Domestic Homicide Review

under section 9 of the Domestic Violence Crime and Victims Act 2004

In respect of the homicide of a woman

In February 2018

Report produced for Safer Telford and Wrekin by
Paula Harding
Independent Chair and Author
June 2019

GLOSSARY

AAFFDA: Advocacy After Fatal Domestic Abuse
AMHP: Approved Mental Health Practitioner
CSP: Community Safety Partnership
CCG: Clinical Commissioning Group
CPS: Crown Prosecution Service
DARS: Drug and Alcohol Recovery Service
DASH: Domestic abuse, stalking and harassment risk assessment model
DoH: Department of Health
DHR: domestic homicide review
DVA: domestic violence and abuse
GP: General Practitioner
IMR: Individual Management Review – reports submitted to review by agencies
IRIS: Identification and Referral to Improve Safety domestic abuse programme in primary care
NICE: National Institute for Health and Care Excellence
MARAC: Multi-Agency Risk Assessment Conference
MHA: Mental Health Act 1983
MPFT: Midlands Partnership NHS Foundation Trust
TWSP: Telford and Wrekin Safeguarding Partnership
WMP: West Mercia Police

Contents

PREFACE

Members of the review panel offer their deepest sympathy to the family and to all who have been affected by the victim's murder.

1. INTRODUCTION

1.1. The homicide

1. This review concerns the homicide of a forty-six-year-old woman who was killed by her partner, then aged forty-four, at their home in Telford in February 2018[1].

2. In the early hours of 21 February 2018, the victim was found with multiple stab wounds by a neighbour after the perpetrator had admitted killing her. The perpetrator fled the scene but was arrested a short time later, claiming not to remember what had happened. Initially pleading not guilty, he eventually changed his plea to guilty of murder and was sentenced to eleven years imprisonment.

3. This minimum life sentence was increased to fifteen years following an appeal by West Mercia Police and the Solicitor General who considered the perpetrator to be a danger to women. The Court of Appeal agreed that the original sentence was unduly lenient and did not take enough account of the aggravating features of the murder concluding, "we highlight the use of two knives, the savagery of the attack, demonstrating an intent to kill, the absence of any defensive injuries and the fact that the offender had taken illegal drugs."

4. This review will consider the circumstances leading up to the homicide.

1.2. Aim and Purpose of a domestic homicide review

5. Domestic Homicide Reviews (DHRs) came into force on the 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR 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

[1] The precise date of the murder has been redacted to protect the anonymity of the deceased and her family

violence, abuse or neglect by (a) a person to whom she was related or with whom she was or had been in an intimate personal relationship or (b) member of the same household as herself; with a view to identifying the lessons to be learnt from the homicide

6. The purpose of a DHR is to:

" a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
b) 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;
c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
e) contribute to a better understanding of the nature of domestic violence and abuse; and
f) highlight good practice" (Multi-Agency Statutory Guidance 2016, para 7)

7. As well as examining agency responses, statutory guidance requires reviews to be professionally curious and find the "trail of abuse". The narrative of each review should "articulate the life through the eyes of the victim…The key is situating the review in the home, family and community of the victim and exploring everything with an open mind". (*Multi-Agency Statutory Guidance 2016, paras 8 and 9*)

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

1.3 Confidentiality

9. This Overview Report has been anonymised and, where stated, redacted, in order to protect the identity of the individuals concerned and their families. The panel considered the use of pseudonyms for the victim and perpetrator in line with Statutory Guidance and as a means to humanise the victim's narrative. However, as there was no family engagement in this review with which to test out the suitability of pseudonyms, the panel concluded that it was inappropriate to proffer them and used the terms 'victim' and 'perpetrator' instead.

10. Whilst the details of each review remain confidential, available only to participating professionals and their direct line management, the report has sought to extract sufficient detail for the lessons and recommendations to be understood, whilst balancing this need for confidentiality.

2. TERMS OF REFERENCE

2.1 Methodology and Timescales

11. Safer Telford and Wrekin[2] were notified by West Mercia Police of the death of the victim in June 2018. It was agreed that the circumstances met the criteria set out in Section 9 of the Domestic Violence, Crime and Victims Act (2004) and the Home Office were notified of the decision to hold a domestic homicide review on 16.08.2018. It was acknowledged that the timescale to conclude the review would be dependent on the criminal processes which did not complete until August 2018.

12. All local agencies were notified of the death and were asked to examine their records to establish if they had been approached by or provided any services to the family and to secure records if there had been any involvement.

13. Arrangements were made to appoint an Independent Domestic Homicide Review Chair and Author, Paula Harding, and agree the make-up of the multi-agency review panel.

14. The Senior Investigating Officer in charge of the criminal investigation from West Mercia Police attended the first panel meeting in July 2018 and was able to provide detail on the findings of the criminal investigation. The subsequent conclusions of the court have been incorporated into this review.

15. The Terms of Reference were drawn up by the Independent Chair together with the review panel incorporating key lines of enquiry and specific questions for individual agencies where necessary. Individual Management Reviews (IMRs) were requested to be undertaken as well as information reports from agencies with less involvement. Briefings were made available for IMR authors by the Independent Chair.

16. The panel met five times during which panel members were able to discuss the progress of the review and request further clarification and additional material, where needed. All panel meetings were minuted and all actions agreed for the panel have been tracked and signed off.

17. The panel considered and agreed the draft Overview Report and the final Overview Report was endorsed by the Community Safety Partnership prior to submission to the Home Office.

[2] Safer Telford and Wrekin refers to the Community Safety Partnership in this area.

2.2. Involvement of family and friends

18. The victim is survived by her father, her two grown-up children and young grandchildren.

19. Close adult members of the family were each informed by letter that the domestic homicide review was taking place, with Home Office and AAFDA explanatory leaflets and advice included. Letters were delivered by the Police Family Liaison Officers who described the role and purpose of the review.

20. Further letters were delivered when the overview report had been drafted but no response was received from any family member and it was taken that they had declined engagement. All family members will be notified before publication of the report and engagement and support will be offered again at this time.

21. The perpetrator had been moved from prison to a secure psychiatric hospital and clinicians were consulted on whether he should be informed about the review and given the opportunity to engage with the review. He agreed to meet with the Independent Chair and a member of the panel, and his contribution has been included in the report.

22. Unfortunately, the review panel was unable to identify any friends of the victim from whom to gain a richer narrative about the life of the victim and to enhance that which was already known, or perceived, by agencies.

2.3. Independent Chair and Overview Author

23. The Independent Chair and Overview Author is Paula Harding, who has compiled the Overview Report and Executive Summary. Paula Harding has over twenty-five years' experience of working in domestic violence and community safety with both senior local authority management and specialist domestic violence sector experience. For twelve of those years, she was a local authority strategic and commissioning lead for domestic abuse and violence against women in a large metropolitan authority and has been an independent chair and author of domestic homicide and safeguarding adult reviews since 2016. She completed an M.A. (Birmingham) in Equalities and Social Policy in 1997, focusing on domestic violence and social welfare, and is a regular contributor to conferences, national consultations and academic research. She completed the OCR certificated training funded by the Home Office for *Independent Chairs of Domestic Homicide Reviews* in 2013. She has also completed the on-line training provided by the Home Office: *Conducting a Homicide Review*[3].

24. Beyond this review, Paula Harding is not employed by any of the agencies of Safer Telford and Wrekin.

[3] Available at https://www.gov.uk/guidance/conducting-a-domestic-homicide-review-online-learning

2.4. Members of the Review Panel

25. Multi-agency membership of this review panel consisted of senior managers and/or designated professionals from the key statutory agencies. The Panel members had not had any direct contact or management involvement with the family of the victim, and, with one exception, they were not the authors of the Individual Management Review reports that their organisations provided.

26. Wider matters of diversity, equality and specialisms were considered when agreeing panel membership. West Mercia Women's Aid provided particular expertise on domestic abuse and the 'victim's perspective' to the panel. Telford Stars Inclusion, who support those affected by drugs and alcohol in the area, provided expertise in respect of substance misuse which was relevant to this review.

27. The review panel members were:

- Paula Harding, Independent Chair and Overview Report Author
- Jas Bedesha, Service Delivery Manager: Community Safety, Telford and Wrekin Council
- Jessica Tangye, Partnership Manager, Telford and Wrekin Council
- John Harrison, General Manager for Telford and Wrekin, Shropshire Fire and Rescue Service
- Christine Morris, Telford and Wrekin Clinical Commissioning Group
- Kerry Woodhouse, Partnership Development Officer, Telford and Wrekin Council
- Mark Walters, Detective Inspector, West Mercia Police
- Michael Darby, Area Manager, Sanctuary Housing Association
- Michelle Astbury, Service and Clinical Lead, Telford STARS Inclusion
- Sue Coleman, Chief Executive, West Mercia Women's Aid
- Sharon Conlon, Head of Strategic Safeguarding, Midlands Partnership NHS Foundation Trust
- Victoria Worthington, Service Delivery Manager: Community Social Work and Safeguarding, Telford and Wrekin Council

2.5. Key Lines of Enquiry

28. The review sought to address the 'circumstances of a particular concern' set out in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) and applied the following key lines of enquiry in this particular case:

- To establish what contact agencies had with the victim and the perpetrator; what services were provided, individually and in partnership; and whether these services were appropriate, timely and effective?
- To establish whether agencies knew, or could have known, about domestic abuse and what actions they took to safeguard and meet the needs of the victim and manage the threat from perpetrator.

- To consider how issues of mental health and substance misuse or any other issues of diversity impacted upon the delivery of services and whether needs or risk arising from these factors were addressed.
- To establish how well-equipped staff were in responding to the needs, threat or risk identified for the family through policies and procedures; management and supervision; training; capacity and resources to meet expected standards of practice.
- To establish what lessons can be learned from the case about the way in which professionals and organisations carried out their duties and responsibilities.
- To identify clearly what those lessons are, how (and within what timescales) they will be acted upon and what is expected to change as a result through the production of a multi-agency action plan
- To recommend to organisations any appropriate changes to such policies and procedures as may be considered appropriate in the light of this review

29. In addition, the following agencies were asked to respond specifically to the following points.

West Mercia Police

- How the victim was supported to engage with the police when domestic abuse was reported
- How the victim was supported to engage with other agencies
- Whether the response to the anti-social behaviour report led to a risk management plan, whether risk to others was identified and if so, how responded to.
- When there were claims of mutual domestic violence, how were decisions made on who was the primary perpetrator?
- A summary of the circumstances that led to the victim's grandchild being made subject to a Police Protection Order.

