# DOMESTIC HOMICIDE OVERVIEW REPORT.

## REPORT INTO THE DEATH OF 'Mary'

Report produced by: Sylvia Manson

Domestic Homicide Review Chair and Overview Author.

Date: 7th February 2014

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# INTRODUCTION

This report of a domestic homicide review examines agency responses and support given to 'Mary', a resident of Leicestershire prior to the point of her death on 18th February 2013. The review will consider agencies contact and involvement with Mary and the perpetrator, who is referred to in the report as Mr A.

The name 'Mary's is a pseudonym agreed by her family.

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

## Timescales

The statutory guidance for DHRs requires the Community Safety Partnership to make a decision on whether or not to proceed with a review within 1 month of the homicide coming to their attention. The overview report should be completed within 6 months of the decision to proceed.

Mary's death occurred on the 18th February 2013 and the DHR was commissioned on the 13th March. According to the guidance, the DHR was due to be completed by 13th September. It was not feasible to complete the review in this timeframe as the criminal proceedings did not conclude until 4th December 2013. The Home Office was advised accordingly.

## Confidentiality

The findings of each review are confidential. Information is available only to participating officers, professionals and their line managers until approval to publish is given by the Home Office.

## Dissemination

The following agencies have received copies of this report.

- A Leicestershire (redacted) Borough Council
- Central Nottinghamshire Clinical Services – LLR Out of Hours GP service
- Medical Practice 1 (redacted)
- East Midlands Ambulance Service
- Leicester City Clinical Commissioning Group
- Leicestershire County Council – Adult and Children's Social Care
- Leicestershire Safeguarding Adults and Children's Board
- Leicestershire County Council Safer Communities

- Leicestershire Partnership NHS Trust
- Leicestershire Police
- Leicestershire and Rutland Probation Trust
- Leicestershire Victim Support
- A Local Domestic Abuse Outreach Provider
- Medical Practice 2 (redacted)
- Specialist therapeutic (redacted) response service
- Swanswell
- University Hospitals of Leicester NHS Trust
- Leicestershire Safeguarding Children's Board
- Leicestershire Safeguarding Adults' Board

# LEICESTERSHIRE DOMESTIC HOMICIDE REVIEW PANEL

# CONCLUDING REPORT

## Preface

This Domestic Homicide Review seeks to understand the circumstances surrounding the tragic death of 'Mary' who was the victim of a homicide on the 18th February 2013. Mary's partner 'Mr A' was found guilty of Mary's murder on 4th December 2013 and is now serving an 18 year and 11 month prison sentence.

All those involved in this review wish to extend their sympathy to the family of Mary. Despite the very difficult and painful circumstances, the families of both Mary and Mr A have been able to make invaluable contributions to the review and we extend our thanks to them for this.

Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). This DHR has been commissioned by a Leicestershire (redacted) Borough Council in line with the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2011

There is a statutory expectation that certain bodies will have regard to the Statutory Guidance for the Conduct of DHRs[1]and that these bodies can be directed by the Secretary of State to participate in a review (section 9(2) of the Domestic Violence Crime and Victims Act 2004). However, there is no legal sanction or power to enforce a request made by the Review Panel Chair or Overview Report Writer that an individual attend for an interview. The report will include reference to any gaps in the information available, as a consequence of any agency not sharing information for this review.

The Domestic Homicide Review Chair wishes to thank the agencies and individuals working within them for their time, cooperation and commitment in contributing to this review.

The Chair for the review was also the overview report writer. The guidance[2] directs that the Chair and author should be an experienced individual who is not directly associated with any of the agencies involved. This was achieved. The Chair is a social worker by profession and has held senior management positions in Health and Social Care relating to mental health and safeguarding children and adults. The Chair has also held Department Health

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[1]Domestic Homicide Review (2013), *Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews,* Home Office, [Available from: https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews] [Accessed: 26.09. 13]

[2]Ibid.

regional and national posts relating to safeguarding adults, the Mental Capacity Act and Mental Health Act. At present the author works independently in Health and Social Care related areas and is a Mental Health Review Tribunal member. The author has had no connection with agencies involved in the review.

The Chair was supported in the DHR by a panel who met on 4 occasions to agree the terms of reference; review the reports from agencies and to review the overview report.

The panel members were selected to bring a range of expertise and perspectives relevant to the circumstances of the review. In appointing to the panel, the Chair ensured there was no conflict of interest and that the panel members did not have direct line management responsibilities for workers who had been involved with Mary or Mr A.

The Chair greatly valued the professionalism and commitment that the panel members brought to the review. The panel comprised:

| Panel Member | Role and agency |
|---|---|
| **Sylvia Manson** | Chair and overview report writer – independent consultant |
| **Bob Bearne** | Director Leicestershire and Rutland Probation Trust |
| **Michael Clayton** | Head of Safeguarding: University Hospitals of Leicester NHS Trust |
| **Phil Hawkins** | Former Head of Youth Justice and Safer Communities (retired) representing Leicestershire County Council (SLF and Safer Communities) |
| **Claire Jeeves** | Locality Manager: Leicestershire County Council Adult Social Care |
| **Dr Srinivas Naik** | Consultant Psychiatrist: Leicestershire Partnership NHS Trust |
| **Julie Robinson** | Head of Neighbourhood Services: (redacted) Borough Council |
| **Detective Chief Inspector Jonathan Brown** | Leicestershire Police |
| **Jackie Wilkinson** | Trust Lead for Safeguarding Adults and Children: Leicestershire Partnership NHS Trust |
| **Elaine Yates** | Head of Children's Safeguarding for the Leicester, Leicestershire & Rutland Hosted Clinical Commissioning Group Safeguarding Team: Leicester City CCG |
| **Julia Young** | Domestic Abuse reduction coordinator; Leicestershire County Council |

The agencies that contributed to the report and staff involved, have had the opportunity to review the draft report in relation to accuracy and to comment on any actual or potential criticism as it concerns them. Family members also had the opportunity to review the final draft to confirm it accurately reflects information they contributed to the review. The report was also shared with Mr A.

# 1.0 INTRODUCTION

1.0.1 This report is an anthology of information and facts from nineteen agencies, all of which were potential support agencies for Mary. Essentially, only 14 agencies had records of contact with Mary or Mr A that was relevant to the circumstances of the review.

1.0.2 Each agency was asked to provide a chronology of their involvement, an analysis of services provided, good practice and any lessons learned. The format and depth of analysis within the reports varied between the agencies according to the nature of the service and level of their involvement.

The 14 agencies providing reports for the review are:

| AGENCY | INFORMATION PROVIDED TO THE REVIEW |
|---|---|
| **Central Nottinghamshire Clinical Services – Leicestershire Leicester Rutland Out of Hours GP service (incorporating(redacted) Medical Group Walk-In Centre)** | Provide some out of hours GP services to Mary and Mr A. This was minimal involvement and a chronology was provided for the review |
| **East Midlands Ambulance Service NHS Trust** | Involvement with both Mary and Mr A during the period under review. Provided a chronology and Individual Management Review. |
| **Medical Practice 1 (redacted)** | GP practice for Mr A. Provided a chronology, factual summary report and analysis |
| **Leicestershire County Council Adult Social Care Services** | No involvement with Mary and minimal involvement with Mr A. Provided a chronology, factual summary report and analysis |
| **Leicestershire County Council Children's Social Care Services** | There was no relevant involvement relating to children in the scope period 2007 - 2013. However, a report was provided giving historical information relating to Mr A that was relevant to the review. |
| **Leicestershire Partnership NHS Trust** | Had some involvement with Mary and extensive involvement with Mr A. Provided a chronology and Individual Management Review |
| **Leicestershire Police** | Had extensive involvement with Mary and with Mr A. Provided a chronology and Individual Management Review.<br>A separate report was provided from the police Multi Agency Public Protection providing historical |

| | |
|---|---|
| | information relating to Mr A and early public protection panels |
| **Leicestershire and Rutland Probation Trust** | Had extensive involvement with Mr A. Provided a chronology and Individual Management Review. |
| **Leicestershire Victim Support** | Had involvement with Mary and Mr A. Provided a chronology and Individual Management Review. |
| **A Local Domestic Abuse Outreach Provider** | Had involvement with Mary and also provided historical information from a previous domestic violence support service. Provided a chronology and Individual Management Review. |
| **Medical Practice 2 (redacted)** | Had extensive involvement with Mary. Provided a chronology and factual summary report. |
| **A specialist therapeutic response service (redacted)** | Had minimal involvement with Mary – provided a factual summary |
| **Swanswell** | Had extensive involvement with Mary. Provided a chronology and Individual Management Review. |
| **University Hospitals of Leicester NHS Trust** | Had extensive involvement with Mary and Mr A. Provided a chronology and Individual Management Review. |

Section 4 of this report provides a detailed account of each agency's involvement.

## 1.1 Involvement of family and others known to Mary and Mr A

1.1.1 Mary's Mother and Father and her 2 daughters 'R' and 'H' were interviewed by the overview report author in the early stages of the review. The family were also consulted about the terms of reference for the review and decided on the pseudonym that would be used in the final report. Mary's family's contribution greatly aided in providing some understanding of Mary as a person and how she may have perceived her situation.

The Chair wishes to thanks the Police family liaison officer for his role in initiating the interviews with the family and for on-going communication with the family during the review.

1.1.2 Attempts were also made to contact 2 of Mary's previous partners to try and understand the nature of earlier relationships Mary had during the review scope period of 2007 – 2013. However, these attempts were not successful.

There were no other close friends identified to consult with and Mary was not in employment.

1.1.3 Mr A's Mother and sister J was interviewed for this DHR. Though Mr A has other siblings, sister J had had the greatest level of involvement with him in recent years. Their information provided valuable insights and supplemented the historical information held by agencies as well as providing perspectives about Mr A's character and motivations.

1.1.4 A past partner of Mr A, Mr B, was also interviewed. Mr A had a 5 year relationship with Mr B during 2006 - 2011 and Mr B was able to provide information and his perspective of Mr A's behaviours.

1.1.5 Mr A was also interviewed following the conclusion of the criminal proceedings and his views are contained within the overview report.

Mr A was not in employment in recent years and no other close friends or partners were identified to consult with.

The Chair also had the opportunity of interviewing a neighbour.

## 1.2 Consent and confidentiality

1.2.1 Mr A was asked to consent to agencies sharing his personal information relevant to the review. The Chair confirmed with the medic in charge of Mr A's care that he was able to give informed consent for this. The Chair thanks Mr A for providing written consent for his records to be accessed and information shared for the purposes of the review.

1.2.2 The family members, past partner and neighbour described in section 1.1. above, all gave consent for the information they provided to be used in the review. Mary's records were accessed and relevant information shared on the basis of public interests. The family were supportive of the DHR and Mary's information being used for this purpose.

1.2.3 The review has redacted information in order to preserve the anonymity of individuals and staff involved. Necessarily, dates of interventions have been included as this is key to understanding events. Names of individuals have been changed and where the size or name of the agency would make the specific area identifiable, this has also been changed.

## 1.3 Legal proceedings and other reviews

1.3.1 The DHR ran in tandem with criminal proceedings. The Police Senior Investigating Officer was involved throughout the DHR to ensure any necessary disclosures were made and that the criminal proceedings were not compromised.

1.3.2 Leicestershire Partnership Trust initiated a Serious Incident investigation relating to the circumstances surrounding the homicide. This was in line with the Strategic Health Authority requirements.[3] This investigation concluded in June 2013 and the learning contributed to their report for the DHR.

[3]NHS East Midlands (2010, review 2012), *Policy for Reporting and Handling Serious Untoward Incidents in the East Midlands*, [Available from: http://www.eastmidlands.nhs.uk/EasySiteWeb/getresource.axd?AssetID=1708&type=full&servicetype=...] [Accessed: 26.09.13]

1.3.3 Leicestershire and Rutland Probation Trust had completed a Serious Further Offences Review as required by the Ministry of Justice.[4] The author for the serious further offences report also authored the probation service's report to the DHR and learning contributed to the process.

1.3.4 Leicestershire was also conducting another DHR – case 'FN.' This DHR was initiated 2 months before the DHR relating to Mary but there was overlap in the 2 reviews. Some of the learning from 'FN' contributed to the agencies' analysis.

## 1.4 Terms of Reference for the review

1.4.1 The terms of reference were established in consultation with panel members and Mary's family.

| Terms of reference and scoping for the Domestic Homicide Review of Mary | |
|---|---|
| **Domestic Homicide Reviews**<br>Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). This provision came into force on 13th April 2011.<br><br>This DHR has been commissioned by a Leicestershire Borough Council (redacted) in Leicestershire Borough Council in line with the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2011. | |
| **1** | **The purpose of a DHR is to:** |
| **1.1** | 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 upon, and what is expected to change as a result. |
| **1.2** | Apply these lessons to service responses including changes to policies and procedures as appropriate, prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working. |
| **1.3** | DHRs, like SCRs, are not enquiries into how the victim died or who is culpable and not specifically any part of any disciplinary enquiry or process.<br>(Source: Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2011) |
| **The following points are considered to be emerging issues to address and analyse to commence the specific learning about this case:** | |

[4]Ministry of Justice (Aug 2011): *Notification and Review Procedures for Serious Further Offences,* [Available from: www.justice.gov.uk/downloads/offenders/probation-instructions/pi-04-2013-serious-further-offences.doc][Accessed: 26.09.13]

**2 Case Specifics**

**2.1** This case concerns the homicide of Mary who was killed on the 18th February 2013. Mary's partner Mr A was charged with her murder on 1st May 2013.

**2.2** Mary had been living with her partner Mr A since September 2011. There was a history of domestic abuse from Mr A to Mary and she had received some support in the past from specialist domestic violence services. Both had needs arising from mental health, drug and alcohol misuse and were involved with local services.

**2.3** Mr A was subject to a Community Order with a Requirement of Supervision and Alcohol Treatment imposed in June 2012 for an assault on Mary.

**2.4** An initial scoping to this review has shown some history of domestic abuse in Mary's previous relationships. Mary has two adult children and a 6 year old grandson who live in the vicinity

**3 The Scoping Period:**

**3.1** The initial scoping for the review covered the period from July 2007 until the death of Mary on 18th February 2013. This took into account earlier instances of domestic violence to Mary in a previous relationship. Agencies conducted their internal reviews covering these dates. The review also took into account particular historical factors that aided the understanding of the context of the case, specifically the period 1987 -1999 relating to the alleged perpetrator's early years and period of being a Looked After Child.

**3.2** The analysis has found that the primary areas of learning relate to the relationship between Mr A and Mary that began in September 2011. Consequently, the overview report concentrates on the period Sept 2011 to February 2013, but makes reference to relevant background from the wider scoping period.

**4. Terms of Reference:**

- Ensure the review is conducted according to best practice; with effective analysis and conclusions of the information related to the case.
- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence, including their dependent children.
- Identify clearly what those lessons are; both within and between agencies, how and within what timescales they will be acted upon and what is expected to change as a result.
- Apply these lessons to service responses; including changes to policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children, through improved intra and

inter-agency working.

- Establish whether family, friends or colleagues want to participate in the review and if so establish if they were aware of any abusive behaviour by either Mr A or Mary on each other, or to other people.
- Whilst it is not the purpose of this review to consider the handling of child protection concerns related to the case, there may be issues that arise from the review that relate to the safeguarding of children and these will be specifically shared with the Safeguarding Children Board.
- Learning from this case will also be shared with the Safeguarding Adults Board.

**4.1 Additional specific issues in this case**

**4.1.1** Mary was known to mental health and drug and alcohol services. She had a history of assaults from previous partners and from Mr A. The review will address the nature of Mary's mental health, drug and alcohol misuse and whether all services involved made use of opportunities to support Mary to address risks of domestic violence.

**4.1.2** Mr A was well known to mental health and drug and alcohol services and was subject to a probation order. The review will address the nature of Mr A's mental health, drug and alcohol misuse and how services supported Mr A to address his self-harming, suicidal and violent behaviours and understanding the correlation between these behaviours and domestic violence.

**4.1.3** To review whether practitioners involved with Mary and Mr A were knowledgeable about potential indicators of domestic violence and aware of how to act on concerns about a victim or perpetrator.

**4.1.4** To establish how professionals and agencies carried out risk assessments, (including assessment of the victim's mental capacity to make decisions relating to risks) including

i) whether the risk management plans were reasonable response to these assessments.

ii) whether risk assessments and management plans of Mr A took account of his early history, including convictions for violence in his adolescent years and assessments of risk made during this period.

iii) whether there were any warning signs of serious risk leading up to the incident in which the victim died that could reasonably have been identified, shared and acted upon by professionals

**4.1.5** To identify whether services that were involved with either Mary or Mr A, were aware of the circumstances of their service user's partner and the agencies involved with them. Whether connections were made and information shared between these services in order to establish a full picture of the vulnerability and risks arising from the relationship.

**4.1.6** To establish whether there were any opportunities for professionals to 'routinely

enquire' as to any domestic abuse to the victim that were missed.

**4.1.7** To establish if any agency or professionals considered any concerns were not taken seriously or acted upon by others.

**4.1.8** To establish if there were any barriers experienced by Mary or her family / friends that prevented her from accessing help to manage domestic violence; including how Mary's wishes and feelings were ascertained and considered.

**4.1.9** To identify whether more could be done locally to raise awareness of services available to victims of domestic abuse.

**4.1.10** To establish whether local Domestic Abuse procedures were properly followed; to include whether the case was, or should have been, considered for MARAC.

**4.1.11** To consider how issues of diversity and equality were considered in assessing and providing services to Mary and Mr A (protected characteristics under the Equality Act 2010 age; disability; race; religion or belief; sex; gender reassignment; pregnancy and maternity; marriage or civil partnership)

**4.1.12** To establish whether local safeguarding procedures were properly followed; to include consideration of the victim or perpetrator as being in need of services as a vulnerable adult.

**4.1.13** To establish how effectively local agencies and professionals worked together.

**4.1.14** To establish any issues affecting public confidence in the protection of the people in vulnerable situations, locally.

**4.1.15** To establish whether domestic violence policies, protocols and procedures (including risk assessment tools) that were in place during the period of review, were applied and whether they were fit for purpose.

**4.1.16** Identify any good practice

**4.1.17** Establish for consideration what may need to change locally and/or nationally to prevent serious harm to victims of domestic abuse.

**4.1.18** The review should make recommendations to be considered when revising the Leicestershire Multi Agency Domestic Abuse Strategy 2010-13.

**Family Participation**

The family and significant others will be asked to contribute to this review process to establish any learning, and a strategy for engagement developed

**5 Scoping Issues**

**These issues are to be addressed to ensure a thorough and effective review:**

**5.1** Consider how this case will dovetail with a criminal investigation; coroner's inquiry; Probation Serious Further Offences review; Independent mental Health

| | |
|---|---|
| | Homicide Investigation HSG(94)27. |
| **5.2** | Consider how media interest is managed. |
| **5.3** | Establish a process for gathering evidence out of the local area where required. |

# 2.0 THE FACTS

## 2.1 The Circumstances of the Homicide

2.1.1 This review relates to the death by fatal stabbing of Mary on 18th February 2013. Her partner Mr A, was found guilty of her murder on 4th December 2013 and received a mandatory life sentence with a recommendation that he serve a minimum of 18 years and 11 months.

2.1.2 On the 20th of February 2013, Mary's eldest daughter and a neighbour entered Mary's Housing Association flat in a town in Leicestershire (address 1). The neighbour had rung Mary's eldest daughter R, as she was concerned about Mary. They found Mary unresponsive and called for an ambulance. The ambulance service found a stab wound to Mary's back. The ambulance service confirmed Mary's death.

2.1.3 It transpired that Mary had died on 18th February 2013. Neighbours reported to the ambulance crew that Mary had been arguing with her partner 3 days earlier and that Mary had '*split up with him'*.

2.1.4 On the 19th February, the ambulance service had been called to another address in the same Leicestershire town. Mary's partner Mr A had been found unconscious at a friend's home. Mr A had taken a large overdose and was admitted to hospital. Police arrested Mr A on the 1st May and charged him with Mary's murder.

# 3.0 BACKGROUND INFORMATION

The author has provided a pen picture of Mary, Mr A and their relationship in order to provide some context in which the agencies had been providing services. This section has drawn on information provided to the DHR author by family; Mr A and a past partner of Mr A.

A genogram of relationships is provided in appendix 1

## 3.1 Mary

3.1.1 Mary was a 42 year old white woman of British origin who had spent most of her life in Leicestershire. Mary was mother to 2 adult daughters, R and H, and grandmother to a 6 year old grandson, R's son.

3.1.2 At the time of her death, Mary was living in a Leicestershire town in her Housing Association flat (address 1). She had been tenant there since 2007.Though Mary was registered as sole tenant of the property, Mr A reports that he had been living with her for the majority of time between January 2012 and February 2013. Mary maintained contact with her family and in particular, her eldest daughter R and grandson who lived in the vicinity.

3.1.3 Mary is described by her family as an '*all or nothing person'*. She was seen as a very caring, fun loving person who also loved to rebel. Her family observed '*If you told her not to do something, she'd have to do it!*' Her daughters recall her '*brilliant, warped sense of humour*' and that '*she would make me laugh so much I would cry*'

3.1.4 Mary's daughter H described how her Mother could act quite impulsively and at times recklessly. Mary's daughter R noted that Mary enjoyed company and never liked to be on her own. She felt this outward confidence hid Mary's low self-esteem. Mary's daughter R described them as being a close family but as soon as Mary met a man '*the blinkers would go on'*.

3.1.5 The family state that Mary's lifestyle revolved around other people using substances and alcohol. Her relationships were often characterised by highly impassioned emotions and volatility fuelled by drugs and alcohol. Mary appeared to gravitate towards a social circle of people who used drugs and alcohol. Her family felt she seemed to feel more confident in this social group. Mary veered between tackling her own drug and alcohol addictions and relapsing back into dependency.

3.1.6 A relationship during 2007 with a partner Mr L, is highlighted by Mary's family and within agency reports, as being particularly abusive and damaging to Mary both emotionally and physically. Police records[5] from this period also note Mr L alleged Mary assaulted him.

3.1.7 It is apparent that Mary had considerable strengths and resolve. Her daughter R recalls that though Mary was in damaging and abusive relationships '*she would just decide one day, ''I've had enough'' and leave'*. Mary also showed resolve in tackling her substance misuse. Mary was working with drug agencies to reduce her dependency. The drugs support service recognised that Mary had engaged well with them and was making good progress in tackling her drug and alcohol dependency. Mary had also voiced a wish to get into work, all indicative of her looking to change her lifestyle.[6]

Mary retained the support of her family throughout.

## 3.2 Mr A

3.2.1 A detailed account of Mr A's early years was provided by Children Social Care and MAPPA. Information was also provided by Mr A's mother and sister.

[5]Leicestershire Police (Sept. 2013), *Agency IMR, for (Mary), Domestic Homicide Report*, 8.10.7, p. 22
[6]Swanswell, *Agency IMR, for (Mary), Domestic Homicide Report*, 9.0, p.18

3.2.2 Mr A is a 30 year old white man of British origin, brought up and lived for most of his life in Leicestershire. He has 2 older sisters and a younger half-sister and half-brother.

3.2.3 Mr A had a traumatic childhood. At age of 5 years, Mr A's father was killed in a road traffic accident. Mr A's sister J felt he was a troubled child '*he was a poorly boy from a young age'.*

3.2.4 Mr A was voluntarily received into the care of the Local Authority in May 1997. This followed some concerns about Mr A's behaviours within the family and the family relationships

3.2.5 On 9 December 1997 Mr A was charged with indecent assault and carrying an offensive weapon. He had held a knife to the throat of a 15 year old girl and indecently assaulted her. Mr A pleaded guilty to the offences. He subsequently received a one year supervision order and was placed on the Sexual Offenders register.

3.2.6 Further offences and incidents in Mr A's adolescent years included being arrested for arson; and assault occasioning actual bodily harm. It was noted that both the Probation and Social Services assessed Mr A as 'High Risk' recording "*high risk areas – sadistic element of offence; feelings towards mother, feelings towards himself, risk if he forms relationships with younger females*."[7]

There were several reports of self-harm and attempted suicide throughout his adolescent years.[8] Mr A's view was that '*instead of getting moved from place to place, they should have let me settle somewhere'.*

3.2.7 Probation and Childrens' Social Care identified the lack of specialist resources for working with this age group at that time. The case was closed to Children's Social Care on 1st October 1999.

3.2.8 Between July 1999 and July 2000 Mr A came to police attention for further offences resulting in a 9 month prison sentence. Mr A's requirements under the sexual offender registration ended in July 2000. In 2002, Mr A had a 3 year custodial sentence for a series of robberies and possession of an imitation firearm.[9]

3.2.9 Mr A's sister, J felt her brother '*had an obsession with knives'* but that she only recognised this now with the value of hindsight.

Mr A was in a relationship with a male partner, Mr B for 5 years (from approximately 2006 to 2011). Mr B also identified Mr A's pre-occupation with knives. Mr B stated that Mr A was always taunting him, making threats. '*He would phone threatening to stab me with his chef knives ….he was obsessed with those knives. He used to say he was watching me….He was a coward though but a bully if he thought someone was weaker than him'*

3.2.10 Mr A has received support from psychiatric services since 1995. At the time of the

[7] Children Social Care, *Factual Summary Report, RE Mary*, p. 4
[8] Ibid
[9] MAPPA Factual Summary Report, Re Mary, section 6.14-6.15

homicide, Mr A was being treated for a personality disorder – emotionally unstable personality disorder and dissocial personality traits. This personality disorder includes characteristics of acting impulsively and without consideration of the consequences. Behaviours can include behavioural explosions and may include self-destructive behaviour. Characteristics also may include unconcern for the feelings of others a low threshold for discharge of aggression and a tendency to blame others.[10]

3.2.11 Mr A was thought to have used drugs sporadically including regular low doze benzodiazepines that he was trying to wean himself off. He had also had a pattern of binge drinking.[11] At time of the homicide, Mr A was on an alcohol treatment programme as part of his probation order but records indicate he was not a dependent drinker.[12]

3.2.12 Agency reports to the DHR show that the high number of incidents of self-harm continued into Mr A's adult life. Some incidents were in circumstances where Mr A would not expect to be found. In others instances, Mr A's plans for self-harm/suicide were highly visible.[13]

3.2.13 The views of family and past partners were that Mr A's deliberate self-harm and suicide attempts were often associated with anger and a wish to control others. Mr B felt Mr A was '*playing head games morning to night'.*

Mr A's sister J, described how her brother could be very supportive and loving but could also be very manipulative. *'It is like he has a split personality ….a little sod and a little gem.'*

3.2.14 The reports that contributed to this review highlighted that the characteristics associated with emotionally unstable and dissocial personality disorder were evident in Mr A's behaviours. It is evident that he was both a vulnerable person and a person who presented substantial risk to others though he had the ability to detract attention from this.

3.2.15 There is evidence that Mr A was beginning to engage well with services for personality disorder offered through Leicestershire Partnership Trust. In December 2012[14] Mr A began a preparation programme for a planned 12 month intervention through a Therapeutic Community, a programme that Mr A viewed positively.

## 3.3 Relationship between Mary and Mr A

3.3.1 Mary had been in a relationship with Mr A since approximately September 2011. Mary's family believed that as in many of her relationships in the early stages, Mary was infatuated with Mr A. Mary's daughter R, described her as becoming obsessed to the exclusion of everyone else and '*she would become paranoid about him seeing other people.'*

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[10]Leicestershire Partnership Trust (July, 2013)*, Agency IMR Template, for (Mary), Domestic Homicide Report* , 8.1, p. 7 ; World Health Organisation, International Classification of Diseases (ICD), ICD-10 Version: 2010, "Emotionally Unstable Personality Disorder", [Available from: http://apps.who.int/classifications/icd10/browse/2010/en#/F60.3] [Accessed: 26.09.13]

[11]Medical Practice 1, *Factual Summary Report DHR, RE: Mr. A*, p. 4

[12]Leicester & Rutland Probation Trust (July 2013), *Agency IMR, for Mary, Domestic Homicide Report,* 4.3, p. 6

[13]Leicestershire Police, *Agency IMR,* 8.11.1, p.25; 8.12.1, p. 26

[14]LPT, *Agency IMR,* 8.18, p. 10

3.3.2 Records indicate that on the 24th November, Mary's GP was informed that Mary was 8 weeks pregnant and that Mary wanted the baby.[15] Sadly Mary miscarried 1 week later. Mr A's mother recalls being informed of this miscarriage by Mary the first time they met and Mary stating it was Mr A's baby. There is no evidence that this miscarriage was as a result of an assault. However, Mary was assaulted by Mr A 2 weeks later and informed workers it was because she had told Mr A's mother about the miscarriage.

