



Domestic Homicide Review

Executive Summary

DHR SW01

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1. Introduction

This is an executive summary of the overview report for a Domestic Homicide Review (DHR) into the death of the victim.

When a death occurs which meets the criteria determined by the Domestic Homicide Review Guidance, the Community Safety Partnership for the area in which the death occurred (South Warwickshire Community Safety Partnership in this case), has a statutory duty to examine the circumstances of the case. This is in accordance with the provisions of the Domestic Violence, Crime and Victims Act 2004, Section 9, statutory Domestic Homicide Reviews (DHRs) which came into force on 13th April 2011.

The Act states that a Domestic Homicide Review should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—

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

(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death

For the purpose of this summary the definition of domestic violence and abuse is in accordance with the current cross-government definition from March 2013:

‘Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality’.

The purpose of the DHR is to:

- Establish what lessons are to be learned from the death regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to the policies and procedures as appropriate; and
- Prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

A DHR is not an inquiry into how a victim dies or into who is culpable as those matters are for Coroners and criminal courts to determine. DHRs are also not part of any disciplinary enquiry or process which happen within individual organisations if deemed necessary.

A criminal investigation into the death of the victim in this case has taken place but a criminal charge was not the result of this investigation. The Crown Prosecution Service determined that there was insufficient evidence to meet the necessary evidential test.

In parallel with this process there has been an independent investigation conducted by the IPCC (Independent Police Complaints Commission) concerning events relating to Warwickshire Police’s response to the victim on the night of her death. This has yet to be published.

Warwickshire Police have also conducted their own internal review of these events and the subsequent investigation.

A Coroner's inquest has yet to take place. The date of the inquest will be announced following the publication of this report and of the IPCC report

In production of this report, agencies have collated sensitive and personal information under conditions of strict confidentiality. The South Warwickshire Community Safety partnership has balanced the need to maintain the privacy of the family with the need for agencies to learn lessons relating to practice identified by the case, and has authorised the publication of sufficient information to enable this to take place.

A decision to undertake a Domestic Homicide Review was made on the 7th August 2013. South Warwickshire Community Safety Partnership determined that agencies would secure and review their files relating to identified key individuals from the 9th June 2008 until the date of the victim's death. Agencies were required to compile an Individual Management Review (IMR) to provide an independent, open and critical analysis of individual and organisational practice. Agencies were given Terms of Reference to guide their responses in the IMRs (see section below).

These IMRs identify lessons learnt by the individual agencies, highlight good practice and include recommendations for single agencies to improve practice. They also suggest recommendations that may be appropriate for multi-agency practice or adoption at a national level.

Agencies were also requested to compile a chronology of their involvement with the victim and key individuals. This information was merged to provide a clear picture of agencies' involvement during the stipulated time period.

2. The Domestic Homicide Review process.

2.1 Contributors to the Review

A DHR Panel was formed, made up of representatives of the agencies who were involved in delivering services to the victim. The Panel met regularly throughout the period of the review.

DHR PANEL MEMBERS	
Dee Edwards	Independent Chair and Overview

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	Report Author
Detective Chief Inspector (Protecting Vulnerable People)	Warwickshire Police*
Lead Nurse for Safeguarding Children and Vulnerable Adults	Coventry and Warwickshire Partnership NHS Trust*
Lead Nurse Safeguarding Adults	Coventry and Rugby Clinical Commissioning Group
Area Manager	Warwickshire Probation Trust*
Senior Operations Manager	Refuge
Safeguarding Adults Lead	South Warwickshire NHS Foundation Trust*
Domestic Abuse Manager	Community Safety and Substance Misuse Team, Warwickshire County Council
Operations Manager	Adult Social Care, Warwickshire County Council*
Domestic Abuse Administrator	Community Safety and Substance Misuse Team, Warwickshire County Council
Area Manager	The Recovery Partnership*
Safer Communities Manager	Warwick District Council
Senior Housing Officer	Warwick District Council*
District Councillor	South Warwickshire Community Safety Partnership Chair
Community Services Manager	Stratford District Council

*denotes those agencies who completed Individual Management Reviews (IMRs)

In addition the following agencies also contributed to the Review:

University Hospital Coventry and Warwickshire (IMR)

NHS Local Area Team (IMR for GP practice)

Swanswell (IMR)

Families First (Chronology)

Bromford Housing (Chronology)

The Way Ahead Project, The Salvation Army (Chronology)

Leamington Night Shelter (Chronology)

Refuge (specialist domestic violence services) was asked to check if they had any Contact with the victim but they had no knowledge of her.

The Co-ordinator of The Stella Project from Against Violence and Abuse (AVA) attended one panel meeting (January 10th 2014) to advise on specific aspects of the Review relating to the causal connections between domestic abuse, alcohol/substance misuse and mental ill health and the relationship between domestic abuse and homelessness.

Family and friends of the victim also contributed to the review either through personal interviews with the panel chair or by a written submission to the chair, providing information which was extremely valuable to the review.

2.2 Terms of Reference

The DHR Panel agreed Terms of Reference for the review. The following provides an indication of the content of these which are outlined in detail in the Overview report. The Terms of Reference are anonymised from the original to protect the identity of individuals.

- What was the history of the relationship between the victim and those individuals present on the night of her death and the other relevant people?
- What was the sequence of events up to the date of the death?
- What knowledge/information did your agency have that indicated that those involved might be victims and/or perpetrators of domestic abuse, and how did your agency respond to this information?
- Does your agency have any information which helps in an understanding of the possible 'triggers' which existed in the victim's life which may have led to her substance misuse and her changes in circumstance?
- Were practitioners alert to potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator?
- Has your agency policies and procedures in place for identifying domestic abuse and dealing with concerns about domestic abuse? Were these assessment tools, procedures and policies considered effective? Was it reasonable to expect staff, given their level of training and knowledge to fulfil these expectations? In particular, did staff have knowledge and awareness of the interrelationship between mental health issues, alcohol misuse and domestic abuse?
- What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been

reached in an informed and professional way and in keeping with organisational and multi-agency policies and procedures?