Adult Social Care

- Analyse specifically the perpetrator's mental health assessment in February 2018 and actions taken as a result. How multi-agency information informed the assessment and whether any risk to others were considered, determined and acted upon

Sanctuary Housing

- Whether any wider or safeguarding concerns arose, or could have arisen, from the day-to-day management of the tenancy
- Whether reports of anti-social behaviour enabled risk to be identified for the victim or others and how this was acted upon

2.6. Time Period

30. The panel agreed that the review should focus on the contact that agencies had with the victim and perpetrator during the period since January 2012 when the victim was known to Multi-Agency Risk Assessment Conference (MARAC) shortly before the couple's

relationship was thought to begin, until the victim's homicide. The review also considered relevant information relating to agencies' contact outside that time frame for contextual purposes.

2.7. Individual Management Review Reports (IMRs)

31. An IMR and comprehensive chronology was requested from the following organisations:

- Midlands Partnership NHS Foundation Trust
- Telford Stars Inclusion
- Telford and Wrekin Adult Social Care including Drug and Alcohol Recovery Services prior to their external commissioning
- Telford & Wrekin Clinical Commissioning Group
- Telford and Wrekin West Mercia Police
- Sanctuary Housing
- Shrewsbury and Telford Hospital NHS Trust

32. The IMRs were authored by professionals who had not had any direct contact or management involvement with the victim or her family.

33. Chronology and/or information reports were requested from:

- Jobcentre Plus
- Telford and Wrekin Children's Services
- Telford and Wrekin Community Safety Team
- West Midlands Ambulance Service

2.8. Agencies without contact

34. The following agencies were contacted but confirmed that the individuals had not been known to them within the period considered within this review:

- Maninplace (Homeless Service)
- National Probation Service
- Shropshire Fire and Rescue Service
- Victim Support
- Warwickshire and Mercia Community Rehabilitation Company
- Wrekin Housing Trust

2.9. The definition of domestic violence

35. The Government's definition of domestic violence, which sets the standard for agencies nationally was applied to this review:

> *"Any incident or pattern of incidents of controlling, coercive or 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. This can encompass but is not limited to the following types of abuse:*
> - *psychological*
> - *physical*
> - *sexual*
> - *financial*
> - *emotional*
>
> *Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.*
> *Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim*." (H.M. Government, 2013)

2.10. Parallel Reviews

36. In view of the recent contact that the perpetrator had with mental health services, Midlands Partnership NHS Foundation Trust reported the homicide on their serious incident reporting system. However, in order to avoid duplication, the Trust made a decision not to undertake a separate Serious Incident Review but identify and act upon learning from the domestic homicide review.

37. Beyond criminal proceedings, the review panel was not made aware of any other parallel proceedings. No inquest was held as the cause of the murder was deferred to the conclusions of the criminal case.

2.11. Equality and Diversity

38. The review gave due consideration to individual vulnerabilities alongside each of the protected characteristics under Section 149 of the Equality Act 2010[4]. The victim was aged forty-six-years and the perpetrator aged forty-four-years at the time of the homicide. Both parties were of white British origin. It was considered that the victim's sex and long-term substance misuse and the perpetrator's sex, mental health and substance

[4] The nine protected characteristics under the Equality Act 2010 are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation

misuse were relevant to this review and will be addressed in the commentary and analysis below.

39. In respect of sex and gender roles, it was noted that during the three years preceding the victim 's homicide, seventy per cent of victims of domestic homicides were female and, in the year of her murder, eighty-three per cent of victims reporting coercive control to the police[5] were female (Office for National Statistics, 2018).

2.12. Dissemination

40. The following individuals and organisations will receive copies of this review

- The victim's family
- Safer Telford and Wrekin and its agencies
- West Mercia Police and Crime Commissioner
- Telford and Wrekin Safeguarding Adult Board and its agencies
- All agencies involved in the review and beyond through publication on the Safer Telford and Wrekin website

3. BACKGROUND AND CHRONOLOGY

3.1 Persons Involved in this review

41. In order to protect the identity of the victim, family and significant others, the following anonymized terms have been used throughout this report:

Designation	*Relationship*	*Age at the time of the victim's homicide*	*Residing with victim at time of the homicide*
The victim	The victim	46	---
The perpetrator	The victim's partner and perpetrator of the homicide	44	Yes
Adult 3	The victim's abusive partner until 2009 and father of her children	Not relevant	No
Adult 4	The victim's abusive partner between 2011 and 2012	Not relevant	No
Elder daughter	Daughter	29	No
Younger daughter	Daughter	22	No

[5] 83% of victims were female where the victim's sex had been recorded. Sex had not been recorded in 22% of cases.

42. The sections below have been based on information provided from agencies' records and interviews with staff; agencies' analysis in IMRs; verbal summaries of the criminal proceedings and an interview with the perpetrator. They represent the Independent Overview Author's view of significant information and events about the victim.

3.2 The victim's background

43. The victim was aged forty-six when she was killed. She had two grown-up daughters and three grandchildren and had experienced significant domestic violence and abuse from her long-term partner and father of her children, and subsequent boyfriends, before her relationship with the perpetrator began.

44. The victim also had a long history of anxiety and substance misuse which appeared to stem from this time. Indeed, health agencies first became aware of the victim's experience of anxiety, panic attacks and alcohol use in 2004 after she had been in a relationship with her abusive ex-partner for over sixteen years. Her GP Practice became aware of incremental drug and alcohol dependence: in 2007 she disclosed depression and anxiety; in 2008 opioid-type drug dependence and in 2011, both alcohol and drug dependence.

3.3 Domestic violence and abuse in previous relationships

45. The review enquired about abuse in previous relationships in order to provide context to the victim's subsequent contact and expectations of agencies and the potential compounding effects of experiencing repeated domestic abuse.

46. The police first became aware of the victim's experience of domestic abuse from her ex-partner and the father of her children (Adult 3) in 1998. The incident involved facial scarring and reports of domestic abuse continued until their relationship ended in 2009. She went on to experience domestic abuse from other boyfriends and overall, she reported domestic abuse to the police on twenty-seven occasions. During these years there were eight reports of physical abuse, two of which involved the suspect being charged.

47. The victim was well known to the police for other matters and both alcohol and drugs were contributing factors to the frequency of her contact with them. Where the police were involved in reports of domestic abuse, both the victim and her partners were each considered to be culpable at various times. A longer-term relationship started in 2011 and the victim's (ex-) partner, Adult 4, went on to place her at high risk of serious harm.

48. At the start of 2012, the victim and Adult 4 were both receiving treatment and key work support from the Drug and Alcohol Recovery Service (DARS). The victim disclosed that Adult 4 was abusive towards her, but she declined refuge and alcohol detox that were offered. When discussing her experiences with her keyworker thereafter, she described

"mutual fighting" and "six of one and half a dozen of another". There was no indication from the case notes that her perceptions and self-blame were explored further to understand the potential impact of coercion and emotional abuse.

49. The victim's attendance at drug treatment appointments from this point onwards was intermittent. Adult 4 went on to contact his keyworker at DARS several times to send a message to the victim's keyworker that she was "lying" about the level of her alcohol and drug use and that she smoked crack cocaine and drank super-strength lager most days. He also contacted his keyworker to deny or provide excuses for several of the assaults of the victim that were to follow.

50. In May 2012, Adult 4 contacted the police to report that the victim was drunk and had attacked him with a knife. However, when police arrived, they found the victim collapsed and a witness reported having observed the repeated assaults that the victim had received from Adult 4. She was taken to hospital where she disclosed that she had been kicked in the chest and face, but she discharged herself before receiving treatment and so the Emergency Department made a referral to Multi-Agency Risk Assessment Conference (MARAC).

51. The victim declined to provide a statement to the police, but Adult 4 was charged with an offence of assault and bailed, whereupon he assaulted the victim again and was charged for a further assault. The victim was advised by paramedics to go to hospital, but she declined. She was assessed by the police as facing medium risk of serious harm and they also referred her to the MARAC. She was advised on personal safety and home security; an alarm was installed in her property and Adult 4 placed on conditional bail to an address outside of the area to keep away from her.

52. Agencies described how the risk management plan was "frustrated" by Adult 4 continuing to have contact with her and the victim retracting her statements. There will often be credible reasons why victims may retract their statements in order to protect their own safety and the level of coercion that the victim was under at this time is not known. The criminal case against Adult 4 appears to have been withdrawn in July by the Crown Prosecution Service, but the reasons have not been established by the review. There is no indication that the victim was allocated an Independent Domestic Violence Advisor through her referral to MARAC.

53. The Drug and Alcohol Recovery Service noted that although Adult 4 was bailed out of the area, the victim had been hanging around at the centre waiting for him to return on the day of his medical review with them. Despite this, by July, she told them that that she felt she was doing much better with Adult 4 in another area.

54. On 19th July 2012, Adult 4 had returned to Telford and reported the victim to the police for slapping him. Recognising the victim to be the one at risk, the Police Domestic Violence Unit took the opportunity to talk with her independently, but she assured the officer that all was well. However, a week later the victim had been seriously assaulted by Adult 4 again whereby he had struck her with a pair of crutches causing facial injuries and she was taken to hospital for treatment. Adult 4 was arrested but released without charge and the case referred back to MARAC.

55. Later that evening, the police were called to the home address a further two times, firstly by neighbours and latterly by Adult 4. The victim had left the address in the first of the calls but was heavily intoxicated and abusive to police during their attendance at this last call that day. She was arrested and detained until the next available Magistrates Court where she was bound over[6] to keep the peace.

56. The next day, Adult 4 contacted the police to report the victim again, but she had left the home address. The police went on to arrest Adult 4 the following day for the serious assault two days earlier and continued enquiries into the matter which resulted in new evidence being obtained. Adult 4 was charged with assault and denied police bail. At court, he was released on conditional bail to a specified address in the Telford area, with a nocturnal curfew.