Mr A however, stated that he had no knowledge of this pregnancy and denied assaulting Mary at this time.

3.3.3 At the beginning of the relationship, Mr A had his own private tenancy at address 2. Mr A reports he moved in with Mary at address 1 from January 2012 and was living there for the majority of the time until her death. This followed his eviction for non-payment of rent at address 2.

3.3.4 It is evident from the interviews with Mr A, Mary's family and from the reports of agencies involved, that the relationship between Mary and Mr A was highly emotionally charged. Mr A and Mary's family noted that the couple had times when they were happy together, but the relationship was marked by conflict, violence and separations. Mr A described *'any time we had a drink, we argued and it got out of hand'*

3.3.5 Mary's daughter R recalls regularly being phoned, often in the middle of the night with Mary telling her what Mr A had been doing. On one occasion Mary had called R '*hysterical*' saying that Mr A had held a knife to her throat. When R went round, the couple were just carrying on as normal and acted as though nothing had happened.

3.3.6 It is believed that Mary was aware of at least some of Mr A's history of offences. R had been contacted by Mr B, ex-partner of Mr A, warning her that Mr A had been on the sex offender's register. Mary had pre-warned R that she would be told this but should just ignore it as it wasn't true.

3.3.7 Mr A's sister J felt that Mary '*was obsessed by him and he didn't return that*" She recalls having a phone call from Mary the day before her death. '*She was hysterical saying he'd met (D) and saying ''I need to wait till he gets home and confront him with it.'' '*

Mr A's reiterated this view, describing Mary as very jealous whereas for him, the relationship was convenient as Mary provided somewhere for him to stay.

3.3.8 Mary's family felt that Mary wouldn't have described herself as being in an abusive relationship. They felt that sadly, Mary just saw the arguments and violence as part of life. Though they felt Mr A was unpredictable, they didn't feel Mary was frightened of him, and described the power balance between them as being about 50:50. Mr A's Mother recalled '*She could look after herself. She wasn't scared ..she'd smack him one……she could give as good as she got'*.

[15]Medical Practice 2, *RE: Mary, Clinical Record,* p. 24

Mr A endorsed this view. He felt there was no real pattern or escalation in the violence within the relationship.

3.3.9 Mary's daughters and parents were of the opinion that Mary stayed in the relationship because of emotional security and a fear of being alone rather than any threats, coercion or financial security.

However Mr B, described a more coercive relationship. He stated Mary had informed him that Mr A would use threats of self-harm to get Mary to do things for him, and would tell her he would kill himself if she ever left him. Mr B stated that he understood how Mary must have felt as Mr A had said similar things to him during their relationship. Mr B recalls about 1 month before Mary's death, he had asked if Mary was frightened of Mr A, she had responded '*Yes*.' When Mr B advised her to leave Mr A, she had answered '*If he hasn't got me he hasn't got anyone'*. Mr B recalls Mary keeping a box containing £5 that she said was her emergency escape money.

# 4.0 INVOLVEMENT OF AGENCIES

This section provides some context for domestic violence services in the area. There follows a review of each agencies involvement, leading to the recommendations arising from their reports.

Section 5 of this report provides further analysis of the agency's intervention and how effectively the agencies worked together.

The table in Appendix 2 provides a summary of significant events extracted from this combined chronology, focusing on the period Sept 2011- Feb 2013.

## 4.1 Context for Leicestershire's Domestic Violence services

4.1.1 Leicestershire Safer Communities Strategy Board established The Leicestershire Domestic Abuse Strategy Board to bring together relevant partners, and develop an integrated approach to domestic abuse.

4.1.2 The Leicestershire Multi Agency Domestic Abuse Strategy 2010-13[16]has four priorities:

1. To improve services for victims and their families
2. To improve the identification and management of risk
3. To effectively manage perpetrators of domestic abuse
4. To increase public awareness of domestic abuse

4.1.3 Across Leicestershire there are specialist support services and networks to improve safety. Domestic abuse help lines direct people to sources of support across Leicestershire,

[16]Leicestershire County Council, *Leicestershire Multi Agency Domestic Abuse Strategy 2010-13*, [Available from: http://www.leics.gov.uk/search.htm], [Accessed: 26.09.13]

Leicester and Rutland.

4.1.4 Outreach workers provide emotional and practical support for male and female victims of domestic abuse, including help accessing legal and financial support. The service can be accessed by men and women where a domestic abuse risk assessment suggests they are not at immediate risk of homicide or serious harm. The risk assessment used to determine this threshold is the CAADA/DASH risk assessment checklist. The Local Domestic Abuse Outreach Provider is the agency commissioned to deliver this service within the area of Leicestershire review.

4.1.5 Independent domestic violence advisors (IDVA) address the safety of victims at high risk of harm from intimate partners, ex-partners or family members to secure their safety and the safety of their children. Serving as a victim's primary point of contact, IDVAs normally work with their clients from the point of crisis to assess the level of risk, discuss the range of suitable options; develop safety plans and ensure completion of actions arising from MARAC meetings.

4.1.6 The Leicestershire Multi-Agency Risk Assessment Conference (MARAC) began in 2008. MARACs are regular local meetings where information about high risk domestic abuse victims (those at risk of murder or serious harm) is shared between local agencies and a package of safety and support measures agreed.

4.1.7 There is a nationally accredited risk assessment process used to determine levels of risk and whether referral to MARAC or the IDVAs is indicated. This is the CAADA DASH (Coordinated Action Against Domestic Abuse, Domestic Abuse, Stalking, Honour based violence risk identification assessment tool).The tool has 27 questions to ask the victim and the risk levels are defined as follows:

- **High (score of 14 or more):** There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious. Risk of serious harm is defined as 'a risk which is life threatening and / or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible'
- **Medium (score of 10 – 13):** There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse
- **Standard (score below 10):** Current evidence does not indicate likelihood of causing serious harm

4.1.8 The DASH is a tool to help assess risk but needs to be considered as part of the wider context and the whole circumstances of the case. The DASH is adopted nationally by Police but is not yet universally adopted by other services. Where the DASH risk identification tool indicates high risk, referral should be made to MARAC. Referral to MARAC is also indicated where there have been three police call outs in 12 months and an escalation of risk.[17]The decision to refer should also be influenced by professional opinion,

[17] This is discussed further in section 4.2.6 reviewing police involvement

for example, where it is felt the victim may be minimising the risk. A victim who has already been referred to a MARAC and who is the victim of a further offence (i.e. violence, harassment, threats or stalking by the same perpetrator) within 12 months will also be referred back to a MARAC.

All cases referred to MARAC are heard. Prior to April 2013, MARAC meetings were held monthly. Since April 2013, MARAC has moved to fortnightly to minimise wait and reduce escalation risks.

4.1.9 Health, Social Care, Police and Probation are all expected to have robust systems and processes in place to identify and respond to domestic violence. This includes signposting people to the support services, assessing risks and referring through to outreach; the IDVAs or MARAC where thresholds are met.

4.1.10 The work of Police and Probation is clearly central to the strategy's priority of '*effectively manage perpetrators of domestic abuse'*. Some specific measures used such as Multi Agency Public Protection Arrangements (MAPPA) and Integrated Offender Management are outlined in the reports from those agencies. Leicestershire also has 9 Joint Action Groups (JAGS). These are multi agency problem-solving forums consisting of local services e.g. housing offices, community services, police, probation, adult social care, who are brought together to problem solve and speedily address community safety issues including those around anti-social behaviour. In the area where this homicide occurred there was a Crime Joint Action Group.

4.1.11 One priority area for this Joint Action Group is *'Protect the most vulnerable in communities, particularly previous and repeat victims of crime.'*[18] The (redacted) Borough Crime JAG will receive referrals relating to domestic violence however this is not the case across all 9 Joint Action Groups covering Leicestershire and Leicester

4.1.12 Specialist Domestic Violence Courts have been established in Leicestershire since 2008. The purpose of the specialist courts is to offer better support for victims, bringing more offenders to justice. They are staffed by dedicated criminal justice staff and specially trained Magistrates. IDVAs support victims though the Specialist Domestic Violence Court (SDVC) as part of their role, supporting victims to obtain sanctions and remedies available through the criminal and civil courts. IDVAs also attend each sitting of the Leicester Magistrates SDVC court to ensure support is also made available to victims who may not yet have engaged with specialist domestic abuse services.

## 4.2 Leicestershire County Council Adult Social Care

4.2.1 Adult Social Care Services had no involvement with Mary and limited involvement with Mr A. The service was asked to provide a factual summary report.

The report author was the Head of Service and had had no direct involvement with Mr A. The methodology used was a review of case records.

[18] Ibid.

4.2.2 **Summary of Involvement**

Adult Social Care was primarily involved with Mr A through assessing Mr A while he was detained in a place of safety for assessment of his mental health under section 136 of the Mental Health Act 1983.

4.2.3 **Issues Arising and Analysis**

The DHR panel questioned whether there would have been a more extensive role for Adult Social Care, given the needs that Mary and Mr A had. The Adult Social Care report author noted the main providers of support for people with mental health problems are the NHS and substance misuse services are commissioned from the independent sector.

4.2.4 The author notes that when Mary experienced domestic violence, if she were suffering from mental health problems or substance misuse impacting on her day to day living and not able to protect herself, she should have been referred to Adult Social Care and the safeguarding procedures followed.

4.2.5 The DHR author notes that no agency assessed that Mary did require referral through safeguarding adults procedures. Though this appeared appropriate in this case, it was noted that the percentage of referrals through Safeguarding Adults Multi Agency Procedures where the individual's support needs relate to drugs and alcohol were very small – out of 1302 referrals in 2011-12, only 3 (0.2%) were recorded as being for people with substance misuse needs.[19]

4.2.6 Furthermore, the data relating to referral sources to MARAC since Dec 2007shows that out of 1880 referrals only 1 (0.05%) was made by Adult Social Care[20]. It is acknowledged that this may be because of close working with police and the domestic violence services under safeguarding adult procedures. The interface between safeguarding adults and domestic violence services is considered further in section 5. Adult Social Care identified a need to bring these 2 areas of work closer together.

4.2.7 **Recommendations arising from the Adult Social Care report**

| Adult Social Care Recommendations |
|---|
| Raise awareness of the role domestic violence services can play in safeguarding vulnerable adults. |

## 4.3 Leicestershire Partnership NHS Trust (LPT)

4.3.1 Leicestershire Partnership Trust (LPT) provides mental health learning disability and community health services for the population of Leicester, Leicestershire and Rutland. The initial review of involvement identified that there was extensive involvement from LPT with Mary and Mr A. LPT provided a chronology and individual management review. As detailed in section 1.3, LPT had also conducted a serious incident investigation relating

[19] Data supplied by Leicestershire County Council
[20] Data supplied by Leicester, Leicestershire and Rutland MARAC

to their involvement with Mary and Mr A.

4.3.2 The report was jointly authored by LPT Adult Safeguarding Named Nurse and the Nurse Team Leader of Mental Health Services. Neither author had had direct involvement in the care of Mary or Mr A.

**The methodology used was**:

| | |
|---|---|
| A review of 7 sets of medical case notes was conducted from July 2007 to present date for the victim. | A review of 6 sets of medical case notes was conducted from July 2007 to present date for the alleged perpetrator. |
| The electronic information system MARACIS was used as a resource for gathering information and to support chronology of events. | The Serious Incident report completed on 18 June 2013 completed by LPT was used to extract useful data and information about both patients involved in this case. |
| Discussion with the Domestic Violence Specialist Nurse on involvement with MARAC processes | Interviews held as part of the Serious Incident process was extracted to facilitate review |
| A review of Safeguard, the incident data reporting system. | A review of medical and, nursing and therapy case records. |
| Review of practice in relation to procedures and protocols in place. | Telephone contact with the Probation officer to establish facts around the alleged injunction order |
| **Consideration of the following policies and procedures** | |
| LPT – Did not attend policy 2010 | 136 Suite Operational Policy 2012 |
| Domestic Violence 2012 | MAPPA LPT 2005 |
| MAPPA – Leicester and Rutland policy 2010 | CPA policy 2010 |
| Risk Management policy 2013 | Clinical Risk Assessment policy 2010 |
| Health Care Record Keeping policy | Adult Safeguarding Policy 2012 |
| Crisis Resolution & Home Treatment Service | Operational Policy June 2011 |
| Mental Capacity Act (2005) policy 2012 | Mental Health Act (2007) policy 2012 |

4.3.3 ## Context

LPT mental health provision includes inpatient facilities, Community Mental Health Team; Crisis Resolution Home Treatment service; specialist services including Personality Disorder services and psychological treatment services such as 'Good Thinking Therapy' and in-patient and community forensic services.

The Good Thinking Therapy Service sits under the umbrella of the "Rethink mental illness'' a national charity. LPT sub contracted to Rethink to help provide Improving Access Psychological Therapy (IAPT) "talking therapy" for clients with mild to moderate anxiety and depression. Rethink also provide on-going health and wellbeing assessments for patients on the primary care Serious Mental Illness Register through the Mental

Health Facilitator Service, who also offer mental health advice and support to primary care. IAPT referrals are made in response to clients presenting with mild/moderate depression or stress via their GP directly to the service. In Mary's case she was referred to the Mental Health Facilitator Service directly from the GP to the clinician involved with the case.

Until 2011, LPT provided specialist drugs and alcohol services. However in 2011 the contract for this service and the care of service users was transferred from LPT to Swanswell, an alternative provider of drug and alcohol services.

4.3.4 The Care Programme Approach (CPA) is a way of coordinating care for individuals with complex mental health needs, often requiring the involvement of more than one agency or a multi-disciplinary team. A CPA care coordinator should be appointed to coordinate the assessment and care process and carry out with the service user a regular review of needs and risks.

4.3.5 People who don't meet the criteria for CPA support should still expect assessment of their needs, care planning and reviews along with multi-agency working according to the individual's needs. Their review should also consider whether care should be delivered through CPA.

4.3.6 The LPT Care Programme Approach policy[21] states the following indicators for support through the CPA process:

| Table 1 – Indicators for the support of formal CPA process |
|---|
| Severe mental disorder, (including personality disorder) with complex health and social needs and/or a learning disability. |
| Current or potential high risk(s), including:<br>• Suicide, self-harm, harm to others (including history of offending)<br>• Relapse history requiring urgent response<br>• Self-neglect/non concordance with treatment plan<br>• Vulnerable adult; adult/child protection e.g.<br>- Exploitation e.g. financial/sexual<br>- Financial difficulties related to mental illness<br>- Dis-inhibition<br>- Physical / emotional abuse<br>- Cognitive impairment<br>- Child protection issues |
| Subject to Section 117 Mental Health Act |
| Previously detained under the Mental Health Act. |
| Subject to Supervised Community Treatment (SCT)<br>Subject to Guardianship under the MHA (section 7) |
| Current or significant history of severe distress / instability or disengagement |
| Presence of non-physical co-morbidity e.g. substance / alcohol / prescription drugs misuse. |
| Multiple service provision from different agencies, including: housing, physical |

[21] Leicestershire Partnership Trust (Dec 2010), *Care Programme Approach (CPA) Policy*, p.30

| |
|---|
| care, employment, criminal justice, voluntary agencies |
| Engaged with Crisis and Home Treatment Team in excess of 6 weeks |
| Significant reliance on carer(s) or has own significant caring responsibilities |
| Experiencing disadvantage or difficulty as a result of<br>• Parenting responsibilities<br>• Physical health problems / disabilities<br>• Unsettled accommodation / housing issues<br>• Employment issues when mentally unwell |

4.3.7 **Summary of Involvement with Mary**

The LPT report details that Mary had been involved with LPT since 1995. From 1995 until 2011, the care provided to Mary primarily related to her drug and alcohol use. However GP records from 2007 made by the LPT drugs team indicate they were also offering Mary some support in relation to domestic abuse to Mary by a previous partner.

4.3.8 **In December 2011**, Mary's GP made a referral for LPT's 'Good Thinking Therapy.'

The report states that Mary positively engaged with the service and used this and her prescribed medication to support her needs. Mary's engagement was evident from her attendance (9 face to face sessions; 5 telephone contacts with 'did not attend' on 7 occasions.) LPT report that in the initial contact, the therapist made inquiry about risk from self: "self-harm", risk from others: "abuse" and "domestic violence" and risks posed to others. There was no risk identified on any clinical assessment areas undertaken.

The records indicate that Mary was willing to discuss and explore some sensitive information about her past life. However, Mary did not disclose she was in any current relationship during the period of time with the therapist.

4.3.9 Good Thinking Therapy made a referral to the Cognitive Behavioural Therapy service on **20th April 2012**. Two appointments were offered but Mary did not attend this and was discharged from the CBT service in line with the Trust 'Did Not Attend' policy.

4.3.10 **On the 2nd May 2012**, Mary discussed with her therapist that she was increasingly angry and anxious. A follow up appointment was made for 16th May 2012. Between these appointments, Mary was subjected to a significant assault by Mr A on the **5th May 2012** and was admitted to hospital as a consequence of her injuries. At her appointment with Good Thinking Therapy **on 16th May 2012**, Mary made no mention of this assault. The therapist was therefore not aware of the incident or the relationship between Mary and Mr A.

4.3.11 Following a further disclosure of a traumatic event in Mary's early life, Good Thinking Therapy service referred Mary to a specialist therapeutic/support service in Nov 2012. The LPT report states '*her treatment ended at this point as she was receiving support from (the specialist service- redacted)*'. Mary's treatment by the Good Thinking Therapy was closed in November 2012. LPT had no further involvement with Mary

4.3.12 **Issues Arising and Analysis Relating to Involvement with Mary**

The report identifies that the referral from Mary's GP to Good Thinking Therapy service in December 2011 was on an informal basis only and did not offer a comprehensive history of events or Mary's background. LPT considered this to be a missed opportunity for pertinent information to be shared and potentially an avenue that could have been explored further by the practitioner.

4.3.13 Though there is evidence of good engagement with Mary and a willingness from her to discuss sensitive information, the report notes that the Good Thinking Therapy service was not aware of any of Mary's history of domestic violence and Mary did not disclose details about Mr A or discuss any relationship within her therapy sessions.

4.3.14 The report stated that the assessment processes for Good Thinking Therapy service provides opportunities for patients to disclose issues of domestic violence and therapists may access a domestic violence risk assessment tool for any identified risk or disclosures. The LPT report author confirmed that the therapist had inquired about risks as part of the assessment process. This included inquiry about self-harm and risk from abuse and domestic violence. There was no risk identified on any clinical assessment undertaken.

LPT reported that relationships are explored as part of the initial assessment and during each interface session. Mary did not disclose she was in any current relationship during this period of time with the therapist.

4.3.15 Mary also did not disclose to the Good Thinking Therapist that she had been admitted to hospital in May 2012 following an assault by Mr A. The LPT report author identified that they would have expected the hospital discharge communication to be shared with the GP and questioned why this information was not then communicated to the Good Thinking Therapist (this is reviewed further in the reports from University Hospital Leicester and Medical Practice 2 below)

4.3.16 It is noted that the GP (Medical Practice 2) record held information relating to domestic violence from the period 2007-8. The entries were recorded in the practice patient record by the LPT drugs worker who was working with Mary at the time. This indicates that records used by different services within LPT were either not accessible, or not accessed by other parts of the service that were working with Mary. The challenge of accessing information from different services within a large Trust was possibly exacerbated by Good Thinking Therapy being a sub-contracted service.

4.3.17 LPT highlighted the importance of confidentiality in establishing the therapeutic relationship. Confidentiality agreements are agreed with clients on initial contact and information is shared with the GP and entered onto the GP patient record systems.

The GP records also contained information from Swanswell drug and alcohol service about their involvement with Mary. Effective care planning involves understanding the contribution and focus of related work by other professionals and agencies and this needs to be taken into account when discussing the confidentiality agreement with service

users. It would have been good practice (with Mary's consent) to consult with the Swanswell worker in order to gain a fuller understanding of any factors that may have been relevant to the therapy. Swanswell knew of the history of domestic violence during 2007-8 and of the assault by Mr A in December 2011. Had the therapist liaised with Swanswell, the Good Thinking therapist would have known about her history of domestic violence. If Mary were willing, this could have been discussed within her therapy, presenting a further opportunity for Mary to disclose current domestic violence.

4.3.18 We are not able to determine whether Mary made an active choice not to discuss domestic violence with the Good Thinking Therapist or whether the complex and potentially coercive nature of her relationship with Mr A prevented her from doing so. We do know that despite the therapist making inquiry about domestic violence (Dec 11), Mary did not disclose the recent assault in December 2011 and did not disclose the assault of May 2012. Mary had been engaged in discussion on other sensitive issues within her life and it maybe that she wished to use their sessions to focus on these aspects with her therapist. The fact that Mary remained engaged with this service does perhaps indicate that she valued the therapy she was receiving.

4.3.19 It is evident that the Good Thinking Therapist was responsive to the needs that Mary discussed in their sessions, referring to other services such as cognitive behavioural therapy and a specialist therapeutic service. However, the LPT report states that her treatment by them ended '*as she was receiving support from (the specialist therapeutic service – redacted).'*A report from this specialist service (reviewed in 4.4) states that Mary declined support. It is not apparent whether the Good Thinking Therapist was aware that Mary had not engaged with the service or whether this would have affected the decision to end the Good Thinking Therapy. LPT states that Good Thinking Therapy is a short term intervention.

4.3.20 LPT confirmed that staff involved would be knowledgeable about indicators of domestic violence and how to act. LPT support staff to address domestic violence through a Domestic Violence Policy; mandatory domestic violence awareness training on induction; training on domestic violence and risk management within their adult 1 day safeguarding programme; a dedicated specialist nurse in domestic violence to provide support and advice; support through the Trust's safeguarding team. The Good Thinking Therapy service had also received a dedicated training session on domestic violence.

4.3.21 LPT state that their policy on Equality Diversity and Human Rights supports practitioners to ensure protected characteristic strands of equality are considered in their work. There were no specific equality issues identified in their work with Mary.

4.3.22 **Summary of Involvement with Mr A**

Mr A was being treated by LPT for a personality disorder – emotionally unstable personality disorder and dissocial personality traits. The World Health Organisation ICD -

10 version 2010[22] lists emotionally unstable personality disorder and dissocial (antisocial) personality disorder as:

**Emotionally unstable personality disorder**
*Personality disorder characterized by a definite tendency to act impulsively and without consideration of the consequences; the mood is unpredictable and capricious. There is a liability to outbursts of emotion and an incapacity to control the behavioural explosions. There is a tendency to quarrelsome behaviour and to conflicts with others, especially when impulsive acts are thwarted or censored. Two types may be distinguished: the impulsive type, characterized predominantly by emotional instability and lack of impulse control, and the borderline type, characterized in addition by disturbances in self-image, aims, and internal preferences, by chronic feelings of emptiness, by intense and unstable interpersonal relationships, and by a tendency to self-destructive behaviour, including suicide gestures and attempts*
***Dissocial personality disorder***
*Personality disorder characterized by disregard for social obligations, and callous unconcern for the feelings of others. There is gross disparity between behaviour and the prevailing social norms. Behaviour is not readily modifiable by adverse experience, including punishment. There is a low tolerance to frustration and a low threshold for discharge of aggression, including violence; there is a tendency to blame others, or to offer plausible rationalizations for the behaviour bringing the patient into conflict with society.*

4.3.23 Mr A had been receiving services from LPT since 2002. This comprised:

| | |
|---|---|
| **Inpatient services** | Dec 2008; Jan 2009; November 2011; March 2012 |
| **Mental health homeless service** | Dec 2008/Jan 2009; June 2010 |
| **Crisis resolution home treatment** | Nov 2011; |
| **Out-patient reviews by Consultant Psychiatrist; psychotherapist** | Oct 2011; Nov 2011; June 2012 |
| **Francis Dixon Lodge -Specialist therapeutic services for personality disorder** | June 2012 – February 2013 |

4.3.24 **During an admission in 2008**, LPT contacted the local probation service. The record from this contact stated '*no known forensic information about Mr A'.*

4.3.25 **In October 2011**, Mr A was seen as an outpatient by a psychotherapist. A risk assessment was completed and Mr A identified that his ex-partner was a risk to him.

**In November 2011**, Mr A made threats of suicide and was referred to the mental health

[22]World Health Organisation, International Classification of Diseases (ICD), ICD-10 Version: 2010, "Emotionally Unstable Personality Disorder", [Available from: http://apps.who.int/classifications/icd10/browse/2010/en#/F60.3] [Accessed: 26.09.13]

crisis team for home treatment. The chronology notes a record '*Mr A said he wants to kill her and her friend*.' This was in the context of talking about his mother and his ex-partner Mr B. A referral was made for Mr A to attend the Community Mental Health Team but he did not attend. He was subsequently discharged from the crisis team.

4.3.26 **In November 2011**, Mr A had an outpatient appointment with a psychotherapist. The psychotherapist made a referral for Mr A to attend the LPT therapy service for people with personality disorder. The service offered Mr A an appointment in January 2012 but he failed to attend.

4.3.27 **In March 2012**, Mr A was admitted to hospital following an episode of significant self-harm. As is practice for all inpatient admissions, Mr A was put on Care Programme Approach. During this admission, he stated to different members of staff at different times, his intent to stab Mary and his Mother. The admission record documents Mr A stating *'I don't mind kill myself/ stab my girlfriend when I go back.'*[23]

4.3.28 The risk assessment tool used[24] recorded evidence that Mr A had a volatile relationship with his girlfriend and hostile relationship with his mother and the need to '*Investigate Mr A's threats that he would stab his mother and girlfriend when he leaves hospital*'.[25] Two days later, Mr A asked for leave from the ward and so the duty Doctor was called. A brief clinical risk assessment is documented that includes asking Mr A about his thoughts and feelings and any thoughts of harming himself or others, which Mr A denied, saying he wanted to stay at Mary's. The report states that the duty Doctor phoned Mary and she agreed he could stay at her address.

4.3.29 The report author notes that at the multi-disciplinary discharge meeting on the **5th March 2012** it was recorded '*CPA review date to be arranged'* indicating intent that CPA should continue. However, the discharge form did not have CPA ticked and at point of discharge on the 5th March, Mr A was no longer on the CPA.

4.3.30 The only service Mr A was referred to on discharge was the out- patient department. The Consultant Psychiatrist had no previous knowledge of Mr A. There was no reference to the documented risks on admission or any mitigation plan found within the clinical record. The risks assessment form was not shared with Mr A's GP or with the outpatient Consultant.

4.3.31 As part of practice standards, there is a requirement to carry out a 7 day follow up from discharge for patients under CPA. As Mr A was not on CPA, this did not happen. 11 weeks elapsed before Mr A was seen **on 26th June 2012** at out-patients by the Consultant Psychiatrist.

4.3.32 Records from this outpatient appointment note that Mr A had assaulted Mary 5 weeks earlier (May 2012) and that he was now subject to a probation order. This did not prompt further interrogation of previous care records, risk assessments or a review of his CPA

[23] LPT, *Agency IMR*, 8.28, p. 13
[24] LPT, *Clinical Risk Assessment Policy*
[25] LPT, *Agency IMR*, 8.29, p. 13

status. A referral was made the following day to Francis Dixon Lodge, the LPT therapy service for people with personality disorder. This information was conveyed to Mr A's GP but was delayed in transit by 8 weeks as it went to the wrong GP practice.

**In July 2012**, Mr A completed a form as part of the assessment process for the personality disorder service. Mr A ticked the box on the form indicating that in the last week he had often been physically violent to others.

4.3.33 Mr A attended his first appointment at Francis Dixon Lodge in **September 2012**. Following a further 3 sessions, a plan for intervention through the Therapeutic Community was identified. This was a psychosocial treatment programme to address enduring personality disorders and is consistent with guidelines from the National Institute for Clinical Excellence for the treatment of personality disorders.

4.3.34 **On 11th October 2012**, the lead therapist from the personality disorder service at Francis Dixon Lodge completed an initial risk assessment form. This recorded that Mr A was a risk to others and included forensic history (as self-reported by Mr A) and his current probation order. The name of the probation officer and frequency of contact is noted as well as record of previous self-harm and 2 suicide attempts during 2012. However though the assault to his partner in 2011 is noted, it did not include the information relating to his expressed intent to harm others (March 2012) or the more recent assault to Mary in May 2012.

