Below is listed the action taken by the IDVA in accordance with the IDVA policy for non-engaging clients –

- **All methods of safe contact have been attempted** - Telephone contact, text messages and letters were used to try and make contact with Ruth. A visit to her parents was not completed
- **Known agencies working with the victim have been contacted and attempts to engage with them have been made and documented** - Contact with South Yorkshire Police Domestic Abuse Team had been made by the IDVA. The Police were the only service that had any sort of contact ongoing with Ruth
- **The referrer is informed** – The referring agency was the Police and Officers knew that there had not been successful contact.
- **Safeguarding are alerted** - Information was shared by the IDVA at the MARAC meeting with all services present. The domestic abuse referrals received by the IDVA service were forwarded to Doncaster Children's Services Trust
- **GP is informed** - This was not completed by the IDVA. The process of informing GP Practices had been an administration function. The practice of routinely contacting GPs was not being undertaken at the time the case was closed. Contact by IDVA's working on cases, with GP Practices, is now standard practice.

The IDVA contact with Ruth is addressed later under Term 3.

<u>Doncaster Bassetlaw Teaching Hospital NHS Foundation Trust</u>

14.2.10 The Trust does use the Domestic Abuse hub referral form and the DASH referral form, where appropriate. There were not indicators of domestic abuse during contact with Ruth that required the completion and submission of these forms. Had a disclosure been made it would have been referred via the completion of the forms and forwarded to the Hub.

<u>DCST</u>

14.2.11 No domestic abuse risk assessments were completed with Ruth by DCST during this time period. Ruth was not in contact with her children and there had been no evidence of children having been present during the incidents under the timeframe of this review.

RDASH

14.2.12 A full needs assessment was undertaken by Hospital Liaison Team in the Emergency Department following Ruth's attendance having taken an overdose. The assessment identified that Ruth had suffered for many years with severe low mood and anxiety as well a prolonged history of substance misuse involving drugs and alcohol. A FACE (Functional Analysis of Clinical Environment) risk assessment completed at the appointment identified that there was 'no apparent risk of abuse/exploitation by others' and therefore was given a risk score of 0. Within the categories of 'personal circumstances indicative of risk', the sub-categories of abuse/neglect/victimisation by others (adults or children including domestic violence), and domestic abuse, are both categorised as 'not known' for historical risks or current risks. The outcome of the assessment was a recommendation that Ruth be referred to the Home Based Treatment Team for appropriate intervention and support to meet her individual needs.

14.2.13 In addition, the FACE risk assessment considered significant history and referenced alleged historical emotional abuse, by her Father and involvement from children's services. A further FACE risk assessment was completed by the Home Based Treatment team on 1 May 2019. The most significant risk identified was that of drug and alcohol relapse, overdose, and self-harm, all of which were considered to be of high risk and the score reflected this. The assessment identified that at times when Ruth "felt hopeless" she would self- harm and overdose on alcohol and medication. It was identified that Ruth did not want to end her life, but these actions were an expression of the "hopelessness" she felt. The assessment identified that a former partner of Ruth's had died suddenly when she was 19 years old and this had been a very difficult experience for her. Ruth was referred to IAPT by her GP, following her partners death, however following unsuccessful attempts to contact Ruth, she was discharged from the service and her GP was informed. It also identified that Ruth had several health problems, COPD and suffered recurrent bouts of pneumonia.

14.2.14 The panel considered the appropriateness of Ruth being sent a letter when she was known at that time to be sofa surfing. The panel were informed that there was evidence in the records that Ruth had been given the contact details for the Single Point of Access Team and an initial

appointment arranged to take place on 17 March 2019, which she did not attend. Ruth later contacted the team by phone, to apologise for not attending the arranged appointment and a further appointment was agreed and arranged for the following day on the 18 March 2019. A further five phone calls were made between the 23 and 26 March, and despite the phone being answered, there was no dialogue with the person that answered the call, and the phone was hung up. This prevented a message being left. The Home-based treatment team held a multi-disciplinary meeting to discuss discharge and the rationale for discharge was that Ruth was aware that she could attend the A&E department for another assessment if she chose to engage in the future, Ruth was in receipt of the single point of access phone numbers, Ruth's GP had been informed of the discharge and there was evidence that Ruth had access to a phone if she needed to access support. The panel concluded that the attempts to engage with Ruth evidenced good practice of a flexible approach for someone who did not have secure accommodation and was transient. It was also recognised that Ruth could attend hospital or contact the Home Based Treatment Team if she chose to engage in the future.

14.2.15 The panel reviewed the risk assessments that had been completed on the case and agreed that the risk levels reached were correct in accordance with the information known at that time.

Doncaster Clinical Commissioning Group

14.2.16 Suicide risk assessments during consultations for depression were recorded on every occasion. On 4 September 2018 this resulted in prompt action by the GP who made an urgent telephone referral to Mental Health crisis team.

14.2.17 There were no risk assessments in relation to domestic abuse completed by primary care as they were not aware of domestic abuse until the MARAC entry on 22 July 2019, and Ruth was not seen by primary care after this date.

14.3 Term 3

What was your agency's knowledge of any barriers faced by Ruth that might have prevented her reporting domestic abuse and what did it do to overcome them?

14.3.1 The Police gathered evidence during the completion of DASH risk assessments that Ruth was a victim of coercive control which could have prevented her from reporting domestic abuse. This included physical

violence, strangulation, jealousy, and isolation. It was also known that Ruth had COPD, reduced mobility and depression and anxiety.

14.3.2 During the MARAC meeting on 31 July information was shared that Ruth was known to suffer from anxiety and depression, self-harm, issues with alcohol and had previously taken overdoses. It was reported in the meeting that when she did engage with services, she did not maintain the engagement.

14.3.3 The IDVA received a voicemail from Ruth at the end of July 2019. The voicemail said, 'Fuck Off". The review has been informed that it was Ruth who had left the message. Whilst the message can be an indicator that Ruth did not want to engage with the IDVA service, it is not known in what context this comment was made and given Ruth's issues with alcohol whether this comment was made when she was sober.

14.3.4 The Police Officer progressing the DVDS and the IDVA did not speak with Ruth. The IDVA sent letters to Ruth's parents on two occasions where Ruth was believed to be living. However, as no agency had spoken to Ruth this could not be confirmed as being her home address.

14.3.5 It is evident from RDaSH records that Ruth did not access the ongoing support offered to her by mental health services. There were two face to face contacts with Ruth during which assessments were completed. All staff who attend RDaSH domestic abuse training are encouraged to use professional curiosity and routinely ask questions in relation to domestic abuse. During the assessments undertaken by RDaSH Ruth did not disclose that she was experiencing domestic abuse.

14.3.6 The panel acknowledged that victims can find it difficult to disclose domestic abuse, particularly when they do not have a trusted relationship with a professional. The impact of family relationships may have been a barrier, in particular Ruth's comments to health professionals around her relationship with her Father, may have prevented her contacting services. It was known during the timescales of this review that Ruth was at times sofa-surfing in between living with her parents, and John.