57. The police informed the victim of the conditions of the bail and provided her with instructions should she become aware that conditions were being breached. She also received regular 'reassurance' visits for the next two weeks from the Local Policing Team.

58. Finding that living at home was too stressful, the victim went to stay with her sister out of the region. The police became aware that communication between the two continued, sometimes indirectly through her child, in breach of his bail conditions.

59. Speaking with the Police Domestic Violence Unit two months later in October 2012, the victim advised that she was not ready to leave Adult 4 and appreciated but declined further offers of support and returned home. The criminal matter was not proceeded with and no further action was taken against Adult 4. Further information around the rationale for not acting on the breach of bail or why the assault matter did not progress via the criminal justice system has not been available.

60. Nonetheless, the case had been re-referred to MARAC and agencies were aware that many measures were not effective as agencies had not been able to engage with the victim. The couple were separated at this point. The victim stated that the relationship was over, and she no longer wanted anything to do with him. The focus of the MARAC action plan was to safeguard the victim's daughter who visited her mother periodically and for the community substance misuse team to continue their work with each individual.

61. Within the month, Adult 4 had returned to their home but was shortly afterwards himself assaulted by a male acquaintance of the victim. He moved out of the flat in November 2012 reporting to the Drug and Alcohol Recovery Service that the victim was out of control, spending all of her money on crack cocaine and suggesting that she was prostituting herself to an older male acquaintance in exchange for money for drugs.

62. In February 2013, the victim attended the Emergency Department intoxicated having been found wandering the streets. She told hospital staff that her partner was staying with her even though he was not supposed to. Consequently, the Emergency Department

[6] A bind over is issued by Courts requiring an individual not to engage in certain activities for a period of time or face a penalty such as a fine. It can be used as an alternative to a trial and requires either a conviction or the individual's consent.

informed the MARAC co-ordinator. The Drug and Alcohol Recovery Service were also aware that Adult 4 was continuing to meet the victim and victim-blaming language was noted that "MARAC are aware of ongoing domestic abuse between them … they are adults making their own choices to continue seeing each other." (Adult Social Care IMR). Despite her missing many appointments, the Drug and Alcohol Recovery Service kept the victim's case open until the end of April 2013.

3.4 An intervening period in 2015

63. In 2015, the victim contacted community mental health services on two occasions, making self-referrals on each. She discussed having suicidal thoughts but not planning to act upon them. However, after both initial telephone conversations she did not attend subsequent appointments that were made for her and did not disclose domestic abuse during her calls.

64. During 2015, the victim also approached her GP Practice on four occasions and on one of these occasions she identified her anxiety in relation to, "being unable to leave the house" and hearing voices. At the time she disclosed taking diazepam which had been provided to her by a friend and the GP advised her that her symptoms were likely to be aggravated by substance abuse and offered a referral to substance misuse services which she declined. On that occasion, she had been accompanied to the appointment by an older man whom she referred to as a family friend that she was living with. Unsurprisingly, as she was not on her own, she was reluctant to disclose the level of her dependencies at this time or why she had stopped engaging with the Drug and Alcohol Recovery Service.

65. The victim missed fourteen appointments with various health services in 2015 and a further nine in 2016. These included appointments for follow-up for significant health risks identified in routine screening for which the GP made a number of urgent referrals for her to be seen by specialists within the recommended two-week period.

3.5 The Perpetrator's Background

66. The victim was thought to start a relationship with the perpetrator at the end of 2015, although this date has not been verified. The perpetrator had enduring mental illness and substance misuse issues with records indicating that he had been experiencing these since the age of 15. He had been registered with mental health services for prolonged periods over forty years and had a diagnosis of paranoid schizophrenia that was believed to be treatment resistant, although it was not known how compliant he had been with medication over the years. He took a number of different medications including anti-

psychotic medication administered, at times, through a 'depot' injection,[7] but reported little to no effect on his mental health symptoms. However, it is not known how compliant he had been with his medication over the years and his poly (multiple) substance misuse had also impacted upon his mental health and at times led to thoughts of suicide.

67. The perpetrator had been in his tenancy with Sanctuary Housing since 2011 and anti-social behaviour was frequently reported to the landlord in the form of noise nuisance and drug related activity. A regular theme of these reports was the frequency of visitors who were allegedly attending to collect or deliver drugs to the perpetrator. Sanctuary knew the perpetrator to be illiterate and generally communicated with him verbally as a consequence.

68. The perpetrator had a long-term relationship with his ex-partner with whom he had three children. His contact with his children had been difficult at times due to his mental health and substance misuse. He struggled with literacy and did not have any employment history and left school earlier than his peers. This relationship ended in 2003 and had involved domestic abuse.

69. Before the victim, he renewed a former relationship with a partner that he had also had a child with. This relationship ended following domestic violence, although mental health services were aware that his ex-partner continued to be a source of support to him thereafter.

70. His earlier history of violence came to the attention of the police on fifty occasions and included both domestic abuse and other offences. Allegations involving two previous partners included: his grabbing his partner round the throat; cutting her hair; punching; burning with cigarettes; deliberately driving a car through his partner's wall and trying to kick the door down before throwing a stone slab through his partner's window. In 2010, he stabbed his partner's dog seven times and then sat on the train tracks intent on killing himself. Aside from this incident, neither the perpetrator nor his partners disclosed thoughts or experience of domestic abuse to mental health services.

71. Whilst he had been convicted of two other violent crimes and served two periods of imprisonment, reports of domestic abuse rarely appeared to lead to further action. Of the fifteen reports of his domestic abuse, criminal action was discontinued twelve times, largely alongside the absence of a witness statement from his victims. For the remaining domestic abuse reports, he received a caution, a conviction for criminal damage, and, on the occasion of stabbing the dog in 2008, he was detained by the police under section 136 of the Mental Health Act 1983[8].

[7] The word 'depot' means that the medication is given in a slow-release form as an injection every 2 to 4 weeks

[8] **Section 136 of Mental Health Act 1983** refers to police powers. Where a person who, in a public place, is thought to have a mental illness and is in need of care or control, this section enables the police to hold them or transfer them to a place of safety

72. The perpetrator was admitted for a period of mental health inpatient treatment and thereafter seen by mental health services to be high risk as a result of this incident although he disclosed no further thoughts to them about hurting animals or people after this time. The thoughts of harm that he did express were directed to ending his own life during periods of decline in his mental health and increased substance misuse. This was his last period of inpatient treatment prior to the murder.

73. Despite having serious mental health issues and poly-substance misuse, the perpetrator was only seen at his GP practice on seven occasions between 2012 and 2018.

3.6 2015 Onwards: The Relationship Between the Victim and the Perpetrator

74. After their relationship began, the couple mostly lived together at the perpetrator's home which was a social housing tenancy. The victim maintained her own social housing tenancy at the same time. The perpetrator's neighbours advised their housing officers that the perpetrator was approachable when not under the influence of drugs or alcohol but reported his behaviour deteriorating after he began a relationship with the victim. The perpetrator advised in an interview for this review that the victim had introduced him to cocaine whilst he had previously been using heroin and alcohol.

75. Agencies were not aware of domestic abuse in this couple's relationship until the homicide. Indeed, agencies' concerns during the time that the perpetrator was in a relationship with the victim, mostly involved his self-harm. The perpetrator's case was open to community mental health services for the majority of the time that the couple were together, although there were periods of engagement and non-engagement with him.

76. In December 2015, the victim referred herself back to the Drug and Alcohol Recovery Service and attended an initial appointment with the perpetrator. She described getting divorced and being abstinent for four-to-five years but had started using heroin and strong lager daily as well as occasional crack cocaine and diazepam. She wanted to be prescribed a heroin substitute but when unable to have it on prescription, went on to obtain it illegally whilst continuing to access the Drug and Alcohol Recovery Service intermittently.

77. In January 2016, the Drug and Alcohol Recovery Service received a referral from the perpetrator's care co-ordinator for support with exploring housing options as he was experiencing problems with his neighbours. A joint visit with his mental health nurse concluded that he was managing most aspects of his life independently despite a somewhat chaotic lifestyle.

78. In April 2016 the perpetrator contacted the Drug and Alcohol Recovery Service stating that he and his partner were anxious and both needed help from the community mental health team with their addiction and needing to move together. A risk assessment was undertaken shortly afterwards in which the perpetrator was deemed at low risk and after

several unsuccessful attempts to engage, the perpetrator was discharged from community mental health services early in August 2016.

79. Later that month, the victim contacted the police stating that the perpetrator had a knife and was intent on harming himself. She clearly stated to the call handler that "… He won't harm me … he has never tried to harm me, he has tried to harm himself before, when he gets these things in his head, he is just schizo, it is not him". In the background of the call, the perpetrator could be heard saying that he was going to the train tracks and saying, "then we are both dead" (West Mercia Police call log). The perpetrator was taken voluntarily by the police to the local hospital to engage with mental health services. The railway tracks had featured in one previous episode of the perpetrator's mental health crisis and went on to feature in the murder itself.

80. The police went on to refer the matter to their Harm Assessment Unit who in turn notified the local Safeguarding Adults Team and Children's Services. It is not known whether attention was drawn to the perpetrator's statement of "then we are both dead" in order for its meaning to be explored by the receiving referral agencies.

81. In May 2016, the perpetrator had an initial appointment with Psychological Services following a referral by the Drug and Alcohol Recovery Service where he described his motivation for drug treatment and his triggers that all of his relationship partners had been involved in drug use. The perpetrator's home was identified as being used by drug users socially. He went on to attend appointments with this service intermittently for the next ten months during which he disclosed that the victim was a source of support to him. However, his views about the victim were not always consistent as during a review in July 2016, he disclosed to his occupational therapist that he had split up with the victim as he believed that she was using him and his contacts to obtain more drugs.

82. In June 2016, a vulnerable adult reported to the police that his neighbour, the victim, was visiting him for long periods of time and attempting to persuade him to take drugs. Police officers visited the victim and the perpetrator and advised them not to visit their neighbour. The local police were informed in order to monitor the situation in view of the person's vulnerability and the matter referred to the Police Harm Assessment Unit to complete any necessary referrals.

