Hull City Council

Domestic Homicide Review Report:

Adult A

Died: 1 February 2015

Tony Blockley
Director: Johnston and Blockley Ltd

Date: 10 May 2016

1 Introduction

Preface

1.1 The city and port of Kingston-Upon-Hull lies on the banks of the river Humber and is positioned at the gateway to Europe. It is linked to the national motorway networks from the west via the M62 and to the south across the Humber Bridge via the M180. The city of Hull covers a relatively compact area of 74 km^2.

1.2 Kingston-Upon-Hull is surrounded by the East Riding of Yorkshire a largely rural area but which contains a number of suburbs immediately adjacent to the city. The population of Hull in mid 2014 was estimated to be 257,700, the highest it has been since 1998, but smaller than the overall population of the surrounding East Riding, which was estimated to be 337,100. The ONS 2011 Census household count for Hull was 112,596, approximately 5% of the total number of households in the Yorkshire and the Humber region. The land registry household count for Hull in 2015 was 118,220.

1.3 Kingston-Upon-Hull consists of 23 wards, containing 166 lower super output areas and 853 output areas, the lowest geographical level for which Census data is measured. There are 3 parliamentary constituencies in the city, East Hull, West Hull and North Hull, each returning one elected Member of Parliament.

1.4 The circumstances that led to this Domestic Homicide Review

1.5 This Domestic Homicide Review (DHR) Overview Report is about Adult A, a 51 - year-old woman, who died in Hull, Humberside, on 1st February 2015. Her partner, Adult B murdered her.

1.6 On 8th June 2015, Adult B appeared at Kingston-Upon-Hull Crown Court and pleaded guilty to manslaughter on the grounds of diminished responsibility. He was nevertheless tried for murder and was found guilty. He was sentenced to life imprisonment with a recommendation that he must serve 22 years before being eligible for parole.

1.7 In his sentencing comments, the trial Judge said that Adult B had carried out the murder *"With brutal determination"* and added that *"…having killed her you left her body in that hotel room and made your departure…that was callous".* When passing sentence, the Judge said, *"It is my view at present that you pose such dangers that I cannot envisage a time when it will be safe to release you".*

1.8 Adults A and B had been in a long-term relationship. Adult A had a child (Adult C) from a previous relationship and they (Adult A and Adult B) had another child (Adult D) together. Adult C was (31 years old) at the time of Adult A's death and Adult D (27 years old).

1.9 Prior to the murder, Adult B had been violent and abusive towards Adult A on several occasions. They had recently separated and on 31st January 2015, the two had met for a meal at a local pub, just outside Kingston-upon-Hull city centre to discuss reconciliation.

1.10 After the meal they booked a room in a hotel in Hull. About two hours later, Adult B left the hotel, clutching the side of his face. He had just murdered Adult A by stabbing and strangling her.

1.11 The following day, hotel staff found Adult A's body in the bedroom and they notified the police. Adult B was arrested later that day in York.

1.12 Following agreed protocols, on 5th February 2015, Humberside Police notified Hull Community Safety Partnership (CSP) of the circumstances of Adult A's death. On 5th March 2015, the Domestic Homicide Review Multi-Agency Core Group meeting decided that a Domestic Homicide Review should be conducted in accordance with section 9 of the Domestic Violence, Crime and Victims Act (2004) because it was clear that a person to whom she had been related or with whom she was or had been in an intimate personal relationship had caused Adult A's death.

At that time the meeting did not feel there was sufficient information available to formulate specific terms of reference for the review.

1.13 A decision was made to postpone the review pending the outcome of any criminal proceedings that may follow.

1.14 On 5th March 2015 agencies were asked to review their records to determine whether they had been involved with Adult A and / or Adult B in the past, and to seal any records they may have had.

1.15 On 17th March 2015, the Home Office was notified of the intention to carry out a Domestic Homicide Review.

The completion of the review has been delayed in an attempt to engage with the family of Adult A. This was considered important to provide background information relating to the relationship between Adult A and Adult B. As the review progressed two further agencies were identified and it was determined they may hold important information and therefore they were asked to participate.

1.16 Scope of the Review

1.17 It is believed that Adult A and Adult B had met 30 years ago. At that time Adult A was working as a sex worker and Adult B went with her to London.

1.18 There had been previous agency involvement with Adult A and with Adult B and consequently the dates of the review were set between 1st February 2012 and the date of Adult A's death 1st February 2015. February 2012 was chosen as the commencement date due to the fact that agencies had started to engage with Adult A and Adult B at this time.

1.19 If there was any other information outside those dates that agencies felt was relevant, they were asked to include it.

1.20 Terms of Reference

1.21 The purpose of the review was to:

- Establish what lessons could be learned from the domestic homicide about the way in which local professionals and organisations work individually and together to safeguard victims of domestic abuse

- Clearly identify 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 those lessons to service responses and include any appropriate changes to policies and procedures

- Prevent future domestic homicides through the improvement of service responses for all victims of domestic abuse, and their children, through improved intra or inter-agency working.

The review aimed to address:

- Whether the incident in which Adult A died was a 'one off' or whether there were any warning signs and whether more could be done to raise awareness of services available to victims of domestic abuse.

- Whether there were any barriers experienced by Adult A or her family, friends and colleagues in reporting any abuse in Hull or elsewhere, including whether they knew how to report domestic abuse should they have wanted to.

- Whether Adult A had experienced abuse in previous relationships in Hull or elsewhere, and whether this experience impacted on her likelihood of seeking support in the months before she died.

- Whether there were opportunities for professionals to 'routinely enquire' as to any domestic abuse experienced by Adult A that were missed.

- Whether Adult B had any previous history of abusive behaviour to an intimate partner and whether this was known to any agencies.

- Whether there were opportunities for agency intervention in relation to domestic abuse regarding Adult A or Adult B that were missed.

- The review should identify any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and / or services in the area covered by the Hull Community Safety Partnership.

- The review will also give appropriate consideration to any equality and

diversity issues that appear pertinent to Adult A and Adult B and any dependent children e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

1.22 The overall rationale for a review is to ensure that agencies are responding appropriately to victims of domestic abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with the aim of avoiding future incidents of domestic homicide.

The review identified the following general areas for consideration:

1.23 Family and Friends engagement

- How should friends, family members and other support networks and, where appropriate, Adult B, contribute to the review and who should be responsible for facilitating their involvement?

- How matters concerning family and friends, the public and media should be managed before, during and after the review and who should take responsibility for it.

1.24 Legal Processes

- How will the review take account of a coroner's inquiry, and (if relevant) any criminal investigation related to the homicide, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process or compromise to the judicial process?

- Does the review panel need to obtain independent legal advice about any aspect of the proposed review?

1.25 Research

- How should the review process take account of previous lessons learned from research and previous Domestic Homicide Reviews?

In order to reach a view on whether Adult A's death could have been predicted and/or prevented, the Individual Management Review (IMR) authors were asked to include information on, and analysis of, all the following issues:

1.26 Diversity

- Are there any specific considerations around equality and diversity issues, such as ethnicity, age and disability that may require special consideration.

1.27 Individual Agency Responsibility

- Was the work undertaken consistent with the organisation's policies and procedures for safeguarding and promoting the welfare of adults and with wider professional standards?

- What were the key relevant points/opportunities for assessment and decision making in relation to Adult A and Adult B.

- What was the quality of any multi-agency assessments?

- Was the impact of domestic abuse on Adult A recognised?

- Did actions accord with assessments and decisions made? Were appropriate services offered / provided or relevant enquiries made, in the light of assessments?

- Was there sufficient management accountability for decision-making? Were senior managers or other organisations and professionals involved where they should have been?

1.28 Issues which relate to ethnicity, disability or faith which may have a bearing on this review

Cultural issues relating to the reporting of domestic abuse were identified and are subject of discussion within the report.

1.29 Other Domestic Homicide Reviews in the region or nationally which are similar, and the availability of relevant research

(None have been identified at the time of writing).

1.30 Methodology

1.31 This overview report has been compiled from analysis of the information supplied in the agency IMRs, open source material, previous Domestic Homicide Review reports and research into various aspects of domestic abuse.