14.3.7 Ruth had not returned voicemails left by the IDVA service and Police. Contact by the Police and IDVA was via the phone and letter. It is not known if Ruth received the letters. The panel considered whether professionals should have undertaken other forms of communication, including face to face meetings, to engage with Ruth. This was of particular importance as the review has seen evidence within the DASH risk assessments, that John 'stood over Ruth' when she was on the telephone and that he prevented her from having her phone. This evidence was

known to the Police and IDVA and the panel questioned whether those professionals who were trying to contact Ruth were aware of the information and if they had taken this into consideration during their contact. This panel have identified this as an area of learning and made a relevant recommendation. [Recommendation 2]

14.4 Term 4

What knowledge did your agency have of Ruth and John's physical and mental health needs and what services did you provide?

14.4.1 Ruth had attempted to take her own life on ten occasions between 2016 and 2019. Ruth had hospital admissions between 2016 and 2018 due to her mental health. It was confirmed during the post-mortem examination that Ruth had incised wounds over her old scars, which were deemed consistent with self-harm and that these had been sustained just before or possibly leading up to her death.

14.4.2 Ruth received a caution in 2016, following an assault, after she had been found attempting to drown herself in a hot tub. At the end of May 2018 Ruth was taken to hospital by the Police after she had presented to Officers with injuries to her wrist and face caused by a razor blade. Ruth was seen by the Crisis Team and referred into services. Ruth's Father informed the Police in 2018 that Ruth had a history of self-harm.

14.4.3 Ruth's mental health and self-harm formed part of the contact and engagement with DCST, which were outside the terms of reference for this review. The contact centred on support around safety planning for the children in times when Ruth's mental health declined and/or she required hospital admission. From 2017 Ruth did not engage with DCST.

14.4.4 At times of crisis Ruth attended at hospital, who provided acute care. Ruth's mental health concerns were referred to specialist services. On the occasions that Ruth was referred to the Mental Health Team, she was seen promptly, whilst in the Accident and Emergency department. Ruth disclosed during her assessments that she had suffered for many years with severe low mood and anxiety, as well a prolonged history of substance misuse involving drugs and alcohol.

14.4.5 The review has seen evidence that in March 2019, Ruth did not engage with Mental Health Services after being referred into the Home Based Treatment Team. When Ruth did not attend an appointment, she was contacted via telephone and a voicemail left. Ruth returned the call and

stated she had got the time mixed up and she was unable to talk as she was with a friend. The appointment was re-arranged but Ruth did not attend that appointment. The friend was not identified. A further five calls were made to Ruth, but she did not answer.

14.4.6 Following a team discussion, it was identified and agreed, in accordance with the Trust policy, that a letter was to be sent out to Ruth asking her to contact the service within 7 days. However, it was unclear as to whether Ruth was residing at the address that the letter was sent to, and whether she received the correspondence as she had previously identified that she had been "sofa surfing" with friends. There was no contact made by Ruth and she was discharged from the service.

14.4.7 The IMR Author has identified learning and made a recommendation for their agency in relation to the adaptation of the RDaSH Disengagement Policy and in relation to patients who are known or assessed to be at risk of dis-engagement and re-engagement with the service.

14.4.8 Ruth was admitted to hospital in April 2019 following an overdose. Upon discharge RDaSH sent a letter to Ruth's GP. It is known that Ruth's overdoses often involved her prescription medications and alcohol. As a result of Ruth's hospital admission there was a review of Ruth's medication by a GP.

14.4.9 Information was provided to the review regarding John's physical and mental health needs. Information shared at the MARAC meeting identified that John suffered from COPD and had heart problems for which he received regular medication, that was reviewed at appropriate intervals. In September 2019 John was diagnosed with depression and prescribed antidepressant medication.

14.5 Term 5

What knowledge or concerns did the victim's family, friends, colleagues, and wider community have about Ruth's victimisation and did they know what to do with it?

14.5.1 In July 2019 Ruth's Mother contacted the Police to report that John had attended her house to speak with Ruth. This incident was two days after Ruth had been assaulted by John in Lincolnshire and she had moved to live with her Mother. Two months later Ruth's Father contacted the Police and reported that Ruth had been assaulted by John. Whilst these incidents are indicators that Ruth's family knew about Ruth's victimisation, the review

panel have not been able to gather further information from the family on their wider knowledge and agencies who could have been contacted.

14.5.2 The panel reviewed what information is available for family, friends, colleagues, and the wider community within Doncaster. A search of the internet using the search term, 'Domestic abuse support Doncaster' produces results[27] for Doncaster Metropolitan Borough Council, Phoenix Women's Aid, RDaSH, DCST and South Yorkshire Police.

14.5.3 In addition, there is a link to a four-page PDF document[28] titled, 'South Yorkshire Domestic Abuse Support Services', which details support services across the South Yorkshire region. The document also details information on mental health services.

14.5.4 The review sought information from the Domestic Abuse Communications Lead at Doncaster Metropolitan Borough Council. The review was provided with a wealth of information in relation to publicity campaigns and information sharing that had taken place over recent years, including within the timescales of this review. The below list contains some of the information that the review received, (this is not the definitive list) –

- Leaflet – 'Domestic Abuse Guide for Practitioners'
- Leaflet – 'Are you experiencing domestic abuse'
- Offline marketing – use of banners in public places such as libraries and family hubs.
- Posters targeting specific groups such as – Men, LGBTQ+ community, Women, General audience and Families
- Press releases
- Online marketing
- Online reporting form
- Ongoing work with council's youth council and young advisors to develop a section of the website specifically for children and young people around unhealthy relationships both familiar and relationships with people of their own age.

[27] https://www.google.com/search?sxsrf=ALeKk01k2_XMi0ZTMCgdNOx45-Gqu0Di2A%3A1615364026040&source=hp&ei=un9IYJIUgt5qo7WgiA0&iflsig=AINFCbYAAAAAYEiNylWYcmNa6ScqmAeOjIW4sZozOeXZ&q=domestic+abuse+support+doncaster&oq=domestic+abuse&gs_lcp=Cgdnd3Mtd2l6EAEYADIECCMQJzIECCMQJzIECCMQJzIHCAAQsQMQQzIECAAQQzILCAAQsQMQgwEQkQIyCwgAELEDEMkDEJECMgUIABCSAzIECAAQQzIICAAQsQMQgwE6BQgAEJECOgQILhBDOgoILhCxAxCDARBDOgoILhDHARCvARBDOgsILhCxAxDHARCjAjoFCAAQsQNQ9QlY_B9ghS9oAHAAeACAAXKIAfYIkgEEMTMuMZgBAKABAaoBB2d3cy13aXo&sclient=gws-wiz

[28] https://sayit.org.uk/wp-content/uploads/2019/10/South-Yorkshire-Domestic-Abuse-Support-Services.pdf

- A specific campaign will be developed to promote this new function and channels for the target audience such as Tik Tok, You Tube and Instagram.
- Resident e-letter (97,000 residents signed up to receive)

14.5.5 The review were also informed that a communications plan has been written for the rest of 2021 up to March 2022, this will be linked with the newly created domestic abuse strategy to ensure communications support the objectives in the strategy. The following campaigns will be running in 2021:

- Inclusion in the Parental Conflict summer campaign
- Inclusion in the mental health campaign
- LGTQ+ to support Doncaster's Pride event in August
- What is Domestic Abuse – explaining the types of control
- International men's day
- 16 days of action
- Christmas and New Year campaign
- Neighbour support campaign – just because it's behind closed doors doesn't mean it should stay private
- Perpetrator campaign
- Targeted campaigns in areas of high instances of domestic abuse.
- Alternative channels – publicity through bus tickets and pharmacy bags.