83. A risk assessment was undertaken in July 2016 where he discussed with his occupational therapist the risks involved regarding his drug dealing acquaintances and he disclosed that he kept a knife under his bed in case of intruders. He was warned against using it and advised to contact the police if he felt under threat.

84. In October 2016, the victim was entrusted with the care of her grandchild overnight and agreed to maintain hourly contact with the child's parent and not take drugs. Whilst caring for the child, the perpetrator was attacked with an axe by drug dealers at her home and the victim sustained a facial injury. The victim escaped with her grandchild out of a bathroom window and the child was placed in police protection. It was found that both the victim and the perpetrator had been taking Class A drugs that evening and the victim was prevented from having care of her grandchildren again.

85. In January 2017, a significant incident form was raised concerning the perpetrator receiving prescriptions from both his GP and the Drug and Alcohol Recovery Service. He was thought to be selling the additional drugs received which was reported to the police. Concerns about his selling prescribed medication had surfaced before and he had been provided with medication by depot injection in previous times in order to avoid this risk. After being challenged, he disengaged with the Drug and Alcohol Recovery Service despite their attempts to maintain engagement with him. The duplicate prescribing error had arisen out of an ambiguity in the letters sent by Drug and Alcohol Recovery Service to the GP. In order to prevent future errors, the format of these letters has since been changed and they have become more explicit.

86. In March 2017, the perpetrator was discharged from the community mental health services due to a sustained period of no contact with any of the mental health services involved in his care. His last contact with a mental health professional had been by telephone in January that year where he reported that he was well. His medication was being prescribed through his GP who went on to refer him back to mental health services a month later, for help with prescribing, but he did not attend the appointments offered by them.

87. In May 2017, the perpetrator contacted mental health services asking to be seen that day due to his mental state: he had been visiting train tracks recently and was struggling with hearing voices. The victim told them that she was struggling to cope with him, and an urgent appointment was arranged for the next day which he did not attend. In contrast, when followed up, the victim answered the phone and said that he was asleep and that everything was then fine. There was no indication that this raised professional curiosity or that attempts were made to engage with the victim further to question her concerns of the day before.

88. The victim returned to the GP on two occasions, one of which related to her ongoing depression. In April 2017, the GP was notified that the victim had been discharged from the Drug and Alcohol Recovery Service due to non-attendance. Her last physical contact with the GP practice was in September 2017.

89. During January 2018, the perpetrator's alcohol and drug taking had been unusually high as a result of his friend's windfall and the perpetrator described how they had spent the best part of £50,000 on drugs over a three-week period.

90. Later in January 2018, a police report was made concerning anti-social behaviour, drug dealing activity and intimidating behaviour from visitors to the perpetrator's home. An offence was also committed against an elderly vulnerable man who was exploited and intimidated by persons attending the perpetrator's home address.

91. At the same time, the local housing association received complaints about anti-social behaviour from affected neighbours. The police's Safer Neighbourhood Team responded by instigating a Risk Management Plan and used various tactics, including undertaking visits to the area in an effort to disrupt and displace those suspected of visiting the address for drug dealing purposes.

92. Early in February 2018, with the prior permission of the housing association, the police delivered the tenancy termination notice to the perpetrator which he duly signed. He was aware that he had twenty-eight days to vacate the property.

3.7 February 2018: critical episode before the murder

93. Later in February 2018, the perpetrator contacted a woman friend in the morning to say that he intended to take his own life by jumping off a railway bridge. The woman contacted the police who commenced a search of the area and found the perpetrator who was intent on suicide. the perpetrator was detained under section 136 of the Mental Health Act 1983 and taken to Redwood Hospital for a mental health assessment

94. Not unusually there was a delay of approximately three hours whilst awaiting the availability of a psychiatrist but then the Mental Health Act assessment was undertaken at 15:00hrs with an Approved Mental Health Practitioner (AMHP), two doctors and a trainee AMHP. The AMHP had contacted the Crisis Home Treatment Team to ask if someone was able to attend the assessment, but they were not available.

95. The AMHP observed that the perpetrator had a history of using drugs and that morning he admitted to taking heroin, crack-cocaine and Subutex and he thought that would last him until the next morning. His most recent assessment as being at low risk was noted, as was his attack of the family dog eight years previously, which he had attacked whilst under the influence of illicit substances and allegedly because he thought that the dog was his cousin.

96. His records also alerted them to the closure of the perpetrator's contact with the Drug and Alcohol Recovery Service and his discharge from the community mental health team psychosis pathway in December 2017 due to numerous missed appointments.

97. During the assessment, the perpetrator was not deemed to be a risk to himself. He admitted that he was fed up with his drug taking lifestyle but also recognised that he needed to take responsibility to work with professionals and come off drugs. He had been described as calm and polite by the nursing staff and had been asleep before the assessment took place. The perpetrator was determined as not meeting the threshold for detention under the Mental Health Act and notes from the assessment stated,

> *"There was no evidence that [the perpetrator] was mentally disordered, he was not seen to respond to unseen stimuli, he made no further threat to harm himself or anyone else and had said he knew he had to take responsibility for engaging with services to help him with his drug problems."*

98. When asked whom he had rung that morning when he was at the railway tracks, he shrugged his shoulders. Mental health records stated that the victim was his partner and when he was asked for her contact number, he said that she did not have a phone. He later confirmed this during his interview for the review, indicating that the victim used his phone as it was the phone that they used for drug transactions.

99. The perpetrator indicated that he wished for further support from mental health services and was happy to be discharged home with support from the Crisis Team who would arrange to monitor his mental health and thoughts of suicide as well as support him to access drug treatment. As he was waiting for his taxi, nursing staff overheard him arranging to obtain drugs on his way home.

100. Following the assessment, the perpetrator was referred to the Crisis Team at 16:15hrs and they agreed to contact him that evening. The team made several attempts to contact the perpetrator by phone that day, but he did not answer the phone. Unbeknown to agencies, he later claimed that he had left the phone in the taxi on the way home. A decision was made by the team to visit him at home the next day. However, between 23.30 hours that evening and 06.10 hours the next morning, the perpetrator killed the victim. He was subject to a Mental Health Act assessment again after his arrest but still did not meet the threshold to be detained under the Mental Health Act and was remanded in custody.

101. The toxicology report recorded that the perpetrator had used cocaine or crack at some time before providing his blood sample and that he may have been under the influence of cocaine or crack at the time of the incident. Lower concentrations of diazepam, anti-psychotic drugs and morphine were detected but it is not possible to say whether he was experiencing the effects of morphine at the time he killed the victim, as the precise time of the homicide is not known.

4. OVERVIEW

102. This section considers the Individual Management Reviews (IMRs) and Information Reports completed by the individual agencies and the panel's contribution to their analysis.

4.1. West Mercia Police

103. West Mercia Police were involved with earlier domestic abuse that the victim experienced from various partners between 1998 and 2012. The review particularly considered her relationship with her (ex-) partner (Adult 4) between 2011 and 2012, in which she went on to face high risk of serious harm.

104. As the number and nature of reports escalated, the police approach extended to incorporate pro-active reassurance visits and monitoring by the Local Police Team; liaison with the Domestic Abuse Unit; safeguarding of the victim's child; implementation of risk management plans and referral to MARAC on two occasions.

105. As their involvement grew, and the police acted to combat anti-social behaviour that was directed towards the couple, the police considered that they had become more

approachable. Nonetheless, they considered that their actions were often thwarted by Adult 4 continuing to contact the victim, often in breach of his bail conditions. The police were aware of the victim's alcohol and drug misuse and her withdrawal of her statements against him. Although she was clear that she missed Adult 4 and wanted him back on at least one occasion it is not known whether the level of coercion and control that the victim faced throughout this time was explored. In this way, it was not known whether the victim could safely evade contact with the perpetrator (Adult 4) or whether she was coerced to withdraw her statements.

106. Whilst the withdrawal of witness statements and the police's difficulty in engaging with the victim appeared to be the most significant reasons for discontinuing criminal prosecutions against Adult 4, the intervening passage of time has made it difficult to establish the reason for not pursuing matters via the criminal justice system on each and every occasion. Adult 4's allegations and counter-allegations against her convinced the Crown Prosecution Service, on at least one occasion, to discontinue the case.

107. Despite Adult 4's allegations, the police demonstrated that they were able to identify which was the primary aggressor, identify the victim's vulnerability and identify the escalating risk that she faced.

108. Although they received no reports of domestic abuse from the victim or the perpetrator of her homicide, the police recognised that the relationship between the couple generated a range of problems for them beyond the domestic abuse. For example, they received reports of drug dealing from their home address, noise, theft and intimidation of neighbours. During this time, they had occasion to talk with the victim on her own and whilst she had opportunities to disclose any abuse, she clearly stated that the perpetrator had never harmed her and did not believe that he would.

109. Nonetheless, the Police recognise that there were potentially missed opportunities to utilise the Domestic Violence Disclosure Scheme[9] (hereinafter referred to as the Disclosure Scheme) and disclose the perpetrator's history of violence to the victim via the 'right to know' route. Under 'Right to Know' the police are able to share information, following consultation with relevant multi-agency partners, with those at risk from harm where it is lawful, necessary and proportionate to protect the potential victim from further harm. Such a disclosure to the victim would have ensured that she was fully informed of the threat the perpetrator potentially posed to her and enabled her to make a decision whether to continue with the relationship or take any appropriate measures to protect herself.

110. The Police identified that a disclosure could have been made under the Disclosure Scheme at any time once the Police or another agency was aware that the couple were in a relationship together. However, the incident in August 2016 when the victim contacted the police due to the perpetrator being in possession of a knife and

[9] Home Office guidance on the Domestic Violence Disclosure Scheme can be found at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575361/DVDS_guidance_the perpetratorINAL_v3.pdf

threatening self-harm, may have presented an appropriate opportunity to do this. Officers attended the address and correctly identified that the perpetrator was in need of assistance and took him to the Mental Health Crisis Team to facilitate this. Greater professional curiosity by officers who dealt with incidents involving the victim and the perpetrator could have resulted in the disclosure scheme process being instigated and appropriate disclosure to the victim that the perpetrator was a serial perpetrator of domestic abuse, particularly in the light of the victim's own vulnerability due to her alcohol and drug use and previous experience of domestic abuse.