- Were joint assessments taking place to assess factors such as substance misuse, mental ill health and domestic violence and abuse?
- How, when and why, your agency shared information with others and its impact?
- Were there missed opportunities for sharing information?
- Was the supervision and management of the case in your agency effective and did it follow agency policies and procedures?
- Should the information known to your agency have led to a different response?
- Was it reasonably possible without the benefit of hindsight to predict, and once predicted work to prevent the harm that came to the victim?
- What services did your agency offer and/or provide to meet the victim's needs? Were they accessible, appropriate, empowering and empathetic to her needs?
- Were there issues in relation to capacity or resources in your agency that impacted on the ability to provide services to the victim, the alleged perpetrator(s) or any other relevant others. If so, did these issues also impact on the agency's ability to work effectively with other agencies?

Additional questions were asked of some agencies. These were as follows:

Warwickshire Police:

- Did the victim's previous history relating to domestic abuse impact upon decision making?
- What level of awareness/information did police have about E's previous history as a perpetrator of domestic abuse? Did this information impact upon decision making?
- What level of awareness was there of F as a potentially vulnerable adult? How did this factor into the risk assessment and decision making process?
- Give an evaluation of the Police intervention on 24th and 25th October 2012.

Adult Social Care:

- At the Social Care and Support meeting (26th October 2012) what factors contributed to the view that F was at risk from the relationship with the victim?
- Was the victim ever subject to the Safeguarding Adult process? If so, what took place?
- What assessments regarding F's mental capacity have been carried out within the specified time period?

The Recovery Partnership:

- What factors prevented The Recovery Partnership from completing a formal assessment after the victim had left hospital (14th February 2012)

2.3 Subjects of the review

Subjects of the review referenced in this executive summary are:

Initial	Identity
A	The victim
F	An individual present the night before A was found dead
E	An individual present the night before A was found dead
G	Former partner of the victim

3. Why was a Domestic Homicide Review undertaken?

At the time of her death on a morning in 2012, A was homeless but spending approximately 3 days a week at the home of F a vulnerable adult who was alcohol dependent. It was also believed that A and F were, or had at some point been, in an intimate relationship.

This house was also frequented by E. There is no information to suggest that A and E had ever been in an intimate relationship.

A's death took place within this household and *may* have occurred as a result of violence from F, who had subsequently disclosed he had repeatedly punched A in the stomach area on the night before she died.

Whilst the police investigation and subsequent consideration of the case by the Crown Prosecution Service identified that there were a number of other plausible explanations for the death of A, the DHR panel made a recommendation to the Chair

of the Community Safety Partnership to err on the side of learning and commission a DHR. This recommendation was accepted.

4. Summary of the events leading to the DHR.

On the night before A's death, Police had received a call from the victim who had alleged that she had been assaulted by one of the men in the house (E)

The Police did not visit the house at the time of the call or during the night. The Police visited the house the next morning but did not get a response. This aspect of the case is subject to an Independent Police Complaints Commission (IPCC) investigation.

Later the same morning the Ambulance service called Police to report the suspicious death of the victim.

Both men were arrested and interviewed by the Police because of their potential involvement in her suspicious death. According to Police records, F at this time, recalled an argument between the victim and E, on the evening of the 999 call, but then gave conflicting versions of events thereafter. F is a vulnerable adult who has memory impairments.

Both men were released from custody the following day on Police bail to allow further enquiries to take place. The following summarises some of the findings from these enquiries:

- A post mortem examination revealed that the victim had died from catastrophic bleeding into her abdomen after her spleen had ruptured. She was found to have suffered with a rare condition named Peliosis of the spleen which may have made the spleen susceptible to rupture. Whether the bleeding was as a consequence of disease or trauma is still unresolved and subject to a Coroner's Inquiry.
- In 2013 additional information was given to the Police by an associate of the two men who had been arrested. This was an admission by F to the associate that he (F) had 'beat' the victim the morning she died. His justification for doing this being that 'she deserved it going behind his back selling herself'.
- During a second interview with F, he claimed that he had repeatedly punched the victim in the stomach area the night before she died.

However, the Crown Prosecution Service determined that because of the medical aspects of the case and the vulnerability and credibility of F, there was insufficient evidence to support a prosecution for any offences.

As mentioned previously, the contact between Warwickshire Police and the victim immediately prior to her death has since been subject to an IPCC investigation. A Coroner's inquest has been postponed until the publication of this DHR.

5. Factors taken into consideration in the review

The Overview report focuses on agencies' interaction with the victim during the five years leading up to her death. The following aspects of the victim's life were uncovered by the review process and thought to be relevant to an understanding of the situation that she found herself in at the time of her death:

- The victim was European and had lived in The United Kingdom for over 17 years, probably having originally arrived in 1992 for a short period, but then returning to the UK to settle here in 1997.
- In 1998 she became a tenant of Warwick District Council with G her long term partner (of approximately 16 years) whom she had met in her country of origin. They developed their own company which was successful with a turnover of £1,000,000 and together purchased a house valued at over £1,000,000. The victim lived in this from June 2008-December 2011 when the property was repossessed. G moved out of the property early in 2010.
- Domestic abuse featured in the victim and G's relationship predominantly during 2009-2011, when 13 disclosures of domestic abuse, were made to the Police. Police records identify the victim and G as dual perpetrators that is, as both victims and perpetrators of domestic abuse. She had also told a number of health professionals about the domestic abuse. The last recorded disclosure of alleged domestic abuse by the victim from G was in June 2012 to health professionals. Agencies' responses to disclosures of domestic abuse within the victim and G's relationship has been analysed within the review process in order that lessons can be learned and policy and practice changed and in order to consider the years before her death to explore all relevant factors that may have contributed to the vulnerable situation she found herself in at the time of her death. However, the DHR report clearly acknowledges that G was not involved in the immediate circumstances which led to the victim's death.