14.5.6 The panel acknowledged the work that was ongoing across Doncaster to raise awareness of domestic abuse and have therefore not made a recommendation in relation to this area of learning.

14.6 Term 6

What knowledge did your agency have that indicated John might be a perpetrator of domestic abuse and what was the response, including any referrals to a Multi-Agency Risk Assessment Conference [MARAC]?

14.6.1 In 2005 John was convicted of domestic abuse crimes relating to harassment and witness intimidation. It was known that John was supervised by Probation following the 2005 convictions; however, Probation records from this time have been deleted in accordance with retention policies. In addition to his convictions John has been identified by the Police as a perpetrator of domestic abuse against previous partners between 2005 – 2012. [See 3.2]

14.6.2 Between 2010 and 2012 the Police received three complaints of assault from ex-partners of John. On one occasion John was reported to have punched his victim in the face twice, on another occasion he spat at the victim and punched her in the eye causing bruising. On the third incident the victim sustained a swollen nose after being punched by John. None of these resulted in a criminal charge.

14.6.3 In addition to these crimes the Police attended a further five incidents of domestic abuse involving John that did not involve criminal offences. These incidents included John banging on victim's doors and verbal arguments.

14.6.4 DCST had information from between 2010 and 2012 in relation to children of John's then partner that he was a perpetrator of domestic abuse. These contacts are linked to the information held by the Police in relation to physical assaults.

14.6.5 There were two referrals to MARAC in relation to John. These were in July and September 2019 for the incidents involving Ruth. Markers were placed on Ruth and John's health record that they were known to be victim and perpetrator's (respectively) of domestic abuse. This flag remains on individual's health records for 12 months from the date of the last presentation to MARAC.

14.6.6 The MARAC meetings were held on 31 July and 9 October 2019. The only action from both meetings was for the IDVA to inform Ruth of the MARAC. The IDVA did not complete the action for either MARAC. The panel were informed that the IDVA was concerned that as Ruth had not responded to previous phone calls and that by sending a letter, it could potentially, have increased the risk for Ruth if she received a letter from the IDVA service and it was read by John. The IDVA service informed the panel that an action on updating clients about meetings is a standard action that is usually carried out by the IDVA or by the service having the most engagement/best relationship with the victim following a MARAC.

14.6.7 The DHR panel agreed that the decision not to send a letter following the MARAC was at variance to letters that had been sent to Ruth by the IDVA service in response to the two high risk DASH assessments. [Recommendation 2]

14.6.8 In August 2019, John was sent a letter from a Respiratory Consultant which stated - " I have been informed by the Community Respiratory Nurses that due to previous allegations regarding domestic violence and class A drug possession the Respiratory Nurses will not be visiting your

house. I hope that you understand this is their decision after a formal hearing." A copy of this letter was sent to the GP.

14.6.9 The Respiratory Nurse informed the IMR Author from the CCG who explained that they had seen the entry on System One which related to MARAC involvement of John whilst reviewing records and felt it would be safer for John to be seen in the clinic rather than a home visit.

14.7 Term 7

Was there sufficient focus on reducing the impact of John's alleged abusive behaviour towards the victim by applying an appropriate mix of sanctions (arrest/charge) and treatment interventions?

14.7.1 There were several opportunities for agencies to implement processes to safeguard Ruth from John.

14.7.2 In July 2019 Ruth had told the Police that she would support a prosecution. Ruth was seen by Officers to have physical injuries for which she received medical treatment. The injuries were also photographed. During the completion of the DASH, Ruth provided additional information that identified coercive control, a fact that was recognised by the attending Officer. John was arrested for assault and coercive control.

14.7.3 When the Police saw Ruth the following day, she declined to provide a statement. John denied the assault and was released from custody. At this point, the Police had an opportunity to consider charging John with offences of assault and coercive control as part of an evidence-based prosecution – i.e. without a victim statement. The decision to charge with these offences would need to be authorised by the CPS.

14.7.4 The Police could have put in place a DVPN at the point of John's release. The College of Policing[29] states – 'Officers have a duty to take or initiate steps to make a victim as safe as possible. Officers should consider domestic violence protection notices (DVPN) and domestic violence protection orders (DVPO) at an early stage following a domestic abuse incident as part of this duty. These notices and orders may be used following a domestic incident to provide short-term protection to the victim when arrest has not been made but positive action is required, or where an

[29] https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/domestic-abuse/arrest-and-other-positive-approaches/domestic-violence-protection-notices-and-domestic-violence-protection-orders/

arrest has taken place, but the investigation is in progress. This could be where a decision is made to caution the perpetrator or take no further action (NFA), or when the suspect is bailed without conditions. They may also be considered when a case is referred by MARAC'.

14.7.5 A DVPN is designed to give breathing space to victims by granting a temporary respite from their abuser and allowing referral to support services without interference. A DVPN/DVPO can be pursued without the victim's active support, or even against their wishes, if this is considered necessary to protect them from violence or threat of violence. The victim also does not have to attend court which can help by removing responsibility from the victim for taking action against their abuser. DVPNs and DVPOs are governed by sections 24 to 33 of the Crime and Security Act 2010 (CSA). The victim does not have to be living with the abuser for a DVPN to be issued.

14.7.6 It was known that Ruth had left John in the days after the incident in July and that she moved to live with her Mother. At the point of leaving John, she had not been contacted by the IDVA service. Whilst the move to her Mothers could be seen that Ruth was safe from John, an incident occurred two days after whereby John attended at the house to see Ruth. John was spoken to by the Police via a telephone call and advised not to attend the address. This incident was risk assessed as medium. No other action was taken. The panel determined that the matter had been treated in isolation and the risk to Ruth not fully recognised. This was another opportunity to consider a DVPN. The panel have identified this as an area of learning and made a relevant recommendation. [Recommendation 3]

14.7.7 In January 2020, SYP established a team to deal with DVPN/DVPO's. Since March 2020 the team have had overall responsibility for DVPO applications Prior to this date applications at court were made by Protecting Vulnerable People Officers (Support Staff and Police Officers) with breaches being presented by the Force solicitor or private legal practice on behalf of SYP. The DVPO team now make all applications and present breaches. Below provides statistical data –

	2014	2015	2016	2017	2018	2019	2020
DVPN applied for by Officer	53	58	63	147	360	628	799
DVPN authorised	43	53	54	122	316	594	757
DVPO Applied for at Court							739
DVPO approved at Court							588
Breach of DVPN	2	0	1	2	3	7	8

Breach of DVPO	3	8	9	30	71	103	135

14.7.8 A DVDS had been initiated by the Police; however, disclosure was not provided to Ruth and the DVDS was closed towards the end of August. The DVDS provides the Police with a framework to share convictions and intelligence to victims of domestic abuse about a perpetrator that they are in a relationship. This process provides victims with information so that they can make an informed decision and about their relationship and assist with safety planning. The DVDS provides a further opportunity for victims to be informed about the availability of support services. Ruth's contact with the Police in July was the first reported incident of domestic abuse; however, during that contact Ruth disclosed that she had been assaulted 3-4 times in the last six months and the abuse was happening more frequently. The panel agreed that the abuse was escalating in the relationship. The DVDS is analysed further under Term 9.