1.32 The following documents have also been referred to:

- The Home Office Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews (Home Office June 2013)
- The Home Office Domestic Homicide Review Tool Kit Guide for Overview Report Writers (Home Office March 2012)
- Call an End to Violence Against Women and Girls (HM Government March 2016)
- Barriers to Disclosure (Walby and Allen, 2004)
- Home Office Domestic Homicide Reviews – Common themes identified and lessons learned (November 2013).

- Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence, (2006).
- 'If only we'd known': an exploratory study of seven intimate partner homicides in Engleshire (July 2007)

1.33 Participating Agencies

1.34 The following agencies were asked to provide chronological accounts of their contact with Adult A and with Adult B.

- Humberside Police
- Hull Domestic Abuse Partnership – Domestic Abuse Support Service
- Hull City Council Housing
- National Probation Service
- ReNew Community
- Corner House
- Preston Road Women's Centre
- Humber NHS Foundation Trust
- General Practitioner, including drug links worker
- Hull and East Yorkshire Hospitals NHS Trust

As the review progressed it was identified that the Together Women's Project had been involved with Adult A and they were asked to provide a summary of their involvement.

1.35 Each agency was required to report the following:

- A chronology of interaction with Adult A and / or Adult B
- What action was taken and to provide an analysis of those actions
- Whether internal procedures were followed and if those procedures were appropriate in light of the death of Adult A
- Conclusions and recommendations

1.36 Domestic Homicide Review Panel Chair / Overview Report Author

1.37 Following the Domestic Homicide Review Core Group meeting on the 5th March 2015 it was decided that Johnston and Blockley Ltd would be approached to act as Independent Chair and Author for the review.

1.38 One of its partners, Mr. Tony Blockley, undertook the task. He is a specialist independent consultant in the field of homicide investigation and review. He has senior management experience in all aspects of public protection. He has been involved in numerous homicide reviews throughout the UK and abroad, was chair of MAPPA and was responsible for all public protection issues when he was head of crime in a UK police force. He has been involved in several DHRs and serious case reviews. He is also a special advisor to a 3rd sector organisation that provides domestic abuse services (not in the area covered by the Hull Community Safety Partnership) and is a Senior lecturer in criminology at the University of Derby.

1.39 The Domestic Homicide Review (DHR) Panel

1.40 The DHR Panel on behalf of Hull Community Safety Partnership agreed the formation of the overview panel comprising of agencies that had contact with Adult A and Adult B during the period under review, and some others, including a representative from a specialist domestic abuse service.

1.41 The DHR Review Panel consists of:

Name	Organisation
Tony Blockley	Independent Chair and Overview Author
Vicki Paddison	Hull Community Safety Partnership
Dawn Clougher	Hull DAP Social Worker- Safeguarding Lead
Tish Lamb	Corner House
Alison Ashton	Preston Road Women's Centre - Independent Domestic Abuse Specialist agency.
Ria Toutountzi	Hull City Council Housing Services
Paul Johnson	Humber NHS Foundation Trust
Tony Cockerill	Humberside Police
Julie Bahn	ReNew Community
Donna Taylor	National Probation Service
David Blain	Hull Clinical Commissioning Group
Wendy Benson	GP Practice Manager.
Kate Rudston & Christine Davidson	Hull and East Yorkshire Hospitals NHS Trust

1.42 Adult A's child - Adult C, was contacted as part of the review however declined to take part. Adult C said they did not feel they had anything to comment on or complain about and felt doing this would only drag everything back up and therefore declined to speak or meet with the Chair.

Adult B has been written to in prison inviting him to participate in the review, but to date he has not responded.

1.43 Parallel processes

1.44 Inquest / Criminal Investigations

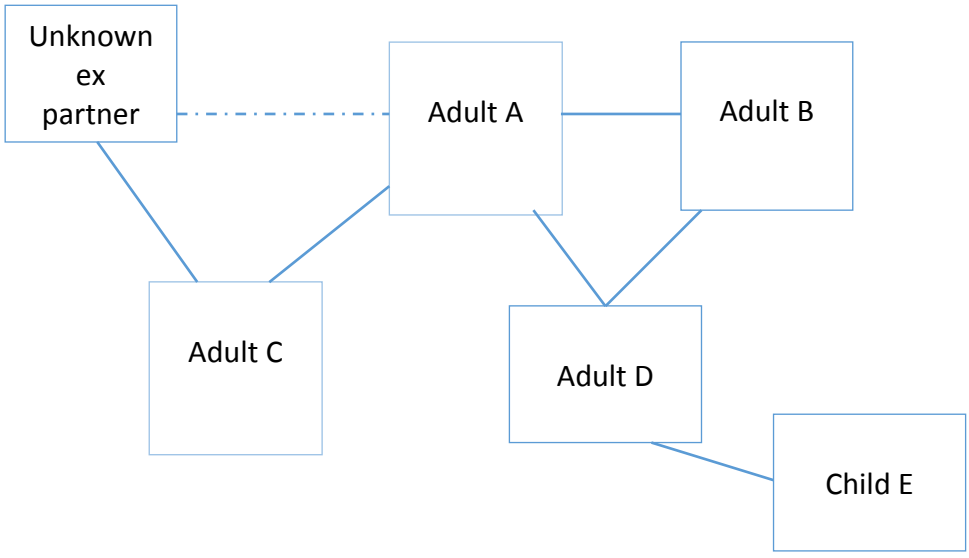
1.45 There was a thorough police investigation into the circumstances of Adult A's death culminating in the conviction of Adult B for her murder. He was sentenced to life imprisonment and he must serve 22 years before he can be considered for parole.

1.46 Although Adult A's death was referred to the Coroner, no inquest will take place because all the evidence and information about it was aired during the criminal proceedings.

1.47 The involvement of family members and friends

1.48 The DHR panel agreed that the review would benefit from the involvement of family members; it was recognised that they may have an important role to play in providing background information about Adult A and about Adult B that agencies may not have previously been aware of.

1.49 Family Composition



1.50 The DHR Panel would like to extend its sincere condolences to Adult A's family and offer continued support in the event they do wish to participate in the review in the future.

2 What the agencies knew prior to Adult A's death

2.1 Adult A (Background)

2.2 Adult A was convicted of numerous criminal offences dating back to 1981, including offences of deception, handling stolen goods, prostitute loitering and prostitute soliciting.

2.3 She had been a sex-worker for several years and had recently taken ownership of a brothel that she managed.

2.4 Adult B (Background)

2.5 Adult B has criminal convictions dating back to 1976, including offences of drug possession and supply, burglary, criminal deception, arson and criminal damage.

2.6 He did not have any convictions for violence related offences prior to the murder conviction relating to Adult A and no convictions for domestic abuse related offending.

3 Chronology of events and analysis

3.1 In November 2010, Adult B was convicted of cultivating cannabis and was sentenced to a suspended term of imprisonment.

3.2 During 2012, Adult B attended six appointments with a drugs worker within his GP clinic and was prescribed methadone. The dosage prescribed was gradually reduced.

3.3 Throughout 2012, 2013 and 2014 up to her death, Adult A had numerous appointments with her GP.

3.4 On 3rd January 2013, Adult A saw her GP, complaining of pains after she had been involved in a road traffic collision. (None of the other agencies have any record of the incident.)

3.5 ***Comment and analysis***

3.6 *It has not been possible to establish conclusively whether Adult A's injuries were actually caused in a road traffic collision; given the known facts, there must at least be a possibility that her injuries may have been caused during an assault upon her.*

3.7 Adult B went to the Hull Royal Infirmary on 3rd February 2013, having ingested a bag of cocaine. He told hospital staff that he had found the drugs and that he had hidden them in his mouth. He had then tripped and had swallowed the bag. He admitted though that he was a regular cocaine, cannabis and methadone user.

In accordance with agreed protocols, the incident was reported to Humberside

Police. Adult B was arrested at the hospital and following treatment was released without charge.

3.8 Adult B's GP surgery received a discharge letter about the incident mentioned above on 9th February 2013.

3.9 On 1st March 2013, Adult A attended the emergency department saying she had twisted her ankle whilst walking.

3.10 ***Comment and analysis***

3.11 *Again, there is a possibility that the injury sustained by Adult A may not have been caused accidentally. There is no definitive evidence either way.*

3.12 On 5th December 2013, Adult A telephoned the police and said that Adult B was being 'aggressive' at Adult C's address. She said he had injured Adult C and that he was continuing to threaten violence. Adult A also said that Adult B was 'going to kill her' (Adult A).The call terminated when the battery on Adult A's phone ran out.