The LPT Managing Risk Policy requires staff to contact other professionals involved in Mr A's care and to complete a more comprehensive assessment where risks are indicated through the initial risk screening form. This was not done. A letter to the GP referred to Mr A's drinking pattern '*can get angry and violent when drunk. Binge pattern 1-2 week – bottle of whisky.'*[26] However the risk assessment form was not shared.

4.3.35 **In November 2012**, Mr A was assessed by a psychotherapist at Francis Dixon Lodge. The psychotherapist completed an LPT 'CPA determination tool' based on the indicators in the CPA policy. Mr A was again assessed as not being eligible for CPA. The rationale given was '*not involved with a range of agencies requiring formal co-ordination.'*[27] The record also includes an entry of assaulting his partner and '*ring probation officer for progress report.'* Though a phone call was made, the therapist was informed the probation officer had moved base – there is no record of any message being left or further follow up.

*Note: through the panel discussion, it was clarified that the therapist had mistakenly asked for the Probation service Alcohol Treatment Worker rather than the Probation Offender Manager and therefore had been misinformed.*

4.3.36 **In December 2012**, Mr A. began attendance at the Preparation Group for the Therapeutic Community. This was 5 sessions delivered across 5 weeks. Mr A had attended four of the sessions, the last contact being 5th February 2013.

[26] Ibid., 8.47, p. 17
[27] Ibid., 8.16, p. 10

4.3.37 **Issues Arising and Analysis Relating to Involvement with Mr A**

**Assessment of Risk to Others:**
The LPT report states that '*LPT had no documented evidence from any other agency involved with Mr A in relation to any forensic history; the only information we received was from Mr A himself which was summarised as arson, burglary and armed robbery at this time'.*[28]

4.3.38 The LPT chronology notes that in 2008, inquiry was made with the probation service about Mr A and '*no known forensic history'* was recorded. 1 month later, a further admission records a summary of personal, psychiatric and forensic history. However this would not have been based on information from his earlier offending and therefore the substantial history and risks arising from Mr A's earlier years were not known to mental health services.

4.3.39 The records indicate that mental health services were aware of the assault to Mary by Mr A in December 2011 and in May 2012. In addition, there were 3 separate occasions where Mr A disclosed to LPT staff his intent or actual harm to others:

1. November 2011 – threats relating to killing his mother and ex-partner.
2. March 2012 – repeated threats to stab his girlfriend and mother.

The Trust has a duty of care to inform individuals where there is a specific and direct threat of harm made regarding them.

Mr A was given leave to go and stay with Mary whom 2 days earlier, he had made threats to stab. Though the duty Dr spoke with Mary and recorded that Mary had '*no worries about him coming home'*[29], there is no record that she was given information about his stated intent to harm her. We do not know therefore whether she was able to make an informed decision about risks to her. Given the concern raised by Mr A's statement, this should also have been used as an opportunity to ask whether there had been any violence between them and to consider whether Mary was feeling under any undue pressure or coercion to accept Mr A's return.

As the Doctor has now left the Trust, it has not been possible to receive a direct account. There is no record that any other member of staff informed Mary or Mr A's mother of the threats of stabbing that Mr A had made. Failure to inform Mary would be a significant omission. Mr A's Mother informed the DHR overview author that she had spoken to Mr A's Doctor about Mr A's threats to harm himself but had not been informed of any threats relating to her.

The LPT report author recognises that though Mr A had been discharged for more than 10 months before the homicide, he had assaulted Mary in May 2012, 6 weeks after this inpatient admission.

[28] LPT, *Agency IMR*, 8.32, p. 13
[29] Ibid., 8.77, p. 22

3. July 2012 – Mr A indicating on the risk assessment form that he had '*often been physically violent to others in the last week*'.[30]

4.3.40 The LPT report highlights the following omissions in relation to completion of risk assessments:

- Though LPT approved risk assessment tools were used, the report highlights that none of the services involved fully complied with the LPT risk assessment policy[31]
- The risk assessment in March 2012 did not consider the previous assault to Mary in Dec 2011. The risk assessment was not shared with Mr A's GP or outpatient consultant.
- The risk assessment in October 2012 was not based on the most recent information or full case records. Though the involvement of a probation officer was known, contact was attempted but not followed up. The risk assessment was not shared with the probation officer or Mr A's GP.

4.3.41 The LPT report states '*It is unfortunate that there is an absence of a co-ordinated multi-agency approach resulting from a comprehensive and dynamic risk assessment and positive management plan.'*

Had there been good inter- agency and multi-disciplinary risk assessment, LPT would have had a fuller understanding of Mr A's forensic history and current offences. The probation service would also have had a fuller understanding of Mr A's mental health and the implications arising from his personality disorder in relation to his presentation and risk to others. This would have enabled a more comprehensive assessment of risk and multi-disciplinary risk management plan.

4.3.42 There is however some evidence of responsiveness to Mr A's behaviours. Referrals were made to specialist services as a means of addressing Mr A's personality disorder. Services attempted to support Mr A according to NICE guidance[32] encouraging individuals to consider the different treatment options and life choices available to them and the consequences of the choices they make. There was evidence that latterly Mr A was engaging with treatment.

4.3.43 The DHR panel asked LPT to consider whether referral to their specialist mental health forensic services should have been considered at any point of their involvement. The report concluded '*Repeat offending of a serious nature in the context of enduring mental illness is the main factor which would necessitate a referral to forensic services. Threats or criminal behaviour of a petty nature would not meet criteria. Expert medical opinion independent to involvement in this case, did not feel Mr A would not have met criteria for referral to forensic mental health services*.'[33]This appears appropriate given what was known about Mr A in that he did not have enduring mental illness.

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[30]Ibid., 8.48, p. 17
[31]Leicestershire Partnership Trust (LPT) (March 2012), *Clinical Risk Assessment Policy*.
[32]Institute for Health and Care Excellence (NICE), *Borderline Personality Disorder*, [Available from: http://publications.nice.org.uk/borderline-personality-disorder-cg78/related-nice-guidance] [Accessed: 28.09.13]
[33] LPT, *Agency IMR*, 8.4, p. 8

4.3.44 The DHR panel also asked LPT to consider responses relating to drug and alcohol use. The LPT report noted that *'Mr A did not declare any dependency on alcohol but described "binge type" drinking; he also stated he was "clean" referring to being drug free'*.[34] However, it is noted that Mr A was at this time subject to an alcohol treatment requirement as part of his probation order. As there was no contact made between probation and mental health services, the details of this were not known or considered as part of the care plan.

4.3.45 **Coordination of Services and Care Programme Approach**
It is important to note that effective communication across professionals and agencies is fundamental to good risk assessment and management for all service users, whether they are receiving care through the Care Programme Approach or not. This expectation is part of the LPT Risk Management policy.[35]

4.3.46 However, had Mr A been subject to CPA, this would have afforded structured multi-agency communication and care planning including assessment and management of risk. This would also include exploration of other social contacts including carers (Mary in this case); their needs and any risks. It would also have enabled others involved, such as the probation officer, to have a better understanding of Mr A's diagnosis of personality disorder, and the characteristics related to this that may be relevant to managing his risks i.e. impulsivity; low threshold for discharge of aggression; tendency to blame others, or to offer plausible rationalisations for the behaviour.[36]

4.3.47 The LPT report identifies that it appeared that the multi- disciplinary team meeting on the 5th March 2012 intended Mr A should remain on CPA after discharge. The fact that he did not was it appears, due to an administrative error.

4.3.48 At this stage there were a number of CPA policy indicators for eligibility, that matched Mr A's circumstances.

- Severe mental disorder, (including personality disorder) with complex health and social needs and/or a learning disability.
- Current or potential high risk(s), including:
  - Suicide, self-harm, harm to others (including history of offending)
  - Relapse history requiring urgent response
- Current or significant history of severe distress / instability or disengagement
- Presence of non-physical co-morbidity e.g. substance / alcohol / prescription drugs misuse.

4.3.49 The LPT report highlights 2 further opportunities where Mr A's eligibility for CPA should have been reviewed.

1. 1st out-patient appointment in June 2012. The violence from Mr A toward Mary five

[34] Ibid., 8.18, p. 11
[35] LPT, *Clinical Risk,* p. 11
[36] ICD-10 Version: 2010, "Emotionally Unstable", [Available from: http://apps.who.int/classifications/icd10/browse/2010/en#/F60.3] [Accessed: 28.09.13]

weeks earlier was recorded and that Mr A was now subject to a probation order. The report author highlights that this should have prompted a review of his CPA status.

2. Mr A's assessment in November 2012 by the psychotherapist. The author of the report identifies '*At the time of assessment by both the out-Patient Consultant and FDL Mr A had an out-patient Consultant, Probation Officer, weekly contact with his General Practitioner and FDL involvement. He has also assaulted his girlfriend twice (Dec 2011 and May 2012) and it is therefore suggested that Mr A was eligible for CPA and this would have provided an opportunity for the care of Mr A to be co-ordinated across primary, secondary and probationary services'.*[37]The LPT report identifies this as a missed opportunity.

A third opportunity to consider Mr A's CPA status was following the risk assessment on the 11th October 2012 when it was identified that Mr A was subject to a probation order, history of self-harm and violence to others.

4.3.50 The LPT report identifies a missed opportunity in March 2012 to refer to MAPPA to manage Mr A's risks across agencies. While it is important for practitioners to consider every avenue for managing risk, as outlined in section 4.2.3 above, MAPPA involves coordination of those with the highest risk offending behaviours and it is unlikely that MAPPA would have been the appropriate mechanism to manage Mr A's behaviours.

4.3.51 Similarly, the report considered whether opportunities for referral through Multi Agency Risk Assessment Conference (MARAC) were missed but concluded following the DHR panel discussions that '*even if a referral had been received this would not meet current thresholds for MARAC management, so it is difficult to predict if this would have made any significant difference in outcomes'.* Referral to MARAC is discussed further in section 5 of this report.

4.3.52 The report also identified a need to strengthen working arrangements between inpatient services and the Community Mental Health teams so that there is consistency of inpatient and community care by Consultants.

4.3.53 There were no specific equality issues identified in their work with Mr A.

The LPT report concludes there were missed opportunities for agencies to co-ordinate and build up a more comprehensive picture of Mr A's risk profile. Their investigation however identified that Mr A's personality disorder was the primary cause. His incidents of self-harm and violence to others were felt by LPT practitioners difficult to predict or prevent. It was viewed clinically by LPT that '*his risks could only be modified through engagement in explorative psychotherapy which was being provided and that he demonstrated the capacity to exercise choice and take responsibility for his actions'.*[38]

4.3.54 The DHR overview report author supports the overall findings and highlights the clear failings in communication and risk management. However, even if LPT had improved

[37]LPT, Agency IMR, 8.16, p. 10
[38]Ibid., 11.2, p. 27

these processes, though the risks may have been modified, it is unlikely that this in itself would have averted the tragic circumstances of Mary's death. The nature of Mr A's personality disorder; his unpredictable and violent behaviours may only be modified through long term therapy that LPT had initiated. Had Mary had more information about the nature of Mr A's personality disorder and the opportunity to talk with workers about safety strategies, this would have given her more informed choice about the risks she was prepared to take – ultimately, it is not possible to say whether she was ready to end the relationship.

4.3.55 Mr A's perspective was that the mental health services needed '*to listen to me when I try to tell them things… look into what's happened and don't fob them off…. Try to understand what's happening.'* However, he also acknowledged that services could not have foreseen the homicide as '*not a lot happened before the incident*'.

He viewed his experiences of mental health services negatively with the exception of the therapy he had begun with Francis Dixon Lodge which was *'…good at coping skills and helping me to identify triggers and to know what would happen. It was starting to help.'*

4.3.56 **Recommendations arising from the LPT report**

LPT had carried out a Serious Incident investigation prior to the DHR.

4.3.57 Some of the learning from their review has already been acted upon.

- The Morgan Risk Assessment is currently under review within mental health services and an assessment tool suitable for both the Trust's electronic mental health record and written records is currently being piloted. The assessment does capture MAPPA, forensic risk, MARAC and risk to others.
- The trust has taken forward professional practice of staff involved within this case.
- Leicestershire Partnership Trust has recently ratified their MAPPA policy. This includes reference to management of specific threats to harm. LPT has also provided a briefing to all staff relating to learning from DHRs and reaffirming staff responsibilities on local MAPPA arrangements.

4.3.58 It will be important for LPT to have assurance that these changes are being implemented in practice. The DHR overview author has made an overarching recommendation that Leicestershire Multi-Agency Domestic Abuse Strategy Board seek assurance from the agencies involved in this review that they have acted on the learning and recommendations arising from this DHR.

| **Leicestershire Partnership NHS Trust Recommendations** |
| --- |
| Francis Dixon Lodge LPT to develop an operational policy which clearly describe all aspects of service delivery and care planning e.g. risk assessment, implementing the CPA process, the service approach to risk assessment, the triage process, admission and discharge planning & effective communication and interagency working. |
| Risk assessment refresher training to be delivered to staff within Francis Dixon |

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| Lodge to increase capability and confidence of practitioners. The LPT CPA lead will deliver this training on risk management planning following assessment for FDL (TSPPD) team. |
| Risk assessment forms to be shared systematically and in a timely way across all involved teams within AMH division, with team members in Francis Dixon Lodge and to agree how this information is shared with GPs |
| Consideration to be given to the reciprocal information sharing agreement with GP's as part of the development of the 'RiO' Electronic Patient Record system |
| Individualised care plans to be implemented for Francis Dixon Lodge clients |
| To continue to deliver Domestic Violence training across the Trust within the Adult Service Safeguarding programmes. |
| To provide staff training and improve staff awareness of MAPPA procedures and processes across the Trust |
| Joint working arrangements across In-Patient and CMHT's to be reviewed to ensure that on balance they are providing the best configuration in relation to information sharing, effective and seamless transition and continuity for patients. |

## 4.4 Specialist Therapeutic Service (Redacted)

4.4.1 There was limited involvement from a specialist therapeutic service that Leicestershire Partnership Trust had referred Mary to. The service provided a factual summary report.

4.4.2 The author of the report was the manager of the service. The author had not had direct involvement in the care of Mary. Methodology was to review the service's records relating to Mary.

4.4.3 **Summary of Involvement**

This specialist therapeutic service received a referral relating to Mary in November 2012. Mary was contacted on 15th November 2012 and offered an appointment, but declined, stating she felt ok and already had support in place. There was no further contact from her.

4.4.4 **Issues arising and Analysis**

The policy of this service is to offer an appointment to the referred person. Should the person decline, contact details are provided and an offer made to contact at any point in the future. The nature of the specialist service requires confidentiality and the service would not ordinarily inform the referring agency where the person declines the service unless there were safeguarding issues.

4.4.5 **Recommendations Arising from the Report**

There were no recommendations made in the report as the service followed procedures. This was accepted by the DHR panel.

## 4.5 Swanswell

4.5.1 The initial review of involvement identified that Swanswell drugs and alcohol service were involved with Mary but not with Mr A. Swanswell provided a chronology and individual management review.

The author of the report was the service's Operations Manager. The author had not had direct involvement in the care of Mary.

4.5.2 **The methodology used was:**

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|---|---|
| A review of interventions delivered as recorded in the services database system | Findings of our own internal review. (Case workers directly involved in Mary's care were no longer available for interview). |
| **Consideration of the following policies and procedures** | |
| Case File Audit Policy | Clinical Governance Policy |
| Common Assessment Framework Policy | Confidentiality Policy |
| Data Protection Policy | |
| DNA Policy | Equality, Diversity and Human Rights Policy |
| Needs Assessment Policy | Prescribing Policy |
| Risk Assessment Policy | Safeguarding Policy |
| Supervision Policy | |

4.5.3 ### Context

Swanswell is a national alcohol and drug charity aiming to reduce problem drug and alcohol use. Swanswell was awarded the contract to deliver alcohol and drug service interventions from July 2011. As a consequence of this, Mary's care and treatment for drugs and alcohol misuse was transferred at this time from Leicestershire Partnership Trust (previous provider of this service) to Swanswell.

4.5.4 ### Summary of Involvement

During the course of their involvement, Mary had three different key workers who had direct contact with Mary on average, 2 to 3 times per month. In addition, there were a number of phone contacts made.

4.5.5 The majority of the interventions related to supporting Mary's use of drugs and alcohol and this will not be reviewed in any detail. The Swanswell report details that over the course of their involvement, Mary had made consistent efforts to address her drug use. As part of drugs reduction plan, Swanswell also talked to Mary about building other aspects of her life such as activities and opportunities for employment.

4.5.6 Particular events that are relevant to this review are as follows:

The Initial Risk Screening dated **23rd August 2008** received from Leicestershire Partnership Trust has a 'no' ticked against being a victim of domestic violence.

The Care Plan Summary received dated **10th January 2011** does not include any actions/goals related to relationships or domestic abuse

4.5.7 **In October 2011**, Mary contacted her key worker to say that her partner (now presumed to be Mr A) had stolen her methadone and an instance of duplicated prescribing. The key worker contacted the GP (medical practice 2) to discuss and a daily collection regime was established to reduce the risks of Mary's partner taking her methadone.

4.5.8 **In November 2011**, Mary reported to her key worker that she was feeling depressed. The key worker liaised with Mary's GP to refer her for a Community Psychiatric Nurse. It is this referral that instigated the involvement of Good Thinking Therapy described in section 4.3.3 above. Consent to liaise with the CPN appears on the Information Sharing documents from October 2011. There was no documented liaison with the CPN other than via the GP.

4.5.9 During her second appointment that month, Mary informed her key worker that she was pregnant. She was tearful and stated that she was bleeding. She also informed them that her partner was requesting evidence that she was drug free. (Sadly, Mary miscarried this baby)

4.5.10 **On the 12thDecember 2011**, Mary phoned her key worker to inform them that she was physically attacked by her partner the previous evening and that he had '*thrown out her clothes and that she now cannot find her methadone.'* The key worker contacted the police and Mary's GP. The Swanswell chronology notes that during an appointment with Mary on the same day, it was recorded '*Stated that boyfriend lost his temper because she had told his mum that she had a miscarriage with his last child. Advised that this was the first time he was violent – left bruises over her body.'*

4.5.11 **On 9th January 2012**, Mary informed her key worker that she had been assaulted by her partner again. The report chronology notes ' *advised that her partner said he was going to overdose so out of concern she went to see him and he subsequently locked her in and got violent. She went to hospital but was discharged yesterday and going to make a police complaint about him*.' (Note: the hospital has no record of this assault to Mary) During an appointment 2 days later, Mary informed her key worker that she didn't want to be in the relationship and had 2 charges against Mr A. There is no record of liaison with GP, police or domestic abuse services following this incident.

4.5.12 **In February 2012**, during an appointment, her key worker confirms with Mary that she is now engaged with a Community Psychiatric Nurse and updates the risk assessment. The risk assessment reports Mary was involved with a violent ex- partner and had to use self-defence in the past to protect herself, that she had got an injunction against him and a court case pending. There is no evidence that information around available domestic violence services was given. The risk of Mary's partner taking her methadone is included along with a plan to reduce this risk.

4.5.13 **In March 2012**, the Swanswell record indicates that during an appointment, Mary was given a leaflet about safeguarding children. It has not been possible to confirm what prompted this but panel members are aware that there was a promotion at that time by the Safeguarding Children Board relating to the safe storage of drugs.

4.5.14 **In April 2012**, Mary phoned her key worker to inform them that Mr A had self-harmed at her address and that he had taken her methadone again.

**On the 30th May 2012**, Mary had an appointment with her key worker and informed them she had missed her appointment with her Community Psychiatric Nurse and that she had had a bereavement. Mary did not mention a significant assault to her by Mr A on the 5th May and the key worker was not aware of this incident.

4.5.15 In **June, September and December 2012**, the risk assessment was again updated and the key worker confirmed with Mary that she was still seeing her Community Psychiatric Nurse. The assessment reiterated previous information about past domestic violence. There were no specific actions relating to domestic abuse within the management plan other than monitoring emotional wellbeing at each session and liaising with GP.

Mary's last appointment with the service was **14th February 2013** but she called to cancel this appointment.

4.5.16 ## Issues Arising and Analysis

The Swanswell report author identified that during the course of their involvement, Mary had had three different workers and there was no evidence that the case was transferred in any systematic way. Nonetheless, it is identified that Mary's attendance and engagement with the service was good.

4.5.17 The author found evidence that the key workers were responsive to Mary's needs and took a flexible and holistic approach to aid engagement. Mary was offered appointments quickly following cancellations of appointments and following incidents of domestic abuse. (It is noted that in the Medical Practice 2 report, there is record of Swanswell worker being responsive and sensitive to Mary '*X advised Mary that she could always talk to her about these problems was available to talk through her problems')*[39]

4.5.18 The service identified that their domestic violence processes were not robust during the period covering this DHR. Though Mary talked to her different key workers about her abuse, it does not appear that this was incorporated into the Mary's care plan. Her key worker did refer to the police and GP following Mary's disclosure of violence in Dec 2011, but not to the newly engaged Good Thinking Therapist. There was no record of any follow up to the statements made by Mary about further domestic abuse in January 2012.

4.5.19 The Swanswell report author identifies that no referrals were made to domestic abuse services or any records of safety plans being discussed with Mary. The further risk

[39] Medical Practice 2, *Factual Summary Report, for (Mary) DHR*, XXXIII, p. 9

assessments in 2012 noted the past incident of domestic violence but no further care planning relating to this.

The Swanswell report author identified that '*Routine enquiries could and should of taken place more frequently'* recognising the high prevalence rates of substance and alcohol misuse in domestic violence both for victims and perpetrators.[40]

4.5.20 The key workers worked with the GP to manage incidents with her prescription and these were dealt with quickly. The author felt that the risk of Mr A taking Mary's methadone was addressed as a form of abuse and managed so that she had to take her dose supervised. He noted that this was however in isolation and should have been addressed more explicitly as a form of domestic abuse.

4.5.21 The Swanswell report author also highlighted that the key worker identified symptoms of anxiety and depression and made a referral to the CPN. The author observed that this was not linked to Mary's domestic violence and an additional referral to domestic abuse services may have been appropriate. The author also identified that though a 'consent to share information' form was agreed with Mary in relation to the CPN, this did not lead to any liaison between them.

4.5.22 The Swanswell report author highlighted that when Mary informed their practitioner about her pregnancy, there was no evidence of expected delivery date being recorded, liaison with midwife or GP regarding medication or any discussions around the safe management of her medication during pregnancy. A further issue raised by the DHR panel was that this was also a missed opportunity to discuss domestic violence and her safety, recognising the increased risk of violence during pregnancy.[41] The Swanswell report author identifies that improved documentation and management of pregnancy is required along with training on the links between pregnancy and domestic violence.

4.5.23 The Swanswell report author highlighted that more could be done to promote their services for both perpetrators and victims to improve joint working. Given there is a high prevalence of substance and alcohol misuse, for both victims and perpetrators of domestic abuse[42], referrals from domestic abuse services to Swanswell are very low. The author highlighted a need for improved joint working to raise awareness in professionals and potential victims.

4.5.24 In relation to equality and the protected characteristics, the Swanswell report considered their response to Mary as a pregnant woman and has made recommendations accordingly. There was no other specific consideration made relating to equality.

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[40]Co-ordinated Action Against Domestic Abuse (CAADA): *Insights into Domestic Abuse 1*, Insights National Data-Set 2011-12 Appendix to: *A Place of Greater Safety*, p. 9 [Available from: http://www.caada.org.uk/policy/Appendix_CAADA_Insights_National_Dataset_2011-12.pdf] [Accessed: 30.09.13]

[41]Sandra L. Martin, PhD, et al., Physical Abuse of Women Before, During, and After Pregnancy, *JAMA. Mar 2001*, Vol. 285(12), pp. 1581-1584.

[42]CAADA: *Insights into Domestic Abuse 1*, Insights National Data-Set 2011-12 Appendix to: *A Place of Greater Safety*

4.5.25 It is evident that the knowledge, training and policy guidance has not been sufficient within Swanswell to adequately equip staff to assess and respond to domestic violence. This is addressed in the service's recommendations.

4.5.26 **Recommendations arising from the Swanswell report**

The Swanswell report highlighted a number of changes that have already been acted upon

- Domestic abuse training is now mandatory for all Swanswell staff, seniors and managers. The training should highlight the importance of routine questioning and Swanswell should evaluate whether the training has improved practice in this area.
- Swanswell team members are aware of domestic abuse services in the area and are currently undergoing some work in order to gather all domestic abuse service information in one place for easy access.
- Swanswell are now represented at the Multi- Agency Risk Assessment Conference in order to share information with other agencies about highest risk cases of domestic violence
- Swanswell have completed a pregnancy audit (provided to the review) and will be addressing the findings as part of their lessons learnt process.
- Swanswell now have a pregnancy workbook for staff which details how to manage working with people who use drugs and alcohol and are in treatment.
- Swanswell has improved their links with specialist midwives and are setting up a pregnancy clinic in our hubs to improve access and engagement for pregnant women.

4.5.27

| **Swanswell Recommendations** |
|---|
| Swanswell will continue to attend to each meeting MARAC on an on-going basis |
| Swanswell will introduce information around domestic abuse into our pregnancy pack from Oct 2013 |
| All team members have been mandated to complete AVA's new e-learning programme, *Complicated Matters: addressing domestic and sexual violence, substance use and mental ill-health.* They will have completed this by end of Sept 2013 |
| Swanswell will include training around Domestic Abuse within its mandatory training program starting in January 2014 |
| DASH training to be arranged for all staff. Currently being arranged but it is hoped that this will take place in Nov/Dec 2013 |
| A Domestic Abuse pack will be developed. This will include advice and information for workers and for potential victims. It will also include contact details and referral pathways for all relevant services. This is due for completion end of Oct 2013 |
| Representatives from domestic abuse services will be invited to attend team meetings of all Swanswell teams from Oct 2013 |
| Although the supervisor role has a significant clinical element we are re-shaping the supervisor role to enhance its clinical overview of domestic abuse cases. This will take from Jan 2013 |
| Supervisor's will audit all cases where there is mental health involvement to ensure |

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| joint working procedures are being adhered to |

## 4.6 University Hospitals of Leicester NHS Trust

4.6.1 University Hospitals of Leicester (UHL) had involvement with Mary and Mr A and provided a chronology and individual management review. This report was limited to the care relevant to the terms of reference. Any attendances within the scoping period for unrelated matters are not referred to within their report. This is accepted as appropriate management of patient confidentiality.

The author of the report was the Trust safeguarding adults lead. The author had not had direct involvement in the care of Mary or Mr A.

4.6.2 The methodology used was:

| | |
|---|---|
| A full critique of the relevant medical records | Chronologies, relating to the scoping period, were recorded and analysed. |
| Senior members of Trust's emergency department nursing and medical team were consulted. | |
| **Consideration of the following policies and procedures** | |
| UHL Safeguarding Adults Policy | Leicester, Leicestershire and Rutland Multi Agency Policy and Procedures for the Prevention of Abuse of Adults in Need of Safeguarding |
| UHL Emergency Department Standard Operating Procedure for Safeguarding adults | UHL Emergency Department Standard Operating Procedure for Domestic Violence |
| UHL Emergency Department Care Pathway for Mental Health | |

4.6.3 ### Context

University Hospitals of Leicester NHS Trust (UHL) is a large multi-sited acute care organisation which provides in-patient and outpatient healthcare services to a population of nearly 1 million people across Leicester, Leicestershire and Rutland.

4.6.4 The Trust has an Emergency Department (ED) sited at Leicester Royal Infirmary that was primarily involved in the care and treatment of Mary and Mr A. This is a high volume rapid flow service that can see over 600 patients a day.

4.6.5 The Trusts electronic information systems record all hospital attendances. These systems are unable to cross reference with other health and social care agencies; however the patient's general practitioner is informed of all hospital admissions/attendances.

4.6.6 The Trust provides Level 1 and Level 2 safeguarding children and adults training to relevant staff groups. Nursing staff within the Emergency Department also receive an annual day's training which covers the Mental Capacity Act, Mental Health, Domestic Abuse and Forced Marriage.

4.6.7 The policies and guidance relating to safeguarding and domestic violence are available on the Trust's Webpages. UHL have Domestic Violence Standard Operating Procedure (DV SOP) 2010 and the process includes use a risk assessment tool (the SPECSS Plus risk assessment) that includes consideration of children and adult safeguarding. There is dedicated advice for staff about domestic abuse and how to signpost patients to available services.

4.6.8 **Summary of Involvement with Mary**

During the review period Mary had two related contacts with UHL Emergency Department, she did not require hospital admission on either occasion.

**On 8th July 2007** Mary was seen at the Emergency Department Leicester Royal Infirmary following a domestic assault by a previous partner. There is no evidence that Emergency Department staff provided Mary with any advice or support in relation to domestic violence during this attendance.