14.7.9 In September a further incident of domestic abuse was reported to the Police. John was arrested and claimed that the injuries sustained to Ruth had been as a result of self-defence. Ruth declined to provide the Police with a statement but did state that she would support a DVPN. John was released from custody and no further action was taken.

14.7.10 Like the July incident, the Police had the options to charge John, release John from custody whilst advice was sought from CPS, utilise the DVPN/DVPO processes and provide disclosure to Ruth via a DVDS. Only the latter action was initiated; unfortunately, this was not progressed due to an error in the DVDS being closed prior to contact with Ruth. See Term 9.

14.7.11 The panel were informed of work that was currently being undertaken between agencies within Doncaster to respond to victims and perpetrators of domestic abuse, including when there are no interventions taking place through the criminal justice route. The panel learnt that Doncaster now has a MATAC (Multi Agency Tasking and Co-ordination) which is a multi-agency approach to respond to perpetrators of domestic abuse. The MATAC targets those perpetrators who are the most persistent offenders, who are not being managed through a criminal justice setting. Other areas of work that are being undertaken will focus on repeat victims of domestic abuse to ensure that victims are known to agencies and that they are signposted to and have access to support. Business process mapping, within and between services, to improve efficiency, is also being progressed. In addition to these areas of work the panel were informed

that a tender process is currently taking place to implement a perpetrator programme to respond to perpetrators of domestic abuse.

14.7.12 Work is also taking place internally within Doncaster Metropolitan Borough Council and external partners in relation to domestic abuse and information sharing and pathways. Process mapping and interagency activity has been and continues to be reviewed to improve efficiency and streamline activity. The work is focussed on the whole family approach to seek to provide appropriate and timely interventions for all individuals affected by domestic abuse. This work was planned as part of a wide-ranging review of partnership working and will be a component of further multi-agency collaboration as the borough moves through 2021 and beyond.

14.7.13 The panel recognised the work that was currently taking place within Doncaster to respond to domestic abuse and have made a recommendation to the Safer Stronger Doncaster Partnership for assurances on the progression of these workstreams. [Recommendation 4]

14.8 Term 8

How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Ruth and John?

14.8.1 Section 11 details the matter of diversity on this case. All agencies involved in the DHR have provided evidence that there were no diversity issues which affected their contact and delivery of service with the subjects of the review.

14.9 Term 9

Did your agency follow its domestic abuse policy and procedures, and the multi-agency ones?

14.9.1 All agencies had in place domestic abuse policy and procedures and provided evidence and assurances to the panel that these were adhered to on this case.

14.9.2 The Home Office Domestic Violence Disclosure Scheme Guidance[30] provides agencies details on how to progress applications under the

30 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575361/DVDS_guidance_FINAL_v3.pdf

scheme. There are two routes for seeking disclosure, 'A right to ask' and 'A Right to know'. On this case it had been determined by the Police that there was information known about John and the potential risk to Ruth that needed to be disclosed. The HO document provides details on timescales around when information should be shared.

14.9.3 The DVDS application was instigated on 18 July 2019 and assigned to an Officer on 27 July 2019. On 6 August and in the days after, there were several attempts to contact Ruth via telephone, which were unsuccessful. The Officer contacted Ruth's IDVA and was informed that the IDVA service had closed the case as Ruth had not engaged. As a result of this information the Officer closed the DVDS without any contact with Ruth. As Ruth had not engaged with the IDVA service this was a further signal of risk. The Police held information that could have been used to contact Ruth which included the details of her parents and John's address, a visit or telephone call could have been made to either of these. The panel agreed that these were missed opportunities to engage with Ruth.

14.9.4 The panel were informed that in January 2019 the DARA were trained in the identification and processes surrounding the DVDS. Initially cases were researched by a single officer and allocated to divisional Detective Inspectors for a decision on disclosure and to progress the DVDS. Since August 2019, the research and oversight of the DVDS has been managed by the PVP Strategic Governance Department which has resulted in an increase in cases being prepared for consideration (there are four researchers within the department). Daily Management Meetings take place with staff and DVDS investigations are monitored to ensure completion takes places within Home Office Guidelines. The introduction of Domestic Abuse Investigation Teams across the Force has also led to an increase of staff with responsibility for DVDS review and authorisation. Below are the stats for DVDS –

Month	2019	2020	2021
January	14	38	59
February	10	46	46
March	6	41	80
April	8	42	57
May	8	36	

June	4	45	
July	8	59	
August	22	54	
September	38	54	
October	50	63	
November	48	70	
December	50	55	
Total	266	603	242 - to date

14.9.5 On 16 September 2019, the DVDS application from July, was re-opened following the further assault on Ruth. An Inspector recorded on the application that due to the current assault, and that Ruth had not been seen, the DVDS still needed to be progressed. The re-opened DVDS was seen by a Supervisor who reviewed the log history on the application, which included an entry from August 2019 that requested the closure of the application. Based on this entry the Officer closed the DVDS on the understanding that it had been re-opened in error. The panel determined that had a new DVDS application been instigated in September then it was likely that this error would not have occurred. South Yorkshire Police have introduced a new process that a new investigation is opened for all identified DVDS applications. These are created by the PVP Governance Department and progressed through the Local Referral Unit eliminates the possibility of the investigation being closed in error.

14.9.6 There were two MARACs on this case neither of which considered the DVDS application. HO Guidance states –

Para 57. 'Once the police have determined whether the initial trigger can be categorised as a "concern" or "no concern", the final decision to disclose must be referred to the local multiagency forum for consideration at their next meeting. While it will be for the police to make the final decision on whether the trigger is a "concern" or "no concern" and, consequently, whether a disclosure should be made, this should be done with the input of the multi-agency forum.

If it is identified there is an immediate/imminent risk of harm to A, then ACTION MUST TAKEN IMMEDIATELY BY THE POLICE to safeguard those at risk.

Para 58. The local multi-agency forum should ideally be the Multi-agency Risk Assessment Conference (MARAC)'.

14.9.7 The panel were informed that within South Yorkshire the decision making to progress with DVDS applications is undertaken by the Police and cases are not taken to the MARAC, unless the action for a DVDS has arisen from the MARAC, or the case is currently within the MARAC caseload. The panel recognised that there had been an opportunity on this case for agencies to have worked together in engaging with Ruth during the DVDS and IDVA involvement. Whilst the panel recognised that it is not always achievable for joint face to face meetings to take place, the panel acknowledged that the learning from this case, identified that opportunities should be considered and undertaken where appropriate, particularly where there is evidence of non-engagement. The panel have identified this as an area of learning and made a relevant recommendation. [Recommendation 5]

14.10 Term 10

Were there issues in relation to capacity or resources in your agency that impacted on its ability to provide services to Ruth and John, or on your agency's ability to work effectively with other agencies?