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- She had a history of substance misuse (the primary substance being heroin) with treatment records in Warwickshire dating back to 1997. From 2008 until her death the victim was alcohol dependent.
- Evidence from a number of agency records indicated that she was misusing alcohol because she was finding it difficult to cope with the following: inability to have children, failure of her long term relationship with G, financial pressures, domestic violence and abuse within the relationship.
- There were growing concerns for the victim's mental health during 2011. Much of her behaviour was interpreted by professionals as being associated with her alcohol abuse. There is evidence to suggest that her mental distress was potentially a direct consequence of her experiences of domestic abuse within her relationship with G. However, this is a complex situation where many factors contributed to A's deteriorating situation. In addition it is reported that she felt isolated and alone following the relationship breakdown in 2010. Her ex -partner also had a role to play in raising agencies' concerns about the victim's mental health, having contacted different agencies about this on 6 occasions over an eight month period in 2011. Although concerns were raised in relation to A's mental health which led to a mental health assessment (in September 2011), it is important to note that she did not have a formal mental health diagnosis other than her substance misuse.
- The last 18 months of her life was characterised by an increasingly chaotic lifestyle which included alcohol misuse, aggressive and anti-social behaviour, homelessness, visits to accident and emergency departments and multiple arrests by Police for thefts and failure to comply with bail conditions. During this time she also served three short terms of imprisonment imposed by the court.
- The victim had disclosed she was the victim of an assault by F at a meeting with her Probation Officer in October 2012. The Probation Officer followed both good practice and procedure by offering support and advising the victim to report the matter to the police. She did not act upon this advice. Excluding this direct disclosure there appears to be very little evidence that agencies believed that the victim may have been subject to domestic abuse with F as the alleged perpetrator. Police recorded the incidents involving both of them as either a result of drunkenness or as anti-social behaviour. They did not consider this to be domestic abuse. Police did have knowledge of F's violent history, but did not consider him to be a threat to the victim.
- The three occasions in October 2012 when the victim reported the conduct of E, appear to have been perceived by the police as

unconnected events. The victim and E were not related and there is no information to suggest they had ever been in an intimate relationship, so the first two occasions when the victim reported that E was following her, and then that he was behaving aggressively towards her, were treated as separate Anti-Social Behaviour (ASB) incidents. No connection was made between these ASB incidents and the third incident of reported assault by E on the victim on the evening of her death. Although correctly not categorised as Domestic Abuse, these incidents never the less represented a pattern of possible escalating risk from E towards the victim.

- Two agencies, Adults Social Care and Warwick District Council Housing had no knowledge of the victim as a victim of domestic abuse. They also did not consider F to be a potential perpetrator of domestic abuse. He was however, categorised as a Vulnerable Adult, following his assessment as such by Adult Social Care in June 2011.
- Police records reveal that both F and E had violent histories but there was no imperative to share this information with other agencies.

6. Themes and Learning Points:

A number of themes emerged as the information was examined during the review process. Many of these themes have been noted and addressed in Domestic Homicide Reviews nationally.

6.1. Missed Opportunities

Five opportunities were identified when increased intervention and support may have led to a different long term outcome for the victim. However, it was not possible to predict whether these would have changed the course of events for the victim.

a) In February 2012 when the victim was transferred from Warwick Hospital to University Hospital Coventry and Warwick for specialist surgery because of her broken jaw (allegedly caused by domestic abuse from G) there was no referral to the Police Protecting Vulnerable People Unit from either UHCW or SWFT. This would be an expectation as the reported assault constituted a criminal offence, and therefore, meets the threshold for reporting (UHCW Safeguarding Vulnerable Adult Policy and Referral Pathway OPER-Pol-004-10). Had this line of enquiry been followed it may have offered the victim a greater level of long term protection.

b) Whilst the victim was in hospital on this occasion she was visited by The Recovery Partnership alcohol and substance misuse service. If she had been offered a service

by them and had accepted this service, it may have assisted in her situation. Specific service delivery factors impacted on the Recovery Partnership's opportunities to engage the victim which related to the early stages of the development of their new contract to deliver drug and alcohol treatment services.

c) WDC Housing and Warwickshire Police responded to incidents at F's house (between 6th August and 15th October 2012) as incidents of anti-social behaviour. Neither agency considered that the victim may have been experiencing domestic violence or abuse or that she was the victim of violence, abuse or neglect from those she was part of the same household as, but instead perceived her to be a 'problem' rather than the potential victim of either F or E, both of whom were known to the Police as having a history of violence to others (including incidents where they had allegedly perpetrated domestic violence.)

d) Two of the anti-social behaviour incidents reported to the Police by the victim's neighbours (on the 18th and 26th September 2012) are described in the Police IMR as incidents where F 'displayed controlling behaviour towards the victim'. This controlling behaviour was not noted at the time in Police records but was an interpretation of F's behaviour by the IMR author. This would imply that officers dealing with these specific reported incidents were viewing them through the 'lens' of anti-social behaviour and did not perceive the possibility of DVA existing between F and A. This serves to further reinforce the perception that agencies missed opportunities to respond to the victim's situation because they did not recognise that she may have been experiencing domestic violence and abuse.

e) In the Police response in the period leading up to the victim's death there are a number of significant missed opportunities:

- Firstly, the Police responded to the victim's reports against E (on 11th, 16th and 24th October) as isolated incidents. Although correctly not categorised as Domestic Abuse, these incidents never the less represented a pattern of possible escalating risk from E towards the victim which, had they been viewed as such, may have elicited a different Police response.
- Secondly, the Police response on the night of the 24th October 2012 and on the morning of 25th October 2012 can be interpreted as significant missed opportunities to intervene in a situation which may have led to the victim's death. Key to an analysis of these two episodes is an examination of the call taker's response to the 999 call, the documented recording of this call and the police response as a consequence of these factors. The reported conversation between the call taker and the victim provides evidence to support the view in the Police IMR that the victim had gained

a particular reputation because of the numerous reported incidents involving her, and that this reputation 'coloured' the response to the situation. This perspective is further reinforced by the advice from the call taker to F and E which identifies the victim as the source of the problem; even though the reported assault was against her and that the initial call was terminated by E whilst the victim was complaining that he had assaulted her.