4.6.9 **On the 5th May 2012**, Mary attended Emergency Department following an episode of domestic violence by her partner (Mr A). Mary reported that she had been punched 3 times on the head by her partner. A scan was carried out due to her head injuries and Mary was assessed by the Ear, Nose & Throat Specialist. Mary was assessed as medically fit for discharge.

4.6.10 Mary informed the Doctor that this was the 2nd episode of domestic violence by the same person and that she wished to leave him. She advised that Police were involved and the perpetrator was in police custody. Details of the perpetrator are not recorded.
The Doctor followed the Emergency Department domestic violence procedure[43] and completed the UHL SPECSS Plus risk assessment - 2 risk factors were noted on the assessment (Mental health issues and drug and/or alcohol issues). With Mary's consent a MARAC referral was completed and the MARAC telephone number was given to her. It was recorded on the referral form that it was safe for Independent Domestic Violence Advisor/specialist officer to contact Mary.

4.6.11 Prior to discharge a copy of the Independent Domestic Violence Advisor Domestic Violence information leaflet was provided for Mary that included details of the 24hr domestic violence helpline. Nursing staff contacted Police who advised that Mary's partner would remain in custody overnight therefore Mary was safe to return home.

Mary was discharged in the early hours of 6 May 2012. A letter was sent to Mary's GP (Medical Practice 2), advising of her attendance at Emergency Department. However, no

[43] LRI Emergency Department (LRI ED) (July 2010), *Standard Operating Procedure for Domestic Violence (DV SOP) Version 10*, University of Leicester Hospital.

explicit reference was made to domestic violence.

4.6.12 That same day, the Doctor faxed the MARAC referral form to the MARAC co-ordinator. However, the fax 'transmission verification receipt' states that the receiving fax was 'busy' at that time. There was no record of a further transmission receipt being printed and there was no follow up phone call. The MARAC co-ordinator has no record of receiving this referral.

4.6.13 **Issues Arising and Analysis from UHL Involvement with Mary**

The UHL report author highlights that in July 2007 there is no evidence of staff responding to the domestic violence. This is acknowledged as a period where there was generally limited knowledge about domestic violence amongst healthcare staff. Subsequent to 2007, the Trust committed resources and implemented guidance to improve awareness.

4.6.14 During Mary's attendance in May 2012 there is evidence of appropriate/good practice in responding to the disclosure of domestic violence.

- Appropriate medical care was given
- Risk assessment was carried out and acted upon
- Nursing and medical staff discussed domestic violence with Mary – sought her consent for a referral to MARAC
- A referral to MARAC was made and contact number provided to Mary (unfortunately it appears there was a transmission error)
- Staff considered whether or not there were any children /others at risk due to the violence suffered by Mary
- Checks were made with police about the management of the alleged perpetrator and safety for Mary's return home
- Mary was provided with information about the Independent Domestic Violence Advisor service and a contact number
- Safeguarding adults procedures were considered by nursing staff- Mary was not considered to be a 'vulnerable adult.' UHL staff were not aware of any substance misuse issues relating to Mary that would warrant consideration about her ability to protect herself.

4.6.15 The UHL report author also highlights issues of learning from this May 2012 admission:

1. **Apparent failed transmission of the MARAC referral.**

This appears to have been an administrative error. At the time of writing the report, the UHL report author identified that there was no alternative method of directly referring patients to MARAC but made a recommendation to develop an electronic referral system. The UHL policy did not require Emergency Department staff to contact the MARAC office before or after making a fax referral.

Since 2009, UHL has been attending MARAC meetings to receive and share relevant information. Where attendance is not possible, relevant information is shared between MARAC and Emergency Department about specific individuals. It is not known whether

or not there was an Emergency Department representative at the MARAC meeting which followed the MARAC referral on 6 May 2012. UHL currently have no system in place to track referrals to MARAC or to receive feedback but will explore this further with MARAC.

Further inquiries[44]made with the MARAC Co-ordinator and Domestic Abuse Investigation Officer Sergeant, confirmed all cases referred are heard and where the MARAC thresholds are not met, alternative responses and means of support are considered, for example referral to the domestic violence outreach services. The review has identified that police had tried to offer support from services which Mary had declined.

Referral to MARAC is considered further within the analysis in section 5 below.

**2. Informing Mary's GP about domestic violence**

Mary's GP was informed of her attendance at Emergency Department and the treatment received. However the GP was not informed of the domestic violence. UHL accept that the GP should have been notified that Mary had experienced domestic violence.

The DHR panel viewed this as a significant omission. It can be expected that GPs will have a holistic overview of their patient and their needs and act as the central point for their healthcare needs. As the GP at medical practice 2, was not informed of the domestic violence, they were unable to inform the other agencies who were engaged with her.

We know from the agency reports that Swanswell and LPT Good Thinking Therapy both had good engagement with Mary. Neither was aware of the domestic violence incident in May 2012 and therefore did not have the opportunity of exploring this with Mary. We do not know if Mary would have taken up the opportunity to discuss the incident (and it appears she intentionally avoided discussing this with them) but as the agencies were not informed; this could not be tested or taken into account in their risk assessments. These issues are considered within the UHL recommendations below.

4.6.16 **Summary of Involvement with Mr A**

Mr A had 3 contacts between September 2011 and February 2013.

4.6.17 The involvement with Mr A was in response to episodes of self-harm. UHL provided a detailed account of their interventions. This report will not provide any detailed review of the care and treatment provided to Mr A as that is not the focus for the review. However, a brief summary is provided.

4.6.18 **On 1st November 2011**, Mr A arrived at Emergency Department having informed his GP of suicidal thoughts and stated he had taken an overdose. The nurse completed a risk assessment and mental capacity assessment – he was deemed competent at that time. After review by a doctor he was referred to the mental health crisis resolution team for further assessment due to suicidal thoughts and then discharged home.

4.6.19 **On 29th March 2012** Mr A was admitted by ambulance after he was found unresponsive at

[44] Police, *Agency IMR*, 8.21.9, p. 36

home, by a friend, (now known to be Mary) with tape covering his mouth and plastic over his head. It is recorded that Mr A had taken an intentional overdose.

4.6.20 Mr A was again deemed competent to make decisions although at risk of suicide and transferred to the acute medical unit for further review. The Doctor recorded that Mr A had not left a suicide note but had taken steps to avoid being found. Mr A was discharged into the care of MH services.

4.6.21 **On 5th December 2012**, Mr A was conveyed to Emergency Department by ambulance, reportedly having taken an intentional overdose of heroin and diazepam. Mr A was found at home unconscious by his partner (Mary) who had begun CPR prior to the ambulance service arriving. The examining Doctor recorded that this was an organised attempt at suicide. Mr A was admitted under high observation and referred for psychiatric assessment by the Deliberate Self- Harm Team the following morning. Mr A discharged himself against medical advice due to delay in response by the Deliberate Self- harm Team.

4.6.22 ## Issues Arising and Analysis of UHL Involvement with Mr A

The UHL report author found that responses to Mr A's needs - assessment of mental health, mental capacity and responses required in the assessments under the Mental Health Act (section 136) were adhered to. Appropriate care was provided in response to physical health needs and referral through to mental health services.

The DHR overview author accepts this view.

4.6.23 ## Recommendations arising from the UHL report

UHL has already taken action on learning from the review

- Revising their process for transmitting MARAC forms
- Contributing to a multi- agency information sharing agreement for safeguarding adults that emphasises the importance of effective and timely sharing of information between agencies in safeguarding and public protection.

4.6.24

| **UHL Recommendations** |
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| That MARAC referrals completed by UHL ED will be received by MARAC co-ordinator -Amend the Emergency Department domestic violence procedure to include a prompt for staff to ensure that a fax receipt, which confirms successful transmission, is obtained and filed in the notes (when a MARAC referral is completed). ***This is already completed*** |
| Explore the possibility of MARAC referrals being completed electronically by senior ED staff |
| Emergency Department medical staff will advise GPs, through the GP letter, when a patient has attended ED following episodes of domestic violence. |
| Develop a standardised protocol (for adult areas) when responding to adults who |

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| disclose domestic violence – this will be developed in consultation with other agencies. |

## 4.7 East Midlands Ambulance Service NHS Trust

4.7.1 East Midlands Ambulance Service (EMAS) had involvement with Mary and Mr A. EMAS provided a chronology and individual management review.

The author of the report was the Lead for Safeguarding Adults. The author had not had direct involvement in the care of Mary or Mr A.

4.7.2 The methodology used was:

| | |
|---|---|
| EMAS searched and secured all available records pertaining to the individuals within the Terms of Reference. | Information which informed the chronology and IMR included Patient Record Forms (PRFs), Computer Aided Dispatch (CAD) database records, and 999 call recordings. |
| Paramedic team leader and children's safeguarding lead were consulted with for information on clinical assessment and due process within EMAS. | Interview with paramedic team leader and the safeguarding lead for children and young people |
| **Consideration of the following policies and procedures** | |
| EMAS Adult Safeguarding Policy | EMAS Domestic and Violence and abuse policy |
| EMAS consent policy | |

4.7.3 **Context**

EMAS provides pre-hospital emergency and urgent care and respond to776,000 emergency calls every year across 6 counties.

EMAS do not case hold and staff are not able to access patient care records from any other NHS service. EMAS transfer the care records through completing an electronic or paper record. Where EMAS do not convey the patient to hospital, EMAS complete an electronic record (where facilities permit). This is automatically sent to the GP practice to inform them of the EMAS attendance. Where electronic transmission is not feasible, a paper record is completed and copy of the record is left with the patient, relying on the patient sharing this information with their GP -this is noted as national practice. When an individual is conveyed to hospital the patient record is made available to the hospital staff to reference in the hospitals discharge report to the patient's GP.

4.7.4 EMAS has established a 24/7 'safeguarding line' within their service, for ambulance crews to report concerns about safeguarding and domestic violence. EMAS has a domestic violence policy.[45]

EMAS staff had received training on domestic violence during 2011 'Think Family' education. Further specific domestic abuse and violence training was disseminated during 2012/2013. All the staff that attended the incidents reported in this review had attended annual safeguarding training within the last 3 years including training on domestic violence and abuse.

4.7.5 Due to the short term nature of ambulance services role, crews do not complete the CAADA Domestic Abuse Stalking Harassment (DASH) risk assessment. Staff are directed to conduct a 'dynamic risk assessment' and provide information/signposting to services – staff have been provided with domestic violence information cards since June 2012.

Staff may also seek additional guidance through their 'safeguarding line' where required. EMAS is working with MARAC leads across the region to develop an ambulance specific domestic violence risk assessment tool.

4.7.6 **Summary of Involvement with Mary**

The EMAS report reviews 3 occasions of responding to Mary during August 2011-February 2013.

4.7.7 **On 14th August 2011,** EMAS attended Mary's home address at the request of the out of hours GP surgery. Mary had contacted the out of hours service asking for help (details not known). EMAS were unable to get access to the address and police were called to assist. When seen, Mary was calm and denied any deliberate self-harm, overdose or suicidal tendencies. She did not want to be conveyed to hospital and was deemed to have capacity to make this decision.

4.7.8 **On 5th May 2012**, EMAS attended Mary's home address for a domestic assault at the request of the police. Mary had been 'punched and hit with a 30cm wooden statue'. Mary was conveyed to the emergency department for further treatment.

4.7.9 **On the 20th February** 2013, EMAS responded to a very distressed call, from a person later identified as Mary's daughter R. R and a neighbour had entered Mary's flat and found her unresponsive. There was also a note under the door to say her partner (Mr A) was in intensive care. EMAS arrived on scene within two minutes of the call being received. Sadly, the ambulance crew confirmed un-equivocal death and no CPR was commenced. Two members from EMAS made further checks to Mary's body and found a stab wound. They awaited the police arrival to ensure that the scene was left intact.

4.7.10 **Issues Arising and Analysis of Involvement with Mary**

There are no issues of particular note in relation to EMAS response to Mary in August

[45]East Midlands Ambulance Service (EMAS) NHS Trust (April 2012), *Domestic Violence & Abuse Policy*, Clinical Governance Group

2011.

4.7.11 In relation to **the 5th May 2012**, the author found that though clinical need was met, it was not evident that EMAS had carried out any dynamic risk assessment or signposted Mary to services. However, the author noted that the paper record provides very limited space to note such discussions and priority would be given to recording clinical need. Crew would have been expected to inform the police but as the police alerted EMAS of the incident this was not required.

4.7.12 The EMAS report author noted that EMAS could have informed the GP about the domestic violence. Their system, as described in 'context' above is to provide the record to the GP via the receiving hospital - as described in UHL report, this system on this occasion did not work. The EMAS author also identifies that there was a missed opportunity for EMAS staff to use the EMAS 'safeguarding line' to share concerns directly with the GP.

4.7.13 The DHR panel raised some concern about the EMAS practice of leaving a paper record in the patient's home where the patient is not going to hospital and there is no mechanism for electronic transfer of information. Their system relies on the patient sharing the information with the GP.

Though the EMAS author states this is a nationally accepted process, the DHR panel were concerned about the risks arising from this practice. In relation to domestic violence, the panel considered this practice to present risks to the victim, for example, in the event of the perpetrator viewing the communication. There may also be other groups particularly disadvantaged, for example patients with sensory or cognitive impairment.

4.7.14 In relation to **20th Feb 2013**, the author assessed that the crew provided appropriate and timely clinical assessment. There was good assessment and documentation at the scene. The response was efficient, ensuring appropriate support, timely response to suspicious circumstances and effective communication with Police

4.7.15 In relation to considerations of Equality and Diversity, the report noted that staff are expected to adhere to policy and procedures. There was evidence that capacity and consent were considered in all the interactions. As noted in 4.7.13, the DHR panel were concerned some groups with protected characteristics would be particularly disadvantaged by the practice of leaving a paper record at the patient's home.

4.7.16 **Summary of Involvement with Mr A**

EMAS report 3 contacts with Mr A. The involvement with Mr A was in response to episodes of self-harm.

**On 29th March 2012**, EMAS responded to a 999 call was made by a female identifying herself as his 'girlfriend' (now known to be Mary). Mary had found Mr A with a plastic tape over his mouth and a knife next to him. Through liaison with police, EMAS were informed that there was a history on that address of 'violent domestics' in the past and that the patient also had markers against his name for weapons and suicide attempts.

Mr A was recorded to have taken an overdose - urgent clinical care was commenced and he was conveyed to the emergency department.

4.7.17 **5th December 2012**, EMAS attended Mr A for an intentional Overdose following a 999 call from Mary. Mr A was unconscious having taken 'Heroin and Diazepam'. On arrival of the ambulance, Mary was administering cardiopulmonary resuscitation under the instruction of the 999 call taker. Emergency medical care was given and Mr A was conveyed to hospital.

4.7.20 **On the 19th February 2013**, EMAS were called to an address as Mr A was found unconscious. Advice was provided by the call centre until the ambulance arrived. On examination of Mr A, the ambulance crew suspected an overdose and conveyed him to hospital

4.7.21 **Issues Arising and Analysis from Involvement with Mr A**

The responses by EMAS to all three incidents were seen to be appropriate.

4.7.22 **Recommendations arising from the EMAS report**

The EMAS report author finds that there are no new recommendations for the Trust in relation to this specific review. The author notes that there is on-going work nationally around the domestic abuse agenda and the development of an ambulance domestic violence risk assessment tool that will be rolled out to their service.

4.7.23 As noted, the DHR panel felt that the EMAS system for communicating information to GPs where a patient is not conveyed to hospital was not sufficiently robust.

EMAS should consider reviewing this practice in relation to risks it may pose in cases of domestic violence and the potential adverse impact on groups with protected characteristics such as people with learning or sensory disabilities.

## 4.8 Leicestershire Police

4.8.1 Leicestershire Police had extensive involvement with Mary and Mr A and provided a chronology and individual management review.

4.8.2 The author of the report works within the East Midlands Regional Review Unit, a regional police unit with a remit to conduct reviews across a wide range of police activity including domestic homicide reviews. The author had not had direct involvement in the care of Mary or Mr A.

4.8.3 The methodology used was:

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| 39 interviews/meetings/correspondence with police personnel<br>• directly involved with Mary or Mr A - N.B. not all officers involved could be interviewed<br>• Involved in domestic violence or safeguarding roles within the force. |

| | |
|---|---|
| Research across 12 different data bases and intelligence systems | Interviews/consultations with other agencies |

| | |
|---|---|
| | • Meeting with mental health nurse<br>• Consultation with Local Domestic Abuse Outreach Provider manager |
| **Consideration of the following policies and procedures** | |
| Leicestershire Police Guidance for Police Officers where Complainants Indicate they are Unwilling to Support a Prosecution (2009 – 2015) | Leicestershire Police Mental Health Policy (2011 – 2013), Section 136 Mental Health Act Procedure (2011 – 2013) and Mental Capacity Act Procedure (2011 – 2014) |
| Leicestershire Police Managing Adults at Risk Policy and Procedure (2010 – 2013) | Leicestershire Police Missing Persons Procedure (2011 – 2013) |
| Leicestershire Police Policy for Producing, Reviewing and Amending Policies and Procedures (2007 – 2015) | Leicestershire Police Incident Response Policy (2011 – 2012) |
| Leicestershire Police 999 Emergency Call Handling Procedures (2009 – 2014) | Leicestershire Police Domestic Abuse Policies and Procedures (covering 2007 - 2013) |
| Tape recording of incidents: LEP-050512-0670, LEP-290312-0168, LEP-070112-0642, LEP-271211-0051, LEP-271211-0048 and LEP-111211-0696 | Leicestershire Police Individual Management Review in relation to FN (Author Mrs Gillian Davies dated 15/07/2013) |
| Report from Detective Sergeant of the Counties Domestic Abuse Investigation Unit dated 16/09/2011 regarding DASH update | HMIC (2013), Essex Police's approach to managing cases of domestic abuse |

4.8.4 **Context**

Leicestershire police Contact Management Department receive on average 2,200 calls per day. Calls are graded 1-4 and dispatched in accordance with the Incident Response Policy.

4.8 5 Leicestershire police has a Safer Neighbourhood Beat Team covering the area of Mary's address (address1). In addition to the Safer Neighbourhood Team, Response Officers provide a 24 hour cover in order to respond to incidents reported to the police.

4.8.6 There were 22,629 domestic incidents reported to the force in the year up to 30th Oct 2013 of which 11,597 related to Leicestershire. The role of the police is to attend the incident, take positive action, conduct an effective criminal investigation, complete a risk assessment and ensure, where appropriate, a safety plan is in place and referrals are made. Officers have to complete intelligence checks, offer / signpost victims to appropriate outreach support.

4.8.7 When dealing with cases involving domestic abuse and vulnerable adults, Safer Neighbourhood Teams and Response Officers are supported by the Domestic Abuse Investigation Unit (DAIU) and the Comprehensive Referral Desk (CRD).

4.8.8 Domestic violence related crimes are allocated to officers working on Safer Neighbourhood Teams for investigation. Since September 2011, where a case is high risk (or certain medium risk cases) it is allocated to a Domestic Abuse Investigation Officers within the Domestic Abuse Investigation Unit.
Prior to September 2011 officers used the SPECSS[46] risk assessment. In high risk cases the CAADA risk assessment tool was also used to indicate whether there should be a referral to a MARAC. In September 2011 the force adopted the DASH risk assessment described in section 4.2.1 above.

4.8.9 From January 2012 officers were advised of actions according to the DASH risk assessment:

- Standard risk - victims should be referred to Victim Support (if a crime) and signposted to support including Women's Aid and the Domestic Violence Helpline.
- Medium risk - refer to local Domestic Violence outreach teams
- High risk - referral to an Independent Domestic Violence Advisor (IDVA) and a MARAC.

4.8.10 Cases are followed up by the Local Police Unit where there are three or more incidents within a year. The Domestic Abuse Investigation Unit will follow up where seven or more incidents have been reported and where there is a clear escalation in incidents or violence over the previous six months. The officers leading this work have received a two day training input which provided them with an enhanced level of knowledge regarding risk factors and where to signpost victims.

4.8.11 The police Comprehensive Referral Desk encompasses:

- the Child Abuse Referral Desk – integrated under the CRD 2011
- Adult Referral and Co-ordination Team (ARC) – began 2010
- MARAC Co-ordinators
- Child Protection Case Conference Co-ordinators
- Child Sexual Exploitation Co-ordinators
- Domestic Abuse Referral Team (DART) - integrated under the CRD 2011

4.8.12 **Domestic Abuse Referral Team:** complete requests for referrals to domestic violence outreach services from police officers and Domestic Abuse Investigation Officers in relation to high, medium and, where appropriate, standard risk victims. The team also view all related medium risk crime reports for the last seven days and make sure, where appropriate, victims have been advised of outreach support. The team will also complete MARAC referrals for Domestic Abuse Investigation Officers and research all of the MARAC cases.

4.8.13 **Adult Referral and Coordination Team:** The ARC respond to referrals relating to vulnerable adults – reviewing and assessing risks, allocating to officers and involving other agencies where indicated and according to a tiered risk system.

[46](SPECSS) Separation, Pregnancy / New Birth, Escalation, Cultural Issues / Sensitivity, Stalking and Sexual Assault. Available from: Police, *Agency IMR*, 8.2.8, p. 13

4.814 Police officers are supported by a Domestic Abuse Policy and Procedure.[47]During the scope period there have been various training inputs to police officers and staff relating to hate crime; domestic abuse and responding to vulnerable people. As part of their initial training, all officers are provided with an input on domestic abuse; they are trained in the use of the DASH risk assessment, risk management, taking positive action and defensible decision making. More recently officers have also been provided with guides for domestic abuse and mental health.

Leicestershire Police has also introduced specific resources and training to improve responses in mental health.

4.8.15 ## Summary of Involvement with Mary

4.8.16 Police had involvement with Mary on 3 occasions during 2007 related to domestic violence with a previous partner, Mr L. Mr L was arrested and bailed with conditions. Prior to the court appearance there were 2 occasions when he breached his bail conditions, due to being in the company of Mary. At the court appearance Mr L was found not guilty of the two counts of common assault as no evidence was offered and the case was dismissed.

4.8.17 Subsequent relevant involvement related to Mary and Mr A

**On 11th December 2011** police received a call from a female saying that she was a victim of domestic violence then the call was terminated. Searches linked the mobile phone number to Mary. Following a further call from Mr A, officers attended his address (address 2). When officers arrived, Mr A stated he wanted Mary out and she was refusing to leave. Both Mary and Mr A were under the influence of alcohol.

4.8.18 Mary stated that Mr A had pushed and dragged her around the flat and had held a knife to her throat. Mr A was arrested on suspicion of assault. A statement could not be taken due to Mary's intoxicated state but she was taken to a friends and a DASH risk assessment was completed - assessed as medium risk.

4.8.19 Mary did not wish to make a statement but her account was written down and evidence such as photographs of injuries, recorded. Mr A was charged with assault and bailed with conditions. An outreach referral was made for Mary to a Local Domestic Abuse Outreach Provider.

4.8.20 During the intervening period before his court appearance there was contact between Mary and Mr A contrary to the bail conditions. Although it was invariably Mary that made the approaches, officers visited Mr A to remind him of his bail conditions.

4.8.21 **On 27th December 2011**, Mr A phoned the police to say Mary was outside his property kicking his door. Police checks found that they had also received a call from Mary who

[47] Leicestershire Police Domestic Abuse Policies and Procedures (covering 2007-2013), Referred to in: Police, *Agency IMR*, 8.2.5-6, p. 12

said Mr A had taken an overdose of methadone at the property and was becoming violent and that she was outside the property. When police responded, they found Mary was intoxicated and that Mr A had not taken an overdose. Mary was conveyed to a friend's house.

Mary maintained she did not want to attend court regarding the assault of 11th December until a further incident in January.

4.8.22 **On 7th January 2012**, a neighbour contacted police reporting screaming from Mr A's address (address 2).Police attended within 7 minutes of the call to find Mr A leading Mary off his property shouting "*just go*" and "*I want you out of here now so f*** off*".[48] Statements were taken – Mr A stated that following an argument, Mary had shattered the outer pane of a double glazed window with a broom handle. Mary was arrested on suspicion of criminal damage and a DASH assessment was completed in relation to Mr A – assessed as medium risk.

4.8.23 Mary stated that she had been staying at Mr A's address for the last four days and after drinking together Mr A became abusive towards her; he pulled her around by her hair, pushed her out of the back door and then, holding her by her upper arms, pushed her against the window pane, breaking the glass. There were no injuries to corroborate her account. Police were also unable to corroborate that she had been at the property for the last four days.

4.8.24 Mary was charged with criminal damage and bailed (without conditions). The risk was assessed as medium. The officer in charge had heightened concerns due to on-going issues between both parties and identified to the Comprehensive Referral Desk that an outreach referral was required. There is no record that an outreach referral to a Local Domestic Abuse Outreach Provider was made.

Mr A attended court **on 26th March 2012** relating to the assault of 11th December - the case was dismissed, no evidence was offered and a not guilty verdict was recorded.

Mary attended court on **16th April 2012** relating to criminal damage charges from 7th January - the case was dismissed; no evidence was offered.

4.8.25 **On 5th May 2012** police received a call and could decipher a disturbance, crying and pleading. Police attended within 5 minutes. Mary had a nasty 'gash' to her head. She described an argument over tobacco – Mr A had punched her face numerous times. Mary had left the property but then returned and the assault continued. Ambulance was called and Mary was conveyed to hospital. Mr A was arrested and a crime report for actual bodily harm completed.

4.8.26 A DASH risk assessment was completed (based on limited information from Mary at that time). The risk was assessed as high due to the history of domestic abuse and the use of a knife on a previous incident. It was noted that Mr A had also recently attempted suicide

[48] Ibid., 8.18.1, p. 30

and that Mary was on methadone.

4.8.27 Mary refused to provide a more detailed statement. She was visited by a Domestic Abuse Investigation Officer. The DASH was reviewed and amended to medium to reflect the answers provided and the perceived risk to Mary. Mr A was charged with common assault the following day – an application for remand was made (and granted), based on risks Mr A posed to himself and to Mary.

4.8.28 **On 1st June 2012**Mr A pleaded guilty to an offence of battery and was given a 12 month community order, supervision, alcohol treatment for six months. The case was heard in a Specialist Domestic Violence Court (SDVC).

4.8.29 **Issues Arising and Analysis of Involvement with Mary**

4.8.30 The police report author found that in 2007, police took positive action against Mary's previous partner Mr L, in relation to the breach of bail conditions. The author could not find any reasons why no evidence was offered and the case was dismissed.

4.8.31 **2011:** The police report author found the incident in December 2011 was dealt with appropriately. The DASH risk assessment was completed, reviewed and verified. An outreach referral was completed following the assault to Mary on 11th December (however there was no record of a second referral being made following the further incident on 7th January). There was evidence that police took positive action when Mr A breached his bail conditions, albeit that Mary had invariably made the approaches.

4.8.32 In relation to '*no evidence being provided*' at Mr A's court appearance for the assault on the 11th December, the author states that Mary should have been supported through the court process by the Witness Care Unit. However, despite extensive enquiries, police were unable to establish what support was offered to Mary as the electronic files held on the Crown Prosecution Service Case Management System have been destroyed.

4.8.33 The Crime Prosecution Service has the ability to pursue a charge even where the victim does not wish to provide evidence. The police policy states: *'The possibility that an initial complaint will not be subsequently pursued is irrelevant, and should not affect the action taken or the manner in which the victim is dealt with. Leicestershire Constabulary will work with partner agencies to help victims of domestic abuse make safe and informed choices'.*[49]

Alongside the policy and procedure, guidance was issued[50] in September 2009 in respect of complainants who are unwilling to support a prosecution and includes a section on domestic violence.

4.8.34 The police report author was unable to establish whether a 'victimless' prosecution (cases where the victim is unwilling to support a prosecution) was proceeded with or whether

[49] Ibid., p. 12

[50] Referenced in Police, *Agency IMR*, 8.2.7, p. 12:*Leicestershire Police Guidance for Police Officers where Complainants Indicate they are Unwilling to Support a Prosecution (2009 – 2015)*

the case was dismissed because Mary did not attend court. The author identified that the charging decisions for this case (and the assault of 5th May 2012) did discuss the possibility of a 'victimless' prosecution but it is not clear how well this was considered.