14.10.1 The panel have not identified that there were any issues in relation to capacity or resources on agency's ability to provide services or work effectively together.

14.10.2 At the time of this case the Police district of Doncaster did not have a Local Referral Unit Manager unlike the other three districts of South Yorkshire Police. The post did not exist at that time however, it has since been established that there is a requirement for this role and a recruitment process is currently in place. In addition, the Local Referral Unit are recruiting for an additional Sergeant which will bring the staffing to three Sergeants, with a Local Referral Unit Manager oversight. These posts will be filled by May/June 2021.

14.11 Term 11

What learning has emerged for your agency?

14.11.1 The below agency learning is taken directly from their IMR's.

14.11.2 Doncaster Children's Services Trust

Whilst DCST had no involvement with Ruth and/or John during the timeframe of this review there is some learning from the period of involvement with Ruth's children prior to them all being in the care of their father's. There are lessons to be learnt from the social work practice and organisational responses to the information we did have that identified Ruth as a victim of domestic abuse in at least two of her previous relationships. It would appear that this was not fully explored as Ruth denied the domestic abuse and those relationships had ended. Therefore no domestic abuse work was completed with Ruth in order to reduce the risk of further DA relationships.

14.11.3 Doncaster Clinical Commissioning Group

- Routine enquiry when indicators of domestic abuse are present.
- Raising awareness of suicide risk related to domestic abuse.
- Improving MARAC communication to primary care.

14.11.4 Doncaster Council IDVA Service

Writing to clients is not used as a standard action from MARAC where contact is difficult by phone or other methods or the client is simply not engaging. Each case has to be assessed by the meeting in the known circumstances. MARAC chairs now ask that letters are sent, if safe and appropriate in the known circumstances. Personal, verbal, contact is always the preferred method of passing on information.

14.11.5 Rotherham Doncaster and South Humber NHS Foundation Trust

All clinicians should consistently apply the Trust's disengagement policy and accurately record in records what safeguarding measures are in place to support those patients who are vulnerable but have a propensity to not engage in a consistent manner despite their ongoing need.

Services need to explore more creative ways in which to engage/communicate more effectively with patients of no fixed abode and consider how the wider multi-disciplinary team can support in this.

14.11.6 South Yorkshire Police

The employment of a Local Referral Unit Manager at the Doncaster District may provide more support for staff, which could have avoided the error by the District Sergeant. The panel were informed that this area of learning has been addressed with additional staff being put in place prior to the review concluding.

More robust and determined attempts should be made when trying to contact victims of domestic abuse regarding DVDS, and coercive and controlling behaviour should be considered when a victim is not responding to calls or messages.

It should be considered that a new Connect investigation is created for each 'Right to Know' received, even if this concerns a suspect and a victim that have been previously referred but no disclosure was granted.

14.11.7 The panel have made a recommendation for South Yorkshire Police to provide evidence to Safer Stronger Doncaster Partnership in how they are addressing the learning identified within their IMR. [Recommendation 6]

14.12 Term 12

Are there any examples of outstanding or innovative practice arising from this case?

14.12.1 The review did not identify any examples of outstanding or innovative practice.

14.12.2 The review did acknowledge that there was evidence of suicide risk assessments when Ruth with depression to the GP which resulted in an urgent referral to the Mental Health Team. In addition, there was timely referral and re-referral to specialist services for alcohol misuse and mental health when Ruth was willing to engage in treatment.

14.13 Term 13

Does the learning in this review appear in other Domestic Homicide Reviews commissioned by Safer Stronger Doncaster Partnership?

14.13.1 The review panel were informed of two other DHR's[31] that were being undertaken at the same time as this review which identified similar learning. The learning included the application of DVDS and use of DVPO/DVPN as well as engagement with victims who are not responding to contact. As these DHR's were still ongoing at the time of this review, the panel have made recommendations relevant for this review for the Safer Stronger Doncaster Partnership to implement alongside any learning that emerges from the other reviews at a later stage.

15. CONCLUSIONS

[31] DHR02 & DHR03

15.1 Ruth had been a victim of domestic abuse in previous relationships and whilst in a relationship with John. Ruth had been in a relationship with John for 12 months. The Police treated the circumstances surrounding Ruth's death as suspicious and a murder investigation was undertaken. The outcome of the coroner's court was that the cause of Ruth's death was undetermined. There have been no criminal charges related to her death.

15.2 Ruth had previously tried to take her own life, self-harmed and overdosed. Ruth was alcohol dependant and had been on prescription medication for anxiety and depression for several years. Ruth contacted professionals at times of crisis, following overdoses or self-harm, which resulted in her being referred into mental health and drug and alcohol services; however, she did not sustain her engagement with professionals.

15.3 Ruth did provide the Police with information about domestic abuse in her relationship with John; however, she declined to support a prosecution, which resulted in no prosecution being progressed. Both Lincolnshire and South Yorkshire Police did not maximise the opportunities that existed to seek an evidence-based prosecution. Other opportunities to provide Ruth with information through the DVDS, around the risk's that John presented as a perpetrator of domestic abuse were not completed. In addition, there were two opportunities to apply for a DVPN/DVPO which did not require the consent of Ruth and would have allowed agencies to have contacted Ruth and discussed the risks that were present in her relationship with John.

15.4 Ruth was referred into the IDVA service and her case was twice heard at MARAC within a three month period. Professionals contacted Ruth via telephone and when this was unsuccessful her case was closed. It was seen by professionals that Ruth was not engaging; however, the reasons for her non-engagement were never fully understood by professionals, who accepted her lack of engagement without challenge or enquiry. Other than at a time of crisis, following initial contact with the Police, Ruth was not seen or spoken to by any professional.

15.5 Ruth had provided the Police with information that identified John was controlling and coercive within their relationship. This level of control included her being prevented from using her phone, without him standing over her. The control that John had over Ruth was not recognised by professionals, as a potential reason as to why Ruth was not responding to agency contact.

15.6 Whilst Ruth's death was not attributed to domestic abuse, the review has identified learning for agencies who are responding to and working with victims and perpetrators of domestic abuse.

16. LEARNING IDENTIFIED

16.1 The Domestic Homicide Review Panel's Learning (Arising from panel discussions)

16.1.1 The DHR panel identified the following lessons. The panel did not repeat the lessons already identified by agencies Term 11. Each lesson is preceded by a narrative which seeks to set the context within which the lesson sits. When a lesson leads to an action a cross reference is included within the header.

Learning 1 [Panel recommendation 1]
Narrative
Victims of domestic abuse may not always support a criminal prosecution. Their decision will be impacted on a range of factors, such as fear, coercion, control. Whilst victim's wishes should be taken into account at every stage, there will be other evidence available that will have been gathered that could support a prosecution and therefore safeguard victims from future harm. This includes evidence of previous abuse.
Learning
Gathering all evidence during criminal investigations maximises the opportunity for the consideration of cases to be progressed through the criminal justice route where the support of victims has not been provided.