111. Although officers at the time would have been aware of the Disclosure Scheme, it was considered that greater professional curiosity and the application of greater domestic abuse awareness may have been needed to appreciate its application. As part of a Force-wide strategy "Protecting People From Harm", since November 2017, West Mercia Police have been providing all front-line officers with College of Policing Vulnerability Training in order to build the skills of staff to respond to the multiple and complex needs of vulnerable individuals as well as dedicated domestic abuse training to student officers.

112. Moreover, 1200 frontline staff including CID, Safer Neighbourhood Teams, Patrol Officers, Front Counter staff and managers are currently being trained on the 'Domestic Abuse Matters' course provided by the domestic abuse organisation, Safe Lives and ratified by the College of Policing. This domestic abuse specific course aims to build long-term attitudinal and behavioural change amongst staff and in combination with the wider vulnerability training enable a more effective response to domestic abuse victims with multiple needs.

4.2. Midlands Partnership NHS Foundation Trust

113. The perpetrator had received mental health services for most of his adult life and his case had been open to the Trust for most of the period considered within this review although there had been periods of engagement and non-engagement. At the time of the murder he had not been actively open to mental health services as the Crisis Team had not had a chance to engage with him before his arrest. However, mental health practitioners knew the perpetrator well and were very surprised by the murder.

114. The predominant purpose of engagement with mental health community services was for access to psychiatric medication and support in managing the symptoms of his illness although his paranoid schizophrenia was believed to be treatment resistant. He often sought other medication for anxiety which was closely monitored due to its addictive qualities. He was also supported on other issues that were impacting on his well-being including literacy classes and accommodation issues as well as substance misuse issues which mental health practitioners considered escalated after he met the victim.

115. It was identified that community mental health services had been particularly flexible and responsive in seeking to maintain contact with the perpetrator who had periods of non-engagement. Practitioners were persistent in maintaining engagement and working with other agencies to maintain contact where necessary. They also responded to concerns raised by family members.

116. The Trust was aware of the incident eight years prior, where he had stabbed the family dog. They were also aware of his previous convictions for serious violence, but they were not aware that domestic abuse was a factor in the perpetrator's relationships. Indeed, the thoughts of harm that he did express were directed to ending his own life during periods of decline in his mental health and as well as times of increased substance misuse. Nonetheless, the incident of his stabbing the dog led him to be considered high risk at the time and this information was carried forward to subsequent assessments despite him not expressing thoughts of harm towards animals or people after that time.

117. It was noted that neither his ex-partner nor the victim disclosed domestic abuse to mental health services, but it is not known if they were directly asked. There was no indication that the incident with the dog was considered within the context of domestic abuse. Had it been, then his partners would have been directly asked about domestic abuse. In particular, the victim's concerns about not being able to cope with the perpetrator in May 2017, abruptly minimised by her the next day, did not appear to arouse professional curiosity. The perpetrator was not known to have displayed any violence to others for a decade and so this may not have led to considerations of domestic abuse, but it did not raise consideration of the victim's caring role.

118. In order to support staff responses to domestic abuse, Midlands Partnership NHS Foundation Trust advised that they have domestic abuse policies and procedures which are readily available to staff; domestic abuse e-learning packages which are mandatory for all staff; robust supervision framework; electronic prompts to encourage the discussion of abuse or neglect and the DASH risk identification embedded into the electronic patient record which has the added advantaged of oversight from their Safeguarding Team. Further support is provided through their supervision policy

119. Nonetheless, the Trust have made a recommendation for their safeguarding team to review their arrangements for raising awareness of and responding to incidents of domestic abuse. This was recommended in order to ensure that when family members come in to contact with the Trust, and domestic abuse is identified, that they are offered an appropriate and timely response by a skilled and supported practitioner. Moreover, the Trust acknowledged that further work was required in order to raise the profile and awareness of domestic abuse across all services and therefore proposed to address this through the re-design of safeguarding which is due to take place in 2019.

4.3 GP Practice

120. Although they were both registered with the same GP practice, neither the victim nor the perpetrator were frequent attenders there. The Practice did not know that they were in a relationship as both held different addresses and neither disclosed their relationship.

121. The victim registered with the Practice in 2011 and the Practice were aware from her records about her incremental poly-substance dependence. The following year, the Practice was notified of her attendance at the Emergency Department and her subsequent referral to MARAC and a marker was placed on her records to that effect.

122. She did not attend the Practice during that time but discussed the relationship being over and being in being in very low mood when she next attended a further year later. Although she disclosed drinking heavily again and being off methadone there was no evidence that the GP referred her to the local drug and alcohol service or explored the impact of the domestic abuse that they were aware of.

123. In relation to other medical matters where screening indicated a significant health risk, it was evident that the GP Practice went to significant lengths to engage the victim and actively tried to arrange and encourage her to attend appointments in order for the health risk to be addressed.

124. The GP records did not identify that the victim had made any disclosures regarding domestic abuse since they received the MARAC notifications early in 2013 but they did not follow-up on known domestic abuse or make routine enquiry when mental health and substance misuse, as indicators of potential domestic abuse, were know. Since this time guidance from the Royal College of General Practitioners (2014) and NICE Guidance on Domestic Violence and Abuse (2016) has identified the need to make further enquiries where possible indicators of domestic abuse, including depression and substance misuse, are presented.

125. The victim did present periodically from 2014 onwards with low mood and anxiety but it does not appear that that domestic violence and abuse was overtly explored and documented. Her GP identified that they did endeavour to explore her past history and substance dependence, but that the victim was reluctant to do so. On one of these occasions, she had been accompanied to the appointment by an older male friend and there is no indication that attempts were made to see her alone.

126. Since this time, the Clinical Commissioning Group has promoted improving responses to domestic abuse in its area through training on domestic abuse awareness and routine enquiry. As a result, the GP Practice concerned now makes routine enquiry, where it is safe to do so, and where indicators of domestic abuse present themselves. In addition, consideration is being given to the addition of a Vulnerable Adult marker on the patient record for patients on the list presenting with conditions such as substance misuse.

127. Telford and Wrekin Clinical Commissioning Group have made recommendations for their service:
- to issue guidance which identifies the importance of fully recording any patient conversations with regard to potential indicators of abuse
- to raise awareness with GP practices about routine enquiry for patients who have a history of substance misuse and also on separation when domestic abuse was known in that relationship
- to raise awareness with GP practices about the importance of seeing patients on their own when concerns about abuse have been identified
- to reinforce the need for GP's to document who has attended with the patient and detail conversations that could be used for evidential purposes to secure protection for domestic abuse victims.
- to assess the impact of recent and ongoing practice development with GPs around domestic abuse
- to enable input from specialist domestic abuse services into training and promote the role of West Mercia Women's Aid in supporting their patients and their practice

128. As a result of work already undertaken and the ongoing plans to improve their area's response to domestic abuse, the Clinical Commissioning Group does not consider that the implementation of the Identification and Referral to Improve Safety (IRIS) programme, a nationally promoted domestic abuse programme for primary care, is specifically required. However, they have committed to the ongoing monitoring and review of their progress in this regard.

4.4. Telford and Wrekin Adult Social Care

129. Before 2016, the Drug and Alcohol Recovery Service was a service within Adult Social Care in Telford and Wrekin. It was also noted that prior to 2016, mental health social workers worked within community mental health services. After this time, they returned to the local authority and used the local authority recording system, but all historical records were kept on the mental health recording system.

130. Within the Drug and Alcohol Recovery Service, the victim was known to be experiencing domestic abuse in 2012 from her partner at the time (Adult 4). There were several incidents of the victim blaming herself for the violence or talking about mutual violence which was not explored further. Likewise, there were several times when Adult 4 claimed that the victim was violent to him or undermined her credibility with the service. There were no indications that this was questioned or challenged even when Adult 4's violence had increased towards the victim to such a high level that the case was referred to MARAC.

131. The victim did not appear to have been offered therapeutic interventions or referred to domestic abuse services. Instead interventions focussed upon her drug and alcohol use with "the rationale of [the victim] having capacity and being able to choose to be in her

relationship." (DARS worker) without appearing to consider whether she was subject to coercive control.

132. The perpetrator's history of domestic abuse was not known to Adult Social Care. However, both the victim and the perpetrator were known to their service for long periods and presented with the same issues throughout their records. The service has recognised that the level of multi-agency working, and information sharing, should have been more robust and a more holistic approach, which was more personalised to the wider presenting issues, should have been taken, exploring the wider context to their issues. Indeed, greater professional curiosity could have identified further multi-agency support needed for wider issues such housing.

133. Had domestic abuse been known within the current relationship, the Adult Social Care IMR author considered that the service would have been able to support interventions or therapeutic support for both the victim and the perpetrator. Although some issues were raised and some practical and therapeutic interventions provided, these were not specific to domestic abuse. Adult Social Care reflected that this could have led to exploration around controlling and coercive behaviours that the victim may have been subjected to and the service would have contributed to a multi-agency risk assessment and multi-agency ownership of any identified risks.

134. Adult Social Care particularly reflected upon the Mental Health Act assessment undertaken with the perpetrator on the day before the murder but as this was a multi-agency assessment, it will be considered in the thematic section to follow.

135. Adult Social Care have made recommendations for themselves concerning enabling access to records; supporting greater professional curiosity and providing domestic abuse training to all staff. In this way, they seek to enable staff to make more informed, holistic and person-centred assessments of risk and needs with a greater emphasis on multi-agency working, domestic abuse and coercive control.

4.5. Sanctuary Housing Association

136. Sanctuary Housing Association were aware of the perpetrator's alcohol dependency when he took on the tenancy in 2011 and suspected that he had other substance misuse issues as well as suffering mental ill health as he and his family were already well known to the Association. They did not consider him to be an inherently dangerous individual, despite strong suspicions that he was involved in illegal activities such as drug dealing. In addition, housing officers quickly identified that the perpetrator was unable to read. Consequently, most communications were verbal as opposed to in a written format.

137. As landlord, they received regular complaints of noise nuisance and anti-social behaviour from the frequent visitors who were allegedly attending to collect or deliver drugs to the perpetrator. Reports of arguments were also common as part of the noise

nuisance allegations, but housing officers did not observe any indicators of domestic abuse between the victim and the perpetrator. When they observed the couple, housing staff did not identify any concerns or consider that the victim was being coerced or controlled in any way.