4.8.35 The Police report author notes that there is a variance between the Police procedures and the Police guidance in relation to whether the assaults met the threshold for a victimless prosecution. The Crown Prosecution Service do not hold data about the number of 'victimless' prosecutions that have been pursued in Leicestershire. Data does however show that approximately 10% of prosecutions for domestic violence fail because of victim issues. The Police report author highlighted the need for further clarity in respect of unwilling witnesses who are victims of domestic abuse and that this was also raised in the other DHR (FN) being conducted in Leicestershire at the same time as this review.

4.8.36 The author identifies

- A need to record the reasoning behind discontinuances of domestic abuse cases – this will assist learning
- The need for a clearer understanding of when and how 'victimless' prosecutions should be pursued.
- The need for a more strategic response in understanding of why domestic violence cases fail because of victim issues.

4.8.37 **2012:** In the response relating to 5th May, the police author found that the initial call was dealt with appropriately and in accordance with force guidance. As Mary refused to engage with any help offered, there was no follow up support. However the police report author covers in some detail the issue of the DASH assessment and whether referral to MARAC should have been considered. The author found very little information from the Domestic Abuse Investigating Officer as to why the DASH assessment was amended from 'high' to 'medium' risk. The report states '*One of the officers who worked on the case remembers that they were dealing with a particularly high workload that weekend; Mary was not willing to support the prosecution or engage with any help offered and a MARAC was not considered as it did not fit the remit in terms of level of risk, escalation or professional opinion.'*[51]

4.8.38 The only other criterion for referral to MARAC which could have applied was three police call outs in 12 months. There had been five police calls outs to Mary and Mr A and three related to domestic violence. A referral to MARAC should have been considered under this criterion. However the police report author notes that there is the understanding that there has to be an escalation of risk associated with the 3 call outs, otherwise the MARAC process would be overwhelmed. The officer investigating the last assault did not consider that there was an escalation of risk and therefore Mary was not referred.

4.8.39 The police report author notes that it was difficult to assess whether there was an escalation of risk; although Mary was the victim of two violent assaults they were five months apart and there was no other violence reported. Nevertheless, the DASH risk

[51] Police, *Agency IMR*, 8.21.8, p. 35

assessment from the 5th May incident states that '*the abuse is happening more often, is getting worse and that they have tried to separate but they both still love each other and resume the relationship'*[52].The police report author concludes it is possible on this basis that a referral to MARAC should have been properly considered and an evidenced decision made as to why a referral was not going to be progressed.

The police report author notes that though it is accepted practice that criterion for referral should be 3 calls outs ***plus*** escalation, this is not within the procedure and needs amending – the procedures are currently being revised.

4.8.40 The police report considered any specific issues of diversity and equality. Police personnel are supported in meeting Equality duties through policy, procedures and training. It was the author's view that officers took account of Mary's individual needs and circumstances.

4.8.41 **Summary of Involvement with Mr A**

In addition to the police involvement with Mr A as perpetrator as described above, police had other interventions with Mr A. A number of these incidents were in response to episodes of self-harm, with Mr A making very overt threats of killing himself, for example by threatening to cover himself with petrol. The police report provided a detailed account of their interventions.

This DHR overview report will not review this, keeping the focus upon how the police responded to relevant incidents during September 2011- February 2013.

4.8.42 **On 24th January 2012** a neighbour reported a disturbance at Mr A's address (address 2). Neighbours reported there were about four males and an older woman at the property. A large hammer / crowbar was being used to 'hammer' on the flat, the front door kicked and windows were being smashed. They were heard to shout "*paedo.*"

Officers attended. Mr A was not present and the offenders had left the scene. Attempts were made by the police to investigate further but the report was filed as 'undetected'.

4.8.43 **On 25th January 2012,** Mr A reported on-going harassment by his mother and Mr B by way of multiple text messages sent via Mary. Mr A had moved out of his flat because of fears for his own safety. Mr A disclosed in a statement a poor relationship with his mother and a previously violent relationship with Mr B. Mr A stated that this had led to a restraining order on Mr B. (Neither the officer in charge or the police report author have been able to corroborate this) .

4.8.44 Mr A reported that Mary had phoned him on the 24th January 2012, to say that his mother and Mr B were on route to his home with a hammer and that he should leave his flat. Harassment warnings were served on both his mother and Mr B. The officer also completed a DASH form (standard risk) because of the relationship between Mr A and his mother.

[52] Ibid., 10.10.3, p. 46

4.8.45 The officer in charge of the harassment incident, did contact the officer in charge who was dealing with the damage to Mr A's property to establish whether it could have been caused by Mr A's mother and Mr B but as there were no witnesses who could identify the offenders it was not taken any further forward.

4.8.46 **On 29th March 2012** EMAS requested attendance. Mr A was unconscious at Mary's flat (address 1) He had tape over his mouth and a knife next to him. In interviewing Mary, police established Mary and Mr A had argued the previous night. She had gone to bed and discovered him in the morning and rang the ambulance. Police completed a DASH assessment. The police report author noted the responses on the DASH form were somewhat confusing as it referred to Mr A as both the victim and perpetrator – assessed as 'standard' risk.

4.8.47 **On Wednesday 11th April 2012** a sergeant from the Comprehensive Referral Desk questioned if a decision had been made about whether an offence had been committed on the 29th March. The Sergeant made a welfare check through Leicester Royal Infirmary and established Mr A had been discharged on 29th March 2012 and seen by the psychiatric team. The Sergeant requested the Adult Referral Co-ordination team contact Mr A's GP to advise them of the incident on 29th March confirm support was being provided. This was followed up **on 16th April.** The GP practice (medical practice 1) confirmed they had received a report from mental health services following his discharge.

4.8.48 **On 8th May 2012**, following investigations into the assault from Mr A to Mary, it had been identified that Mr A also posed a risk to himself. The officer in charge flagged the crime report to the Adult Referral Co-ordination team. A Referral Officer was tasked with contacting Mr A's GP but advised not to disclose details regarding the circumstances of the arrest. **On 10th May 2012** the ARC Referral Officer spoke to medical practice 1 who advised they were aware of similar incidents and would record this information on his record.

4.8.49 ## Issues Arising and Analysis of Involvement with Mr A

The police report highlights some issues in relation to mental health and multi-agency assessment process under the provisions of the section 136 of the Mental Health Act. This is not detailed further in this report.

4.8.50 **Jan 2012**: The police report author found that the offences relating to the harassment warning and attempts to investigate the damage to Mr A's property were dealt with satisfactorily.

4.8.51 The DHR author notes that Mary warned Mr A that his Mother and Mr B were coming to his address. This incident occurred 17 days after Mary had been arrested for charges of smashing Mr A's windows and gives some indication of the ambivalent and changeable nature of their relationship, a view endorsed in the interview with Mr A.

**29th March 2012**: The police report author highlights that the completion of the DASH

assessment arising from this incident of self-harm was poor and that there were delays in follow up notification to the GP.

The DASH assessment was confusing as it referred to Mr A as both the victim and perpetrator. The officer had overlooked two domestic related crime reports, a vulnerable adult report and three records where Mr A had threatened suicide.

4.8.52 The Domestic Abuse Procedure requires a supervising Sergeant to review and agree the initial DASH risk score for all crimes and incidents and record this on the DASH form. The police report highlighted that whilst officers are discussing high and some medium risk cases, evidence suggests they are not discussing standard risk cases. In this case the supervisor had no recollection of any discussion.

4.8.53 The DASH form does not record the name of the officer completing the form. The officer in charge acknowledges that the quality and thoroughness of the intelligence checks they completed fell below the standard required. A recommendation is made in relation to this.

4.8.54 There was a significant delay in managing response to Mr A as a vulnerable adult and informing the GP surgery of risks of self-harm (from 29th March 2012 to 16th April 2012). The report author suggested this may be due to problems accessing staff within GP surgeries as contact can only be made by phone at specified times for some surgeries. The police Comprehensive Referral Desk Manager is currently working with partners to give GPs access to secure email which should alleviate some of these problems.

4.8.55 **8th May 2012:** The DHR panel had asked for further clarification about why Mr A's GP (medical practice 1) had not been informed about the context of Mr A being at risk of self- harm/suicide i.e. the GP was not informed that Mr A had assaulted Mary on the 5th May 2012 and subsequently been charged with actual bodily harm. The police report author confirmed that the working practices within the Comprehensive Referral Desk maintain that information regarding a vulnerable adult's arrest should not be disclosed to GPs.

4.8.56 Medical Practice 1 reports that they were not aware of risk that Mr A presented to others. This issue is discussed further in section 5 – analysis.

4.8.57 The police report identifies a need for a more cohesive approach to how the Comprehensive Referral Desk is structured; how roles responsibilities are defined and staff supported. A review is currently underway. Learning from the DHR is feeding into this review and forms one of the police recommendations.

4.8.58 The police report found that, taking account of all the information available to Leicestershire Police, Mary's death in February 2013 could not have been predicted; the police had no involvement with either party between December 2012 and February 2013 and there were no domestic incidents reported after May 2012, a period of nine months. This view was reiterated by Mr A.

The DHR overview report author endorses these findings and the learning identified from the police report.

4.8.59 **Recommendations arising from the Police report**

The police report identified some changes that are already underway as a result of this incident and another DHR 'FN' that was being investigated concurrently.

- The Domestic Violence Procedures are being revised and will make clear the criteria for referral to MARAC relating to repeat call outs being associated with escalation – repeat victims can still be referred to a MARAC based on an escalation of risk or professional judgement.
- A review is underway of the structure of the Comprehensive Referral Desk and learning from the review will feed into this
- The manager of the Comprehensive Referral Desk is working with others to ensure GPs have access to secure email to allow timelier sharing of information about vulnerable people.
- Standardised working sheets have been introduced for Domestic Abuse Investigating Officers and police officers investigating domestic incidents to improve documented decisions. All referrals made by the Adult Referral Coordinators and Domestic Abuse Referral Team are now also copied to Crime Intelligence System, to ensure an auditable process
- In January 2013 GENIE2 (the force intelligence search system) was upgraded to 'red flag' all incidents involving a vulnerable adult, ensuring officers do not miss such cases when completing intelligence checks. A similar process has since been proposed for domestic incidents and offences which have been identified as domestic related
- Police are currently reviewing guidance on grounds for sharing information with other agencies.

  The learning from this DHR suggests this review should also consider the current practice of not disclosing information regarding the arrest to other agencies in the course of sharing information about welfare concerns. As highlighted in this DHR, there will be circumstances where sharing such information would be necessary and proportionate within the provisions of the Data Protection Act 1998**.**

| **Leicestershire Police Recommendations** |
|---|
| It is recommended that Leicestershire Police reissues guidance reminding officers of the need to add a separate Crime Intelligence System incident for all breaches of bail conditions. |
| It is recommended that Leicestershire Police reissues guidance reminding officers that when granting bail for Crown Prosecution Service referral or after charge for domestic abuse, conditions are attached or, where applicable, reasons why conditional bail has not been given are recorded. |
| It is recommended that Leicestershire Police puts in place a system, with the assistance of the courts, whereby the reasoning behind discontinuances of |

| |
|---|
| domestic abuse cases at court are recorded. |
| It is recommended that Leicestershire Police engages at a strategic level with the CPS and HM Courts and Tribunals Service to develop and implement a clearer, stronger and more victim-focused policy on how and when 'victimless' prosecutions (cases where the victim is unwilling to support a prosecution)should be progressed; this should also include standardising the terminology used. |
| It is recommended that Leicestershire Police makes changes to the DASH risk assessment on Crime Intelligence System ensuring the collar number of the officer completing the form is added and restricting officers from adding their supervisor's collar number; this will ensure that all incidents involving domestic abuse are subject of supervisory review. |
| It is recommended that as part of its current review of the Comprehensive Referral Desk and Domestic Abuse Investigation Unit, Leicestershire Police considers the line management of the Assistant Referral Officers working within the Domestic Abuse Referral Team and ensures a more cohesive approach is taken to dealing with outreach referrals and looking at repeat victims. |
| It is recommended that, following the IMR for FN and the implementation of a system that identifies and reviews repeat victims of domestic abuse, Leicestershire Police reviews the current process, evaluating the sustainability of this work being completed by LPUs and whether it is having a positive impact on reducing further victimisation. |

## 4.9 Leicestershire Victim Support

4.9.1 Leicestershire Victim Support had limited involvement with Mary and Mr A and provided a chronology and individual management review.

The author of the report was a manager from the Victim Support service. The author had not had direct involvement in the care of Mary or Mr A.

4.9.2 The author methodology used was:

| | |
|---|---|
| Review of Case Management System (CMS) current and archive | Internal staff interviews were not undertaken due to the limited contact with client |
| **Consideration of the following policies and procedures** | |
| Service Delivery Operating Instructions – Domestic Violence | |

4.9.3 **Context**

The victim support service works to Domestic Violence Service Delivery Operating Instructions. In July 2012 new operating instructions were launched and linked to CAADA accredited training in domestic violence for all staff.

4.9.4 **Summary of Involvement**

**In August 2007**, victim support provided phone support to Mary following assault by a previous partner Mr L.

**On 12th December 2011**, victim support offered Mary support by phone following assault by Mr A. Mary stated she was fine and had support and the case was closed.

4.9.5 **On 7th January 2012**, victim support phoned Mr A following the incident of Mary smashing his windows at his address. He declined support saying he was fine – the case was closed.

4.9.6 **On 24th January 2012**, victim support phoned Mr A following the harassment from his Mother and Mr B. Mr A said he was ok at the moment but would take Victim Support number in case 'things kicked off again'. Case closed.

4.9.7 **Issues Arising and Analysis**

There are no particular issues of note arising from the Victim Support report. The report author found that all actions taken complied with their guidance.

4.9.8 **Recommendations Arising from the Victim Support Report**

Victim Support offered no recommendations.

## 4.10 Local Domestic Abuse Outreach Provider

4.10.1 A Local Domestic Abuse Outreach Provider had involvement with Mary but no involvement with Mr A. They provided a chronology and individual management review.

The author of the report was their strategic manager. The author had not had direct involvement in the care of Mary or Mr A.

4.10.2

**The methodology used was**:

| | |
|---|---|
| Review of case notes dating back to 2007 | Telephone interview with one ex-member of staff. |
| **Consideration of the following policies and procedures** | |
| Referral, Initial Assessment and Application Policy | Equality and Diversity Policy |
| Vulnerable Adults Policy (in 2007) | Safeguarding Adults Policy (in 2011) |
| Working with Service Users with Substance Misuse Issues | Working with Service Users with Mental Health Issues Policies |

4.10.3 **Context**

The Local Domestic Abuse Outreach Provider provides outreach support to victims of domestic violence. They report that the demand for their service significantly exceeds capacity and the waiting lists are extensive. Consequently the service has reduced its public awareness raising since 2011 and are focusing awareness raising on enhancing skills and knowledge amongst professionals.

4.10.4 They were not the service provider during the 2007 but have been able to access records from the domestic violence service from that time.

During 2007, outreach services were still new in the area, had limited capacity and were focused on preventing homelessness. AMD received emotional support via telephone from a refuge worker. There were also no Independent Domestic Abuse Advisors and the DASH risk assessment was not in use.

4.10.5 **Summary of Involvement**

They provided support to Mary from September 2007 to February 2008, following domestic violence from a previous partner Mr L.

4.10.6 **On 15th December 2011** they received a referral for Mary from the police following an assault by Mr A. The allocated Outreach Worker tried to make telephone contact. There was no answer and the outreach worker sent a text and checked with police if it was safe to send a letter. Further attempts were made on 22ndDec with no response. On 23rd the call connected but no one spoke.

4.10.7 A letter was sent to Mary on 3rd January 2012 with information regarding drop in sessions and explaining that the case would be closed in two weeks if she did not make contact. As there had been no response by 19th January 2012, the case was closed.

4.10.8 **Issues Arising and Analysis**

There are no particular issues of note arising from their report.

4.10.9 In relation to the referral in December 2011, the author found that staff responded appropriately and had good interaction with the police.

The author notes there was a lack of referrals from other services and this could be a training/awareness raising issue for domestic abuse specialist services that they will take up with the Council.

4.10.10 Following DHR panel discussions about multi-agency information sharing where cases do not meet the threshold for MARAC, they suggested discussing non-engaging referrals at the Joint Action Group before closing, to see if other professionals have a positive working relationship and could encourage engagement with our service.

4.10.11 They state that their service is user led and tailored to needs in terms of equality and diversity.

4.10.12 **Recommendations arising from the Local Domestic Abuse Outreach Provider report**

| Local Domestic Abuse Outreach Provider Recommendations |
|---|
| Before a specialist domestic abuse services closes a referral that they have not been able to make contact with they take it to a JAG or appropriate multiagency meeting |
| DASH risk assessment training to include details of local services. |

## 4.11 Leicestershire and Rutland Probation Trust

4.11.1 Leicestershire and Rutland Probation Trust had substantial involvement with Mr A but no involvement with Mary. Probation provided a chronology and individual management review.

4.11.2 The author of the report was a Senior Probation Officer. The author had not had direct involvement in the care Mr A. The author had also completed a Serious Further Offence review as required by the Ministry of Justice.

4.11.3 The methodology used was:

| | |
|---|---|
| Reading of Oasys including reviews and risk management plan | Reading of CRAMS, LRPT's case management records |
| Interviews with Offender Manager, Senior Probation Officer and Treatment worker | |
| **Consideration of the following policies and procedures** | |
| Leicestershire, Leicester and Rutland Probation Trust Domestic Violence Policy | Associated policies listed within the Domestic Violence Policy |

### Context

4.11.4 An integral part of Leicestershire and Rutland Probation Trust (LRPT) work is offender management, aimed at the management of risk and reducing re-offending. The assessment of risk posed by an offender and the identification of the factors which have contributed to the offending, are the starting points for all work with offenders.[53]

4.11.5 Probation use a computerised assessment system called the Offender Assessment System (OASys-R). OASys-R is a detailed assessment that begins at an offender's appearance at Court and, if sentenced, continues until the end of their supervision. OASys-R is designed to help practitioners to make sound and defensible solutions, manage any escalating risk, and ensures there is continuity in the management of each offender through sharing information.

[53]Leicestershire & Rutland Probation Trust (LRPT), 'Under Supervision', [Accessed: http://lrpt2013.wpengine.com/under-supervision/] [Accessed: 30.09.13]

4.11.6 In relation to domestic violence, the service has a domestic violence policy that specifies responsibilities of Offender Managers when working with offenders[54]

- Offender Manager Senior Probation Officer to provide effective management oversight for domestic violence cases;
- To supervise and manage domestic abuse offenders in accordance with LRPT practice requirements and standards;
- To undertake accurate assessments and reviews and in particular complete 'e' Spousal Assault Risk Assessment in OASys on each domestic violence case;
- To ensure effective communication with all agencies involved with the case.

4.11.7 All domestic violence perpetrators are allocated a risk of harm score according to OASys Domestic violence work with offenders and victims is delivered within the wider context of multi-agency approaches to perpetrators and victims of crime including MARAC; MAPPA and Safeguarding Children and Safeguarding Adult procedures. The Probation service also utilise Integrated Offender Management as a multi-agency approach with offenders whose crimes have a greater community impact, for example anti-social behaviour – domestic violence could fall within this remit. Use of Integrated Offender Management relates directly to severity of risk.

4.11.8 Offenders may be managed through an Integrated Domestic Abuse Programme. The programme offers an integrated case management and group work process for those offenders with an order or licence condition to attend it. The programme requires approximately 18 months to complete and there are certain precluding criteria including alcohol dependency and unstable mental health.

4.11.9 ## Summary of Involvement

**In May 2012**, the Probation Service became involved through producing a 'pre-sentence report' for the Court to consider in their sentencing, accessing information relating to Mr A's offending history including probation records from Mr A's period as a Looked After Child.

4.11.10 **On 1st June 2012** Mr A was convicted of Actual Bodily Harm against Mary on 5th May 2012 and was subject to a six month Alcohol Treatment Requirement, and twelve months Supervision Requirement. Mr A was not made subject to an Integrated Domestic Abuse Programme (this was seen as appropriate due to precluding factors of length of sentence; personality disorder and alcohol use).The Offender Manager who had prepared the pre-sentence report was also responsible for Mr A under the Supervision Requirement. This responsibility included overseeing the Alcohol Treatment Worker and their work with Mr A under the Alcohol Treatment Requirement.

4.11.11 **On 22nd June 2012** at the beginning of the supervision requirement, the Offender Manager completed a sentence plan.

[54]Leicestershire, Leicester and Rutland Probation Trust, *Domestic Violence Policy*, 8.5, p.6

**On 25th July 2012**, Mr A was seen by the Offender Manager. It was felt Mr A was demonstrating reduction in alcohol use and Mr A reported he was engaging with mental health services. There were discussions about Mr A's relationships with his wider family but no discussion about Mary as the victim. The Offender Manager made a decision to reduce contact.

4.11.12 The Offender Manager subsequently saw Mr A on 15th& 29th August; 3rd& 19th October 19; 22nd November; 2nd& 23rd January 2013

The Alcohol Treatment Worker had weekly contact with Mr A from 6th June 2012 to 11th July and then fortnightly. The Alcohol Treatment worker used the 'Alcohol Use Disorders Identification Test' This test was primarily reliant on self-disclosure by Mr A and was carried out in July, October, November 2012 and January 2013. Though the first score indicated there may be an alcohol dependency, throughout the order, Mr A did not disclose being a daily drinker and during treatment disclosed his alcohol was consistently reducing. The Treatment Worker stated that Mr A's presentation and functioning indicated he was not a dependent drinker and had made real progress addressing his alcohol use.

4.11.13 Mr A also informed the Treatment Worker in July 2012 that he was using cannabis daily but by October he reported this to have reduced to 4 times per week and then none in November and January. A record was also kept of health and social functioning based on Mr A's self-rating 0 (poor) to 20 (good). The prompt question for overall quality of life is '*able to enjoy life, gets on well with family and partner*'. In July 2012, Mr A rated quality of life '10', in October'15', November '18' and January '16'.

4.11.14 **Key events were:**
**On 31st October 2012**, Mr A discussed with the Treatment Worker, feeling very low and related this to renewed contact with his Mother. He also discussed pressure in his relationship (non- specific) and wanting his own accommodation.

4.11.15 **On 30th November 2012**, the Alcohol Treatment Requirement ends. Mr A is offered voluntary appointments. He misses the first one on **6th December 2012** (it transpires that he was in hospital on this date following self-harm) but attends the following week. His final appointment was on the **23rd January 2013.**

4.11.16 ## Issues Arising& Analysis

The probation report author found that there were significant errors in the management of this case.

**Frequency of contact**

The Offender Manager saw Mr A in the first week of his order and did not see him again for another six weeks. The national standard recommends offenders are seen once a week by the Offender Manager in the first sixteen weeks of the order, recognising that most productive work is in the early stages. Though there is professional discretion to change this, in this case, there was no justification made. The author is clear that Mr A

should have been seen weekly given the nature of the offence. The Offender Manager relied upon weekly contacts with the Treatment Worker during this period, to the detriment of the assessment and offending behaviour work.

4.11.17 The probation report author also highlighted that no contact was made by the Offender Manager with Mr A during December 2012. The festive period is a known high risk period linked to alcohol use and domestic violence. The Offender Manager is not aware of Mr A's incident of significant self-harm and hospital admission in December 2012.

4.11.18 **Quality of risk assessment and management.**
The probation report author highlighted deficiencies in the risk assessment; the focus of the supervision plan and carrying out the objectives within the supervision plan. The author found that the Offender Manager correctly assessed Mr A as vulnerable. However, it appears that there was lost focus on the index offence and Mr A as a perpetrator.

4.11.19 The probation report author identified that the supervision plan lacked any offence or victim focus. The plan noted liaison with mental health agencies, housing support, notifying police and social services '*as deemed necessary*'. The author felt the plan was not sufficiently specific, measurable, realistic, achievable or time-bound.

4.11.20 The author also questions the risk assessment underpinning the supervision plan. The plan was not based on information from mental health services as no contact had been made. The Offender Manager had a good level of detail about Mr A's history and his preparedness to use weapons including the offences in Mr A's teenage years. However the Offender Manager felt that the age and subsequent gap meant this bore little relation to the current offending. There was no consideration of Mr A's relationship with Mr B and that the gap in offending during the period of this relationship may have been due to a degree of financial security which was no longer present. Triggers for offending such as arguments about ex- partners and contact with his Mother were also known.

4.11.21 The Oasys assessment indicated that the biggest risk factor in Mr A's offending was relationships. However, the Offender Manager's assessment was that the main areas for concern related to alcohol use and emotional well-being/mental health.

4.11.22 Though the Offender Manager's assessment was mental health was a primary factor, this did not prompt any contact with mental health services. Had the Offender Manager contacted mental health services this would have enabled him to have a clearer understanding of Mr A, his diagnosis and how the features of the personality disorder such as low tolerance to frustration; tendency to blame others and impulsivity were relevant in his relationships, risk assessment and supervision plan.

4.11.23 A Spousal Assault Risk Assessment was completed and Mr A was correctly assessed as a medium risk of harm to partners from this assessment. However, the probation report author found there were two areas that were underscored. This was in relation to use of a weapons and minimisation/blame.

4.11.24 The other major area of concern was how well the supervision plan was carried out. The

supervision plan specified contact with other agencies and the Offender Manager was aware the personality disorder service was working with Mr A. However, no attempt was made to seek consent and speak to professionals in this service or other health agencies, housing, or the police. The LRPT domestic violence procedures specify '*Offender Managers should liaise closely with any other agencies involved with the offender or their family and Safeguarding should be a central focus of all work undertaken.'*[55]

4.11.25 The probation report author found that the Offender Manager was not working closely enough with the Treatment Worker. The Treatment Worker appeared to discuss a wide range of issues with Mr A, including coping strategies. The Offender Manager felt that by addressing alcohol and emotional well- being this would lead to a reduction of risk. As Mr A appeared to be making progress in areas of alcohol and emotional well-being, the Offender Manager felt he was not presenting any imminent risks. However, issues reported to the Offender Manager by the Treatment Worker relating to difficulties with relationship, low mood and accommodation issues were not picked up as concerns and explored further**.**

4.11.26 Perceptions that Mr A was progressing well were overly reliant on self-reporting. As noted, the Offender Manager failed to check perceptions from other agencies such as Mental Health; Police or Mr A's GP. Though Mr A was on an Alcohol Treatment Programme, his GP (Medical Practice 1) was not aware of this and could not therefore incorporate this into their wider health care plan.

4.11.27 There was reference in the supervision plan to doing work relating to the impact of Mr A's behaviour upon his victim. The probation report author highlighted that as Mr A was not involved in Integrated Domestic Violence programme, it was even more important that offence focused work was undertaken with Mr A. No such work was undertaken. The author noted the Offender Manager had no knowledge of Mary and the level of her vulnerability and stated that the Offender Manager should have ascertained whether Mary was receiving any support, and ideally this should have been incorporated into the risk management plan.

4.11.28 In addition to issues identified above, key aspects of the Domestic Violence procedures were not followed:

- There was no liaison with police to establish 'call out requests.' This is an information sharing system between police and probation that allows probation to be informed of further incidents. This is crucial for risk assessment and consideration of victim safety, and may trigger a request for police to carry out a DASH assessment and where indicated, refer to MARAC.
- No home visits were carried out. '*Home visits are an important aspect of risk management and should be undertaken and be purposeful. The frequency of home visits should be determined after consideration of other statutory agency involvement and feedback and may be undertaken in partnership with another agency'*[56]
  The Offender Manager had not confirmed where Mr A was living. We now know that Mr A was living with Mary throughout this period. Had the Offender Manager known

[55] Ibid., 9.6, p. 7
[56] Ibid., 9.7, p. 8

this, the victim may have come more to the forefront of the work and prompted contact with other agencies.

4.11.29 It is poignant that Mary is not mentioned by name in either the Oasys assessment or the risk management plan. Effectively Mary, and the context of the index offence had become lost.

4.11.30 The probation report author noted that the Offender Manager was regarded as an experienced officer who had completed domestic violence training and was used to doing pre-work with men conditions to attend Integrated Domestic Violence Programmes. There were no indicators from the team work profile that the team was particularly overstretched or that the Offender Manager was any busier than other team members.

4.11.31 The probation report author identified that the Offender Manager had been receiving regular supervision. However, because Mr A was assessed as posing a medium risk of harm, there was less management oversight in this case. As the Offender Manager was an experienced officer, supervision involved discussing the high risk and most concerning cases. The author felt the case also highlights a need for managers to have a better oversight of medium risk of harm domestic violence cases, recognising that it is medium rather than high risk cases that make up the majority of their incidents of Serious Further Offences.