The Police analysis of the call taker's response to the victim (in their IMR) concludes that there was 'no recorded explanation as to why the victim's complaints were not responded to appropriately or why E and F were considered to be at risk to the extent that they were advised to phone 999', but that this may be 'an example of the victim's antecedent history impacting upon decision making'.

In addition to the call taker's response to the victim, the Police IMR states that there is also no evidence of the call taker accessing information systems which may have linked the victim's allegations of E's assault with his previous history as an alleged perpetrator of domestic abuse. If these information checks had occurred then the victim's allegation may have been responded to in a more appropriate way.

Further analysis of the call taker's response by the Police within their IMR also states that 'policy and procedure in respect of dealing with complaints from members of the public was not adhered to'. This comment highlights the fact that despite the call being received by Warwickshire Police at 20.13pm on 24th October 2012 and assessed and recorded as requiring a priority response,¹ Police did not visit the address until 07.42am on the 25th October and then, on getting no reply left the address.

The Police IMR notes that this situation evidences a critical missed opportunity for police involvement, assessment and intervention.

6.2 Good practice

Services did demonstrate considerable efforts to offer support to the victim.

For example, her GP practice maintained her as a patient despite their knowledge that she was not still living at the address she had used to register with them.

¹ A Police called graded a 'priority' is one where there is a degree of urgency or importance associated with it which requires police officers to respond as soon as possible, or within one hour

Both Probation and The Recovery Partnership records show that she was developing some trust and positive engagement with them in the weeks before she died.

Coventry and Warwickshire Partnership NHS Trust (CWPT) records also show and demonstrate that staff made every effort to engage with her on numerous occasions and services were tolerant and understanding of her sometimes chaotic approach.

Like many other individuals with complex needs and an increasingly chaotic lifestyle, the victim failed to attend appointments or was not contactable at the known addresses or given mobile phone numbers. However, all agencies continued to repeatedly attempt to engage with her despite her tendency to fail to respond.

Some positive multi-agency working, good information sharing and good communication is clearly evidenced from the Police, GP practice and CWPT's Mental Health Crisis team when they shared concerns about her mental health and formulated a plan to ensure that a mental health assessment was carried out in September 2011.

6.3 Access to Services

The victim's nationality does not appear to have been a barrier to her accessing services. Her friends identified that her English language skills were quite sophisticated in that she would help them to understand any official letters that they received and advocate on their behalf. She also was a successful business woman whilst in her relationship with G.

However the author's meeting with her friends from the same European community identified the following:

- The typical pathway to information about services, for individuals from this community who live in this area of Warwickshire, is via self-identified 'key' people from the same European community. These may either work in the Voluntary Sector or may simply earn this status as a result of time spent in the UK, their level of language skills and their knowledge of local services and their understanding of how the 'system' works.
- Members of this European community appear to have very little knowledge of local domestic abuse services and the referral pathways into these, and this in itself presents a barrier.
- It is also unlikely that the 'key' people in the community have knowledge of domestic abuse or the local services available to victims.

Although the victim did disclose domestic abuse to statutory services, there needs to be recognition that other migrants from a similar European background now living in

Warwickshire may not have the language skills or knowledge of services to enable them to access appropriate support and help. It is therefore important to recognise the need to equip the identified 'key' individuals with relevant and up to date information about local domestic abuse services.

Learning point

Further work needs to be done to engage minority communities in Warwick District to provide information about domestic abuse services

6.4 Recognising domestic abuse

Examination and analysis of service interventions and responses to the victim identify a number of factors which influenced a lack of recognition of her as a victim of domestic abuse. They were as follows:

- Agencies often focussed on what they considered to be specific presenting issues which related to their profession and therefore did not identify domestic abuse e.g. Housing officers saw her in relation to her anti-social behaviour and her potential exploitation of F as a vulnerable adult; Health professionals often responded to her because of her alcohol/drug misuse; Police officers viewed her as both a perpetrator and victim of domestic abuse but also as someone who had considerable contact with them because of the crimes committed in the context of her alcohol dependency; Probation workers saw her as an Emerging Prolific Offender.
- Professional's perceptions of her character, behaviour and her own fluctuating recognition of risk may have prevented them from considering her to be a victim. This point is supported by evidence from IMRs when staff were interviewed and described the victim as being 'feisty' 'lively', 'volatile', 'a survivor' with a strong 'defence mechanism,' a character who 'did not see herself as a victim'. She was also perceived by some staff to be a 'flamboyant' character who 'gave as well as she got'.
- The above points of view were compounded by the victim's increasingly aggressive and chaotic behaviour, fuelled by alcohol consumption (and methadone) which often made it incredibly difficult for professionals to assess her situation (either in relation to her mental health needs or the possibility of domestic abuse).

These presenting features helped to camouflage her vulnerabilities and often prevented services from regarding her as a victim of domestic abuse. In some instances this demonstrated a failure by staff in a number of agencies to recognise indicators of domestic abuse and to respond to disclosures. This was primarily due

to a lack of DVA training and guidance at the time. It would appear that professionals did not see beyond the social norms and assumptions about addiction and use professional curiosity to ascertain what had triggered her behaviour and addiction. In particular, it identifies the need for professionals to have a good understanding of the complexities of domestic abuse and the causal connections between domestic abuse, substance and alcohol misuse and mental health.

Learning point

The review has identified the need for all agencies to look beyond an individual's presenting issues; to challenge commonly held stereotypes of what constitutes a domestic abuse victim; to recognise the causal connections between domestic abuse, alcohol/substance abuse and mental ill health; and to use professional curiosity to help them reach a deeper and broader understanding of the individual.

6.5 Domestic violence and abuse: policies, procedures, training and supervision.

The review found that the presence of domestic violence and abuse policies, procedures and training was variable across the agencies and that there had been revisions to all of these during the timescales specified by the review. The Overview report refers in detail to this with reference to individual organisations and their progress in relation to policies, procedures and training.