138. There was only one recorded contact with the victim without the presence of the perpetrator and that was to enquire about the possibility of the victim being added to the tenancy. The Housing Officer recalled no discernible difference in the victim's behaviour as compared to when previously interviewed in the perpetrator's presence, hence nothing raised suspicions of potential domestic abuse at that time. Sanctuary Housing Association advised that all staff are trained to recognise indicators of domestic abuse and respond according to their policy and procedures.

139. In respect of the anti-social behaviour, the complainants were reluctant to formalise their reports for fear of reprisals. This absence of statements meant that there was little evidence immediately available to enable Sanctuary to take formal action despite the reports continuing in this way until the homicide in 2018. Whilst there was evidence that Sanctuary had liaised with mental health services and the police, it was not until the latter months of 2017 that Sanctuary and the police began to explore the possibility of installing CCTV to seek evidence for themselves. That said, on one occasion, Sanctuary were taking formal action but were encouraged to desist by mental health workers supporting the perpetrator.

140. Nonetheless, due to the frequency and duration of allegations, Sanctuary considered that alternative approaches could have been applied at an earlier stage and they have made a recommendation for themselves to ensure that a multi-agency approach and evidence gathering is considered and initiated at an early stage in anti-social behaviour cases where substance misuse and or mental health issues are prevalent.

141. Their individual management review also identified that the follow up to anti-social behaviour was inconsistently recorded and regular case reviews were not formally documented, exposing areas for learning and improvement which have been included in their recommendations for their service.

4.7. Shrewsbury and Telford Hospital NHS Trust

142. Women experiencing domestic abuse are three times more likely to attend Emergency Departments than other women (Feder et.al. 2006). Indeed, the victim was admitted to the Emergency Department of the Trust on two occasions during 2012 in respect of physical injuries and another occasion the next year due to her intoxication. Her GP was duly notified of each admission.

143. On the first occasion, the victim did not disclose the name of the perpetrator before leaving the department. During her triage, the victim was given a lip balm with the West Mercia Women's Aid contact number and, as she had left the hospital before

treatment, a MARAC referral was completed without the victim's consent but as a professional concern. The registered nurse also contacted the emergency duty team of the local authority to ensure that there were no minors in the household.

144. On her second admission, the victim informed staff that her facial injuries had been caused by her husband (Adult 4) hitting her with his walking stick and that he was in police custody. The Emergency Department consultant informed by letter the GP, MARAC co-coordinator and hospital's lead nurse for domestic abuse. A clinical alert concerning the MARAC was then held on the hospital's system until its removal was requested by the MARAC co-ordinator the following year.

145. On her third admission the following year, the victim was intoxicated and had been found wandering the street. She disclosed that her partner often stays with her even though he was not supposed to. Again, the MARAC Co-ordinator was alerted, together with the GP. On this occasion, an adult safeguarding referral was also completed, and the emergency duty social worker contacted.

146. The Shrewsbury and Telford Hospital NHS Trust were able to demonstrate that they had systematically provided domestic abuse training for Emergency Department staff since 2010 and that this was updated three yearly for all staff. They further identified robust domestic abuse policies and procedures and a lead nurse for domestic violence. Their responses demonstrated good practice in terms of staff awareness of domestic abuse, identifying and responding to high risk and sharing information and that these responses were well in advance of NICE guidance for domestic abuse published in 2016.

147. However, on two of the admissions to the Emergency Department it was documented that the victim was intoxicated and informed staff that she had an alcohol problem. Despite this information, there is no documentation to evidence that a referral had been made to the Alcohol Liaison Team within the hospital or signposted to an external agency, although on both occasions the GP was informed that the victim had been drinking heavily. The Trust has therefore made a recommendation for itself that patients admitted with excess alcohol or intoxication are offered the services of the Alcohol Liaison services and/or signposted to external agencies.

148. In respect of the perpetrator, the Emergency Department was only aware of his admission on two occasions during the review period, both with mental health issues. He was referred to the Crisis Team, was being followed up by the Community Mental Health Team and a letter was also sent to his GP in keeping with policies and procedures.

4.6. West Midlands Ambulance Service

149. The Ambulance Service responded to the victim on four occasions during 2012 when she was experiencing domestic abuse from her ex-partner and where the police were also present. However, they responded to a call in 2015 from the victim's ex-partner who believed she had taken an overdose. When they arrived, the victim refused any

observations and did not want assistance, saying that there had been a domestic argument and that she had just been drinking. The paramedic advised her to contact the police and no safeguarding concerns were noted.

150. West Midlands Ambulance Service recognised that they have made significant improvements in their response to domestic abuse since this time by providing a domestic abuse policy; domestic abuse guidance for staff and delivering mandatory training on domestic abuse within wider adult and child safeguarding modules. They confirmed that the training considers the interface between domestic abuse, substance misuse and mental health and how domestic abuse is distinguished and responded to in this context.

151. Whilst the Ambulance Service considered a range of methodologies for evidencing practice improvements, the lack of dedicated domestic abuse training is considered by the review panel to be a deficit and will be addressed for a range of health agencies in the thematic section to follow.

5. THEMATIC ANALYSIS, LEARNING & RECOMMENDATIONS

5.1 Domestic violence and abuse

152. A key function of domestic homicide reviews is to contribute to a better understanding of domestic abuse (Section 7, Multi-Agency Statutory Guidance, 2016). Whilst there was no evidence of domestic abuse in the victim's relationship with the perpetrator prior to the homicide, it is clear that she had experienced significant abuse in her earlier relationships.

The Victim's experiences of domestic abuse

153. We have seen that the victim experienced domestic abuse during her sixteen-year relationship with the father of her children (Adult 3) and her substance misuse, depression, anxiety and panic attacks incrementally increased during this relationship. The multiple needs displayed as a result would likely have left her vulnerable to being preyed upon by abusers thereafter. Indeed, her subsequent partners were each abusive to her.

154. Adult 4 was particularly violent and the risk that he posed to the victim meant that she was referred to MARAC on two occasions. However, there were more subtle indicators of domestic abuse that appear to have missed. For example, she attended her GP with an unnamed, older male and disclosed that she felt unable to leave the house. Although her being accompanied precluded further enquiry with the man present, there was no awareness apparent that she may have been experiencing domestic abuse or attempts

made to see her on her own. Other examples of indicators would be her mental health and substance misuse which will be considered in a later section.

Learning Point:
Practitioners need to be alert to indicators of abuse and disguised disclosures such as feeling unable to leave the home.

"Adults making choices"?

155. The victim was seen by agencies to have frustrated the MARAC risk management plan by having continued contact with Adult 4 and by retracting her witness statements. It is common for victims of domestic abuse to retract their statements for a variety of legitimate reasons including fear of reprisals, intimidation or not wanting to feel responsible for their partner being prosecuted. It is equally common for victims of domestic abuse to continue to have contact with their abusers, particularly where perpetrators may demand or manipulate contact or where contact with them is maintained through fear or coercive control. It is therefore often more helpful to see the perpetrator as the one who is, directly or indirectly, maintaining contact and frame responses around how to effectively engage with the victim as someone who is experiencing trauma and how to manage the perpetrator's ongoing control.

156. The victim was observed by drug workers, waiting for Adult 4 outside his prescribing centre whilst he was bailed not to contact her and, alongside other incidents, she was seen to be an adult freely making unwise choices to maintain the abusive relationship. There was no indication that practitioners considered her behaviour within the context of coercive control nor considered reporting the perpetrator to the police for his breach of bail conditions. In the absence of an independent domestic violence advisor working with her, it was not known whether she felt sufficiently safe to disclose her rationale, fear or concerns at that time with any of the agencies involved.

Learning Points:
Before making judgements about choices being made, practitioners need to consider how coercive control may be affecting a domestic abuse victim's behaviour and decision making.
When agencies know that bail conditions have been breached, then they should report it to the police themselves.

Mutual Violence: who does what to whom?

157. The victim was well known to the police for drug-related behaviour and offences and as a result of her intoxication it would have been difficult, at times, for the police to be able to distinguish the nature of the abuse being reported in these earlier relationships. This would have been particularly the case when Adult 4 reported her violence towards

him. However, the police rightly distinguished that Adult 4 was the primary aggressor on a number of significant occasions, irrespective of his making those reports.

158. However, the Drug and Alcohol Recovery Service, which was run by Adult Social Care at the time, did not appear to analyse the circumstances in the same way. The victim disclosed abuse to them and talked about "mutual fighting" and "six of one and half a dozen of another". Whilst they did offer the victim refuge, there was no evidence that the victim's self-blame for mutual violence was explored or challenged or the compounding effect of repeated domestic abuse explored.

159. Adult 4, who was also in their service went on to repeatedly seek to undermine the victim by telling them that she had lied to them about her drug use and denying his abuse of her. The challenge to agencies providing services to both abuser and abused will be considered further. However, it is clear that Adult 4 was a highly violent perpetrator who sought to manipulate agencies and undermine the victim's credibility in reporting.

160. This example amply demonstrates how perpetrators can attempt to distort the perspective of professionals as well as their victims. Adult 4's behaviour has been included in this review as it is likely that his attempts to undermine her and make counter-allegations when confronted with his violence will have contributed to the victim's understanding and trust in services thereafter.

Learning Point:
Practitioners need to view allegations and counter allegations from domestic abuse perpetrators through the prism of coercive control and be alert to how perpetrators may manipulate and control situations to undermine their victims and disguise their abuse

Confidence in reporting domestic abuse

161. In these earlier relationships, the victim reported domestic abuse to the police twenty-seven times and appeared to have confidence that they would respond. Indeed, we have seen that the police were robust in identifying that her abuser was the primary aggressor on a number of significant occasions.

162. Although that abusive relationship came to an end, it is not possible to know whether all of the victim's interactions with the police during these times were seen by her as positive. We have seen that the victim, as a known victim at high risk of serious harm, was arrested and charged for breach of the peace after being verbally abusive to Adult 4 and police officers whilst heavily intoxicated. Earlier that day, Adult 4 had been released without charge after allegedly striking her with a pair of crutches causing sufficient facial injury to need hospital treatment. The police action against the victim appears to have sought to prevent an escalation of risk to herself at that time, and each incident would have been dealt with by different officers. However, it is not known how this

course of events may have been understood by the victim and may have dissuaded her from reporting abuse in the future.