4.11.32 The DHR panel and the overview report writer agreed with the findings of the probation report. There does need to be caution in reviewing incidents and drawing conclusions that are clear with the value of hindsight but may not have been evident to the practitioner at the time. However, it does appear that in this case, there were basic procedures that were not followed and an absence of multi-agency working that could have improved the risk assessment and management.

4.11.33 The probation report author finds that whilst it may not have been possible to predict the homicide, it was possible to predict the potential for harm and to take steps to try and reduce that risk.

4.11.34 The interview with Mr A, endorsed many of the findings within the probation report. Mr A's perspective was that he had had a positive relationship with the alcohol treatment worker and he had '*really liked him. He tried to get me to do things differently and manage my anger differently'* He described talking to the treatment worker about the need to find alternative accommodation.

Mr A acknowledged probation didn't understand *'the whole picture of him'*. When discussing the incidents of domestic violence, Mr A described it as '*not abuse, just a smack'* which is perhaps indicative of the minimisation of the index offence described in the probation report.

4.11.35 **Recommendations arising from the Probation report**

Leicestershire and Rutland Probation Trust have already acted on findings from the review

- The Senior Probation Officer has been working with the Offender Manager in relation to this case and the areas of concern it has raised.
- The Trust has initiated training on personality disorders so that officers have improved understanding of presentation and risks arising relating to different personality disorders.

| **Leicestershire and Rutland Probation Trust Recommendations** |
|---|
| Accurate completion of Spousal Abuse Risk Assessment (SARA) and Specific; Measured; Achievable Realistic Time-bound Supervision plans – sample check Offender Managers' SARA and supervision plans |
| Liaising with statutory agencies. Ensure that anyone subject to a Drug Rehabilitation Requirement or Alcohol Treatment Requirement, that their GP is routinely notified |
| Liaising with other statutory agencies. To go through all Offender Manager's domestic violence cases to ensure offender manager has gathered and shared information with other relevant agencies. |
| Risk management plans incorporate direct reference to victims. Ensure that domestic violence risk management plans are making reference to victims. |
| Use of weapons are addressed in risk management plans. LRPT to review resources re working with perpetrators who use a weapon. |
| Levels of Offender management contact and home visiting. Recommend changes to LRPT Domestic Violence policy so that Offender managers are clear about the levels of contact expected in Domestic violence cases. |
| Quality of Domestic violence work with medium risk of harm cases and oversight by line managers. The majority of Serious Further Offences come from medium risk cases, and are most often domestic violence in nature. In line management supervision, there is inevitably a focus upon high risk cases. LRPT will be doing sample audits across all Offender Manager teams once a month, looking at medium risk domestic violence and safeguarding cases using the RADAR tool. |

## 4.12 Medical Practice 1 – Mr A's GP Practice

4.12.1 Medical Practice 1 had involvement with Mr A but not with Mary and provided a chronology and factual summary report.

4.12.2 The author of the report was a Doctor from Medical Practice 1. As the size of the service is small and Mr A had contact with a number of different practitioners within it, it was not possible for the author to have had no direct involvement in the care of Mr A. However, the report was reviewed by the Leicestershire Clinical Commissioning Group Hosted Safeguarding Team in order to provide a degree of scrutiny and objectivity.

The methodology used was a review of clinical records and an account from the Doctor involved in Mr A's care.

4.12.3 **Summary of Involvement**

**In February 2012,** Mr A was first registered with Medical Practice 1 and remained registered at the practice through to the end of the period covered by this review. Mr A had regular contact with the surgery throughout 2012 – 2013. There was on average 2-3 direct consultation and 2-3 phone consultations with Mr A each month.

4.12.4 Medical Practice 1 report author stated that Mr A was highlighted as being a risk to himself and had informed the GP about mental health problems since childhood, several attempts at self-harm, admission to mental health units and forensic involvement. The continuing risk of self- harm was evident to the practice through further overdoses. Mr A talked to the surgery about his grief reaction following the death of his Grandmother and this was indicated as the reason for many of the consultations.

4.12.5 Mr A was using a regular low-dose of benzodiazepines. The practice records included regular reviews of medication as Mr A was trying to wean himself off diazepam.

4.12.6 **Key events:**

**On 3rd April 2012**, Mr A phones surgery and reports he had taken an overdose and had been admitted to hospital (this had occurred on the 29th March).The surgery arranged to see him the following day. As Mr A was identified as a self-harm risk, a decision was made that medication should be issued only a week at a time.

The practice received a discharge summary from the mental health inpatient unit **on 5th April 2012**. A relationship breakdown with Mr A's girlfriend was cited as reason for his overdose. The correspondence did not mention any threat or risk to this girlfriend from Mr A, but simply described the relationship as '*volatile*'. No threat or risk to any other individual was mentioned.

4.12.7 **On 16th April 2012**, police rang to inform GP of Mr A's overdose on the 29th March. The GP saw Mr A **on the 17th April 2012** and discussed plans to reduce the benzodiazepine. Mr A agreed to attend all his appointments with his councillor (referring to Francis Dixon Lodge).

4.12.8 **On 10th May 2012** police rang to notify the GP that they had had contact with Mr A who had threatened suicide. This was already known to the GP. The Police did not indicate any threat or risk to any third party. *Note: this incident followed Mr A being arrested for assault to Mary.*

4.12.9 The GP saw Mr A **on 14th May 2012** the record indicates – grief reaction; no current suicidal ideation; good insight into problems; abstained from alcohol following previous police incident; medication issued.

4.12.10 **On the 11th of September2012**, Mr A spoke to a GP and referred to an attendance at Probation by way of excuse for missing a telephone appointment the previous day. There was no further discussion on this as the discussion revolved around Mr A's attendance at the personality disorder service that were commencing their input into Mr A's care.

4.12.11 **On 5th November 2012** – Notified by the personality disorder service that Mr A was found to have submitted a prescription with a forged request for Temazepam. It was agreed that the personality disorder service Doctor would take over all psychiatric medication prescribing to avoid future script problems.

The practices last contact with Mr A before the homicide was on the **11th February 2013.** Mr A reported feeling stable with both good and bad days.

4.12.12 ## Issues Arising and Analysis

Medical Practice 1 author reports they tried to address risks of Mr A's self-harm through offering frequent contact and continuity of practitioner where possible. Mr A was seen on a weekly or fortnightly basis, and enquiries about thoughts of self-harm and suicide were regularly made.

4.12.13 The practice was aware that Mr A's personality disorder meant his mental health could deteriorate very rapidly when faced with a challenging or stressful situation. However, with the exception of a remark from the previous GP summary stating '*inappropriate sexual behaviour towards younger siblings, vandalism'*, the practice was not aware of any information regarding recent or on-going violence or aggression towards any particular individual. '*The practice was aware of a relationship with a girlfriend and that Mr A had elected to move in with her. Mr A made no reference to discord in this relationship, but rather attributed most of his mental health issues to the effect of others including his father and mother*'.[57]

4.12.14 The Medical Practice 1 author stated that Mr A had always presented to the surgery in a calm and non-confrontational manner. The report author noted that from May 2012 the remaining period seemed to be a period of clinical stability. Mr A was in regular contact with the surgery, and was receiving specialist input and medication. The practice had no concerns about his capacity to make decisions.

4.12.15 The DHR panel questioned whether consideration had been given to specialist services for substance and alcohol use. The Medical Practice 1 author judged that Mr A's drug and alcohol use was minor by clinical standards and that such pattern of drug and alcohol use would not normally require referral to specialist agencies. The author noted that the practice was now aware that Mr A had been receiving a service relating to his alcohol use (the Probation Alcohol Treatment Requirement) and observed poor communication in this regard.

4.12.16 The DHR panel also questioned whether further inquiry should have been made by the GP when Mr A informed them on 11th Sept 2012 that he was seeing probation. The author's view was that as they had no history of abuse to others, questioning his

[57] Medical Practice 1, *Factual Summary Report for Mr A*, p. 4

probation and offence in the context of when this statement was made seemed inappropriate.

4.12.17 The author reported despite frequent and sustained contact with the practice and psychiatric services, Mr A's impulsive tendency to self-harm was not curtailed. The author's view was that the practice employed reasonable strategies within its means to address risk to Mr A, including frequent encounters, continuity with a lead practitioner, rationed and monitored prescribing and integration of inter-agency information to clinical care. Though it was plausible that these strategies had avoided some episodes of self-harm, Mr A's presentation prevented timely intervention in the cases where he had taken decisive action.

4.12.19 The practice had limited evidence of risk of harm to others and was unaware of a violent relationship with Mary. This meant that no constructive strategy to minimise risk to others was employed**.**

In relation to lessons learned, Medical Practice 1 author identified:

- Increased vigilance in cases of personality disorder where risk to self and others may present in atypical ways
- encourage other agencies to disclose information of risk to others as freely as they would volunteer risk to patient
- Had the practice known of said risk to Mary, further enquiry could have been made, either directly with Mr A or via affiliated agencies (for example, substance misuse practitioner)

4.12.20 The DHR panel accepted these findings – the lack of information sharing with Medical Practice 1 has been highlighted within the reports from Leicestershire Partnership Trust; Leicestershire and Rutland Probation Trust and Leicestershire Police.

Mr A's perspective was that the medical practice had been responsive to him and he viewed the service positively.

4.12.21 **Recommendations arising from the Medical Practice 1 report**

| **Medical Practice 1 Recommendations** |
|---|
| Case to be discussed at Practice clinical meeting once outcome of review known and final recommendations made. |
| Practice education around domestic violence, its signs and assessing risk |
| At the point of registration with a GP; patients to be asked for consent to allow relevant and proportionate information about them to be shared and received with other services to reduce the risk of harm and safeguard themselves or others |

4.12.22 Medical Practice 1 report author also made a recommendation relating to police sharing information. As noted, police are currently reviewing their information sharing protocols.

## 4.13 Medical Practice 2 – Mary's GP Practice

4.13.1 Medical Practice 2 had involvement with Mary and some very limited involvement with Mr A. Medical Practice 2 provided a chronology and factual summary report.

4.13.2 The author of the report was a Doctor from Medical Practice 2. As the size of the service is small and Mary had contact with a number of different practitioners within it, it was not possible for the author to have had no direct involvement in the care of Mary. However, the report was reviewed by the Leicestershire Clinical Commissioning Group Hosted Safeguarding Team in order to provide a degree of scrutiny and objectivity.

The methodology used was a review of clinical records and an account from the Doctor involved in Mr A's care.

4.13.3 ### Context

Medical Practice 2, as many GP Practices within Leicestershire provides a 'Shared Care.' This is a mechanism of sharing patient care between primary and secondary care services. Medical Practice 2 report it has a significant number of patients in shared care treatment compared to other local surgeries. Medical Practice 2 provides facilities for other health professionals including Swanswell and Good Thinking Practice Counsellors. These attached services record any involvement with the patient in the practice's clinical record.

4.13.4 Swanswell hold sessions at the surgery four times a week. GP's meet with the counsellors every six months to discuss client lists. Practitioners contact GPs over and above this where required. GPs work with Swanswell in the management of prescriptions. A 'Permission to Share' form is used to consent to share information between those involved in the Shared Care plan.

4.13.5 ### Summary of Involvement with Mary

Mary had been registered with Medical Practice 2 since 2006. Records show from 2006 there were 155 face to face consultations with GPs or others involved in the Shared Care team. There were a further 114 phone contacts, predominately about repeat prescriptions for Mary's on-going mental health issues and drug and alcohol dependency.

4.13.6 The Medical Practice 2 report included a number of the entries from their records relating to Swanswell and Good Thinking Therapy involvement. These have already been reviewed in other parts of this report so will not be repeated here.

4.13.7 **Key Events**

**On 11th October 2011** GP Registrar was contacted by the drugs counsellor regarding prescriptions for methadone. There had been a duplicated prescription for methadone issued in error. Mary had reported Mr A had stolen a script from her and a further script had been issued. The practice carried out a 'significant event review' relating to the error

and Mary was transferred to 7 day supervised use.

4.13.8 **On 29th March 2012** Mary phoned her GP in tears; her ex-partner (Mr A) had taken her methadone again. He was in Leicester Royal Infirmary. The GP prescribed medication, advised Mary to contact her key worker at Swanswell the following day and cancelled all future scripts. As Mary did not collect her prescription by the end of the following day, the GP cancelled the prescription. The GP asked the Swanswell worker to contact the pharmacist and informed reception staff that if Mary made contact, she may have one week of 7 day supervised consumption prescription and must contact Swanswell.

4.13.9 **On 16th May 2012** Mary failed to attend an appointment with psychotherapy services that the Good Thinking Therapist had made. She reported having a panic attack. She asked the GP to revise her medication, re-starting previous medication she had found helpful. The GP restarted this medication the same day.

4.13.10 At the beginning of **September 2012** Mary reported feeling anxious and the GP was asked by Swanswell to prescribe medication. She was started on Subutex (used to prevent or reduce withdrawal from opiate use). Mary felt sufficiently improved to want to start driving and saw her GP again on **25th September 2012** to go through DVLA forms.

4.13.11 On **15th November 2012**Mary spoke to her GP about a traumatic event which occurred 26 years ago. Mary described having panic attacks and was prescribed medication to help with anxiety.

4.13.12 Mary spoke to a GP Registrar on **7th December 2012** as she had run out of medication. Her mood was stable and there were no thoughts of deliberate self- harm. Mary was advised by the GP that if she had any further problems or dip in mood to make an urgent appointment to come and discuss this.

4.13.13 Mary phoned the GP Registrar on **12th February 2013** stating that she had forgotten to collect her script for Trazadone (an anti-depressant) the previous week. She stated that she felt well in herself but wished to continue with her medication. The GP explained the importance of taking her medication regularly. Mary informed the GP she felt well in herself and had no thoughts of deliberate self-harm. She was advised by the GP to contact the surgery if she had any problems. This was the last contact with Mary.

4.13.14 ## Summary of Involvement with Mr A

Medical Practice 2 had minimal involvement with Mr A on 26th January 2012 - Mr A was asking for temporary care as he could not return to his home area. The GP issued a short supply of medication and requested a summary from Mr A's surgery. On receiving the summary, Mr A's previous history of self-harm and overdose was noted. The GP registrar added a comment in patient consultation that no further prescriptions were to be issued.

4.13.15 ## Issues Arising and Analysis

Within the report, the author provided a detailed account of all the interventions that both the GP and others involved in the Shared Care approach to Mary had made.

The records indicate that the GP was responsive to Mary. There was also evidence of two way communication between the GP and other agencies involved in the Shared Care i.e. Swanswell and Good Thinking Therapy. What is not evidenced (and is now known from reviewing the other reports) is communication between all those involved in the Shared Care i.e. GP; Swanswell and Good Thinking Therapy discussing Mary's care together.

4.13.16 Medical Practice 2 should review the Shared Care policies and procedures to ensure there are effective systems for sharing information between all primary and secondary care parties providing care through Shared Care.

4.13.17 The DHR panel recognised the central part that GPs play in coordinating the health care for patients. The practice was asked what actions they would have taken had they been made aware that Mary's admission to University Hospital Leicester on the 5th May 2012 was due to domestic violence. The GP advised that the practice would have checked to see when Mary's next appointment was due and passed to that team member for discussion. The accident and emergency slip would also be scanned into the notes for reference. If Mary had confirmed this as a domestic violence incident the appropriate information would have been given to her or a referral on to an appropriate agency or other team member would have been made.

4.13.18 The Practice reported they use to good effect, a system of alerts which will 'flag up' on the computer screen when a patient's notes are opened. .

4.13.19 The DHR overview report writer notes that the report from Leicestershire Partnership Trust, highlighted that information from the GP at point of referral to Good Thinking Therapy (Dec 2011) was on an informal basis only and did not offer a comprehensive history regarding Mary. Medical Practice 2 did hold records from2007-8 that related to domestic violence. These were not flagged up in the referral information. However, it is also noted that the source of the information in the GP clinical record was from the drugs worker, employed by Leicestershire Partnership Trust who was recording in the practice's patient record.

4.13.20 **Recommendations made within the Medical Practice 2 report**

Medical Practice 2 identified a number of lessons learned and actions for the practice. These included

- All patients in shared care will have a good behaviour contract and this will be reviewed six monthly by the drug counsellor and scanned into medical records
- Confirm the contract of good behaviour specifically states that if there are safeguarding issues they will be discussed with the wider Practice team – revise accordingly.
- Reinforce the importance of six monthly meetings with the drug counsellors with specific regard to establishing whether there are any safeguarding concerns – to be standing agenda item. This is now in place.
- Further guidance to all clinicians about management of subutex and methadone

prescriptions has been issued

- Induction of new staff or trainees (electronic and hard copy 'induction pack')
  - Awareness that resource information relating to domestic violence is on computer desktop
  - Update Registrar guide that any domestic violence and safeguarding issues must be discussed the same day at debrief
  - Guidance on methadone/Subutex requests

4.13.21

| **Medical Practice 2 Recommendations** |
|---|
| Practice Manager to contact Safeguarding office to clarify training status of all clinical staff within the Practice as regards safeguarding training for adults and children |
| Practice Manager to contact Managing Director of West Leicestershire CCG to suggest the possibility of a Locality wide Protected Learning Time event on domestic violence |
| Practice Manager to make contact with local Domestic Violence service with regards to an in-house training session for all staff |

4.13.22 The DHR overview report writer has included within the overarching recommendations in section 7, a further recommendation for NHS England and the Hosted Safeguarding Team regarding sharing learning across all GP practices.

## 4.14 Central Nottinghamshire Clinical Services –Leicestershire Leicester Rutland out of Hours GP Service (incorporating (redacted) Medical Group Walk-In Centre)

4.14.1 Out of Hours services had minimal involvement with Mary and no relevant involvement with Mr A.

The providers of Out of Hours services have recently changed. A chronology was provided from archived records but no more information was available. The information was provided by the Leicester, Leicestershire and Rutland GP Out of Hours (OOH) Director of Clinical Governance and Quality who had not had direct involvement in the care of Mary or Mr A.

4.14.2 **Summary of Involvement**

Relevant involvement was on **14th August 2011.**Mary contacted OOH saying she had tried to contact LPT crisis team but stated the phone was put down. OOH tried to phone Mary 3 times but no response. OOH requested ambulance attendance that subsequently made contact – all was well.

4.14.3 **Issues Arising and Analysis**

There are no particular areas of note from OOH involvement. Each contact with the service had a recorded outcome as follow up by the GP. On each occasion the OOH followed the correct procedures and protocols. This was accepted by the DHR panel and overview author.

**Recommendations arising from the Out of Hours GP service report**

There were no recommendations arising.

# 5.0 ANALYSIS

The review in of each agency's involvement detailed in section 4, has revealed some key issues of learning for that agency. This section of the report reviews this against each of the specific terms of reference for this review.

5.1

**Terms Of Reference 4.1.1**

Mary was known to mental health and drug and alcohol services. She had a history of assaults from previous partners and from Mr A. The review will address the nature of Mary's mental health, drug and alcohol misuse and whether all services involved made use of opportunities to support Mary to address risks of domestic violence.

5.1.1 There was evidence from the review that Mary was receiving good support from Swanswell (and historically from Leicestershire Partnership Trust) in relation to her substance misuse. There was some evidence that Swanswell was taking a holistic approach. However there appeared to be insufficient follow up when Mary did disclose domestic violence.

5.1.2 There was also evidence that Mary was receiving a responsive service from the Good Thinking Therapist in relation to her mental health in relation. Mary engaged well and discussed a number of sensitive issues that triggered further referrals to other services albeit that Mary chose not to follow these up at that time. As the Good Thinking Therapy service was not aware of any domestic violence, Mary was not supported to address this.

5.1.3 Mary appeared to value the input from both of these services - their work had the potential to build Mary's self-esteem, broaden options and life choices and help build her resilience. Had either agency been able to support her specifically in relation to domestic violence, this could have helped Mary to also explore managing her safety and making informed choices about the potential risks of harm.

5.1.4 It is evident that Mary appeared to make a choice not to discuss her relationship or domestic violence with her Good Thinking Therapist despite questions from the service to explore this. She also did not discuss the significant assault to her on the 5th May with her

Swanswell drugs worker. It maybe that she wanted to compartmentalise different aspects of her life and engage with services on that basis.

5.1.6 It is of note that when the DHR overview author asked Mary's daughter R, what services could have done that may have helped, R felt that services need to focus on the person not on the relationship to understand why they enter into and stay in that lifestyle. R felt that at that time, Mary was not prepared to change. Mary's younger daughter H felt that Mary would always hide things from the services and would not tell them the full truth.

5.1.7 It does seem that Mary found it difficult to acknowledge her experience as a victim of abuse for the most part. The reasons for this may be complex – perceptions of her self-worth; viewing violence as a normal part of relationships and/or that her use of substances resulted in minimising risk.[58] It is acknowledged that broaching the subject of domestic violence can often be very difficult for victims of domestic violence. There was a complex relationship between Mary and Mr A and there are some indications that Mary had taken on something of a role as 'rescuer' in response to his self- harm. If Mary was feeling any sense of coercion arising from Mr A's self-harming behaviours, this may also have made it difficult for her to raise the subject of domestic violence.

Swanswell are now providing training for their staff on domestic violence and developing their policies. The service should ensure this includes asking routine questions about domestic violence.

5.1.8 There was however some instances where Mary was seeking or accepting of support in relation to domestic violence. The reports from Police and the Local Domestic Abuse Outreach Provider indicate the appropriate actions taken to offer Mary specialist support. University Hospital Leicester also took the opportunity to engage Mary with services at a point when she was willing to accept help – it is unfortunate that despite this good intent, the referral to MARAC was not transmitted.

## 5.2

**Terms of Reference 4.1.2**

Mr A was well known to mental health and drug and alcohol services and was subject to a probation order. The review will address the nature of Mr A's mental health, drug and alcohol misuse and how services supported Mr A to address his self-harming, suicidal and violent behaviours and understanding the correlation between these behaviours and domestic violence.

5.2.1 The review learned that Mr A had a diagnosis of emotionally unstable personality disorder and dissocial personality traits. He was also known to use substances and alcohol though this was assessed to be minor by clinical standards. He was being supported to address his mental health, drug and alcohol misuse primarily through 3 services:-

[58] Stella Project, *Against Violence & Abuse (AVA)*, p. 5 [Available from: http://www.avaproject.org.uk/our-projects/stella-project.aspx] [Accessed: 28.09.13]

5.2.2 **1. Leicestershire Partnership Trust:**

The review has considered in some detail how LPT responded to Mr A and attempted to support him to address behaviours arising from his personality disorder. There was some evidence of responsiveness to Mr A's needs and successfully engaging him with specialist service personality disorder services. This treatment is recognised as meeting the national guidance for managing his personality disorder. Mr A reported this service to be beneficial.

5.2.3 What was less evident was how well the management of self-harm, suicidal and violent behaviours correlated to addressing Mr A's behaviours as a perpetrator of domestic violence. Though some instances of self-harm appeared to be due to despair, there also appears to have been a coercive element in some of the episodes. Threats of suicide can be linked to coercive control and consequently the DASH checklist includes a question on whether the perpetrator has threatened suicide. It is not evident that these links were made.

Mr A's perspective was that '*when things were getting worse and I wanted to kill myself….they just gave me pills and told me to go away'* He felt mental health services '*needed to listen more and try to understand what was happening'*.

5.2.4 Referral to specialist mental health forensic services or substance misuse services was not indicated at that time.

There were significant omissions in addressing Mr A's needs through the Care Programme Approach which would have provided a structured multi-agency approach. These points are considered further in the 5.4 and 5.13 below.

5.2.5 **2. Leicestershire Probation:**
Section 4.11 detailed the support that Mr A was receiving from Probation in relation to his alcohol use through a 6 month Alcohol Treatment Requirement His alcohol treatment worker appeared to discuss a wide range of issues with Mr A, including coping strategies– a service that Mr reported as being helpful to him. Mr A appeared to make good progress and improved in relation to alcohol use and overall quality of life (based on self-reporting). However the Offender Manager laid too much reliance that management of his alcohol use was an effective means of reducing risk of harm to others. The review of probation's involvement also found the Offender Manager was not sufficiently aware of Mr A's mental health needs.

Mr A acknowledged that services did not understand the entire picture.

5.2.7 **3. Medical Practice 1:**
Medical Practice 1 provided regular contact and employed reasonable strategies to minimise risks to Mr A from self-harm. The practice acknowledged that despite this, Mr A's impulsive tendency to self-harm was not curtailed. The practice was not aware of any violent behaviours risk that Mr A presented to others.

5.3 **Terms of Reference 4.1.3**

To review whether practitioners involved with Mary and Mr A were knowledgeable about potential indicators of domestic violence and aware of how to act on concerns about a victim or perpetrator.

5.3.1 The review of each agency's involvement has demonstrated varying degrees of understanding and awareness of domestic violence. All of the agencies involved had policies and procedures in place. Many of the services, such as EMAS, Victim Support and UHL had incorporated domestic violence training as part of standard training - UHL in particular demonstrated significantly improved responses to domestic violence from 2007 to 2012.

5.3.2 Other agencies such as Police; Probation and Leicestershire Partnership Trust had provided additional specialist/targeted training for staff. For some agencies, such as Swanswell the learning from the review has highlighted a need for further training relating to domestic violence. It has also highlighted the need for increased use of routine questioning, awareness of service provision and pathways.

5.3.3 The DHR has also highlighted the need for improved understanding of personality disorder and perpetrator typology, including the links between self-harm/suicidal ideation and domestic violence.

5.3.4 In all, 8 out of the 14 agencies contributing to this review included some recommendation relating to increasing knowledge of practitioners of potential indicators of domestic violence and/or acting on concerns.

5.4 **Terms of Reference 4.1.4**

To establish how professionals and agencies carried out risk assessments, (including assessment of the victim's mental capacity to make decisions relating to risks) including

i) Whether the risk management plans were reasonable response to these assessments.

ii) Whether risk assessments and management plans of Mr A took account of his early history, including convictions for violence in his adolescent years and assessments of risk made during this period.

**iii)** Whether there were any warning signs of serious risk leading up to the incident in which the victim died that could reasonably have been identified, shared and acted upon by professionals

5.4.1 The quality of risk assessments and the responses to risk assessments has been a major area of learning identified by this DHR.

5.4.2 **Risk assessment and risk management relating to Mary:**
In relation to work with Mary, the review of Swanswell identified that though risk assessments were carried out, they did not incorporate updated information about domestic violence and nor was there evidence of sufficient follow up an incidents disclosed. The service had considered issues of consent in relation to sharing information with other services, namely Good Thinking Therapy, but had not then acted upon this consent.

5.4.3 There was evidence presented by LPT that risk assessments were carried out by the Good Thinking Therapist as part of the clinical assessment process and included questions relating to risk of self- harm; risk from others, including abuse and domestic violence and risk to others.

Other services such as UHL and EMAS demonstrated appropriate responses to clinical risk and considering Mary's capacity to make decisions relating to risk. UHL made an effective risk assessment in May 2012 and acted on this (albeit an administrative error affected the outcome) having sought consent and taken Mary's mental capacity for this into account. However, key information from UHL about treatment for domestic violence was not shared with her GP which was a block to risk assessment and management by other services involved with her.

5.4.4 Police also conducted risk assessments in relation to incidents of domestic violence and acted on these according to the assessed risk. This is considered further in the terms of reference relating to referral through MARAC.

5.4.5 An overarching issue raised within this DHR is recognising that though a person may be deemed to have mental capacity to make decisions relating to risk, their judgement may be impaired where they are using substances. *'Some survivors' drug or alcohol use could make it difficult for them to assess the severity of the violence they are experiencing. Their substance use may be 'dulling' both the physical and mental pain they are in.'*[59]
The training needs identified by agencies such as Swanswell and Medical Practices are particularly relevant here.

5.4.6 There is also an issue about how well practitioners understood how much Mary's judgement was subject to coercion and how well this was considered for example, when she retracted her complaint to police. The recommendation from police regarding gathering data relating to prosecutions without victim witness will make an important contribution to our understanding of this.

5.4.7 **Risk assessment and risk management relating to Mr A:**
The findings from reviewing individual agency reports highlight significant failings in how well risk assessment and risk management of Mr A was carried out.

5.4.8 The nature of Mr A's personality disorder meant that he was liable to be impulsive with behaviours that could be self-destructive or violent to others. Whilst it may not have been

[59]Stella, *AVA*, p. 5

possible to predict the sad circumstances of Mary's death, there was a potential for improved risk assessment and management plans to try and reduce the risk of harm occurring.