3.13 A second call was received from Adult A to the effect that an unknown male was banging on the door demanding to be allowed in and that he had threatened to kill her. She added that her grandchild was also there and was in tears.

3.14 When the police got there, Adult A asked them to take her to the police station so that she would be safe. The police spoke to Adult B outside the address. He was described as being 'calm and composed' and when they asked him to leave, he did so. A SPECS (Separation, Pregnancy, Escalation, Community Issues and Isolation, Stalking and Sexual Assault) risk assessment was completed which was judged to be 'medium', which recognised there was some risk but not sufficient that Adult A was in immediate danger of harm.

3.15 Whilst at the police station, Adult A made her own arrangements for somewhere safe to stay. She declined offers of support saying she was going to contact a domestic abuse worker.

3.16 ***Comment and analysis***

3.17 *This is the first recorded incident between the two parties. The comments regarding 'threats to kill' are significant and are one of the five key indicators of high-risk domestic abuse. (Pregnancy; separation; threats to kill; hands around the throat; guns and knives)*

The assessment was made as medium because Adult A and Adult B were thought to be living separately and Adult A intended to stay with friends.

It is noted that the police officers said Adult B was 'calm and composed'. It is known that perpetrators can use this tactic and exhibit such behaviour as part of their exercise of power and control - disguised compliance; officers should be

aware of this trait when assessing domestic abuse incidents. (Controlling and Coercive Behaviour in an intimate or Family Relationship, Home office, December 2015)

The officers recorded details of Adult A's grandchild, however no further checks or referrals to Children's Social Care were made.

There was no secondary risk assessment completed by specialist officers until seven months later. The secondary risk assessment is standard practice for Humberside police and should have been carried out within days of the incident. The secondary assessment is to review the circumstances and the decision making to ensure the appropriate level of risk has been applied and the relevant future actions can be facilitated.

3.18 Adult A went to her GP's practice on 9th January 2014 and told them that she had been buying methadone illegally on the street. Her prescribed dosage was increased and an appointment was made for her to see a drug support worker on 29th January 2014.

3.19 ***Comment and analysis***

3.20 *This is recognised as appropriate action and support and is in line with NICE guidance.*

The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care. NICE's role is to improve outcomes for people using the NHS and other public health and social care services by:

- ***Producing** evidence based guidance and advice for health, public health and social care practitioners.*

- ***Developing** quality standards and performance metrics for those providing and commissioning health, public health and social care services.*

- ***Providing** a range of informational services for commissioners, practitioners and managers across the spectrum of health and social care.*

3.21 Adult A did not keep the appointment. When asked about it she said she had been on holiday. Records indicate that she did not attend any appointments relating to the increased prescription of methadone until 17th June 2014.

3.22 On 31st May 2014, neighbours of Adult A and Adult B called the police to report that Adult A and Adult B were arguing and they had heard Adult A screaming. The neighbour went on to say the couple argued everyday and that the arguments sometimes carried on until the early hours of the morning.

3.23 When the police got there, Adult A stated she had been moving out with the

assistance of Adult B and that tensions had become high leading to an argument. The police conducted a SPECS risk assessment, which was recorded as 'standard'.

3.24 ***Comment and analysis***

3.25 *This is the second incident that police were called to. The officers who attended were made aware of the previous incident although it is not clear if the information provided by the caller about the presence of children was communicated to them.*

The mention of separation is significant as it is one of the five key indicators of high risk domestic abuse. When this incident is viewed in conjunction with the incident on 5th December, it becomes clear that the risk was escalating. There is no indication that any safety planning or information regards support services was offered by the attending officers.

3.26 On 6th June 2014, the incident was secondary risk assessed and was recorded as 'standard'. The document read, *"This is the second recorded Domestic Incident between this couple. The last incident was in December 2013. This was a verbal dispute but [Adult A] said that there had previously been violence from [Adult B] but she was reluctant to go into detail. There is no consent to share information with other agencies. Letter to be sent."*

A letter was duly sent to Adult A outlining what services were available to her. This was good practice

3.27 Adult B attended his GP surgery on 5th June 2014 for an appointment with a drugs worker. During the appointment he told the worker that he was not coping well as his parent was terminally ill. The drugs worker referred him to counseling and provided Adult B with details of the mental health services for a self-referral.

3.28 ***Comment and analysis***

3.29 *This appears to be a relatively standard appointment, but there is nothing recorded in the notes to suggest there was any consideration given to the effect of his 'not coping well' could have on them.*

3.30 On 17th June 2014, Adult A attended the GP surgery and met with the drugs support worker. Adult A said she had been assaulted the previous day by Adult B. Adult A was seen by a GP who requested another member of staff (practice manager) to be present due to the disclosure.

3.31 ***Comment and analysis***

3.32 *The identification and subsequent management of information relating to domestic abuse is good and the inclusion of another member of staff was appropriate.*

No relevant risk assessment was carried out. The use of a risk assessment would also have informed ongoing safety planning and is also an opportunity to engage with individuals and direct them to and identify appropriate resources and support agencies.

At the time of this incident risk assessments were not within the practice policy or procedure, this has now been amended to ensure staff are aware of the need to make appropriate assessments, their role in assessing risk and information sharing.

3.33 During the appointment, Adult A discussed her history as part of the assessment. It was decided that Adult A should attend the emergency department although the reason or rationale was not recorded. Adult A was reluctant to attend and did not want the police informing.

3.34 The drugs support worker telephoned the Together Women Project (TWP) and asked for a support worker to attend the emergency department. The practice manager took Adult A to the emergency department in her own car. During the journey Adult A telephoned Adult B and told him they were going to the hospital.

3.35 ***Comment and analysis***

3.36 *Contacting the Together Women Project was good practice and demonstrates the desire to share information, however as the incident involved an assault there was an opportunity to further share this information with the police.*

It should be noted that Adult A was not a 'vulnerable adult' and had capacity. She was provided with information and was able to make informed choices.

3.37 Adult B later arrived at the hospital and was shown into a private cubicle where Adult A and the practice manager was. The practice manager stayed in the cubicle whilst Adult A and Adult B discussed the assault the previous day and it is recorded that Adult B appeared remorseful about the incident.

3.38 The hospital records and the GP records are slightly different as the practice manager describes Adult B being present and that the support worker from Together Women attended some time later. The hospital records show that when Adult A was first seen, two people were with Adult A and although their details are not recorded, the staff member, when interviewed as part of this review, thought that one of them was from the Domestic Violence Unit. It is highly likely that she was referring to the support worker from the Together Women Project and the practice manager.

3.39 ***Comment and analysis***

3.40 *There was a lack of accurate recording relating to visitors accompanying Adult A in the emergency department. The records do not state who was with Adult A and assumptions had been made.*

Adult A arrived at the hospital and Adult B arrived 5 or 10 minutes after. There was a gap in the assessment and consequently staff were not in possession of the full information.

3.41 Adult A disclosed to hospital staff that her partner had punched her in the face several times the previous day and that she had also been strangled. She had swelling to her face and had a sore throat and had lost consciousness due to the strangulation; She told hospital staff that it had happened 'many times' before.

3.42 ***Comment and analysis***

3.43 *Adult A reported the strangulation, it was not corroborated and other than reported sore throat, there were no physical signs of strangulation.*

Adult A disclosed a number of domestic abuse incidents in the past. Consideration was given to whether Adult A had dependent children. The question was asked by the Nurse Practitioner in the emergency department. However, the Nurse Practitioner did not enquire as to whether any children were or could be exposed to the incidents of domestic abuse in other properties. It is noted that because Adult A was deemed to have capacity and that she had refused any assistance, further sharing of information or referral was considered to be a breach of confidentiality.

This should be re-examined. Adult A had already disclosed to the hospital staff a number of high risk factors and also to others namely the GP, practice manage and Together Women's Project, so information should have already been shared.

Although Adult A had capacity it is difficult to determine when the patient is considered under duress due to the domestic abuse experienced.

The responsibility of HEY is to ensure the safety of patients and the need to recognise when to share information. This also includes the importance of risk identification and assessment and to understand when to override consent and share information. In such circumstances HEY would welcome positive guidance in this.