The existence of robust domestic abuse policies, procedures and training should reflect positively in frontline professional's ability to recognise and respond appropriately to domestic abuse.

Although some agencies had domestic abuse policies in place during the timescale of the review, there was evidence that these did not exist in some agencies e.g. GPs had no domestic abuse policies or procedures at the time when they were engaging with the victim; Warwick District Council Housing had no Domestic Abuse Policy but used an Anti- Social Behaviour Policy in cases of domestic abuse. However, Warwick District Council Housing were involved in referring individuals identified into the Multi-agency Risk Assessment Conference (MARAC). WDC Housing Advice does have a domestic advice procedure which enables professionals to make decisions bound by legislation. There is a code of guidance identifying which steps must be taken when someone presents to housing as a victim of domestic abuse.

Even when domestic abuse policies were in place, during 2008-2010 Coventry and Warwickshire Partnership Trust staff did not receive specialist domestic abuse training. Staff did however receive Safeguarding training at levels 1 and 2 which identifies the signs and symptoms of domestic abuse and ensures that they have an

understanding of the process for referring victims of domestic abuse in line with the organisation's domestic abuse policy.

Prior to 2011 South Warwickshire NHS Foundation Trust's IMR states that they 'are unable to establish if staff received specific safeguarding training on domestic abuse and what to do if they had concerns'.

SWFT staff have received Safeguarding Adults training since 2008 which is an awareness session provided for all levels of clinical staff. Maternity services provide specific domestic abuse training for midwives. However it has been identified that domestic abuse training was lacking for the Accident and Emergency department. This is now a key action in their Action plan.

UHCW did have a Domestic Violence and Abuse Policy which provided staff with guidance on recognising the potential indicators of DVA and how to respond appropriately. However, the efficacy of the guidance was difficult to judge in relation to A's limited period of time spent in hospital (1 day in February 2012). Although staff training did raise awareness about the interrelationship between mental health issues, alcohol misuse and DVA, there is no evidence that UHCW staff specifically considered this as an associated problem when they were dealing with A. Staff did however recognise the risk associated with her returning home by referring her to appropriate agencies to facilitate safe housing and the alcohol services to provide advice with regard to her alcohol dependency. As part of the lessons learned from this DHR, UHCW are sustaining their existing training schedule to ensure that all key staff (including Emergency Department staff) are aware of their responsibilities for reporting and referring appropriately in relation to Domestic Violence and Abuse.

Some Police officers who responded to domestic disputes between A and G between 2009-2011, despite receiving some domestic abuse training, did not appear to understand the possible complexities of domestic abuse and also demonstrated a lack of professional curiosity.

From many agencies' perspectives, knowledge of domestic abuse care pathways and specialist local domestic abuse services was also variable.

Learning point

The specific learning from the review is the need to ensure that domestic violence and abuse policies are developed and updated; that a multi-agency countywide domestic abuse referral protocol is developed and that these are integrated into agencies' domestic abuse training programmes.

6.6 Assessment processes

The victim was subject to a number of assessment processes which included assessments to identify the level of risk from domestic abuse, health assessments undertaken whilst she was in Police custody, a formal mental health assessment and an assessment for an Alcohol Treatment Order by The Recovery Partnership.

The Overview report considers these in more detail.

There were no domestic abuse risk assessments undertaken by any agency in relation to the victim and F although there was conflicting evidence as to whether A and F were in or had been in an intimate personal relationship which is a qualifying factor before certain behaviours can be considered as domestic violence in accordance with the Home Office definition of DVA.

Police did not perceive that A was a victim of domestic abuse within her relationship with F.

In the one instance where A disclosed that F had assaulted her (to Probation on 23rd October 2012) it appears that there was no formal risk assessment undertaken. However, probation staff did offer support and advice to A regarding the disclosure, but A did not choose to take this advice.

No assessment of risk was undertaken by any agency in relation to the victim and E.

Although not domestic abuse, when Police received three calls from the victim (on 11th, 16th and 24th October) which complained about E's behaviour towards her, these incidents were treated in isolation and were not assessed as representing a pattern of possible escalating risk from E towards the victim.

It would appear from the evidence presented to the review that the majority of agencies were not systematically using recognised domestic abuse risk assessment tools when the victim disclosed domestic abuse in her relationship with G. The exceptions to this were Warwickshire Police, Warwickshire Probation Trust and The Recovery Partnership.

It is important to reiterate here that the victim's relationship with G has been explored not because G had any direct connection with the events leading up to her death but because agencies' records highlight a decline in the victim's circumstances (both her physical, emotional and financial circumstances) during the period under scrutiny which includes a period of time when the victim was in a relationship with G. It is believed that it is during this period of the victim's life that things began to deteriorate for her, which led to a 'spiral' of decline.

The following summarises the key points identified by an analysis of the domestic abuse risk assessments carried out by Warwickshire Police in their responses to A in

her relationship with G during the period 2009-2011. This was a complex situation where police assessed A and G as dual perpetrators; there was also evidence of both drug and alcohol misuse within the relationship.

- Risk assessments were undertaken with a lack of reference to previous risk assessments which lead to an inconsistency in the levels of risk. This led to incidents being treated in isolation rather than as a series of linked incidents. This may have reduced the potential for intervention and support. The intervention and support may have helped the victim and reduced the likelihood of her situation worsening. However, it seems unlikely from her responses to other services offered, that she would have engaged with services at this stage.
- There were noted inconsistencies between what was written in police logs and what was written in risk assessments. Some of the omissions and /or inconsistencies relate to the alcohol and drug issues that were factors in G and A's relationship. These inconsistencies may have prevented the elevation of risk levels. There is also noted inconsistency between risk assessments and Police logs where the risk assessment names the victim as the victim whereas the log records G as the victim. A had never been assessed as a 'high risk' ²victim of domestic abuse. Police had referred her (with her consent) to Warwickshire Domestic Violence Support Services (WDVSS) and to Stonham's Domestic Abuse Support Service, but she had not pursued these offers of support.