5.4.9 The review has identified a number of significant omissions:

- Information regarding Mr A's past forensic history

Information from Mr A's early offending was not used to inform risk assessment and management. With the exception of probation and police, other agencies involved such as LPT and Medical Practice 1 had no knowledge of his forensic history or the relevant features of this such as use of weapons. While it is not reasonable or acceptable for detailed offender history to be shared for all patients, information should be sought and shared as proportionate and necessary.

5.4.10

- Quality of risk assessments and management plans

The probation report details concerns about the quality of the risk assessment – specifically that it was not well founded and had lost focus on the index offence of domestic violence. Mr A was viewed as vulnerable (which he was) but this overshadowed work with him as a perpetrator of domestic violence. There was an overreliance on self-reporting without accessing specialist knowledge from other services. Had probation had a better understanding of Mr A's personality disorder, this could have improved understanding of his presentation and the risk he posed. Probation had insufficient over sight of Mr A, omitted basic processes in managing the risk he posed.

Risk assessments carried out by LPT relied on self-reported history and were not accurately updated when risks were known. It was not clear how well the risks that were identified then led onto an effective management plan. In some aspects, the judgements and actions were significantly flawed. An example was authorising Mr A to go on leave to Mary's, 2 days after threatening to stab her with no record of informing her of this.

5.4.12

- Sharing information with others to manage risk

Information sharing is fundamental to the effective assessment and management of risk. Sharing information not only brings together a fuller picture of historical, actuarial and clinical risk factors, it allows practitioners to challenge their assumptions and develop a more comprehensive, problem solving approach to risk management. The DHR has shown that there were failures in sharing information between many of the agencies involved. This includes (but is not limited to)

  - LPT in transferring information within their service and sharing information with other agencies, such as GP and Probation
  - Probation in working with mental health, requesting police 'call out' information and informing GP of their work in alcohol treatment.
  - UHL in informing Mary's GP of her attendance relating to domestic violence.
  - Police in informing the GP that the context of Mr A's self-harm risk related to

charges of domestic violence.

5.4.13 However, despite these omissions, there was not any evidence of serious risk in the weeks preceding Mary's death that agencies could reasonably have identified. Mr A described tensions building between himself and Mary 3 days prior to the homicide but stated 'I *don't think services could have foreseen anything because not a lot happened before (the incident)'.*

5.5 **Terms of Reference 4.1.5.**

To identify whether services that were involved with either Mary or Mr A, were aware of the circumstances of their service user's partner and the agencies involved with them. Whether connections were made and information shared between these services in order to establish a full picture of the vulnerability and risks arising from the relationship**.**

5.5.1 The DHR has highlighted that with the exception of the police, there was no connection between agencies working with Mary and agencies working with Mr A.

It is not reasonable, nor would it be consistent with requirements under article 8 of the Human Rights Act (right to privacy and family life), to expect services to share information about all individuals they are involved with. However, effective risk management and care planning should take account of proportionate seeking and sharing information to understand the person's wider social circumstances, needs of carers/others they are involved with and factors of resilience or risk. Practitioner should use professional judgement in determining what information to seek and share as part of their standard practice

5.5.2 There are a number of formal multi-agency forums where the needs of victims and perpetrators can be reviewed, information shared by the agencies involved and a joint approach made to care planning.

1. **Mental Health Care Programme Approach**. The review of LPT highlighted this was not used and should have been. Adopting the CPA for Mr A, would have afforded the opportunity to consider Mary, her needs as a carer and potentially make the link between services provided for Mr A and for Mary.
2. **Safeguarding Children and Safeguarding Adults Procedures –** these procedures bring together relevant agencies to share information about those at risk as well as those alleged to cause harm. There were no issues relevant to safeguarding children in this review. Safeguarding adults procedures were considered but not assessed as required. This is considered further in section 5.12 below
3. **MAPPA –** MAPPA is a statutory requirement that focuses primarily on the offender but also shares information about victims. MAPPA applies to the highest risk offenders and Mr A's offending did not meet this criteria.
4. **Integrated Offender Management** - a multi-agency approach with offenders whose crimes have a greater community impact. This could include domestic violence where information about the perpetrator and victim would be shared. However IOM relates

directly to severity of risk and was not appropriate in this situation.

5. **Joint Action Groups -** multi-agency intelligence led local partnerships focussed on anti-social behaviour and related crime & disorder. They apply collaborative problem solving to manage perpetrators and support victims. In the area of the DHR, there was a crime JAG that considered cases of domestic violence that fall below threshold for MARAC. However, this approach is not consistent across the area and it is acknowledged that the referral criteria are not clear. No referral was made to the JAG.
6. **MARAC** – this is the primary multi-agency route for managing high risk cases of domestic violence. Strategies to support the victim and minimise risk from the offender are considered. In this case, a referral to MARAC would have been heard, but it is unlikely that the MARAC process would have been used to manage the risks to Mary. This is considered further in section 5.10 below.

5.5.3 Each of the multi-agency forums necessarily has specific criteria and thresholds for referral - this is acknowledged as necessary to enable prioritisation of limited resources. Broadening the thresholds could potentially introduce new risks for victims in that agencies would simply be overwhelmed and not be able to make effective and proportionate responses.

5.5.6 A Home Office funded independent assessment of domestic violence services across Leicestershire and Leicester reported in January 2013 and presented to Leicestershire Domestic Abuse Strategy Board in April 2013. The findings note the need to review how service work together in domestic violence. '*…there is much experience and expertise that could be shared across the county if joined up better ….. Strong leadership is required to coordinate the County's response to DVA'*[60].

The DHR overview author has made a recommendation in relation to this.

5.6

**Terms of Reference 4.1.6**.

To establish whether there were any opportunities for professionals to 'routinely enquire' as to any domestic abuse to the victim that were missed.

5.6.1 The review has identified points where services such as Swanswell may have used opportunities to routinely inquire about domestic abuse. As noted in section 5.1 above, there may be many complex reasons why Mary chose not to inform services about domestic violence and routine questioning opens the door for victims to broach the subject.

5.6.2 Swanswell is improving their training, policies and procedures as a result of learning from the review. The service should ensure this incorporates the use of routine inquiry, recognising the increased prevalence and particular vulnerabilities of users of these services.

[60]Leicestershire Domestic Abuse Strategy Board; Standing Together Partnership Assessment; April 2013

The DHR overview author has included an overarching recommendation for Leicestershire Multi-Agency Domestic Abuse Strategy Board to seek assurance from the agencies about how they have acted on the learning and recommendations from the DHR.

5.7

**Terms of Reference 4.1.7.**

To establish if any agency or professionals considered any concerns were not taken seriously or acted upon by others.

5.7.1 There are no instances that have comes to light where a practitioner or agency raised concerns that were not taken seriously or acted upon by others.

5.8

**Terms of Reference 4.1.8**

To establish if there were any barriers experienced by Mary or her family / friends that prevented her from accessing help to manage domestic violence; including how Mary's wishes and feelings were ascertained and considered.

5.8.1 The DHR has not revealed barriers by Mary or others in accessing help. It is acknowledged that Mary chose not to inform the services she was working with about an assault to her in May 2012.

5.8.2 It is not clear the reasons why Mary chose not to share this information. As noted in response to 5.1, the reasons for this are likely to be complex and may relate to her perception of herself as a victim; feeling compromised in a sense of responsibility to Mr A and/or that her use of substances reduced her perception of risks. Agencies need to improve their understanding of these complex issues in order to be facilitate victim's disclosure and encourage them to access support.

5.8.3 We do know that during the DHR scope period, Mary had accessed specialist domestic violence services and had felt able to contact the police on a number of occasions. The evidence from the review is that on these occasions, her wishes and feelings were ascertained and considered, as was her capacity to make decisions.

5.8.4 The police report has identified some recommendations to help understand the reasons why victims decide not to be witnesses. This will aid our understanding of victims experience and barriers they may encounter to accessing effective support.

5.9

**Terms of Reference 4.1.9**

To identify whether more could be done locally to raise awareness of services available to victims of domestic abuse.

5.9.1 Mary did appear to be able to access services. Some agencies, such as the Local Domestic Abuse Outreach Provider, Swanswell and Medical Practice 2, have identified a need for agencies to improve knowledge about services available and referral routes.

5.10 **Terms of Reference 4.1.10**

To establish whether local Domestic Abuse procedures were properly followed; to include whether the case was, or should have been, considered for MARAC.

5.10.1 The probation report in particular, highlighted that basic aspects of the Probation service's Domestic Violence procedures were not followed. Swanswell also identified that their responses to Mary's disclosure were not adequate. LPT did not take sufficient action to manage risks from Mr A as a perpetrator in accordance with clinical risk policies. For other agencies, such as UHL, practitioners followed the procedures well, discussed with Mary options open to her and endeavoured to make a referral to MARAC.

5.10.2 There was a detailed account in the Police report of the assessments that Police carried out when responding to incidents of domestic violence to Mary. On each occasion 'medium' risk was assessed through using the DASH risk indicator checklist. The police report questioned whether in May 2012 the officer's initial assessment of 'high' risk, should have been reclassified to 'medium' risk by the police Domestic Abuse Investigation Officer. The Police author's conclusion was that this should have had more consideration.

5.10.3 There are 2 questions arising in relation to MARAC:

1. Should a referral to MARAC have been made?
On balance, the panel felt that from the information known, the criteria were not met however had a referral been made, the case would have been heard and opportunities for alternative interventions discussed.

2. Had a referral been made, what difference would this have made to Mary?
At this time, Mary appeared to have some ambivalence about what she wanted to happen. Mary consented to UHL making a referral to MARAC. However, the Police report that Mary refused to make a statement to Police and was not willing to engage with any help offered. MARAC however, is not dependent upon the active engagement by the victim, and could have been used to explore managing risks from Mr A.

5.10.4 The DHR noted that the independent assessment of domestic violence arrangements across Leicestershire and Leicester (Jan 2013) reported, '*Concern was raised on a number of occasions regarding the screening of non-police referrals to the MARAC by Police colleagues – partners were concerned that the process for this was not agreed, clear or transparent and this needs further attention'*[61]

[61] In Search of Excellence; Delivering an effective domestic and sexual violence partnership in Leicestershire; Sarah Lawrence Standing Together Against Domestic Violence; January 2013

5.10.5 As noted, all referrals to MARAC are now heard by the MARAC members. However the DHR overview author accessed data from the MARAC coordinator about sources of referral. These figures do highlight the low number of referrals to MARAC from partners outside of police and specialist services. This reinforces the need for further work on a multiagency strategy and common procedures that unify approaches to domestic violence. A recommendation is made in relation to this.

| MARAC - Total Referral Cases Discussed December 2007 – April 2013 = 1880 | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Referring Agency** | **Police** | **IDVA** | **Children's Social Care** | **Primary Care Services** | **Secondary Care/ Acute trust** | **Education** | **Housing** | **Mental Health** | **Probation** | **Voluntary Sector** | **Substance Abuse** | **Adult Social Care** | **Other** |
| **% of Total Referals (real figure)** | **49% (930)** | **46% (863)** | **0.4% (8)** | **0.5% (10)** | **0% (0)** | **0% (0)** | **0.6% (12)** | **0.05% (1)** | **0% (0)** | **1.3% (26)** | **0% (0)** | **0.05% (1)** | **1.5% (29)** |

5.10.6 The probation service may wish to consider how well the Spousal Assault Risk Assessment is used to trigger further responses to victim safety such as completion of a DASH and referral to specialist services including MARAC.

5.10.7 Assessment of risk is a dynamic risk process. Many victims may actively shy away from engaging, and may also minimise their experiences. The partnership agencies need to move toward a more sophisticated understanding of risk and use of DASH, which requires appropriate training and consistent, quality assured processes and a culture which supports routine questioning.

5.11 **Terms of Reference 4.1.11**

To consider how issues of diversity and equality were considered in assessing and providing services to Mary and Mr A (protected characteristics under the Equality Act 2010 age; disability; race; religion or belief; sex; gender reassignment; pregnancy and maternity; marriage or civil partnership)

5.11.1 The agencies considered how well they had considered issues of equality and diversity in meeting the needs of Mary and Mr A. Overall, agencies met individual needs and demonstrated considerations of capacity and consent throughout.

5.11.2 A particular area of learning for Swanswell related to their response to Mary on learning she was pregnant and the sad subsequent miscarriage. This has highlighted for them the need for greater awareness of increased risks of domestic violence in pregnancy. The service has already taken action to improve their service in this area.

5.11.3 The DHR panel also raised some concern about the current EMAS practice of relying on patient's to share the paper record of EMAS attendance with their GP where the patient is not admitted to hospital. The panel questioned whether this may disadvantage some patient groups and increase risk where a victim of domestic violence is living with the perpetrator. EMAS should review this practice in the context of domestic violence and conduct an Equality Impact Assessment.

5.12 **Terms of Reference 4.1.12**

To establish whether local safeguarding procedures were properly followed; to include consideration of the victim or perpetrator as being in need of services as a vulnerable adult.

5.12.1 For some people, their needs fall within criteria for support both through safeguarding adults procedures[62]and domestic violence services[63]

5.12.2 The evidence from the review is that agencies did consider whether referral through safeguarding adults procedures was indicated. No referral was considered necessary and from the evidence available, this appears to have been a reasonable judgement.

5.12.3 However, the DHR has highlighted 2 relevant factors

1. Out of 1180 discussed at MARAC, only 1 was referred by Adult Social Care
   It is accepted that there may be multiple reasons for this such as decisions being made at safeguarding adults strategy meetings that police should refer to MARAC rather than Adult Social Care.
2. Referrals through safeguarding adults procedure where the individual's support needs relate to drugs and alcohol were very small – out of 1302 referrals in 2011-12, only 3 (0.2%) were recorded as being for people with substance misuse needs.[64]

[62]Leicestershire County Council, *No Secrets – Multi Agency Policy & Procedures*, [Available from: http://www.leics.gov.uk/index/social_services/asc_support/asc_keeping_people_safe/asc_suspected_abuse/adult_protection_procedures/safeguarding_adults_procedures/safeguarding_adults_policy.htm] [Accessed: 02.10.13]

[63]County Council, *Domestic Abuse Strategy,* [Available from: http://www.leics.gov.uk/search.htm], [Accessed: 02.10.13]

[64] Data supplied by Leicestershire County Council

5.12.4 A recent Local Government Association report[65] makes specific reference to the need to align the 2 agendas of safeguarding adults and domestic violence more closely. The report also references that the needs of people using substances may be overlooked both in relation to domestic violence and safeguarding.

5.12.6 The review did not identify any missed opportunities to refer Mary or Mr A through safeguarding adults procedures. However, bringing safeguarding adults and domestic violence services into closer alignment is likely to strengthen services to vulnerable people.

Adult Social Care has made a recommendation in relation to ensuring domestic violence expertise is provided to relevant safeguarding adults strategy meetings. The service may also wish to consider closer alignment from a strategic perspective.

## 5.13

**Terms of Reference 4.1.13**

To establish how effectively local agencies and professionals worked together.

5.13.1 The review has highlighted some significant omissions in how well agencies worked together

- UHL did not inform Mary's GP that she had attended hospital following an episode of domestic violence – this blocked other services who were engaged with her being able to offer support to her.
- Police did not inform Mr A's GP of the context of him being a self- harm risk i.e. due to being arrested for an assault to Mary
- Probation and LPT therapists failed to communicate – missed opportunities to share perspectives and specialist knowledge and agree approaches to minimise risk
- LPT missed opportunities to communicate risks within and between services.
- Swanswell, Good Thinking Therapy and GP – there was no communication between Swanswell and Good Thinking Therapy and 2 way rather than 3 way communication under the 'Shared Care' plan.
- Probation did not inform the GP about Mr A being subject to an Alcohol Treatment Requirement

5.13.2 The review also considered missed opportunities for agencies to share information and address needs of Mary and Mr A as a couple through multi agency forums such as Care Programme Approach and MARAC. This was reviewed in section 5.5 so will not be repeated here.

[65]Local Government Association (April 2013), *Adult safeguarding and domestic abuse:A guide to support practitioners and managers*, Association of Directors of Adult Social Services (ADASS)

5.13.3 There were 2 key areas of learning:

1. Value of multi-agency working

Practitioners need to recognise that they hold only partial information and insight. Working with others involved with the service user brings different perspectives; specialist expertise and extends opportunities to be creative in problem solving. Multi-disciplinary and multi-agency working must be seen as standard practice.

5.13.4 2. Clarification about consent and sharing information.

Overall, the agency reports indicated good understanding of seeking consent and grounds for sharing information without consent. For some agencies such as Medical Practice 2 and Swanswell, there were good practices in place including 'consent to share' forms. However, this was not then applied and information shared.

5.13.5 The DHR panel had discussion with agency report authors about grounds to share information. One example is when Police are liaising with agencies about welfare concerns relating to a vulnerable adult, their stance is not to inform the agency about the context of arrest, even where the person has been charged. The impact of this was that Mr A's GP (Medical Practice 1) had no knowledge of Mr A's violent offences which had implications for their care and treatment plans and also potentially, safety of lone workers. This blanket approach by Police did not appear compatible with duty of care and the permissive provisions within the Data Protection Act 1998.

Police are currently reviewing their information sharing practices.

5.13.6 In March 2013, revised guidance was issued by the Department of Health in relation to information sharing[66] This reinforces the six original principles for the protection of people's confidentiality known as 'Caldicott Principles' There were concerns about misinterpretation of when sharing of information ***is*** appropriate. The revised guidance therefore specified a further principle:

"*The duty to share information can be as important as the duty to protect patient confidentiality"*[67].

5.13.7 The Review highlights that for health professionals to act in a patient's best interest, they need to have all the available information. GPs are a main point of contact for all healthcare services and will hold a holistic overview of their patient and their needs.

5.13.8 Medical Practice 1 and 2 both emphasised the importance of them receiving full information regarding Mary and Mr A. Those practices may have had effective systems in place to receive information, flag it within the patient record and communicate to other agencies where required. However the panel were not assured that robust arrangements were in place across all GP practices.

5.8.9 A recommendation is made for NHS England as Primary Care commissioners and Clinical

[66] Information: To share or not to share? The Information Governance Review; Dept Health 2013

[67] Ibid p21

Commissioning Group (with responsibility to improve quality in Primary Care) to consider the findings from this report and to seek assurance across all GP practices of how information relating to domestic violence is flagged, tracked and acted upon.

5.8.10 A new Multi-agency Safeguarding Adults Information Sharing Agreement has been developed to facilitate the lawful and appropriate sharing of information. This has been endorsed by the Leicestershire and Leicester Safeguarding Adults Boards.

5.14.2 The Probation and Police report highlighted that scrutiny, review and supervision of cases inevitably focuses on higher risk cases. However, as the Probation report author highlighted, the majority of Serious Further Offences arise from medium risk cases. Case supervision and case sampling of medium and high risk cases is needed to provide public confidence in the protection of vulnerable people and management of offenders. Probation and police have made recommendations accordingly.

5.14.3 The review also highlighted learning about the need to assure effective responses are made when service users make specified threats of harm to others. Recommendations for Leicestershire Partnership Trust have been made accordingly.

5.15

**Terms of Reference 4.1.15**

To establish whether domestic violence policies, protocols and procedures (including risk assessment tools) that were in place during the period of review, were applied and whether they were fit for purpose.

5.15.1 Section 5.10 of this report has considered whether the domestic violence procedures were applied including referral to MARAC.

The DHR panel had discussions about a shared understanding of risk. Having a shared risk assessment tool enables common language and understanding in relation to defining standard; medium and high risk and DASH is the national and locally accepted tool for this purpose. All agencies should have an awareness of DASH, understand the routes into specialist services and access to those that may complete DASH.

It is noted that one of the actions from the Leicestershire Domestic Violence Strategy 2010-13 was '*To develop and adopt a single risk management recording tool for Leicestershire'*[68]

The reports to this DHR and findings from the independent assessment of domestic violence arrangements in Leicestershire and Leicester (Jan 2013) highlight this is not yet in place. A recommendation from the independent assessment was *'Work with providers to support improved relationships, closer working and develop protocols to clarify and support whole system working and improve communication across*

[68]Leicestershire Multi Agency Domestic Abuse Strategy 2010-13; p 18

*the partnership to improve support to survivors of domestic abuse'.*[69]

The DHR support this view and a recommendation is made in relation to it.

5.16 **Terms of Reference 4.1.16**

Identify any good practice

5.16.1 The DHR has identified a number of areas of good practice, not least of which is the willingness of all agencies involved to scrutinise their practice and engage in learning.

This review has necessarily focused on missed opportunities and some specific failures of agencies and practitioners to deliver expected standards of practice. However, it is emphasised that across the services, many practitioners and agencies offered services to Mary and Mr A in a way which *did* meet expected standards and in some cases went beyond this.

Some examples of expected or good practice are:

- Medical Practice 2 – responsive to Mary and initiating a Shared Care approach. This is as an effective model in place across Leicestershire.
- Leicestershire Partnership Trust – effectively engaged Mr A in specialist personality disorder services, beginning to address some very complex needs and challenging behaviours.
- Leicestershire Partnership Trust – Good Thinking Therapist engaged Mary well, helped her manage some very sensitive issues and was responsive to her needs.
- Swanswell – engaged well with Mary, were responsive to her and offered holistic care.
- Medical Practice 1- was responsive to Mr A, maintained regular contact and provided a consistent practitioner.
- Leicestershire Police – consistently responded to domestic violence incidents, assessed risk and tried to engage Mary in services.
- Leicestershire Police – provided a welfare response to Mr A as a vulnerable adult.
- UHL – engaged well with Mary and followed all procedures in managing the domestic violence incident in May 2012
- Local Domestic Abuse Outreach Provider – workers in 2007 offered support over and beyond normal practice.
- EMAS – effectively managed the difficult and distressing discovery of Mary's homicide.

5.17 **Terms of Reference 4.1.17**

Establish for consideration what may need to change locally and/or nationally to prevent serious harm to victims of domestic abuse.

[69] In Search of Excellence; Standing Together Against Domestic Violence; January 2013

5.17.1 The review has identified a number of changes for individual agencies and recommendations have been made accordingly.

Section 5.5 and 5.15 of this report has considered the changes that Leicestershire Multi-Agency Domestic Abuse Strategy Board may need to consider in partnership with other related Boards such as Safeguarding Adults' Board and Safeguarding Children's Board.

These relate to:

1. A strategic review of how the different multi-agency forums relating to vulnerability; victims and perpetrators interface.
2. Developing a multi-agency area wide procedure for domestic violence that connects to related procedures and to which the individual agencies' internal procedures for domestic violence can be cross referenced.
3. To agree a single risk assessment tool for adoption within the multi-agency wide procedure for domestic violence.

5.18

**Terms of Reference 4.1.18**

The review should make recommendations to be considered when revising the Leicestershire Multi Agency Domestic Abuse Strategy 2010-13

The areas for change outlined in 5.17 will need to be taken into account when revising the Leicestershire Multi-Agency Domestic Abuse Strategy. The Strategy will also wish to take account of the wider learning from this review along with learning from the other DHR (FN) that was being conducted concurrent with this DHR.

# 6.0 CONCLUSIONS

## 6.1 Summary and Lessons Learned

The review has revealed some key issues of learning in relation to how well agencies worked individually and collectively with Mary and Mr A.

Reducing risks of domestic violence and potentially the homicide are reviewed from 3 perspectives

- Direct work with Mary
- Direct work with Mr A
- Multi-agency work focused on Mary as the victim and Mr A and perpetrator.

### 6.1.1 Direct Work with Mary

6.1.1.1 The review has considered how well services engaged with Mary and used opportunities to support her in relation to domestic violence.

During 2012 – 2013, Mary engaged well with Swanswell and Good Thinking Therapy. Mary appeared to value these services and made good progress in relation to addressing her substance misuse and various psychological issues. It is likely that these services were in themselves beneficial in supporting Mary through strengthening her resilience and self –esteem, broadening options, life choices and potentially reducing dependency on others. Mary's daughter R made the perceptive comment that '*Services need to focus on the person not on the relationship to understand why they enter into and stay in that lifestyle.'*

6.1.1.2 However, the review has also considered in some depth, how well services supported Mary in responses to domestic violence. We know that Mary was aware of how to access services and had accessed specialist domestic violence support services during 2007 and also made a number of contacts with police. However in 2012 Mary was more ambivalent about accepting help, declining support offered through the police but accepting a referral to MARAC.

6.1.1.3 Mary appeared to make active choices not to inform Swanswell and Good Thinking Therapy about her domestic violence during 2012. The reasons for this are likely to be complex but it may be linked to feeling a sense of responsibility for Mr A; minimising risks to herself and, as her family suggest, viewing violent relationships as a normal part of life.

6.1.1.4 Mary was aware through personal experience, of the volatile and aggressive nature of Mr A and his potential to use weapons. However, if Mary had had a greater understanding of Mr A's personality disorder and the risks he presented, she may have been able to make more informed choices about whether to remain in the relationship.

6.1.1.5 Opportunities were not taken by all services working with Mary to broach the subject of domestic violence. Had routine questions been asked, Mary may have taken the opportunity to discuss her relationship and safety strategies. We do not know whether Mary would have made use of this. There is some evidence from the review that even when Mary was asked routine questions by Good Thinking Therapy about relationships and violence; she chose not to discuss this.

Mary may not have been ready to leave Mr A. However, it was the responsibility of services to take all opportunities available to help her to make informed choices.

6.1.1.6 **Lessons Learned:**

- The need for more effective communication and multi-agency working between all involved.

- The need for practitioners to better understand the complexities of domestic violence, the experiences and motivations of victims in order to take all opportunities to offer support.

- The need to take opportunities to routinely inquire as to any domestic violence or

safeguarding issues people may be experiencing.

### 6.1.2 Direct Work with Mr A.

6.1.2.1 Reducing incidence of domestic violence requires work to reduce risks from the perpetrator as well as work to support the victim.

The review has highlighted a number of incidents where risk assessments and management plans were not effectively carried out. In some instances, the outcome did not make a material difference to Mary at that time - an example is Mr A being given leave to stay at Mary's 2 days following threats to stab her. Nonetheless, learning from this is crucial to reduce risk of harm to others.

6.1.2.2 There were failures by Probation and Leicestershire Partnership Trust, to share information regarding Mr A. This would have afforded both services a much more accurate appraisal of Mr A. and the risks that he presented to others.

6.1.2.3 Had the probation offender manager had greater understanding of Mr A's personality disorder, this may have increased vigilance for Mary, refocused attention on Mr A as a perpetrator of domestic violence and enabled greater challenge of his tendency to minimise responsibility.

6.1.2.4 Had the Leicestershire Partnership Trust personality disorder service had more understanding of Mr A's latest offence and forensic history, this may have enabled more focus of intervention upon his violent behaviours as well as self-harm.

6.1.2.5 It is however emphasised that the very nature of Mr A's needs and the characteristics of his personality disorder meant that he could be very impulsive and direct his emotions through physical violence toward himself or others with little regard for consequence.

There was potential for the practitioners involved to improve how well risk was understood. However it was particularly challenging for practitioners to reduce the risks Mr A presented, given the unpredictable and impulsive nature of his behaviour.

There was not any evidence of serious risk in the weeks preceding Mary's death that agencies could reasonably have identified. Mr A described tensions building between himself and Mary 3 days prior to the homicide but stated 'I *don't think services could have foreseen anything because not a lot happened before (the incident)'.*

The primary intervention was engaging him in a long term therapeutic work that helped him to consider his life choices and behaviours and the consequences of the choices that he made. Leicestershire Partnership Trust had engaged him in this work.

6.1.2.6 **Lessons learned:**

- Practitioners should not lose sight of the fundamentals of good risk assessment and risk management - multi-agency working will deliver more accurate and full information and enable better decision making.

- Risk management can only occur when there are effective systems in place for transfer of information within and between services, so that information about risk is known to those involved.

- Where explicit threats of harm are made, individuals have the right to be informed; for practitioners to make further inquiry about current or historical risks and for this to lead to a risk management plan.

- The need to understand requirements and boundaries of confidentiality, consent and when it is permitted and appropriate to share information.

- The need to improve understanding of personality disorder as part of wider awareness of perpetrator typology.

- The needs and experiences of the victim must be central to work with perpetrators.

### 6.1.3 Multi-agency work focused on Mary and Mr A

6.1.3.1 The review has considered the potential multi-agency forums where information about Mary and Mr A could have been brought together.

The review has identified that Mr A's care should have been provided through the Care Programme Approach. This would have provided a structure to coordinate the multi-agency approach to Mr A's mental health needs but would also have considered the needs of Mary as a carer/key person in Mr A's life.

6.1.3.2 In relation to wider learning, the DHR recognised that there are a number of other multi-agency structures with remits relating to vulnerable adults, victims, perpetrators and offenders sharing a common function of bringing together multi agency information.