There was no written evidence in the care records of discussion between hospital staff, the practice manager or the Together Women's Project worker and this should have taken place, however, the offer of support / information with regards to domestic abuse was given by the Nurse to Adult A in the presence of her 'friend and key worker'. It must be noted that Adult A was adamant that she did not want to involve other agencies or access support that may have helped her at this time. This is a missed opportunity to share information and decide a coherent course of action and a multi-agency response.
There is no evidence that a formal DASH risk assessment was carried that would in turn inform safety planning and this should be seen as a missed opportunity.

The nurse did offer support and information following the consultation with Adult A, and this could be looked on as an informal risk assessment and some consideration was given to her safety. However, there is a need for HEY to strengthen and formalise a more robust risk assessment process.

3.44 The practice manager suggested that Adult B should attend an anger management course to address his behaviour.

3.45 ***Comment and analysis***

3.46 *Whilst this suggestion may have been made with the best of intentions, it was inappropriate in the circumstances.*

Research shows that Domestic Violence Prevention Programmes (or domestic violence perpetrator programmes, as they're otherwise known) are behaviour-change programmes for men who use violence and abuse towards their (ex) / current partners, they are not anger management courses that are designed to control anger and not address the fundamental cause and impact of the behaviour

They aim to

- *Help men stop being violent and abusive*
- *Help them learn how to relate to their partners in a respectful and equal way*
- *Show them non-abusive ways of dealing with difficulties in their relationships and cope with their anger*
- *Keep their partner safer*

3.47 A support worker from Together Women arrived and the practice manager asked Adult B to leave the hospital, which he did.

3.48 ***Comment and analysis***

3.49 *A member of staff from the Together Women's Project attended the hospital. This worker is no longer with the project and has not been spoken to as part of the review. From the limited information within the project the visit was 'uncomfortable' as Adult B was present throughout.*

The staff member tried to engage with Adult A after the visit but she refused to engage. There are no records that show what type of engagement, when and the specific advice given.

The Together Women's Project is examining their current policy to ensure similar situations are managed more appropriately and that information is recorded accurately.

3.50 Following an initial X-Ray, the support worker from Together Women offered to provide safe accommodation for Adult A that night, but she declined it. The support worker provided Adult A with further details of support opportunities and contact details and then left.

3.51 Within the hospital notes, it is recorded that *"Patient declined information regarding support / information re domestic violence. Has friend and key worker present. No dependent children at home"*

3.52 The practice manager stayed with Adult A for the next five hours, until she was discharged. Adult A said she was going home to Adult B but she had no money. The practice manager gave her £10 of her own money and some cigarettes.

3.53 ***Comment and analysis***

3.54 *The practice manager was very kind and caring, but support would have been more appropriately given by The Together Women's Project due to their role and training.*

There does not appear to have been any consideration by the practice manager for the ongoing safety of Adult A in returning home, nor any consideration of notifying other agencies, particularly the police.

3.55 On 18th June 2014, Adult A visited her GP for a new Methadone prescription. She had left the home she shared with Adult B and did not dare to return. The GP initially refused, but after consulting with the practice manager about the events of the previous day, issued one.

3.56 During this visit it was noted and recorded that Adult A still had bruising to her left eye and cheek with tenderness to her nose. She was advised to see her dentist.

3.57 ***Comment and analysis***

3.58 *There is no record of any form of risk assessment being completed or a GP referral to the police, any other agency or sharing of information. This should be seen as a missed opportunity.*

3.59 During the same day, 18th June 2014, Adult B contacted the Single Point of Access service, Humber NHS Foundation Trust. He made a self-referral seeking counselling in relation to relationship difficulties with Adult A. He was triaged by the nurse who concluded that his mood was low and that he had some thoughts of suicide, it was noted that the risks were unclear. An urgent mental health assessment was arranged at Miranda House for 25th June 2014

3.60 ***Comment and analysis***

3.61 *Adult B identified relationship difficulties, however there does not appear to have been any enquiries made about the relationship and the effect it may have had on Adult A or any other family members. This was a missed opportunity to conduct a risk assessment*

3.62 On 18th June 2014, Adult D telephoned Humberside Police using the 999 systems. Adult D reported that Adult A was suffering physical and mental abuse from Adult B and she was too scared to call the police but that she had attended hospital two days previously with a black eye and a swollen cheek bone following the latest assault, although the incident was not reported to police

3.63 Adult D went on to state that Adult B was mentally ill and needed sectioning; it was also stated that Adult B believed that Adult A was having an affair with Adult B's cousin. Adult D was concerned that Adult B would *'hurt someone or even himself'.*

It was ascertained that at the time of the call Adult A was safe at Adult C's address and was attending hospital as a follow up to the injuries she had sustained as a result of the assault.

Adult D told the call taker that Adult A would be available after 5pm.

3.64 A telephone call was made to Adult D to ascertain Adult A's availability and during the call, Adult D told the operator that Adult A did not wish to make a formal complaint. Despite several attempts over the next few days, the Police were unable to contact Adult A or Adult D.

3.65 ***Comment and analysis***

3.66 *This was a further reported incident of violence towards Adult A and details longer term physical and psychological abuse which should be viewed as an escalation.*

Adult D was told that Adult A would need to be seen and spoken to by officers and this should be seen as good practice.

3.67 On 21st June 2014, police officers attended Adult C's address, as they had been unable to contact Adult A. Adult A was there; she had a bruised and swollen left eye. She stated she did not want any action taking and refused to provide a statement. A SPECS risk assessment was completed and a crime-complaint was recorded. The crime report was sent for filing marked 'No further Action' due to the lack of a formal complaint.

3.68 ***Comment and analysis***

3.69 *The officer who saw Adult A recorded the bruising and swelling. Adult A did not want the police to take any action and did not want Adult B telling she had spoken to the police.*

Despite the officers recognising the need for positive action in domestic abuse cases and advising Adult A of the possibility they may pursue an investigation, they failed to conduct a thorough initial investigation in order to gather the evidence to support a victimless prosecution.

Her injuries were not photographed and the officers did not seek consent from Adult A to obtain copies of her medical records in relation to the treatment she had received for her injuries.

Neither Adult C nor Adult D were asked if they would provide a statement detailing the domestic abuse they had witnessed and describing the effect it was having on their mother (Adult A).

The officers made no attempts to identify the scene of the assault in order to identify any potential witnesses or CCTV. The officers detailing the injuries they saw did not complete hearsay statements or the explanation provided by Adult A.

There is no evidence of any information been provided for local domestic abuse services.
These were missed opportunities.

3.70 On 23rd June 2014, a secondary risk assessment was completed for the incident of 18th June 2014 and it recorded:

"Case assessed as MEDIUM risk. Allegation of assault, [Adult A] does not wish to make a formal complaint, she has moved out to her child's address and separated from [Adult B]. Copy of F913 to DAP [Domestic Abuse Partnership Domestic Abuse Support Service] to offer support"

A form 913 is a domestic violence incident log and is completed with sufficient information to allow for effective investigation of scene attendance and investigation.

The information contained within the forms is monitored by Domestic abuse administration and if the quality and information is lacking they are returned to the attending officers for clarification, therefore maintaining high standards.

A referral to the Domestic Abuse Partnership Domestic Abuse Support Service was completed.

3.71 The seriousness of the incident was recognised by the police officer that reviewed the crime report relating to 18th June 2014 and who sent the report to the Protecting Vulnerable People Unit for review. This was good practice.

3.72 On the same day the report was reviewed by a police officer from the Protecting Vulnerable People Unit who decided to send it to the Criminal Investigation Department Interview team for further enquiries. The report was endorsed: *"However it appears it is likely to be filed undetected as per the victim's wishes."*

3.73 ***Comment and analysis***

3.74 *This comment should not have been made; it is wrong to make a judgment of the likely investigative outcome before an investigation takes place. The officer was not a trained detective and did not possess the relevant knowledge or experience of criminal investigations to make an assessment of the evidence in the case, nor the likely outcome. In any event, the assumption that the case was likely to be filed undetected was premature and did not take into consideration alternative sources of potential evidence or the possibility of a victimless prosecution.*

There is an acknowledgement of inadequate practice by the officer in this case which has undoubtedly contributed to the subsequent decision making by others involved in the case.

The procedure by which officers investigate and recommend the appropriate investigation teams ceased in April 2015 with a new process of cases being allocated based upon complexity and the specialist needs of the investigation rather than purely an assessment of risk.