The Police IMR closely analyses the numerous domestic dispute call outs they made to the victim and it makes the following points:

- There have been significant changes to Police perceptions and understanding of domestic abuse since this case. Some of these are as a result of increased training and awareness raising and others as a result of risk assessment improvements. For example:
- Many of the 'domestic disputes' between the victim and G (in 2009) which were viewed as arguments over divisions of property when the couple were in the process of separating, would now be viewed by the Police in a different light and would have provided greater opportunities for intervention.

² ACPO Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH) risk assessment model determines the level of risk to the victim. Those identified as 'high risk' are at risk of serious harm or potential homicide cases and are referred into a Multi-Agency Risk Assessment Conference.

- There have also been amendments to the DASH risk assessment which now includes a question about the suspect mistreating an animal or family pet. If this had been in the DASH risk assessment tool in 2009 it would have elicited a significantly different police response to the victim's claim that G was threatening to 'kill her dogs'. (11th November 2009)
- The perception of the victim that G was threatening to kill members of her family would now be seen as potential harassment and intimidation of her.

It is unknown that if the victim had been referred into MARAC, as a consequence of more rigorous and consistent risk assessment by police, that she would have responded to the support offered to her.

West Mercia and Warwickshire Police Forces' Draft Domestic Abuse Strategy (October 2013- March 2016) outlines the aspiration for 'consistency in approach to domestic violence across areas'. It also states that the forces will 'ensure compliance with the DASH risk assessment tool, but seek to rationalise it to a right first time approach'.

In addition, the recent HMIC (Her Majesty's Inspectorate of Constabulary) report '*Everyone's business: Improving the police response to domestic abuse*,' (2014) Warwickshire Police were one of eight police forces in the UK who were identified as having demonstrated good practice in its response to victims of domestic abuse. The report stated that, 'The public in Warwickshire can have confidence that the force is working well with partners to tackle domestic abuse and keep victims safe. Tackling domestic abuse is a priority for the force and staff demonstrate a high level of commitment and understanding throughout the organisation'.

In the report, two of the six recommendations to further strengthen Warwickshire police response to victims of domestic abuse, have relevance for the findings of this DHR and are as follows:

- The force should implement a robust quality assurance process that provides systematic audits of domestic abuse calls.
- The force should conduct a training needs analysis to establish what domestic abuse training is required across the force, and develop a timed implementation plan.

Learning point

During the timescale determined by the Terms of Reference for this DHR, some services (e.g. Housing, Adult Social Care, Health organisations) were unfamiliar with domestic abuse risk assessment tools.

The inclusion of a common risk assessment process across all agencies within their current practices is now evident and many of the updated domestic abuse policies now refer to the CAADA DASH Risk Indicator Checklist. However there is a need for ongoing training of frontline staff to ensure their familiarity with the tool and a recognition that this should be done in conjunction with recognised good quality domestic abuse training.

6.7 Responding to individuals with complex needs (e.g. domestic abuse substance/alcohol misuse, mental health problems, homelessness)

The victim's situation in October 2012 represented the plight of many homeless women in the UK today who have 'severe, interrelated and exceptionally complex problems which contribute to their homelessness and make their recovery challenging'³.

It is recognised by recent research that substance misuse is 'both a cause and consequence of homelessness and is often used as a coping mechanism to deal with mental health problems or experiences of violence, abuse or trauma'.⁴

During the 5 years that this review covers, the victim's personal situation deteriorated and became more complex; professionals did not often share information regarding her situation because she failed to reach the levels at which it is deemed that she required safeguarding support as a vulnerable adult or as a domestic abuse victim.

Although extremely vulnerable as a consequence of her alcohol and drug misuse, her experiences of domestic abuse and her homelessness, she had no diagnosed mental health issues and no one had identified her as a 'vulnerable adult'. She clearly demonstrated that she had 'mental capacity' to make and take her own decisions. Possibly because of her resilient independence, she did not have any professionals who advocated on her behalf. This situation can be compared with F who was judged to be vulnerable and therefore had professionals and volunteers supporting him and advocating for him which had led to his assessment as a vulnerable adult and the implementation of a care plan which supported him.

Her lifestyle as a homeless woman who was a street drinker, associating with other alcoholics, put her in positions of risk. The Police IMR states that there was a strong possibility that the victim was exchanging sex for a roof over her head and that she was also prostituting herself in order to have enough money to buy alcohol. Both of these acts can be interpreted as acts of exploitation and highlight her increasing

³ Rebuilding Shattered Lives: The Final Report Getting the right help at the right time to women who are homeless or at risk. Sarah Hutchinson, Anna Page and Esther Sample. St Mungos. March 2013

⁴ Ibid.

levels of risk and vulnerability. The Police IMR also states that there was evidence that she had been subject to assault from her fellow associates and that she had assaulted others.

Learning point:

The victim's situation has highlighted a gap in both process and services in relation to vulnerable individuals with complex problems who fail to reach the thresholds for support, and therefore, fall through any safety net that is currently in place. The panel concluded that this was not a unique gap relevant only to Warwickshire, but one which is a national issue.

7. Conclusion

With the information gathered from the review process, the panel believe that there were many complex factors that contributed to the situation that the victim found herself in just before her death. Many of these factors had existed for some time in the victim's life but it was the cumulative effect of them which created the climate for her vulnerability. The main factors included: the victim's experiences of domestic abuse(within her relationship with G) and her inability to have a child both of which appear to be the key triggers and contributory factors for her ongoing substance and alcohol misuse and her mental distress. The sense of isolation that she experienced following the breakdown of her long term relationship with G was seemingly compounded by the physical isolation she felt living in a large house in a very rural setting. She also felt isolated from her family and friends in her country of origin. The financial pressure from a failing business was an additional stressor.

All of these interconnected factors most likely contributed to her eventual homelessness and her chaotic lifestyle. As a homeless woman dependent on alcohol, her life choices were limited; she had mental capacity to make decisions but the decisions that were open to her were restricted by her situation and more often than not, these decisions placed her in risky situations with associates who were similarly struggling with their own problems and survival.