Learning 2 [Panel recommendation 2]
Narrative
It is important that professionals who are engaging with victims of domestic abuse are aware of all known risk factors, including use of alcohol, and that these are taken into consideration when contact with the victim is undertaken. It is good practice for an agreement to be made with the victim as to how that contact should be undertaken.
Learning
Contact with victims should take account of known risk factors and contact should be undertaken with this knowledge and the views of the victim as to how contact should be made.

Learning 3 [Panel recommendation 3]
Narrative
Victims of domestic abuse often need time away from the perpetrator of their abuse, to reflect on their individual circumstances. The application of a DVPN/DVPO provides the victim with a degree of safeguarding and opportunity for engagement with professionals to receive information and options to help them make an informed decision in terms of their current situation.

Learning
A DVPN/DVPO allows the victim the opportunity to engage with professionals and be provided with information to help them make an informed decision in terms of their own circumstances, whilst not in contact with the perpetrator.

Learning 4 [Panel recommendation 4]
Narrative
This case has identified the need for a multi-agency response to victims and perpetrators of domestic abuse and how agencies respond and work together to address offending behaviour whilst safeguarding victims.
Learning
The learning from this case should be used to inform the ongoing work that is being undertaken around domestic abuse within Doncaster.

Learning 5 [Panel recommendation 5]
Narrative
Victims of domestic abuse may present as not wanting to engage with professionals. Understanding the reasons behind this decision are key to ensuring that victims are safeguarded, and this decision is not based on coercion and control. A multi-agency response in these circumstances can provide an opportunity for engagement with victims by statutory and non-statutory agencies.
Learning
By having a multi-agency approach during engagement with victims of domestic abuse, ensures that victims are provided with a co-ordinated response and provision of support to victims.

Learning 6 [Panel recommendation 6]
Narrative
There were opportunities for information to be disclosed to the victim. At times the victim did not respond to contact. More robust and determined attempts should be made when trying to contact victims of domestic abuse regarding DVDS, and coercive and controlling behaviour should be considered when a victim is not responding to calls or messages.
Learning
Understanding the reason why victims may not respond to contact, should be taken into account when determining how to engage with victims to deliver disclosure through the DVDS.

17. RECOMMENDATIONS

17.1 Panel Recommendations

Number	Recommendation
1	That South Yorkshire and Lincolnshire Police provide assurances and evidence to Safer Stronger Doncaster Partnership that all available evidence is gathered and considered during investigations into cases of domestic abuse.
2	That all agencies provide assurances and evidence to Safer Stronger Doncaster Partnership that all known risk factors and vulnerabilities such as alcohol use, are taken into consideration, and that contact with victims of domestic abuse is undertaken in cognisance and with agreement of the victim.
3	That South Yorkshire and Lincolnshire Police provide assurances and evidence to Safer Stronger Doncaster Partnership of their processes to consider utilising a DVPO/DVPN to safeguard victims of domestic abuse.
4	That Safer Stronger Doncaster Partnership ensures that the learning from this case is used to inform the ongoing workstreams in responding to domestic abuse.
5	That Safer Stronger Doncaster Partnership reviews the multi-agency response to victim engagement during DVDS and criminal investigations.
6	That South Yorkshire Police provide assurances and evidence to Safer Stronger Doncaster Partnership as to how they have embedded learning into practice in relation to DVDS applications and processes.

17.2 Single agency recommendations

17.2.1 Single agency recommendation are contained within the action plan at Appendix D.

Appendix A

Definition of Domestic Abuse

Domestic violence and abuse: new definition

The cross-government definition of domestic violence and abuse is:
any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to:

- psychological
- physical
- sexual
- financial
- emotional
-

Controlling behaviour

Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour

Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. This is not a legal definition.

Appendix B

Controlling or Coercive Behaviour in an Intimate or Family Relationship

A Selected Extract from Statutory Guidance Framework[32]

- The Serious Crime Act 2015 [the 2015 Act] received royal assent on 3 March 2015. The Act creates a new offence of controlling or coercive behaviour in intimate or familial relationships [section 76]. The new offence closes a gap in the law around patterns of controlling or coercive behaviour in an ongoing relationship between intimate partners or family members. The offence carries a maximum sentence of 5 years' imprisonment, a fine or both.
- Controlling or coercive behaviour does not relate to a single incident, it is a purposeful pattern of behaviour which takes place over time for one individual to exert power, control or coercion over another.
- This offence is constituted by behaviour on the part of the perpetrator which takes place "repeatedly or continuously". The victim and alleged perpetrator must be "personally connected" at the time the behaviour takes place. The behaviour must have had a "serious effect" on the victim, meaning that it has caused the victim to fear violence will be used against them on "at least two occasions", or it has had a "substantial adverse effect on the victims' day to day activities". The alleged perpetrator must have known that their behaviour would have a serious effect on the victim, or the behaviour must have been such that he or she "ought to have known" it would have that effect.

Types of behaviour

The types of behaviour associated with coercion or control may or may not constitute a criminal offence. It is important to remember that the presence of controlling or coercive behaviour does not mean that no other offence has been committed or cannot be charged. However, the perpetrator may limit space for action and exhibit a story of ownership and entitlement over the victim. Such behaviours might include:

- isolating a person from their friends and family;
- depriving them of their basic needs;
- monitoring their time;
- monitoring a person via online communication tools or using spyware;
- taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep;
- depriving them of access to support services, such as specialist support or medical services;
- repeatedly putting them down such as telling them they are worthless;
- enforcing rules and activity which humiliate, degrade or dehumanise the victim;
- forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities;

[32] Controlling or Coercive Behaviour in an Intimate or Family Relationship Statutory Guidance Framework. Home Office 2015

- financial abuse including control of finances, such as only allowing a person a punitive allowance;
- threats to hurt or kill;
- threats to a child;
- threats to reveal or publish private information [e.g. threatening to 'out' someone].
- assault;
- criminal damage [such as destruction of household goods];
- rape;
- preventing a person from having access to transport or from working.

This is not an exhaustive list

Appendix C

EVENTS TABLE

The following table contains a summary of important events that will help with the context of the domestic homicide review. It is drawn up from material provided by the agencies that contributed to the review.