3.75 On 23rd June 2014 a Domestic Abuse Support Worker from the Domestic Abuse Partnership Domestic Abuse Support Service contacted Adult A to offer her advice and support, however no contact was made. The worker telephoned Adult A again on 24th June and managed to speak to her. She declined to provide any details about her relationship and declined support. She did agree for a domestic abuse booklet to be sent to a safe address. The booklet aims to raise awareness of domestic abuse and informs victims of the range of services available in the city.

3.76 On 9th July 2014, the crime report was reviewed and filed marked 'no further investigation' The rationale was recorded as:

"I have read the summary from this CR [crime report] and the associated log. [Adult A] *does not wish to pursue a complaint against the suspect and has not furnished the police with any information as to how she has been assaulted.* [Adult A] *has sustained bruising to her eye which is confirmed not to be serious nor any other injury which is likely to cause a more sustained injurious period. The level of threat in this case is assessed as medium and I feel under these circumstances we have no further information to suggest that this should be escalated. The family of* [Adult A] *have intervened and necessary support has*

been offered to [Adult A], *but she has declined this also. We are not in a position to pursue this matter as the public and evidential interests are not met. All possible police intervention has been applied where possible in this case, and there are no further meaningful lines of enquiry."*

3.77 The crime report was reviewed by a supervising officer within the Criminal Investigation Department (CID) Interview Team and concluded, *"the public and evidential interests are not met. All possible police intervention has been applied where possible in this case, and there are no further meaningful lines of enquiry".* He subsequently filed the crime as 'no further action'.

3.78 ***Comment and analysis***

The original rationale was inappropriate and there was an opportunity to highlight the need for a thorough investigation, which was not taken. There was no consideration for a victimless prosecution and no consideration given to the collection of evidence.

This was subsequently endorsed by the supervising officer who also neglected to identify the missed investigative opportunities

This was a missed opportunity

3.79 On 4th July 2014 Adult B attended to his GP and was prescribed medication for his presenting problems. During this appointment a referral was made for him to attend Strength to Change (Voluntary Perpetrator programme). There is nothing recorded as to what prompted the referral but it should be seen as good practice.

3.80 Adult A contacted Single Point of Access (Humber NHS Foundation Trust) on 24th July 2014 and said that Adult B was using excessive amounts of cocaine and sleeping tablets. She added that he was paranoid and becoming more aggressive towards her. Adult A also said that she would accompany Adult B to an appointment with them.

3.81 During the subsequent appointment and assessment on 25th July 2014, Adult B told the nurse that he had been violent towards Adult A three times over the previous nine months. Adult A was present when Adult B disclosed this and stated that she did not want any action to be taken and that she did not want any support. It was recorded that Adult B had an extensive history of illicit drug use, involving cocaine and cannabis. He also had a drug worker at his GP practice.

3.82 Adult B discussed his concerns that Adult A was being unfaithful with his cousin, which he believed had been ongoing for nine months, and that he had a fight with his brother a week earlier for interfering in his problems with Adult A.

3.83 Adult B stated that Adult A had *"obtained credit cards without telling him, lied to him, and had paid Adult D £200 – £300 a day for drug use*". Adult B stated he had lost trust in Adult A but acknowledged that the cocaine he was using might have increased his thoughts that she was cheating on him.

3.84 Adult B said he had experienced fleeting thoughts of suicide during the last two years, but never acted on them. However, he had taken an overdose of 20 Ibuprofen 600mg tablets with juice a few days earlier. Adult C had turned up unannounced and had seen the empty packets, but Adult B refused to go to hospital.

3.85 ***Comment and analysis***

3.86 *There is no record of a risk assessment taking place or any consideration that the behaviours may have been increasing the risk of domestic abuse.*

No information on local Domestic Abuse perpetrator programmes was given to Adult B. Nor was the opportunity taken to see Adult A on her own and for her to be provided with information on domestic abuse services. This is a missed opportunity to engage with Adult A and Adult B and provide information around domestic abuse to both.

3.87 It is recorded in the appointment notes that Adult B presented with '*no evidence of an acute, severe or enduring mental illness'*. He denied any thoughts to harm others.

During the appointment there was a discussion concerning the level of violence towards Adult A and it is recorded that this level of risk was deemed moderate due to his (Adult B's) belief that Adult A was being unfaithful.

It is also recorded that the nurse conducting the assessment would liaise with Adult B's GP. Contact was made with the GP surgery, however, the relevant GP was not there; a message was left to contact the mental health services but there is no record that the GP ever did.

3.88 ***Comment and analysis***

3.89 *The notes record the levels of violence and subsequent risk as being moderate but there is no rationale as to why that assessment was made – or who made it.*

Making judgmental assessments about acceptable levels of violence and assumptions of risk without any formal recognised risk assessment process taking place or being recorded is unacceptable practice.

3.90 On 26th July 2014, someone reported that two men were fighting. The person said there was lots of screaming and shouting and the operator could hear children crying in the background. The caller added *"He was trying to get him away from his mother".*

3.91 The police attended and found that Adult B and Adult D had been arguing and that there had been an 'altercation' but it had stopped before they got there.

3.92 The officers discovered that Adult A and Adult B had been fighting and Adult D had joined in to protect Adult A. No risk assessment was carried out as everyone refused to provide any details of the incident. It was also recorded that the incident was a *"type 2 domestic between family members"* and states *"no 913 required".*

3.93 ***Comment and analysis***

3.94 *When the incident was reported, mention was made of children crying although it is not clear if that information was communicated to the officers. When the officers attended the address there was no sign of any children or evidence to suggest they had been there.*

There were no checks made of the Domestic Violence Register (DVR) and as a result of this omission, Adult A was not recorded on the log and no checks were completed in relation to her. Without a clear understanding of the previous domestic history between Adult B and Adult A officers would not have understood the true level of risk or recognised the need for robust intervention.

At the time of this incident the Police definition of domestic abuse was limited to intimate relationships and did not include family members. However, the information clearly identified that Adult A and Adult B were involved and so an appropriate risk assessment and the appropriate domestic abuse '913' form would have been required. This should be seen as a missed opportunity

The definition has now changed to include family members.

3.95 On 29th July 2014, this incident was given a secondary risk assessment which recorded:

"STANDARD risk: 4th incident between this couple. Circumstances not clear as all parties not engaging / giving details. Seems to be initially argument between [Adult A] and [Adult B] which has ended with [Adult D] getting involved and fighting with Adult B in order to protect [Adult A]. Checks done."

3.96 ***Comment and analysis***

3.97 *The secondary risk assessment process linked the previous incidents logged on the DVR and highlighted that this was the fourth incident. If this information had been linked to the DVR at the time of the call and shared with the attending officers their response may have been different. It appears that this incident was lightly dismissed and that more enquiries should have been made.*

This incident further demonstrates the lack of identifying patterns of abuse through dealing with incidents in isolation. This is also the fourth incident and there does not appear to be any identification or recognition of escalation or safety planning for all incidents.

There was no consideration of a victimless prosecution and there are no records that indicate information was shared, nor are there any records to suggest Adult A was contacted by or informed of support services within the area.

3.98 On 11th September 2014, Adult B attended his GP and said *'he was feeling low'*, due to a parental death. Adult B refused counseling. The GP gave him his repeat Methadone prescription.

3.99 ***Comment and analysis***

3.100 *There is no record that any consideration was given to the wider family and the impact that Adult B's feelings might have had on them. This was a missed opportunity to gather further information and assess any risk to other members of Adult B's family.*

3.101 That same day Adult A attended her GP and said she had been using illicit Methadone because Adult B had stolen her prescription. The GP issued a repeat prescription and told Adult A to report the theft to the police which she agreed to do.

3.102 ***Comment and analysis***

3.103 *The GP had a responsibility to report the theft to the police before issuing a replacement, this did not happen and the GP relied on Adult A to make the report.*

Given that Adult B had already discussed his low mood and that he had been provided with a methadone prescription, there does not appear to have been any consideration of the impact of him having Adult A's methadone as well.

In light of all the circumstances, the relationship between Adult A and Adult B and the impact of coercive and controlling behaviour in abusive relationships, it may have been more appropriate for the GP surgery to report the theft.

3.104 Sometime before Christmas 2014, (records do not provide the date), a worker from the Corner House Project saw Adult A, who had a black eye. Adult A said she had slipped in the shower, although later in the conversation she said she had banged her face on the corner of a cupboard. Adult A was encouraged to go to and provided information for various domestic abuse support projects, although the worker does not believe she attended.