The panel concluded that given the situation that she found herself in during the last months of her life, it was very likely that something life threatening would have occurred. However, having analysed the evidence from agency records and friends and family contributions, it was difficult for agencies to predict the possibility that she might die as a result of domestic abuse or from violence, abuse or neglect from a member of the household to which she was a part of. Although some agencies recognised that A had experienced domestic abuse within her relationship with G,

this was unconnected with events that surrounded the circumstances of her death. In the immediate period before her death, the majority of agencies who came into contact with A had no information which suggested that she was a victim of domestic abuse within her relationship with F. The only agency that recorded that A had been assaulted by F was Probation (on the 23rd of October). A was advised to report the matter to the Police, but chose not to do this.

Although Police records have information documenting the victim's concerns and allegations relating to E's behaviour towards her on three occasions during October 2012, they treated these incidents in isolation and did not interpret them as representing a pattern of possible escalating risk from E towards the victim.

Other agencies who were involved with A's life during the period immediately prior to her death perceived her as someone who was involved in anti-social behaviour and not as a person at risk of harm from violence (domestic violence & abuse, or otherwise).

An additional significant factor that is central to the victim's situation and one that has to be considered is her undiagnosed and rare health condition, Peliosis of the spleen, which could have (and indeed may have) terminated her life at any moment.

The review has highlighted the ways in which agencies could have improved their responses to identifying domestic abuse and to the victim's disclosures of domestic abuse. Recommendations are in place with an aim to increase the support to individuals who have complex needs similar to those she experienced.

In conclusion, the victim's fiercely independent personality, her increasingly chaotic lifestyle and her reluctance to accept offers of support, make it difficult to determine whether additional and /or different offers of support, if they had been in place, would have been accepted by her.

8. Recommendations

By examining the themes above, the review has identified a number of areas where improvements could be made by implementing changes to promote good practice and a more effective response to victims of domestic abuse.

8.1 Addressing the updating of domestic violence policies, procedures and training of front line professionals so that they can intervene with confidence and with a clear understanding of the dynamics of domestic abuse and an understanding of appropriate care pathways.

Relevant recommendations:

8.2 Domestic Violence and Abuse Policies

1. As part of the requirements of The Care Act (2014), Adult Social Care to revise the Safeguarding Vulnerable Adults' Policy to be integrated into the development of the Care Act responsibilities around provision of Information and Advice, and into support planning pathways for adults with care and support needs who are at risk of domestic abuse.
2. A Domestic Abuse Policy and common referral process for Warwick District Council to be written (with appendices to cover specific services within the Council).
3. NHS England and South Warwickshire Clinical Commissioning Group to develop a Domestic Abuse Policy and procedural guidance.
4. Swanswell to develop a national domestic abuse policy and guidelines.
5. Multi-agency recommendation: To develop a county wide Domestic Abuse Protocol for all agencies.

8.3 Domestic Violence and Abuse procedures

1. Warwickshire Probation Trust to ensure that Additional Domestic Abuse Checks are requested by Offender Managers when significant new concerns are identified. Staff to recognise/consider that the offender is not always the perpetrator of domestic abuse – but may be the victim.
2. Warwickshire Probation Trust to undertake home visits when DV concerns are identified. Home visits provide valuable information that would contribute to the management of offenders, even when the offender is not assessed as High or Very High Risk of Serious Harm.
3. The Recovery Partnership to ensure that all clients are asked about domestic abuse; that brief interventions for victims of domestic abuse are introduced; to improve communication and domestic violence outcomes by ensuring information is appropriately shared with other agencies when a domestic violence risk (either current or historic) is identified; to improve joint working with police around domestic abuse incidents through seeking police assistance in steering victims and perpetrators into treatment; to improve record keeping and record management standards specifically relating to Domestic Abuse Managers.
4. Swanswell to complete an audit on all patients where domestic abuse has been recorded.
5. Coventry and Warwickshire Partnership Trust to reinforce the importance of accessing specialist domestic abuse supervision (available via the safeguarding team) to staff who hold complex domestic abuse cases.

6. South Warwickshire NHS Foundation Trust to review Emergency Department (ED) documentation to include a prompt for staff to investigate the possibility of domestic abuse.
7. NHS England to introduce a system where DA cases are identified on GP electronic systems to assist effective identification and information sharing.
8. Multi-agency recommendation: The panel recognised the centrality of the GP's role and the need for local GPs to be able to identify and respond to domestic abuse and to refer in to support services and the MARAC where appropriate. To this end they have recommended that a process is developed whereby local GPs are informed about the MARAC process and are involved in 'two way' information sharing and referrals into MARAC.
9. Recommendation for local and national health economy. The panel are aware of the recent NICE Domestic Violence and Abuse Guidance⁵ and wish to support and strengthen this with the following recommendation:
An agreement is made among local health agencies to ensure that all the Warwickshire Health Services ask the question about abuse and signpost and employ strategies to help and support victims and perpetrators in domestic abuse situations. This will be achieved by incorporating Domestic Abuse/Domestic Violence into the 'Making Every Contact Count' Agenda

8.4 Domestic Violence and Abuse Training

The panel identified the following aspiration for any domestic abuse training which was to be delivered to local professionals; Training should:

- Improve awareness amongst professionals of the causal connections between domestic abuse, alcohol and substance misuse, and mental health issues;
- Ensure that professionals look at clients with a wider lens than the single issue that they may be presenting with to their service;
- Provide professionals with the ability to recognise/identify domestic abuse, respond appropriately , sensitively and safely;
- Help professionals to understand and respond to risk through the inclusion of a common risk assessment process i.e. the CAADA DASH Risk Indicator Checklist;
- Provide professionals with information about the local care pathway and specialist domestic violence services.

⁵ 'Domestic Violence and Abuse: How health services, social care and the organisations they work with can respond effectively'. Public Health Guidance. NICE PH50 February 2014. <http://guidance.nice.org.uk/PH50>

The recommendations below have been formed with these elements in mind.