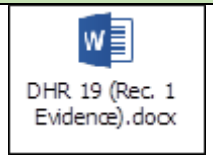
Events Table	
Date	**Event – Pre TOR**
1999 - 2011	John in contact with Adult Social Care regarding mobility.
2005	John convicted of domestic abuse incidents. Probation records no longer in existence.
2008	John assaulted member of public. No action taken.
2009	John cautioned for possession of cannabis.
23.02.10	DCST record of domestic abuse with Ruth. No further details within the electronic records.
2010	John involved in five incidents of domestic abuse.
2011	John involved in two incidents of domestic abuse.
2012	John involved in two incidents of domestic abuse.
02.07.13 – 13.01.14	Ruth known to Riverside Doncaster Mental Health Floating Support.
02.02.16	Ruth attended hospital having taken an overdose.
08.02.16	Ruth informal inpatient following accidental overdose.
16.05.16	John referred to ASPIRE from Criminal Justice for Alcohol. Discharged as assessed as not needing support
29.07.16	Ruth discharged from drug and alcohol services due to disengagement.
30.08.16	Ruth cautioned for an offence of battery.
06.11.16	Ruth admitted to hospital.
2016 - 2018	Ruth known to DCST due to mental health and alcohol abuse and impact on her children.
2017	Ruth known to Adult Social Care due to adaptations in her home.
13.07.17	Police attend incident involving Ruth and ex-partner.
27.11.17	Police received report of domestic abuse incident involving Ruth.
10.01.18	Police attended domestic abuse incident between Ruth and ex-partner.
24.01.18	Ruth self-referred to RDaSH for support to remain alcohol abstinent.
29.03.18	Ruth discharged from RDaSH services due to disengagement.
13.04.18	Police attended domestic abuse incident involving Ruth and ex-partner.
18.04.18	Police attended domestic abuse incident involving Ruth and ex-partner. Referral to IDVA.
10.05.18 – 17.05.08	IDVA unsuccessful attempts to contact Ruth.
31.05.18	Police attended domestic abuse incident between Ruth and ex-partner. Vulnerable adult form submitted with concerns for Ruth's mental health.
26.06.18	Case discussion with IDVA Manager re non engagement. Case closed.
16.07.18	Police attended domestic abuse incident involving Ruth and ex-

	partner.
21.07.18	Police attended domestic abuse incident involving Ruth and ex-partner. Referral to IDVA.
23.07.18 – 21.08.18	IDVA unsuccessful attempts to contact Ruth. Initial letter of support and leaflet sent to Ruth. Case closed.
05.09.18	Ruth referred to Community Mental Health Team by GP.
18.09.18 – 20.09.18	Face to face attempts made in response to Vulnerable adult form received from Police on 31.05.18. Contact with Ruth's father. Ruth declined support and case closed.
20.09.18	Ruth reported to GP that she was sofa-surfing.
Date	**Events during TOR**
14.03.19	Ruth attended hospital having taken an overdose of Codeine and Diazepam, with alcohol. Ruth seen by Crisis Team and discharged following day with further appointment on 17.03.19
17.03.19	Ruth did not attend scheduled appointment.
17.03.19	Ruth contacted GP practice and call transferred to Accident and Emergency.
18.03.19	Ruth allocated to Home Based Treatment Team. Case to be discussed at Multi-disciplinary Team meeting.
23.03.19 – 26.03.19	Five calls attempted to arrange appointment with Ruth, no answer on each occasion
29.03.19	Multi-disciplinary team meeting held. Agreed for letter to be sent to GP offering Ruth further support if she wishes to engage
01.04.19	GP practice received letter regarding discharge.
04.04.19	Ruth discharged from Home Based Treatment Team.
05.04.19	GP provided letter to Personal Independent Payment application.
21.04.19	John attended hospital after road traffic accident.
24.04.19 – 01.05.19	Ruth attended Accident and Emergency department having taken an overdose. Admitted to ward. Seen by Mental Health practitioner. Discharge letter sent to GP. Referred to Aspire.
01.05.19 – 21.05.19	Aspire unsuccessful attempts to contact Ruth via telephone and letter. Discharged and case closed due to no contact.
13.05.19	Ruth seen by GP following admission to hospital.
16.07.19	Lincolnshire Police dealt with domestic abuse incident between Ruth and John. Case referred to MARAC. DVDS initiated. John arrested and released. Ruth did not support a prosecution. No further action taken.
18.07.19	Police attended incident at home address of Ruth's Mother following contact from John.
18.07.19	IDVA received MARAC referral.
23.07.19	IDVA sent letter to Ruth.
27.07.19	DVDS assigned to Police Officer.
29.07.19	IDVA received voicemail from Ruth.
31.07.19	MARAC meeting
06.08.19	Police attempted to telephone Ruth regarding DVDS. Voicemail left.
12.08.19	John sent letter from Respiratory Consultant regarding future contact.

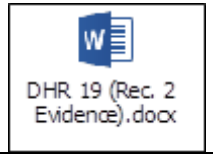
13.08.19	Police requested contact details for Ruth from IDVA. Further voicemails left over following three days.
21.08.19	DVDS closed by Police.
14.09.19	Police attended domestic abuse incident between Ruth and John. Ruth assaulted. Incident risk assessed as high. DVDS referral made. Referral to IDVA and MARAC.
15.09.19	IDVA attempted to telephone Ruth. No reply. Letter of support sent to parents' address.
16.09.19	DVDS recommenced.
07.10.19	GP practice informed of change of address for Ruth.
07.10.19	Policed tried to contact Ruth to progress DVDS.
09.10.19	MARAC meeting.
October 2019	Ruth found deceased. John arrested on suspicion of murder.

Appendix D

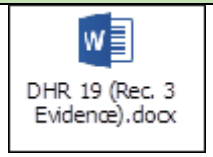
Action Plans

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
1	That South Yorkshire and Lincolnshire Police provide assurances and evidence to Safer Stronger Doncaster Partnership that all available evidence is gathered and considered during investigations into cases of domestic abuse.	Regional	The introduction of District DA teams in 2019 to ensure that allegations of DA are investigated by specifically trained officers and staff for High and medium risk DA offences. This year SYP has also created 200 roles for DA Champions from all ranks, grades and departments across the organisation. These DA champions receive additional training to become specialist domestic abuse Single Point of Contact (SPOCs) for the force, who are	SYP		March 2022	Ongoing

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
			there to support and advise staff affected by domestic abuse, as well as providing advice on domestic abuse investigations. The role of a DA Champion is with the view to keep the DA Matters training alive within the force, to act as a role model and provide specialist support to colleagues in terms of dealing with DA incidents. DA Champions also have access to the DA Matters Champion Network across the country and continuous refresher training to ensure Continue Professional Development. Currently SYP has				

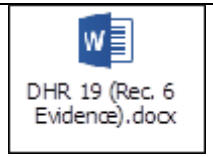
DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
			176 trained DA champions and aims to have reached the target of 200 trained by the end of 2021.				
2	That all agencies provide assurances and evidence to Safer Stronger Doncaster Partnership that all known risk factors and vulnerabilities such as alcohol use, are taken into consideration, and that contact with victims of domestic abuse is undertaken in cognisance and with agreement of the victim.	Local and Regional	Ongoing delivery of Domestic Abuse Training courses by DMBC , accessible by all services. The training suite is accessed by DMBC Services, The Childrens Trust, Regional Health Authorities, CCG, DA partners, Police services, local business and other partners. SYP specific. Referrals to Liaison and Diversion in custody is	DMBC SYP	Agenda items ongoing as part of the Doncaster DA Strategic Board and DA and SA Theme Group (Operational Board) Provision for continued and expanded training programme throughout 2022/23. 	March 2022	Ongoing

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
			incorporated into the booking on process and are submitted for anyone with alcohol and substance misuse issues. As part of VCOP standards, victims of DA will be contacted every 28 days. Victims can now choose how and when they want to be contacted i.e., high risk DA victim can choose a safe timeframe when the perpetrator will not be around to be contacted by telephone, they can also agree a code with Officer in Case if they are not able to speak freely.				