3.105 ***Comment and analysis***

3.106 *The records regarding this contact are poor. There is no date or time; there is no detail of what was said or what information was provided.*

It is obvious that the worker had concerns regarding the injury to Adult A and suspected that domestic abuse was the cause as indicated by the recommendation to contact domestic abuse projects, however no DASH risk

assessment was carried out.

There does not appear to have been any consideration about information sharing, nor the impact of domestic abuse on Adult A.

3.107 On 4th December 2014, Adult B attended an appointment with a drugs worker in the GP surgery and said he was depressed following his relationship breakdown.

During the appointment information was taken to provide an assessment including:

- *Current Prescribing information & Dose (22ml methadone)*
- *Health information*
- *Demographics & address/ contact information*
- *Family / support network information*
- *Safeguarding information*

Nothing was disclosed relating to the question about family / support network information. It is not clear if Adult B was asked about domestic abuse, or what information was recorded in relation to domestic abuse.

3.108 ***Comment and analysis***

3.109 *The contractual arrangements to provide substance misuse services in the city had recently changed by this date and the service was now provided by ReNew.*

ReNew is an integrated drug and alcohol service. ReNew provides an end to end service and support for adults within Hull who may have alcohol or drug issues or who are a family member / significant other of those with a drug and or alcohol issue..

There had been no handover of clients between providers, therefore this was an introductory appointment to 'get to know clients' and to gather information, assess need and inform support options.

3.111 On the same day (4th December 2014), Adult A also visited a drugs worker in the GP surgery (a different person to Adult B's drug worker).

During this appointment information was taken to provide an assessment including

- *Current Prescribing information & Dose (22ml methadone)*
- *Health information*
- *Demographics & address/ contact information*
- *Family / support network information*
- *Safeguarding information*

Again, nothing was disclosed relating to the question about family / support

network information. It is not clear if Adult A was asked about domestic abuse, or what information was recorded in relation to domestic abuse.

3.112 ***Comment and analysis***

3.113 *It is unclear whether Renew had access to the previous commissioned service case records or whether these were not accessed. If the information had been available / accessed the worker would have seen the history of domestic abuse previously disclosed.*

Unless such information is provided, workers will not be aware of incidents and patterns of domestic abuse. In this case it should be seen as a missed opportunity.

The drugs workers now have access to the computerised GP records.

3.114 On 8th December 2014, Adult B attended an appointment with his GP and said he had split up with his partner and had been left in a lot of debt due to buying Adult A's child (Adult C) a car. He was again offered and refused counseling.

3.115 ***Comment and analysis***

3.116 *Adult B indicated domestic abuse risk factors, that they had split up and that he was in debt due to Adult A's child (Adult C).*

There does not appear to be an apparent recognition of this increased risk of domestic abuse. No DASH risk assessment was completed and this should be seen as a missed opportunity.

3.117 Adult B attended an appointment with a drugs worker at the GP surgery on 29th December 2014. During the appointment he stated he was feeling depressed due to splitting up from his partner (Adult A). He stated that he had no intention of self-harming but that he was not coping well. The drugs worker offered counseling but Adult B declined it.

3.118 ***Comment and analysis***

3.119 *This is the same information provided to the GP and there was still no recognition of the impact on Adult A, or the potential for escalation within the context of domestic abuse.*

These events also show a lack of information sharing or access to records within the surgery and that individual staff members have the full facts and history concerning patients.

No DASH risk assessment was completed and this should be seen as a missed opportunity.

3.120 On 30thDecember 2014, Adult A attended an appointment with a ReNew drugs

worker at the GP surgery. An assessment was made regarding current health, welfare; reported use / non use of drugs or any other concerns and an initial care plan was completed. Again, this was a 'get to know' client appointment following a re-commissioning contractual handover.

3.121 Both Adult A and Adult B had a further appointment with ReNew drugs workers, Adult B on the 26th January 2015 and Adult A on the 27thJanuary 2015. Initial ReNew risk assessments were completed on both of them but there does not appear to have been any consideration of domestic abuse and the worker did not recall any disclosure or reference to domestic abuse. The assessments did cover social & cultural requirements, health & wellbeing, housing / social, safeguarding and family and actions to address risks.

3.122 Sometime during the week before she died (records do not provide the date) a worker from the Corner house project saw Adult A who told her that she and Adult B had had a *'massive bust up'* and that she (Adult A) had moved back to Adult C's house. She said that they had split up due to his cocaine use and that they had had no contact over the New Year period. They had just started seeing each other again as friends but he (Adult B) was not allowed to stay at Adult C's house overnight.

3.123 ***Comment and analysis***

3.124 *The record keeping regarding this contact is poor. There is no date or time; there is no detail of what was said or what information was provided.*

Despite Adult A providing some details regarding violence within the household, there was no apparent recognition of domestic abuse. There was no consideration of the impact on the children within Adult C's house and the increased potential for risk as she had left the relationship. No DASH risk assessment was carried out to inform appropriate risk management or safety planning.

There does not appear to have been any consideration for information sharing, nor the impact of domestic abuse on Adult A.

3.125 On 1st February 2015, police were called to a hotel in Hull where Adult A was found dead.

4 Analysis of involvement summary

4.1 Analysis has been completed within the body of the report. This section condenses the information provided so far. Further analysis will take place in the next section directly answering the terms of reference for this review.

4.2 Humberside Police

4.3 The importance of the five key high risk indicators *(Pregnancy; separation; threats to kill; hands around the throat; guns and knives)* of domestic abuse is recognised by

officers making assessments and they consider and understand the wider domestic abuse impact these may have by:

4.4 • Recognising behaviours that perpetrators may exhibit to minimise their involvement and understand the impact this may have on their decision making

4.5 • Understanding the impact of domestic abuse on children and ensuring that all possible enquiries are made to establish if children were or are present and making the necessary referrals in a timely fashion.

4.6 • All assessments, either at the incident or secondary are carried out in a timely manner irrespective of risk. The assessments should also include safety planning for victims.

4.7 • Understanding the patterns of abuse within specific incidents and not treating incidents in isolation.

4.8 • Recognising the escalating behaviours of abuse and the need for accurate and timely information to be provided to officers.

4.9 • Use of other investigative opportunities and acknowledging other disposals that may be available – victimless prosecutions

4.10 • The need to provide objective assessments of information and suitable investigation plans, without making judgmental statements and assumptions

4.11 • Ensuring the staff is skilled and competent in key roles within domestic abuse and avoiding the use of presumptive statements regarding individuals or incidents.

4.12 **Hull and East Yorkshire Hospitals NHS Trust**

4.13 There should be accurate record keeping of involvement with victims of domestic abuse identifying who may be accompanying victims to hospital, the relationship to the patient / victim or the organisation they represent and their role with their client at that time.

Staff needs to be aware of how they manage disclosures and the consequential impact to the victim and to their wider family members.

4.14 Carrying out domestic abuse risk assessments to understand the risk to the victim and make appropriate referrals.

4.15 Ensure that the alleged (or potential) victim of domestic abuse are seen separately at some point in their episode of care to allow specific questions by the healthcare worker to be asked and for any disclosure to be in private.

It is also important to recognise staff are cognizant that to stop a perpetrator from visiting a patient would infer that the patient had disclosed domestic abuse and therefore may put the patient at more risk when they leave hospital

4.16 Appropriate sharing of information regarding incidents of domestic abuse using an agreed and relevant risk assessment tool as guidance for staff.