1. To review Domestic abuse training for adult practitioners within Adult Social Care to consider a more specific training menu for domestic abuse issues. The aim of the review is to ensure that awareness of domestic abuse and use of the CAADA DASH Risk Indicator Checklist is fully embedded.
2. Domestic Abuse training to be arranged for all frontline housing staff, with invitation to other frontline staff within the District Council. The training will be delivered by CAADA (Co-ordinated Action Against Domestic Abuse).
3. Coventry and Warwickshire Partnership Trust to review Scars of a Quiet Denial and CAADA/DASH Risk Indicator Checklist training to ensure that issues identified in the DHR, including the importance of considering domestic abuse during any assessment, and awareness of the toxic trio, are included. A post learning audit to be conducted to establish effectiveness of training.
4. University Hospital Coventry and Warwick to continue their training schedule throughout 2014/15 to ensure all the key staff (ED /maternity/paediatrics), are aware of their responsibilities for recognising, reporting and referring appropriately in cases of known and suspected DVA. This training to be regularly monitored as part of the quality and audit process.
5. Targeted training to be developed and delivered for the South Warwickshire Foundation NHS Trust Emergency Department on domestic abuse/Safeguarding Adults. This training is to include 'the case finding question', DASH Risk Indicator Checklist and follow up actions.
6. NHS England to develop domestic abuse training for GPs.
7. Multi-Agency training: To improve agencies' understanding of domestic abuse so that they understand and recognise the complexities and dynamic of domestic abuse and its impact on victims ,a programme of domestic abuse multi-agency training will be provided for both Voluntary and Statutory sector organisations. Training will be audited and for those attending, a sample survey will be used to capture the possible impact of the training on an individual's perception and understanding of domestic abuse and of how this will impact on their work role.

8.5 Improving domestic abuse risk assessment processes

As seen from some of the recommendations above relating to training, domestic abuse risk assessment processes will form an integral part of this delivery.

Other relevant recommendations are:

1. Warwickshire Police to review their working practices in relation to the identification of repeat Domestic Abuse incidents risk assessed as Standard/Medium, which when taken together could be collectively considered to be High Risk and introduce a process for the escalation of such cases into MARAC.
2. The Recovery Partnership to review risk assessment and domestic violence assessment tools.

8.6 Engaging with key members of minority communities to help develop an understanding of domestic abuse and local referral and support processes.

Recommendation:

To improve awareness about local domestic abuse services with 'key individuals' of minority communities within Warwick District through the organisation of events to provide information about local domestic abuse services.

8.7 Developing systems for supporting vulnerable adults with complex needs which when taken together exposes them to high risk.

Multi- Agency Recommendation:

For Warwickshire Agencies to carry out a scoping exercise to explore the feasibility of a co-ordinated multi- agency approach to sharing information, risk assessing and supporting individuals with complex needs(e.g. victims of domestic abuse, homeless, alcohol/substance misuse/mental health issues) who may be vulnerable, but who do not meet current statutory thresholds.

Within this process to consider:

- a single point of contact to co-ordinate responses and professional involvement and a lead practitioner to co-ordinate service responses;
- A multi- agency care management system (similar to a MARAC) to assess and manage cases;
- a review of existing agency assessment tools to ensure that relevant questions are included which cover the following: domestic abuse, mental ill health, substance misuse, accommodation needs;

- the development of an advocacy system for this client group to broker relationships with agencies;
- information sharing protocols;
- Guidance for voluntary organisations (who support this client group) who work in partnership with the statutory sector.

The panel believe that because of the ongoing context of budget constraints for all public sector organisations, this recommendation should be considered in the light of, and in tandem with, other developing initiatives in Warwickshire. E.g. Empowering Communities Inclusion and Neighbourhood management System (E-CINS) and Multi- Agency Safeguarding Hub (MASH) models

8.8 Other recommendations arising from the DHR:

1. To ensure that community treatment orders are not issued without the individual being assessed, The Recovery Partnership initiated a meeting between The Recovery Partnership, Probation and Court representatives in February 2014 to reinforce that standard, and accepted procedures are adhered to.
2. Warwickshire Police to review Police working practices to ensure that Custody Staff accurately record injuries to detainees and the learning from this to be disseminated as part of Custody training.
3. To explore future housing options /alternatives that could be offered to individuals who have complex needs who become homeless. This to be considered within the current review of The Homelessness Strategy.
4. To consider whether it is appropriate to include a section in the HomeChoice application form asking applicants if they are experiencing domestic abuse.(Home Choice is a district wide housing register used by the Council and Housing Associations)
5. To improve agencies' ability to confidently participate in Domestic Homicide Reviews the panel recommends that The Home Office DHR Quality Assurance Panel produces clear and detailed guidance for DHR IMR authors.
6. That The Home Office produces guidance to Community Safety Partnerships on the recommendation to seek legal assistance and guidance at the onset of DHR processes where there have been no criminal convictions or where the scope of the DHR encompasses events and /or individuals which are not directly connected with the circumstances of the death, but are deemed to be relevant to the overall review or in any other circumstances that may warrant the need for legal guidance.

9. Implementation of Learning

The lessons to be learned from this Review must be followed up to ensure that practice improves, and where practice has already been addressed as a result, mechanisms must be put in place to embed and maintain the improvements.

The IMRs provided evidence in their reports and on this basis Action plans with the above recommendations for each agency have been formed. These have within them identified actions which are to be achieved within a specified timescale. These will be monitored regularly by The South Warwickshire Community Safety Partnership.

Each agency is expected to provide feedback to their agency and the IMR authors, as well as to the professionals who were involved with the IMR process.

The dissemination of key learning will be targeted to the professionals in the member agencies of The South Warwickshire Community Safety Partnership. There will also be a shared learning event which disseminates learning from this and another Warwickshire DHR which will be available for professionals from a wide range of agencies.

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***Independent Chair, Domestic Homicide Review Panel and Overview Report
Author***

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