Holding Perpetrators Accountable

163. It was clear that the police were responsive to the victim and pro-active in identifying the risks that she faced in these earlier relationships. Their referral of her to MARAC when considered to be facing medium risk was identified as good practice.

164. However, of the twenty-seven reports of domestic abuse that the victim made to the police during these earlier times, eight involved physical assaults, yet the suspect (Adult 4) was only charged on two occasions and the prosecution was withdrawn each time. He was also known to have breached bail conditions, and this was not prosecuted either. The intervening period of time since these incidents has meant that it has not been possible to determine the reasons for criminal justice not to have run its course, but it is not uncommon in circumstances where a victim withdraws her witness statement or, by virtue of intoxication or other offending, is seen as an unreliable witness. Neither is it known how these earlier experiences of the criminal justice system framed the victim's future confidence in seeking assistance, if indeed she had needed it.

The perpetrator's history of violence

165. The perpetrator had come to the attention of the police regarding domestic abuse against two previous partners with allegations of serious violence towards them. He had also served terms of imprisonment for assaults against other people. However, his history of violence was largely seen as historic as he was not known to have displayed violence to others in the intervening eight years. His recent offending behaviour was largely related to anti-social behaviour through alleged drug-dealing and involving the victim herself.

166. The review considered how helpful this notion of 'historic' violence and abuse is to current determinations of risk and considered that all previous violence is significant in understanding the threat that domestic abuse perpetrators present. This is not only because prior violent and abusive behaviour is an indicator of propensity to violence and abuse but also because domestic abuse is rooted in power and control and there are many ways in which domestic abuse perpetrators can secure their power and control without resorting to physical violence. Indeed Stark (2009) identified that it is not the level of violence that is the greatest indicator of risk but the degree of control that the perpetrator has.

167. It is not known whether the perpetrator had power and control in his relationship with the victim. Indeed, some agencies considered the victim to be the one in control. What is important for practice is that prior domestic abuse should automatically lead professionals to question the perpetrator's future relationships.

Learning Point:
Practitioners need to recognise how a perpetrator's prior history of violence informs future risk and should automatically lead practitioners to question the perpetrator's future relationships

Animal abuse as an indicator of domestic abuse

168. Although mental health practitioners were not aware of domestic abuse in this relationship, the incident of his stabbing a dog which led him to be admitted to psychiatric hospital eight years prior was rightly still seen as concerning and this information was transferred to his most current risk assessments with them. This was good practice and recognised the threat inherent in animal abuse. However, as this history did not lead to consideration of a threat to the victim, it appeared that either the connection had not made between animal abuse and domestic abuse or that his mental illness and substance misuse was wholly attributed to the incident in question.

169. Research has revealed a significant link between animal abuse[10], domestic abuse and child abuse as well as a strong indicator of domestic homicide (Arkow,2014). It has been established that perpetrators who abuse animals will use significantly more dangerous and varied controlling behaviours and forms of violence towards their partners as compared to those domestic abuse perpetrators who do not (Volant et al., 2008; Coorey et al, 2018). They are considered to be more prone to marital rape, sexual violence, stalking and emotional violence (Arkow, 2014) and may be five times more likely to physically or sexually abuse their partners than those who do not abuse animals (Conroy, 2015).

Learning Point:
Animal abuse should always be taken seriously as a significant risk indicator for a perpetrator's domestic abuse in current or future relationships (see DASH Risk Indicators). Perpetrators who abuse animals have been found to be significantly more dangerous and use more varied methods of control than others.

170. The review has therefore been able to expose diverse aspects of domestic abuse which practitioners need to be alert to. They do not in themselves lead to a recommendation beyond the need for agencies to embrace these issues within training of staff, which is addressed later in this report.

[10] Animal abuse is defined as the deliberate harm, neglect or misuse of animals by humans resulting in animals suffering physically, mentally and/or emotionally

5.2 Engaging with Domestic Abuse Victims with Multiple Needs

171. Women who have experienced domestic and sexual abuse have been found to be three times more likely to be substance dependent than those who have not (Rees et.al., 2011). Likewise, experiencing domestic abuse can cause a severe loss of self-esteem, anxiety, depression, panic attacks and disorientation (Feder et al, 2006, Rose et al, 2011; Department of Health, 2017). In this way, women experiencing domestic abuse are far more likely than others to be using or needing mental health and substance misuse services.

172. Health professionals have a privileged position in identifying potential domestic abuse. The National Institute for Health and Clinical Excellence (NICE) provides a list of evidence-based health markers that are indicators of abuse including depression, anxiety, panic attacks, alcohol abuse and substance misuse. Whilst not all individuals presenting with these concerns are being abused, any combination of these complaints should be a red flag for health workers to investigate the possibility of domestic abuse.

173. The victim's substance misuse and mental health symptoms first came to light after she had experienced years of domestic violence and abuse from her former long-term partner and father of her children (Adult 3). We have seen that the GP did not make further enquiries about domestic abuse when the victim disclosed her substance misuse, despite high risk domestic abuse already being marked on her records. Neither did the GP refer to substance misuse services or see the victim on her own on one occasion where her substance misuse was discussed and the Practice has recognised the need to address these shortcomings in line with RCGP (2014) and NICE guidance (2014). Appropriate and sensitive routine enquiry must be standard practice across all services that women with experiences of abuse come in to contact with.

174. We have also seen that the Drug and Alcohol Recovery Service offered refuge as a solution to the domestic abuse that she was experiencing, although her poor compliance with treatment for drugs and alcohol may have made that option difficult to sustain and there was no evidence of assisting her to engage with domestic abuse services and consider wider options that might have been available. Whilst mental health services were not aware of the victim's history of domestic abuse, they were aware of her having substance misuse issues but did not appear to have directly asked her, or the perpetrator's former partner, about domestic abuse.

175. There is a growing body of research which explores the needs of women with multiple needs experiencing domestic abuse (Alcohol Concern & AVA,2016; AVA and Agenda, 2017; Ava, 2019). The victim's long-term experiences of domestic abuse left her vulnerable to further abuse from subsequent partners as well as experiencing substance abuse and mental health concerns. Research tells us that women having experienced abuse and the consequences of abuse in this way, will have particular needs which are rarely met by the way in which existing services are set up (Department of Health and

Social Care & Agenda, 2018). Indeed, the National Commission for Domestic and Sexual Violence and Multiple Disadvantage recently recommended that

> *"services should work collaboratively to break down service silos and offer person centred, holistic support for women…Enquiry into current and historic domestic and sexual violence should be standard practice …Where abuse is identified, there must be appropriate trauma-informed support and pathways into care…"* (AVA & Agenda,2019, p.54)

176. The Commission goes on to identify the need for women only spaces, particularly in addiction settings as a means to provide safety for women. When the victim was in addiction recovery services with her then partner (Adult 4), the perpetrator appeared to seek to undermine her by talking with the keyworkers about how she lied about her substance misuse and how she was abusive towards him when in fact he was the primary aggressor and posed a high risk to her. It is hard to see how the victim might have been able to explore her experiences of abuse with the perpetrator so close to her source of support and highlights the need for safe spaces for women service users.

177. The recent report from the Women's Mental Health Taskforce (Department of Health and Social Care & Agenda, 2018), explored the need for both trauma-and-gender-informed practice and for service structures that support them. They described 'trauma-informed' services as those "which recognise the impact of trauma, often through violence and victimisation, avoid any likelihood of re-traumatisation for staff or service-users and which identify recovery from trauma as a primary goal" (p37). Moreover, trauma-informed practice for women acknowledges behaviour as legitimate responses to life events and grounds behaviour in experience.

178. The Taskforce further recognised that trauma-informed services are complementary to gender-informed services, which take account of and respond to the particular lives and experiences of women. Trauma-informed services

> *"ensure that staff have the right competencies to work with women, that the environment makes women feel safe and welcome, and that appropriate structures are in place to be able to deliver this kind of service. These types of approaches also take account of the ways in which different parts of a woman's identity can overlap and result in different experiences of disadvantage*" (Department of Health and Social Care & Agenda, 2018, p.33)

179. The Taskforce developed a set of trauma-and-gender informed principles, intended to be used as a high level and strategic tool to help providers, practitioners and commissioners at a local level consider the specific needs of women with mental illness, including substance misuse. In the victim's case, there appeared little enquiry from health services into the background to her mental health and substance misuse and no evidence of joint working with domestic abuse services or exploring wider options that may have been available to her.

Learning Point:
In order to address the multiple needs of women who have experienced domestic abuse and suffered mental ill-health and substance misuse as a consequence, agencies need to develop their trauma-and-gender-informed practice. The Department of Health and Social Care's Women and Mental Health Taskforce provides a set of principles to help agencies achieve this.

Recommendation 1: Routine Enquiry
Safer Telford and Wrekin should seek assurance that all health services in their area have implemented policies, pathways and staff training to support routine enquiry in domestic abuse.

Recommendation 2: Multiple Disadvantage
Safer Telford and Wrekin should seek assurance from agencies that services and pathways are trauma-and-gender informed and flexible enough to effectively engage with women facing multiple disadvantage, using the principles of the national Women's Taskforce on Mental Health as a guide.

5.3 Domestic Abuse Training

180. We have seen how health professionals have a privileged position in identifying potential domestic abuse and all agencies involved in this review were able to show that they were delivering training on domestic abuse to their workforce. Commonly, the review found that this was being delivered to health practitioners within mandatory safeguarding training modules in accordance with the recommendations of the health inter-collegiate safeguarding competencies frameworks for children (RCN, 2019) and adults (2018).

181. Despite its widespread impact upon safeguarding, domestic abuse was found to have to compete with a great many other issues which also impact upon safeguarding issues and the degree to which domestic abuse was included in health agencies syllabuses therefore varied between agencies. Whilst the commitment to skilling staff to respond to domestic abuse was clear across health agencies, this need to compete for valuable training time clearly frustrated some and, in some cases, it became questionable whether staff would have had opportunity to explore the range of domestic abuse issues which featured in the victim's life, in sufficient depth.