4.17 GP Practice and Drugs Link Worker

4.18 Recognising the impact of domestic abuse when patients present with injuries. This is acknowledged as difficult however in light of the now known information could have been the case

4.19 Understanding the impact of behaviours on the wider family and giving consideration to the safety of the wider family

4.20 The use and completion of domestic abuse risk assessment and the sharing of appropriate information with agencies

4.21 Clarity of role and appropriateness of behaviour assessing future risk.

4.22 Ensuring information contained within systems is available to all those involved with patient welfare.

4.23 **ReNew Community**

4.24 Ensuring full information is known when making assessments

4.25 The use and completion of domestic abuse risk assessment and the sharing of appropriate information with agencies

4.26 **Corner House**

4.27 Ensuring there is up to date and accurate record keeping within the organisation and with staff.

4.28 Ensuring appropriate and timely information sharing

4.29 Understanding and recognising domestic abuse

4.30 The use and completion of domestic abuse risk assessment and the sharing of appropriate information with agencies

4.31 **Humber NHS Foundation Trust (Mental Health)**

4.32 Carrying out risk assessments and appreciating the increased risk of abuse from certain behaviours.

4.33 Consider the appropriateness of identifying acceptable levels of risk with regard to domestic abuse

4.34 **Together Women Project**

4.35 Ensuring risk assessments are completed and information shared at appropriate times and with appropriate cases

4.36 Reviewing current policy and process to ensure all contacts with clients are recorded and managed in a suitable way to ensure the safety of the worker and client

4.37 Providing appropriate support to victims

5 Addressing the Terms of Reference

5.1 Whether the incident in which Adult A died was a 'one off' or whether there were any warning signs and whether more could be done to raise awareness of services available to victims of domestic abuse.

- The incident was not a one off as Adult A had been involved in several incidents before, stretching over several years.

- On several occasions Adult A was provided with details of services for victims of domestic abuse (Humberside Police in December 2013 and June 2014, Corner House, Together Women's Project and the GP in June 2014. She did not use the services, however, it cannot be ascertained by this review whether that was through choice or through the coercive and controlling behaviour of Adult B.

5.2 Whether there were any barriers experienced by Adult A or her family / friends / colleagues in reporting any abuse in Hull or elsewhere, including whether they knew how to report domestic abuse should they have wanted to.

- During the review process no friends or colleagues were identified who could possibly take part in the review.

- There were some barriers to reporting identified in that it was clear Adult A was reluctant to, and, often didn't report incidents to the police. Incidents were however called in by neighbours. Adult A's family were aware of the domestic abuse. Adult D telephoned the police for Adult A and stated Adult A was "*too scared to call the police"*. There is some indication that Adult A did not want to get Adult B into '*trouble*'. Was she also fearful of the consequences of reporting to the police?

- It is easy to speculate on possible reasons including her fear of involving the police around perceived concerns around their illicit drug use, however it is just that, speculation.

- The review had evidence that she had disclosed domestic abuse to agencies, who had offered her support and information. A specialist

domestic abuse agency contacted her to offer support. She did not engage with the service.

- It was clear that she wanted to help Adult B to access support as she accompanied him to see his mental health worker and telephoned the police to try and get him some support for his mental health.

- There was evidence in the review that she was regularly accessing other services, i.e., Corner House - sexual health services and a drugs worker. Had there been a more joined up co-ordinated community response, sharing of information and partnership working then there may have been the opportunity for those agencies providing support to Adult A to have worked in partnership with specialist domestic abuse agencies. This would have been an alternative way of providing further information, advice and support to Adult A, or to consider alternative strategies to engage with her. It is often through partnership working that barriers to accessing support can be identified and removed and that every opportunity to engage with agencies is provided.

- It remains important to analyse local areas to ensure that any barriers are removed and that services and information are available to all that may need them.

5.3 Whether Adult A had experienced abuse in previous relationships in Hull or elsewhere, and whether this experience impacted on her likelihood of seeking support in the months before she died.

- There is no suggestion that either Adult A or Adult B had been involved in other relationships during the 30 years they had been together

5.4 Whether there were opportunities for professionals to 'routinely enquire' as to any domestic abuse experienced by Adult A that were missed.

- There were a number of opportunities to 'routinely enquire' that were missed by the GP, Mental Health services and ReNew in June, July and December 2014.

- There were a number of opportunities to conduct a recognised domestic abuse risk assessment that were not taken; i.e., GP in June 2014, Humberside Police in June and July 2014, HEY 2014, Corner House in 2014, Humber NHS foundation trust 2014 and ReNew in early 2015.

- It is not possible to say that the missed assessments would have changed the outcome but they would have created a better understanding of the abuse Adult A was suffering.

5.5 Whether Adult B had any previous history of abusive behaviour to an intimate partner and whether this was known to any agencies.

- Adult A and Adult B had been in a relationship for approximately 30 years and no other relationships were identified for either party, so this is not applicable.

5.6 Whether there were opportunities for agency intervention in relation to domestic abuse regarding Adult A or Adult B.

- There were opportunities to intervene and agencies did engage with Adult A and Adult B, it is also recognised there were further opportunities that were not taken.

- Adult A had a long standing and positive relationship with her worker at Corner house who had encouraged her to access domestic abuse services several times and provided information on domestic abuse services in the city. The police also referred her to a domestic abuse agency that in turn offered support and advice.

- On the occasions when interventions, advice and support were offered it wasn't taken. Both Adult A and Adult B had capacity and so were free to make choices. The review recognises there are many barriers that effect victims of abuse and the difficulties associated with them, however there was information provided to Adult A on several occasions although the review cannot ascertain why she did not engage with those services.

5.7 The review should identify any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and / or services in the city.

- There should be a review of training and awareness to understand the cumulative effects of domestic abuse, the high-risk indictors and a wider awareness raising campaign for all professionals.

- This should also include the wider responsibility of agencies towards children and the role of organisation impacting on domestic abuse.

- These are included within the recommendations.

5.8 The review will also give appropriate consideration to any equality and diversity issues that appear pertinent to the victim and perpetrator e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

- It is clear from the review that both Adult A and Adult B had additional needs within their lifestyle choice. This included the use of illicit drugs and the harmful effects associated with them.

- There is an indication that Adult B's mental health was deteriorating,

which could have been linked to bereavement and/or his illicit drug use, however these do not seem to have been considered in the context of domestic abuse.

- Research in 2008 by Feingold, Kerr and Capaldi identified a direct link between drug use and increased abusive and violent behaviours. The use of drugs in relationships and the link to mental health and violence should be recognised as a key indicator of potential abuse and greater emphasis on domestic abuse should be considered.

5.9 Family and family Engagement

5.10 How should friends, family members and other support networks and where appropriate, the perpetrator contribute to the review, and who should be responsible for facilitating their involvement?

- Adult A's children have been written to inviting them to take part in the review, but they didn't respond. On behalf of the review the Police Family Liaison Officer was asked to contact Adult As children directly which they did. Adult As children said they didn't want to take part in the review.

- A letter has been sent to Adult B inviting him to contribute to the review, but to date, he has not responded.

- No Friends were identified to take part.

5.11 How matters concerning family and friends, the public and media should be managed before, during and after the review and who should take responsibility for this?

- The Hull Community Safety Partnership is responsible for all matters of communication.

- An executive summary of the review will be published on the Hull Community Safety Partnership website, with an appropriate press statement available to respond to any enquiries. Any recommendations from this review will be distributed through the CSP website. The Hull Community Safety Partnership will oversee and manage the implementation of any learning from this review and any other learning opportunities with partner agencies involved with responding to domestic abuse.

5.12 Legal Processes

5.13 How will the review take account of a Coroner's inquiry, and (if relevant) any criminal investigation related to the homicide, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process?

- There will not be an inquest into Adult A's death because all the matters relevant to such proceedings were aired during the criminal process.

5.14 Does the Review Panel need to obtain independent legal advice about any aspect of the proposed review?

- No conflicts or issues have been identified that would suggest this will be necessary.

5.15 Research

5.16 How should the review process take account of previous lessons learned from research and previous DHRs?

- Previous DHR's have been scrutinised during this review to elicit best practice. Research was extended to include academic sources including: Kemshall (2013), Walby and Allen (2004); Bain (2008); Munro (2007); Nash (2010); Brandon et al (2009); Barry (2009).

Specific documents have also been considered;

- The Home Office Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews (Home Office June 2013)
- The Home Office Domestic Homicide Review Tool Kit Guide for Overview Report Writers (Home Office March 2012)
- Call an End to Violence Against Women and Girls (HM Government March 2016)
- Barriers to Disclosure (Walby and Allen, 2004)
- Home Office Domestic Homicide Reviews – Common themes identified and lessons learned (November 2013).
- Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence, (2006).
- 'If only we'd known': an exploratory study of seven intimate partner homicides in Engleshire (July 2007)

5.17 Diversity

5.18 Are there any specific considerations around equality and diversity issues, such as ethnicity, age and disability that may require special consideration?

- Equality and diversity issues were considered by the review and Adult B's mental health was identified and considered.