- MAPPA
- MARAC
- Safeguarding Children and Safeguarding Adult procedures
- Integrated offender Management
- Joint Action Groups

6.1.3.3 The nature and degree of risk that was known about Mary and Mr A, meant that their needs did not meet criteria for these services. Though there are robust multi-agency structures in place to manage high levels of risk, the Probation report highlighted that Serious Further Offences in domestic violence are occurring in medium rather than high risk cases.

6.1.3.4

**Lessons learned:**

- Care Programme Approach offers an effective structure for coordinating and delivering care for service users and their carers and should have been applied in this case.

- There is a need to review how well the existing structures focusing on vulnerable people, victims and perpetrator inter relate, address gaps and duplications in order to provide a comprehensive multi-agency response to medium as well as high risk cases of domestic violence.

- Practitioners should not have to be reliant on formal structures to carry out effective multi-agency working. This is part of standard practice

## 6.2 Final Conclusion

6.2.1 There has been a great deal of learning from this review relating to missed opportunities and omissions. Understanding this will greatly assist individual agencies and the partnership to reduce risks of harm and domestic homicide for others. However in relation to Mary and Mr A, had alternative decisions and actions been taken it is unlikely that this in itself would have made the crucial difference to the eventual outcome.

6.2.2 The conclusion that the DHR panel and overview author reached was the tragic circumstances of Mary's death could not reasonably have been prevented by individual or collective agencies while the relationship between Mr A and Mary continued.

# 7.0 RECOMMENDATIONS

## 7.1 Changes Already in Place

7.1.1 Many of the agencies involved have already taken action on learning from the review – this is detailed in section 4. Actions include:

- A new Multi-agency Safeguarding Adults Information Sharing Agreement has been developed to facilitate the lawful and appropriate sharing of information.
- Leicestershire Partnership Trust has begun a review of the risk assessment processes and a revised risk assessment tool is being piloted.
- Leicestershire Partnership Trust has recently ratified their MAPPA policy. This includes reference to management of specific threats to harm. LPT has also provided a briefing to all staff relating to learning from DHRs and reaffirming staff responsibilities on local MAPPA arrangements.
- Agencies have taken up issues of learning and professional practice with practitioners involved.
- Swanswell has introduced mandatory training on domestic violence; the service now attends MARAC and the service is setting up a pregnancy clinic to improve access and

engagement with pregnant women

- University Hospital Leicester has revised their procedure for sending MARAC referrals by fax and is working toward electronic referrals.
- East Midlands Ambulance Service is talking with MARAC coordinators about how information from their service can best contribute to the MARAC. Nationally, Ambulance Trusts are developing an ambulance domestic violence risk assessment tool.
- Leicestershire Police are revising their domestic violence procedures and a review is underway of their Comprehensive Referral Desk – the structure that supports domestic violence work. The service is working with other to ensure GPs have access to secure email to improve information sharing. Police are also reviewing their guidance for information sharing.
- The Local Domestic Abuse Outreach Provider is discussing with their local Crime Joint Action Group, using this forum to share information where a specialist services have not been able to make contact with a victim – this is an interim measure pending the wider review.
- Leicestershire and Rutland Probation Trust has initiated training on personality disorders.
- Medical Practice 2 has set up Practice Learning Session on domestic violence.

## 7.2 Recommendations by Agencies and DHR Overview Author

Each of the 14 agencies involved in this review has considered the learning from the review and any recommendations for changes. The DHR overview author, in consultation with the panel has also identified some additional multi-agency recommendations.

### Recommendations made by agencies from their internal reviews

**7.2.1**

7.2.1

| **Leicestershire County Council Adult Social Care Recommendations** |
|---|
| Raise awareness of the role domestic violence services can play in safeguarding vulnerable adults. |

7.2.3

| **Leicestershire Partnership NHS Trust Recommendations** |
|---|
| Francis Dixon Lodge LPT to develop an operational policy which clearly describe all aspects of service delivery and care planning e.g. risk assessment, implementing the CPA process, the service approach to risk assessment, the triage process, admission and discharge planning & effective communication and interagency working. |
| Risk assessment refresher training to be delivered to staff within Francis Dixon Lodge to increase capability and confidence of practitioners. The LPT CPA lead will deliver this training on risk management planning following assessment for FDL |

| |
|---|
| (TSPPD) team. |
| Risk assessment forms to be shared systematically and in a timely way across all involved teams within AMH division, with team members in Francis Dixon Lodge and to agree how this information is shared with GPs |
| Consideration to be given to the reciprocal information sharing agreement with GP's as part of the development of the 'RiO' Electronic Patient Record system |
| Individualised care plans to be implemented for Francis Dixon Lodge clients |
| To continue to deliver Domestic Violence training across the Trust within the Adult Service Safeguarding programmes. |
| To provide staff training and improve staff awareness of MAPPA procedures and processes across the Trust |
| Joint working arrangements across In-Patient and CMHT's to be reviewed to ensure that on balance they are providing the best configuration in relation to information sharing, effective and seamless transition and continuity for patients. |

7.2.4

| **Swanswell Recommendations** |
|---|
| Swanswell will continue to attend to each meeting MARAC on an on-going basis |
| Swanswell will introduce information around domestic abuse into our pregnancy pack from Oct 2013 |
| All team members have been mandated to complete AVA's new e-learning programme, *Complicated Matters: addressing domestic and sexual violence, substance use and mental ill-health.* They will have completed this by end of Sept 2013 |
| Swanswell will include training around Domestic Abuse within its mandatory training program starting in January 2014 |
| DASH training to be arranged for all staff. Currently being arranged but it is hoped that this will take place in Nov/Dec 2013 |
| A Domestic Abuse pack will be developed. This will include advice and information for workers and for potential victims. It will also include contact details and referral pathways for all relevant services. This is due for completion end of Oct 2013 |
| Representatives from domestic abuse services will be invited to attend team meetings of all Swanswell teams from Oct 2013 |
| Although the supervisor role has a significant clinical element we are re-shaping the supervisor role to enhance its clinical overview of domestic abuse cases. This will take from Jan 2013 |
| Supervisor's will audit all cases where there is mental health involvement to ensure joint working procedures are being adhered to |

7.2.5

| **University Hospitals of Leicestershire NHS Trust Recommendations** |
|---|

That MARAC referrals completed by UHL Emergency Department will be received by MARAC co-ordinator -Amend the Emergency Department domestic violence procedure to include a prompt for staff to ensure that a fax receipt, which confirms successful transmission, is obtained and filed in the notes (when a MARAC referral is completed).

Explore the possibility of MARAC referrals being completed electronically by senior Emergency Department staff

Emergency Department medical staff will advise GPs, through the GP letter, when a patient has attended ED following episodes of domestic violence.

Develop a standardised protocol (for adult areas) when responding to adults who disclose domestic violence – this will be developed in consultation with other agencies.

7.2.6 **Leicestershire Police Recommendations**

It is recommended that Leicestershire Police reissues guidance reminding officers of the need to add a separate Crime Intelligence System incident for all breaches of bail conditions.

It is recommended that Leicestershire Police reissues guidance reminding officers that when granting bail for Crown Prosecution Service referral or after charge for domestic abuse, conditions are attached or, where applicable, reasons why conditional bail has not been given are recorded.

It is recommended that Leicestershire Police puts in place a system, with the assistance of the courts, whereby the reasoning behind discontinuances of domestic abuse cases at court are recorded.

It is recommended that Leicestershire Police engages at a strategic level with the CPS and HM Courts and Tribunals Service to develop and implement a clearer, stronger and more victim-focused policy on how and when 'victimless' prosecutions ( cases where the victim is unwilling to support a prosecution) should be progressed; this should also include standardising the terminology used.

It is recommended that Leicestershire Police makes changes to the DASH risk assessment on Crime Intelligence System ensuring the collar number of the officer completing the form is added and restricting officers from adding their supervisor's collar number; this will ensure that all incidents involving domestic abuse are subject of supervisory review.

It is recommended that as part of its current review of the Comprehensive Referral Desk and Domestic Abuse Investigation Unit, Leicestershire Police considers the line management of the Assistant Referral Officers working within the Domestic Abuse Referral Team and ensures a more cohesive approach is taken to dealing with

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| outreach referrals and looking at repeat victims. |
| It is recommended that, following the IMR for FN and the implementation of a system that identifies and reviews repeat victims of domestic abuse, Leicestershire Police reviews the current process, evaluating the sustainability of this work being completed by LPUs and whether it is having a positive impact on reducing further victimisation. |

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| 7.2.7 | **The Local Domestic Abuse Outreach Provider Recommendations** |
| | Before a specialist domestic abuse services closes a referral that they have not been able to make contact with they take it to a JAG or appropriate multiagency meeting |
| | DASH risk assessment training to include details of local services. |

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| 7.2.8 | **Leicestershire and Rutland Probation Trust Recommendations** |
| | Accurate completion of Spousal Abuse Risk Assessment (SARA) and Specific; Measured; Achievable Realistic Time-bound Supervision plans – sample check Offender Managers' SARA and supervision plans |
| | Liaising with statutory agencies. Ensure that anyone subject to a Drug Rehabilitation Requirement or Alcohol Treatment Requirement, that their GP is routinely notified |
| | Liaising with other statutory agencies. To go through all Offender Manager's domestic violence cases to ensure offender manager has gathered and shared information with other relevant agencies. |
| | Risk management plans incorporate direct reference to victims. Ensure that domestic violence risk management plans are making reference to victims. |
| | Uses of weapons are addressed in risk management plans. LRPT to review resources re working with perpetrators who use a weapon. |
| | Levels of Offender management contact and home visiting. Recommend changes to LRPT Domestic Violence policy so that Offender managers are clear about the levels of contact expected in Domestic violence cases. |
| | Quality of Domestic violence work with medium risk of harm cases and oversight by line managers. The majority of Serious Further Offences come from medium risk cases, and are most often domestic violence in nature. In line management supervision, there is inevitably a focus upon high risk cases. LRPT will be doing sample audits across all Offender Manager teams once a month, looking at medium risk domestic violence and |

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| safeguarding cases using the RADAR tool. |

7.2.9

| **Medical Practice 1 Recommendations** |
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| Case to be discussed at a practice clinical meeting once outcome of review known and final recommendations made |
| Practice education around domestic violence, its signs and assessing risk |
| At the point of registration with a GP; patients to be asked for consent to allow relevant and proportionate information about them to be shared and received with other services to reduce the risk of harm and safeguard themselves or others |

7.2.10

| **Medical Practice 2 Recommendations** |
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| Practice Manager to contact Safeguarding office to clarify training status of all clinical staff within the Practice as regards safeguarding training for adults and children |
| Practice Manager to contact the Managing Director of West Leicestershire CCG to suggest the possibility of a Locality wide Protected Learning Time event on domestic violence |
| Practice Manager to make contact with local Domestic Violence service with regards to an in-house training session for all staff |

## 7.2.11 Multi-agency recommendations made by DHR author

| **Recommendation for NHS England Leicestershire & Lincolnshire Area Team and the Hosted Safeguarding Team** |
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| NHS England (Leicestershire & Lincolnshire Area Team) and the Hosted Safeguarding Team to consider the findings from this report and to seek assurance across their Leicester and Leicestershire GP practices of how information relating to domestic violence is flagged within the patient record and is acted upon. |
| **Recommendations for Leicestershire Multi-Agency Domestic Abuse Strategy Board** |
| It is recommended that Leicestershire Multi-Agency Domestic Abuse Strategy Board conduct a strategic review of how the different multi-agency forums relating to vulnerability; victims and perpetrators interface, identifying any gaps or duplication. The outcome from the review is to deliver a comprehensive; cohesive and proportionate multi- agency approach to medium and high risk cases. |

It is recommended that Leicestershire Multi-Agency Domestic Abuse Strategy Board

i) Develop a multi-agency area wide procedure for domestic abuse that connects to related procedures and to which the individual agencies' internal procedures for domestic abuse can be cross referenced.
ii) Adopt DASH as the single assessment tool for relevant agencies to use within the multi-agency wide procedure for domestic abuse**.**

It is recommended Leicestershire Multi-Agency Domestic Abuse Strategy Board seek assurance from the agencies involved in this review, that they have acted on the learning and recommendations arising from this DHR.

# GLOSSARY

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|---|---|
| **ASAP** | *Adolescent Sexual Abuse Project* |
| **AVA** | *Against Violence & Abuse* |
| **CAADA** | *Co-ordinated Action Against Domestic Abuse . CAADA is a national charity supporting a multi-agency response to domestic abuse; it provides practical help to support professional and organisations working with domestic abuse victims.* |
| **CMHT** | *Community Mental Health Team* |
| **CPA** | *Care Programme Approach* |
| **DASH** | *Domestic Abuse, Stalking and Honour based violence* |
| **DAIO** | *Domestic Abuse Investigation Officer (Police)* |
| **DHR** | *Domestic Homicide Review* |
| **DV SOP** | *Domestic Violence Standard Operating Procedure* |
| **EMAS** | *East Midlands Ambulance Service* |
| **FSR** | *Factual Summary Report* |
| **ICD** | *International Classification of Diseases* |
| **IDAP** | *Integrated Domestic Abuse Programme (Probation)* |
| **IDVA** | *Independent Domestic Violence Advisor* |
| **IMR** | *Individual Management Reviews* |
| **JAGs** | *Joint Action Groups* |
| **LPT** | *Leicestershire Partnership Trust* |
| **LDAOP** | *Local Domestic Abuse Outreach Provider* |
| **MAPPA** | *Multi-Agency Public Protection Arrangements* |
| **MARAC** | *Multi Agency Risk Assessment Conference* |
| **NICE** | National Institute for Health and Care Excellence |
| **OASys-R** | Offender Assessment System |
| **SARA** | *Spousal Assault Risk Assessment Tool (probation)* |
| **SDVC** | *Specialist Domestic Violence Court* |
| **SPECCs** | Separation, Pregnancy / New Birth, Escalation, Cultural Issues / Sensitivity, Stalking and Sexual Assault |
| **UHL** | University Hospital of Leicester |

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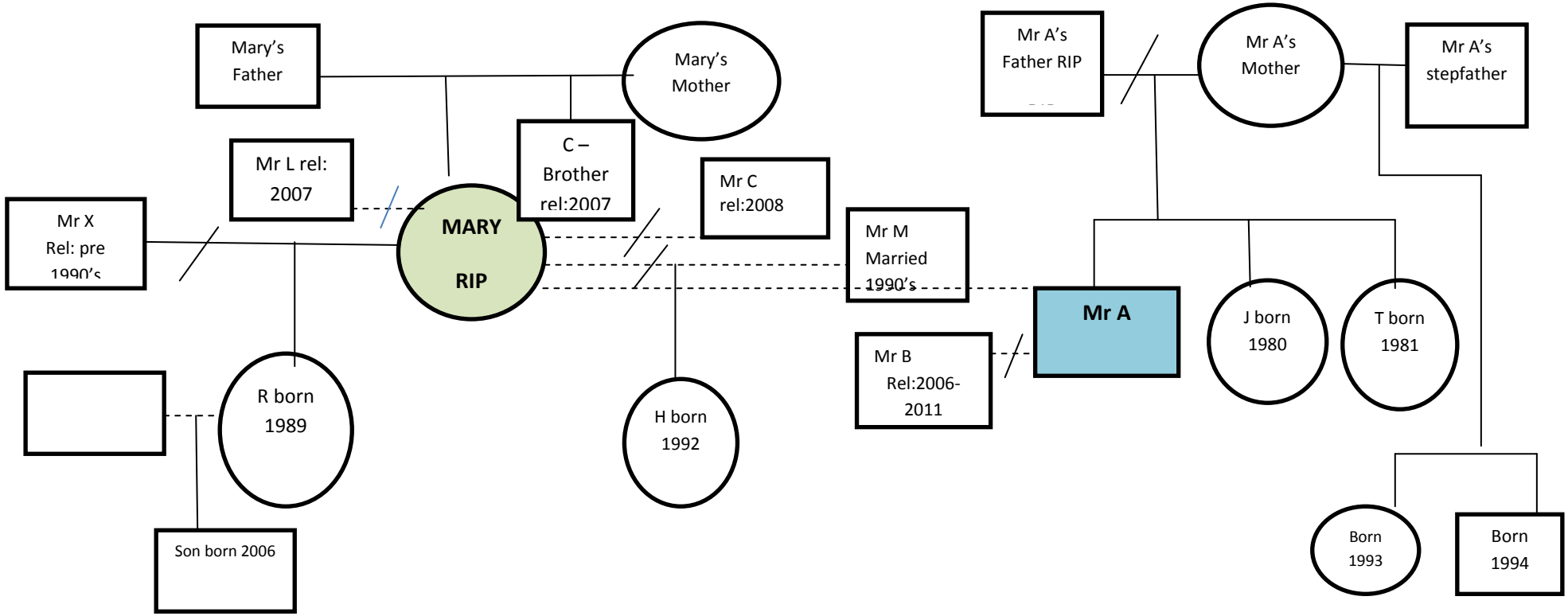
# APPENDIX 1: GENOGRAM



# APPENDIX 2: SUMMARY OF KEY EVENTS

| DATE | SIGNIFICANT EVENT |
|---|---|
| **Sept 2011** | **Mary & Mr A**: beginning of relationship |
| **Oct 2011** | **Mr A:** Outpatient appointment with psychotherapist. Risk assessment completed – identified risk from ex-partner |
| **Nov 2011** | **Mr A**: threats of suicide and referred to mental health crisis team. Mr A disclosed to mental health services, thoughts of wanting to kill his mother and Mr B. Referral made to personality disorder service. Referral made to Community Mental Health team (did not attend) |
| **Nov 2011** | **Mary**: Reporting to Swanswell drugs agency feeling depressed – referred to GP for community psychiatric nurse.<br>Mary 8 weeks pregnant but miscarried baby. Reports baby is Mr A's. |
| **11th Dec 2011** | **Mary & Mr A**: Mary contacts police alleging assault by Mr A. Reported Mr A held a knife to her throat. Mr A charged and bail conditions. 'DASH' form completed – medium risk identified. Mary reports to Swanswell this was 1st episode of violence. |
| **14th Dec 2011** | **Mary:** Referred to 'Good Thinking Therapy' by GP at the request of drugs worker to assess mental health. Subsequent 9 face to face contacts; 5 telephone contacts and 7 appointments where Mary did not attend |
| **15th Dec 2011** | **Mary**: Referral from police domestic abuse investigation officer to police Domestic Abuse Referral Team outreach. Various attempts made to contact Mary – no response and case closed. Referral made by police to the Local Domestic Abuse Outreach Provider DV service. Note: attempts made for follow up but no response – the Local Domestic Abuse Outreach Provider closed case 19th Jan 2012. |
| **27th Dec 2011** | **Mary and Mr A**: Mr A contacted police as Mary at his property (address 2) causing breach to his bail conditions. Ambulance service had received call that Mr A had taken an overdose – not substantiated. Mary reported to be intoxicated. |
| **7th Jan 2012** | **Mary and Mr A**: Mary had gone to Mr A's property (address 2) and smashed his windows. Mr A still on bail. Police referral made re on going domestic violence. Mary arrested and charged. Mary subsequently reported to Swanswell drugs agency she went to address 2 as she thought Mr A was going to over dose. He got angry, locked her in and cracked her ribs.<br>Note: no corroboration from police or (medical records?) for this. |
| **11th Jan 2012** | **Mary**: Informs Swanswell she does not want to see partner again. |
| **23rd Jan 2012** | **Mr A**: Discharged from crisis resolution team on 23rd Jan due to failure to attend appointments – GP informed |

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| **24th Jan 2012** | **Mr A**: Phoned police having been alerted by Mary that Mr A's mother and ex-partner, Mr B were en route to his property (address 2) with a hammer and he should leave. Neighbours phoned police reporting youths at address 2 smashing windows. Mr A subsequently evicted from property due to non-payment of rent. |
| **25th Jan 2012** | **Mr A**: Report to police harassment by his Mother and ex-partner Mr B. 1st harassment warning issued to Mr A's Mother and Mr B |
| **Jan 2012** | **Mary and Mr A:** Believed that Mr A moves in with Mary to address 1. |
| **3rd Feb 2012** | **Mr A:** Did not attend 1st appointment for personality disorder service engagement group meeting |
| **20th Feb 2012** | **Mary:** Swanswell drugs service update risk assessment. Risk of partner taking methadone included and mitigation outlined – no information about domestic violence. |
| **26th March 2012** | **Mary and Mr A:** Mr A attends court. Case dismissed as no evidence offered. Not clear whether Mary presented evidence Note: Mary informs Swanswell drugs worker she attended court but he was let off due to lack of evidence. |
| **29th March 2012** | **Mr A:** Mary found Mr A at her home (address 1) having taken over dose and put tape over his mouth. Admitted to hospital and then to mental health inpatient (LPT) as an informal (voluntary) patient. Informs LPT '*I don't mind to kill myself. I'll stab my girlfriend when I go back'*<br>Admission document records Mr A's suicidal and homicidal thoughts '*I will succeed one day –I don't mind killing them- girlfriend/mum- she is a selfish bitch.'* Mr A put on 'Care Programme Approach' as per all inpatients. |
| **31st March 2012** | **Mr A and Mary:** Duty Dr gave Mr A leave from ward until 5th April. Duty Dr had phoned Mary who agreed to Mr A staying with her. Note: not able to establish if Mary was informed of threats to kill but Mr A's Mother states she was not informed of threats relating to her. |
| **5th April 2012** | **Mr A:** Discharged from mental health inpatient care. GP subsequently provided with discharge summary.<br>Note: Mr A was no longer on Care Programme Approach. Follow up care was limited to Community Mental Health Team outpatient appointments. Risk assessments were not shared with GP or outpatients.<br>11 weeks elapse before Mr A is seen at outpatients on 26th June 2012. |
| **11th April 2012** | **Mary:** LPTs 'Good Thinking Therapy' service refers Mary to cognitive behavioural therapy following disclosure about early traumatic events – Mary made appointment but did not attend and was discharged. |
| **16th April** | **Mary:** Attended court for charges relating to smashing Mr A's windows. No evidence offered and case dismissed |

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| **2012** | |
| **20th April 2012** | **Mary:** Referral made by Good Thinking Therapy, to a cognitive behavioural therapy service. Mary did not attend either of the 2 appointments offered so was discharged. |
| **5th May 2012** | **Mary and Mr A:** Mary assaulted by Mr A. Punched and hit with wooden ornament. 'DASH' assessment completed – initial high risk, regarded to medium risk. Mr A arrested and charged. Mary admitted to hospital |
| **6th May 2012** | **Mary and Mr A:** Mary treated in hospital for injuries. Referral faxed to Multi Agency Risk Assessment conference (MARAC) Note: no record of MARAC receiving this referral – possible transmission fault. A&E report sent to GP 10th May but no reference made to DV |
| **10th May 2012** | **Mr A:** Police contact Mr A's GP to inform he had contact with police and threatened suicide. Note: no mention made of the context being due to arrest for DV. |
| **25th May 2012** | **Mr A:** probation complete pre-sentence report for offence of ABH to Mary. Probation access records of historic offences since 1997 through to 2005. Assessed as 'medium' risk. |
| **1st June 2012** | **Mr A:** Received 12 month supervision order with a 6 month alcohol treatment requirement |
| **6th June 2012** | **Mr A:** Seen by probation offender manager. Appeared motivated to address alcohol and emotional wellbeing problems. |
| **17th June 2012** | **Mary:** Swanswell update their risk assessment (–no reference to domestic violence?). |
| **22nd June 2012** | **Mr A:** probation offender manager completes initial sentence plan. Plan includes referral to the Community Mental Health team by GP, notification of police and Children Social Care as necessary and to notify mental health about any deterioration. Note: No contact with mental health, police or Childrens Social Care took place and no work done on impact of offending on victim. |
| **26th June 2012** | **Mr A:** seen in mental health outpatients – letter sent to GP. Confirmed referral to personality disorder service and disclosure of assaulting girlfriend and being arrested for ABH. |
| **27th June 2012** | **Mr A:** Referral to personality disorder service by Community Mental Health team Consultant Psychiatrist. Summary provided including conviction for ABH – no reference made to probation service. No updated risk assessment |
| **11th July 2012** | **Mr A:** Was being seen on weekly basis by Probation Alcohol Treatment Worker. Mr A self- reporting consistent reduction in alcohol. Treatment worker reporting to offender manager. Becoming clear that Mr A remains in relationship with Mary and is living with her. |

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| **25th July 2012** | **Mr A:** Seen by probation offender manager. Felt Mr A was demonstrating reduction in alcohol use and engaging with mental health services. Discussions about relationships with Mr A's wider family but no discussion about Mary as the victim or contacts made with mental health. Decision to reduce contact (normally would be weekly contact for first 16 weeks)<br>Note: further contact with Offender manager occurred: 15.8.12; 29.8.12; 3.10.12; 19.10.12; 22.11.12; 2.1.13; 23.1.13<br>Contact with probation alcohol treatment worker was approximately weekly |
| **5th Sept 2012** | **Mary:** Swanswell update their risk assessment–(no reference to domestic violence?). |
| **7th Sept 2012** | **Mr A:** Begins attendance at LPT personality disorder service, Francis Dixon Lodge – individual sessions with psychotherapist(extended to therapeutic community from Nov 2012) |
| **11th October 2012** | **Mr A:** Lead therapist at personality disorder service completes risk assessment. Background history and assault to Mary in 2011 recorded but not threats made in March 2012 or assault to Mary May 2012. Current probation order and probation officer noted. Phone contact attempted but probation officer had moved base – not followed up. |
| **31st Oct 2012** | **Mr A:** Discussed with probation alcohol treatment worker feeling low and that relationship not going well, that he was in contact with his mother and wanted to get his own accommodation. These were risk triggers for Mr A that the offender manager did not follow up. |
| **Nov 2012** | **Mary:** Referred by Good Thinking Therapy service to another specialist therapy service (redacted) for care relating to an historical traumatic event. |
| **15th Nov 2012** | **Mary:** contacted by specialist therapy service (redacted) and offered support, but declined, stating she felt ok and already had support in place. No further contact. |
| **20th Nov 2012** | **Mr A:** Psychotherapist completed 'Care Programme Approach' determination tool to assess if Mr A should go on CPA. Decision made that criteria were not met as 'not involved with a range of agencies requiring formal coordination.'<br>Attempt made to ring probation but informed he had moved base. |
| **21st Nov 2012** | **Mary:** Referred by Good Thinking Therapy service to another specialist therapy service (redacted) for care relating to an historical traumatic event. Treatment with Good Thinking Therapy ended at this point as was receiving care from this other service. |
| **30th Nov 2012** | **Mr A:** 6 month probation alcohol treatment programme concludes. Mr A is offered and accepts continued voluntary support |
| **5th Dec 2012** | **Mr A:** Found unconscious by Mary who attempted CPR. Police reported accidental overdose of a friend's heroin and his diazepam. However, hospital emergency dept. Dr noted it to be an organised attempt at suicide and that Mr A had no regrets |

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| | and would attempt again. Remained in overnight and referral made for LPT deliberate self- harm team. Delayed response from team and Mr A self-discharged against advice 6.12.12 |
| **11th Dec 2012** | **Mr A:** Probation offender manager reviews supervision plan<br>Note: Offender manager was not aware of deliberate self- harm on 5.12.12. No direct contact made with Mr A from 22nd November to 2nd January |
| **14th Dec 2012** | **Mary:** Swanswell complete risk assessment -–(no reference to domestic violence?). |
| **18th Dec 2012** | **Mr A:** attended 4 preparation groups during December 2012 as a pre-requisite to a five day therapeutic programme at Francis Dixon Lodge |
| **22nd Jan 2012** | **Mary**: Swanswell drugs agency carries out screening test. Negative for opiates. |
| **12th Feb 2013** | **Mary:** Rang GP surgery as had forgotten to collect anti-depressant. Surgery inquired about mood and wellbeing. Reported she is feeling well and stable and no thoughts of deliberate self- harm. |
| **18th Feb 2013** | **Mary and Mr A:** Mary is stabbed and dies. Rest in Peace.<br>Mr A subsequently arrested and charged with her murder |
| **19th Feb 2013** | **Mr A:** Ambulance service called to address 3, friend of Mr A. Mr A found unresponsive having taken large overdose. Admitted to hospital. Police subsequently contacted. |
| **20th Feb 2013** | **Mary:** Mary's daughter R and a neighbour contact ambulance service. They find Mary collapsed and unresponsive. Paramedics identified unequivocal death and secured the scene. Police attended |