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
3	That South Yorkshire and Lincolnshire Police provide assurances and evidence to Safer Stronger Doncaster Partnership of their processes to consider utilising a DVPO/DVPN to safeguard victims of domestic abuse.	Regional (County)	The DVPO Team is now fully functional, fully staffed and committed to bringing awareness to SYP service users and support to front line officers/staff members. They are responsible for processing all applications through the court system, including breaches. A training package has been developed and has already been delivered to a number of frontline officers/staff (this will remain an on-going process). The Policy and associated procedural	SYP. Research and Project Officer.		March 2022	Ongoing

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
			documents are currently being updated and are due to be published and accessible to all officers/staff by early 2022. Recent benchmarking with other forces has evidenced that SYP's DVPO Team have now had more DVPO'S granted that any other force. Since their inception in April 2020, they have secured 856 DVPO's.				
4	That Safer Stronger Doncaster Partnership ensures that the learning from this case is used to inform the ongoing workstreams in	Local	DA Strategy Launched in Nov 2021. DA Champions network Launched. Survivor Liaison	DMBC	DA Strategy Launched in Nov 2021. DA Champions network Launched.	March 2022	Ongoing

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
	responding to domestic abuse.		Worker appointed in July 2021. Community engagement Officer appointed in July 2021		Survivor Liaison Worker appointed in July 2021. Community engagement Officer appointed in July 2021		
5	That Safer Stronger Doncaster Partnership reviews the multi-agency response to victim engagement during DVDS and criminal investigations.	Local/Regional	Work in partnership with SYP to review DVDS process. Work is ongoing to inform professionals across the borough about what action to take in relation to Right to know applications and the appropriate advice top give to people living with persons believed to be DA Perpetrators.	DMBC/SYP	Review is being undertaken by SYP regarding the DVDS pathways for both Right to know and Right to Ask.	March 2022	Ongoing

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
			Serial Perpetrator database with multiagency access opportunities are being explored with the web hosting service provider for the Doncaster DA Service database.				
6	That South Yorkshire Police provide assurances and evidence to Safer Stronger Doncaster Partnership as to how they have embedded learning into practice in relation to DVDS applications and processes.	Regional (County)	2020 - The DA Matters training that was rolled out across the force includes providing an awareness of the domestic abuse disclosure scheme. SYP are already seeing an increase in right to know applications being identified. Nov 2021 - SYP	SYP. Research and Project Officer.		June 2022	Ongoing

DHR Panel Recommendations							
No	**Recommendation**	**Scope local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target Date Completion**	**Completion Date and Outcome**
			Guidance is near completion and due to be finalised by the end of 2021.				
7	That Safer Stronger Doncaster Partnership ensures that there are services and referral pathways in place for perpetrators of domestic abuse, in particular, for those perpetrators who are not being managed within the criminal justice system.	Local and Regional	Countywide Perpetrator Programme embedded. Publicity and training for staff regarding referrals and the criteria for applications is delivered across services.	DMBC	November 2021. Cranstoun Inspire to Change perpetrator Programme Launched. Launch event held on 26 November 2021.	November 2021	November 2021. Perpetrator Programme Launched.

Doncaster Clinical Commissioning Group						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
1	Improving the	Work being	IDVAs make	MARAC communication to	Ian Boldy	June 2021

Doncaster Clinical Commissioning Group						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
	communication from MARAC to primary care.	progressed between Tim Staniforth and Ian Boldy	routine contact with GP surgeries to inform that cases are subject to MARAC.	primary care via IDVA service.		
2	Training for primary care staff to raise awareness of suicide risk in domestic abuse and the importance of routine enquiry when a patient presents with indicators of domestic abuse.	Target Training sessions for all Doncaster GPs in May 2021	Dr Kirby Slide presentation	First session – 12.05.21 Further training – 26.05.21	Ian Boldy	26.05.21

Doncaster Council IDVA Service						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
1	All IDVAs attend Safelives accredited IDVA training within the first twelve months of their appointments.	Courses are financed and accessed.	IDVAs attend Safelives training.	Consistent updated practice from all staff. Staff receive the same level of training.	Tim Staniforth	31.03.2022
2	IDVA Process Guide is being amended and	Updated guide delivered to	IDVA Processes updated.	Consistent updated practice from all staff. IDVA Process Guide	Tim Staniforth/Cal Lacey (IDVA	September 2021

Doncaster Council IDVA Service						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
	refreshed. (Ongoing)	staff		reviewed annually.	Manager)	
3	MARAC Steering Group has been reinstated.	Next Meeting scheduled for 23.06.21	Meetings scheduled quarterly	Inclusion of all agencies involved in MARAC. Improved information sharing in MARAC.	Tim Staniforth	23.06.2021
4	IDVA Chair training being facilitated with Safelives on behalf of SYP. (To be arranged	Work to identify dates is underway	Training to be delivered by Safelives	All Doncaster MARAC Chairs have the same accredited Chair Training.	Tim Staniforth/ Kayley Charlton(SYP DA Coodinator)	September 2021

Rotherham Doncaster and South Humber NHS Foundation Trust						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
1 [33]	Clinicians should consider: • The Trust's 'Engagement and Discharge of Patients Referred to and in	Supervision Team Meetings	Meeting Minutes Documented risk assessments	Reduce risk of non-engagement and improve patient safety	Stuart Green Service Manager	Q4 21/22

[33] These actions will be part of the action plan for RDASH in relation to a SAR – Adult F

Rotherham Doncaster and South Humber NHS Foundation Trust						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
	Contact with Aspire Drug and Alcohol Services Policy' • Complete Risk Assessments To mitigate the risk to patients who are vulnerable but have a propensity to not engage in a consistent manner despite their ongoing need.					
2	ASPIRE Drug and Alcohol Services to provide awareness sessions to the Safeguarding Adult Board	Planned sessions to be mutually agreed	Minutes of the SAB	To provide an understanding of ASPIRE Drug and Alcohol Services given that there have been a number of cases where the victims of SAR and DHR have had contact with this service	Stuart Green Service Manager	Q4 21/22
3	Services to explore ways in which to engage / communicate with patients of no fixed	Quality Assurance Meetings Team	Meeting minutes	Improve the care provided to this group of vulnerable patients	Stuart Green Service Manager	Q4 21/22

Rotherham Doncaster and South Humber NHS Foundation Trust						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Sign off date**
	abode and consider how multi agencies can support in this.	Meetings Supervision SAB to provide direction				
4	All staff to understand what the definition of Domestic Abuse is.	Training Supervision 7 Minute Briefing	Audit	Assurance that staff are aware	Nurse Consultant Safeguarding	Q4 21/22
5	All staff to ask patients about their relationships with their family	Training Supervision 7 Minute Briefing	Audit	Assurance that staff ask patients	Nurse Consultant Safeguarding	Q4 21/22
6	All staff to understand when a referral to Domestic Abuse services should be considered.	Training Supervision 7 Minute Briefing	Audit	Assurance that staff know when to refer to DA services	Nurse Consultant Safeguarding	Q4 21/22