5.19 Multi Agency Responsibility

5.20 Was Adult A or Adult B subject to a Multi-Agency Risk Assessment Conference (MARAC) / Multi-Agency Public Protection Arrangements (MAPPA)?

- Neither Adult A nor Adult B was subject to MARAC or MAPPA.

- The review identified a number of opportunities for agencies to have completed a relevant risk assessment to clearly identify the level of risk, which may or may not have resulted in a MARAC referral.

5.21 Did Adult A have any contact with a domestic abuse organisation or helpline?

- Adult A did have one contact, however she declined support.

5.22 Consideration should also be given as to whether either the victim or the perpetrators were 'vulnerable adults'.

- Neither Adult A nor Adult B was 'vulnerable adults' within the definition of Law Commission Report of 1997

5.23 Were there any issues in communication, information sharing or service delivery, between services?

- There were opportunities to share information across and within agencies that were not taken, HEY, GP, Together Women's Project, Corner House, Humber NHS Foundation Trust and drugs worker. These have been recognised by the agencies and incorporated within their action plans.

5.24 Individual Agency Responsibility

5.25 Was the work in this case consistent with each organisation's policies and procedures for safeguarding and promoting the welfare of adults, and with wider professional standards?

- Organisation's policy and procedures were followed although some have subsequently been changed, (Humberside Police, GP, ReNew Together Women Project, Corner House and Humber NHS Foundation Trust to include wider perspectives on domestic abuse.

5.26 Was the impact of domestic abuse on the victim recognised?

- There is evidence in the review that agencies recognised the domestic abuse, however the impact this had on Adult A was not as clearly understood. If agencies had taken the opportunity to see Adult A on her own and gained further information from her and completed a DASH risk assessment, than a greater understanding of the impact would have been more clearly identified.

- Adult A was offered and provided with information and support, both at times of crisis and following individual interventions. However, the report has highlighted some missed opportunities for DASH Risk Assessments, signposting and information sharing to be undertaken.

5.27 Did actions accord with assessments and decisions made? Were appropriate services offered / provided or relevant enquiries made, in the light of assessments?

- The review has highlighted a number of discrepancies between individual agency assessment and actions being taken within Humberside Police, GP and Humber NHS Foundation Trust. It should be noted that on these occasions assessments were completed, however there are other instances previously referred to when assessments could have been completed but were not.

- There were a number of occasions when different actions such as a victimless prosecution, may have created different outcomes but isn't possible to assess whether this would have reduced or increased the levels of risk towards Adult A.

5.28 Was there sufficient management accountability for decision-making? Were senior managers or other organisations and professionals involved at points in the case where they should have been?

- Management accountability for decision-making was considered and assessed by the officers undertaking the Individual Management Reviews. None identified issues for their agencies.

5.29 Lessons to be learned from the review

5.30 Recognising domestic abuse, its components and the effects on victims and the wider family. Together with identifying patterns of abuse and not managing incidents in isolation.

5.31 Understanding the need for the use of evidence based domestic abuse risk assessments by all agencies and the importance of safety planning.

5.32 The need to ensure timely and appropriate information sharing regarding victims and perpetrators of domestic abuse.

5.33 There is a need to identify those people with additional needs (drug use and mental health needs) and recognise the importance of multi agency working

6 Conclusions

6.1 The review has not identified any opportunities to predict the death of adult A and there were no opportunities to prevent it.

6.2 It appears that Adult A had suffered domestic abuse and violence for a number of years at the hands of Adult B.

6.3 Both Adult A and Adult B were illicit drug users and dependent on methadone. The drugs appear to have been having an impact on the mental health of Adult B

and this should be considered in the wider context of abuse within the family unit.

6.4 There were opportunities for agencies to be involved. Humberside police had the opportunity to consider a victimless prosecution and this may have been the only way to engage Adult A as when she was provided with information or opportunities she did not take them. The review acknowledges that victims of abuse often do not take those opportunities and so with hindsight a victimless prosecution may have been an appropriate course of action.

7 Recommendations

7.1 Hull Community Safety Partnership

7.2 There should be a single cross agency risk assessment that can be shared and used by all partners across the Hull area when supporting individuals.

7.3 A single risk assessment process should be introduced and utilised by all partners within the Hull area.

7.4 The Hull Community Safety Partnership should design and implement a common language for all organisations to create a standardised understanding relating to risk thresholds and MARAC criteria.

7.5 Review of the current training and awareness provision and ensuring the cumulative effect of domestic abuse and coercive and controlling behaviour and also the impact on children is highlighted and understood.

7.6 To raise awareness of the impact of additional needs within relationships and the effects on individuals and the increased risk of vulnerability to domestic abuse. This should enable staff to make better-informed risk assessments and safety plans for those individuals.

7.7 Hull Domestic Abuse Partnership Domestic Abuse Support Services

The learning from this whole Domestic Homicide Review process be disseminated to the DAP Domestic Abuse Support Service and reflected upon to consider any improvements to practice that can be made and acted upon.

7.8 For the DAP team to continue to raise awareness of domestic abuse and coercive and controlling behaviour and services available.

7.9 The lessons learned from this review are cascaded via training provided by the DAP team, including Safeguarding Adults and Children training.

7.10 Humberside Police

7.11 The learning from this case in respect of child protection checks by The Hub, communication of information to attending patrols and appropriate safeguarding to be disseminated force-wide by means of a ‘lesson learned’ bulletin and recorded on the force action plan.

7.12 Guidance around the use of victimless prosecutions to be disseminated to all front-line police officers and supervisors. This will also be incorporated into the domestic abuse training that is currently being delivered and also into the (Independent Crime Investigation and Development Programme (ICIDP) and Initial Management of serious Crime (IMSC) courses.

7.13 **Hull and East Yorkshire Hospitals NHS Trust**

7.14 Ensure this case study is used as an example in Safeguarding training and emphasis and explain the rational for accurate record keeping.

7.15 Ensure all clinical staff are aware of the need to see the patient on their own at first contact. This would give the opportunity for confidential disclosure. Raise awareness on information sharing, documentation, private consultation and acting in person/public interests.

7.16 Staff must ensure that an accurate and comprehensive record is kept of any consultation including the names and relationships of anyone accompanying the patient at the time of the visit.

7.16 Staff know who to contact for advice when they are unsure what to do if the patient is reluctant to access support if offered, specifically relating to Domestic Abuse

7.18 **Humber NHS Foundation Trust (HFT)**

7.19 HFT to ensure that clinical staffs in all care groups receive training in the Care Act 2014 commensurate to their area of practice and its application in relation to domestic violence.

7.20 HFT Safeguarding Adults Policy January 2012 should be reviewed and updated to incorporate guidelines/recommendations of the Care Act 2015.

7.21 The 'safeguarding' section in HFT Mental Health Assessment paperwork should be updated so that adult/child-safeguarding issues can be clearly documented and actions to be taken/completed recorded in line with policy and expected practice standards.

7.22 Hull Secondary Mental Health Service operational procedures October 2014 to be reviewed to include a section on discharge procedures to ensure that information sharing where identified as an outcome is achieved and completed.

7.23 **Hull Clinical Commissioning Group on behalf of The GP Surgery**

7.24 Review and update the practice domestic abuse policy and procedure. To include specifics re roles/responsibilities, professional boundaries and support for staff.

7.25 Review the contractual arrangements with ReNew services with specific focus on

domestic abuse and violence.

7.26 Improve Systmone clinical notes with implementation of a Prompt/Flag for DA.

7.27 Remind all practice staff of the reporting duties, systems and processes for stolen prescriptions.

7.28 Share lessons learnt from this Domestic Homicide Review process with local GP practices.

7.29 **ReNew**

7.30 Revisit with all agency staff team DV training and signs / symptoms of DV so practitioners could feel more confident in having ‘ difficult conversations’ Revisit current DA & MARAC pathways & paperwork as part of refresher training to ensure both are updated to reflect current policy and practice.

7.31 **Together Women’s Project**

7.32 To ensure that all contacts with clients are managed according to current protocol and policy.

7.33 Appropriate information sharing takes place within professionals.

7.34 Risk assessments are completed when contact is made with clients.

7.35 **Corner House**

7.36 Develop and implement a process and protocol for accurate record keeping within the organisation and with staff.

7.37 Ensuring appropriate and timely information sharing is completed and staff are aware of their responsibilities.