Learning Point:
It was not easy for practitioners to respond to the domestic abuse that the victim experienced in her earlier relationships. They needed to be able to see behind the victim's presentations and understand how coercive control may have been affecting her judgements and choices. They needed to be able to recognise that her abuser may also have been manipulating them. In order to appreciate this complexity and develop the understanding and skill to respond effectively, practitioners need to have dedicated time and opportunity to explore domestic abuse and their role in sufficient depth.

Recommendation 3: Dedicated domestic abuse training
Safer Telford and Wrekin should seek assurance from its agencies that dedicated time and opportunity is provided by each of its agencies for domestic abuse training in order that practitioners are able to understand domestic abuse, coercive control, its impact upon victims and become skilled in responding safely and effectively.

5.4 Co-existence of severe mental illness with substance misuse

182. The perpetrator experienced the co-existence of severe mental illness with substance misuse, known as dual diagnosis, throughout the period covered by this review. The National Collaborating Centre for Mental Health (NCCMH) established that substance misuse effects approximately 40% of users of secondary care mental health services (2016). Research also suggests that outcomes for people with a dual diagnosis are worse than for other groups of service users of these services and that they are more likely to disengage with services (NCCMH, 2016).

183. We have identified in this case that community mental health services had been particularly flexible and persistent in seeking to maintain contact with the perpetrator who had periods of non-engagement. They were also shown to have worked with other agencies to maintain contact when this was necessary. However, the perpetrator did not meaningfully engage with substance misuse treatment, which inevitably will have impacted upon his outcomes in mental health services. Substance misuse services generally only work with individuals who are committed to attend and the interface between mental health and substance misuse services is therefore a crucial element of successful outcomes for service users with dual diagnosis.

184. It would not be within the scope of a domestic homicide review to consider the local policy and arrangements for dual diagnosis against the evidence collected as a systematic review for the National Institute of Health and Care Excellence. This evidence review considered the effectiveness and efficiency of service delivery models for health, social care and voluntary and community sector organisations at meeting the needs of people with a severe mental illness who also misuse substances (NCCMH,2016a, 2016b). However, given that the perpetrator did not engage with substance misuse services, which was his choice, a recommendation is made that this is considered locally.

Recommendation 4: Dual Diagnosis
Safer Telford and Wrekin should work with local commissioners to consider whether there is sufficient flexibility within current commissioned arrangements to enable assertive outreach services to pro-actively re-engage with service users with dual diagnosis

5.5 Missed opportunity: the 'Right to Know'

185. Whilst the victim was of the opinion that the perpetrator was not a danger to her and thought that he would never harm but only ever harm himself, it was not clear whether she knew anything about him having been a serial perpetrator of domestic violence and having previous convictions for harming others.

186. West Mercia Police have reflected upon the missed opportunities to disclose the perpetrator's history of violence under the Domestic Violence Disclosure Scheme, at any time once the relationship with the perpetrator was known by any agency engaging with the couple. However, they recognised a potential missed opportunity to disclose the perpetrator's history to the victim when she reported an incident to them in 2016 involving the perpetrator's possession of a knife and his threats of self-harm. They also reflected that the disclosure could have been all the more important in view of the victim's vulnerability arising from her previous experience of domestic abuse. There is no indication that the disclosure would have affected the victim's commitment to the relationship with the perpetrator, but it would have given her an opportunity to consider the perpetrator's behaviour in this context and plan accordingly if she had concerns.

187. The Domestic Violence Disclosure Scheme provides an opportunity for any agency to raise the need for a disclosure with the police (Home Office, 2016). Whilst the police have recognised that they needed greater professional curiosity and awareness of the potential benefits of disclosure, other agencies also need to apply professional curiosity and engage with the police if they have concerns.

Learning Point:
Practitioners need to be alert to the benefits and opportunities provided by the Domestic Violence Disclosure Scheme, including both the Right to Ask and the Right to Know, when any concerns about risk to others arise.

Recommendation 5: Domestic Violence Disclosure Scheme
Safer Telford and Wrekin should ensure that the Domestic Violence Disclosure Scheme, including both the Right to Ask and the Right to Know, is well known by agencies and the public alike.

5.6 MARAC

188. Back in June 2012, when the victim was referred to MARAC, she had been referred whilst assessed to be facing medium risk, and also referred by the Emergency Department which was good practice. There appeared to be a robust risk management plan and good information sharing between agencies. However, this was let down by not having an Independent Domestic Violence Advisor (IDVA) to support the victim and ensure that she could both feed into the MARAC and adjust her own safety plan in full knowledge about agencies' planned interventions. Indeed, the role that the IDVA plays has been shown to be the essential ingredient of a successful MARAC and the element that was most valued by victims of domestic abuse (Coy and Kelly, 2008)

189. Agencies were frustrated that they were unable to maintain their engagement with the victim and that the perpetrator (Adult 4) continued to contact her. Without an IDVA supporting her, it is not surprising that they were unable to engage the victim or understand the coercion that she may have faced, and her case was heard back at MARAC three months later. It did not appear that agencies considered interpreting the victim's responses within the context of coercive control as we have seen earlier.

190. Since this time in 2012, the panel heard how the IDVA services has been linked to MARAC and is now seen as an intrinsic element of MARAC arrangements. It was therefore considered that no recommendations was needed on this matter.

5.8 The last Mental Health Act assessment before the homicide

191. At the last MHA assessment before the homicide, the perpetrator did not display any indicators of psychosis or mental illness such as to warrant detention under the Mental Health Act. His records indicated that the perpetrator had previously self-reported his psychosis, but psychosis had not been witnessed by professionals. The AMHP had asked for a member of the Crisis Home Treatment Team to attend the assessment, to provide a recent history of his services, but they were unavailable. Whilst the Crisis Home Treatment Team would attend assessments if resources and service demand allowed, it was not expected practice that they would be able to, as resources would rarely enable this to happen.

192. The AMHP did not check the mental health records herself but relied upon one of the assessing doctors to do so and considered that nothing that was shared provided additional information to what was already known or understood. Neither Adult Social Care nor mental health services were aware of domestic abuse in the perpetrator's current relationship. However, there were two risk assessments on social care electronic records available to the AMHP which identified: his history of physical abuse to others; his ideas about harming others; two convictions and prison sentences for violent assaults; his stabbing the family dog thinking it to be his cousin; his keeping a knife under his bed for fear of intruders and his lack of impulse control. The risks identified on each of these assessments were categorised as low by Adult Social Care.

The incident involving the family dog, eight years previously, had been considered high risk by mental health services, although there was no current assessment of risk available. In more recent years, the perpetrator had only been known to Adult Social Care as a threat to himself. On this occasion, the AMHP had not identified any safeguarding concerns and also considered his risk of harm to be low. Had the AMHP considered that the information presented a higher level of risk, or revealed a history of domestic abuse, it would have been expected practice to liaise with police for further information.

193. On the day of the assessment, there was some pressure of time, but not to an unusual degree. However, the review recognised that the assessment could have slowed down, giving the AMHP the opportunity to access mental health records herself, as would be usual practice, particularly as these records were available to her on the 136 Suite. Had the AMHP accessed the records independently, they could have considered what other more up to date information should be taken into account during the Mental Health Act assessment, and not rely upon the doctor sharing all relevant information. Whilst it would have been assumed that the doctor would have shared all relevant information, without checking the records herself the AMHP could not have known that this was the case. Slowing down the assessment would also have given the AMHP the opportunity to contact the police for more information.

194. One of the doctors confirmed that in advance of assessing the perpetrator, the mental health records had been accessed and information shared with the AMHP and the other 'Section 12 Approved Doctor'[11]. The perpetrator's experience of hearing voices telling him to kill himself was identified as long-standing, but he was judged to have no active plans to end his life. The doctor also confirmed that risks to others were considered by the assessment team, but the perpetrator did not express any thoughts or desire to cause harm to any other individual during the assessment. The assessors considered that there was nothing in his behaviour that would suggest that this was not the case during the assessment.

195. The AMHP tried to establish contact details for the victim but the perpetrator said that she did not have a phone. In the absence of having established any risk to others, and because the Crisis Home Treatment Team were to pick the case up, no other attempts were made to contact her. As the perpetrator had not been detained, there had been no requirement to make contact with a next of kin, his nearest relative. Nonetheless, Adult Social Care reflected that as the victim had been described in his records as a protective factor, alerting professionals in the past to his mental health deterioration, had contact been made with her, she may have been more attune to any presenting risks arising from his mental health state.

196. Had domestic abuse been known, Adult Social Care procedures would have required that the Police be contacted for further information; attempts would have been made to contact the victim to discuss her abusive partner's Mental Health Act assessment

[11] This refers to a doctor trained and qualified in the use of Mental Health Act 1983

itself as well as its outcome; domestic abuse support been offered; a more informed risk assessment undertaken and risk management plan developed. As part of the risk management process, consideration could have been given to contact with the victim later in the day or into the night from the Emergency Duty Team as well as multi-agency action as required. However, neither Adult Social Care nor mental health services were aware of the domestic abuse.

197. It has been recommended that AMHPs are provided with reader's access to mental health records and vice versa, enabling mental health staff to have reader's access to Adult Social Care records, in order that fully informed assessments can be made. It is also recommended that practitioners, across disciplines, are supported to be more professionally curious about the history and context of the individual when undertaking assessments. For Adult Social Care, this support has already included issuing best practice guidance and domestic abuse workshops for all front-line staff.

Learning Point:
In order to respond to domestic abuse and risk effectively, practitioners need to be professionally curious about an individual's history of risk.

Recommendation 6:
Safer Telford and Wrekin should ensure that mental health services and adults social care services have sufficient access to records to enable informed Mental Health Act assessments to be undertaken.

6. CONCLUSION

198. Although agencies were not aware that domestic abuse was a feature of the relationship between the victim and perpetrator, several agencies were aware that the victim had experienced domestic abuse in her previous relationships. The compounding effect of years of abuse, together with substance misuse and mental health issues, meant that the victim would be vulnerable to abuse from others. Working with women experiencing multiple disadvantage in this way requires a new way of working that is both trauma and gendered informed for effective engagement to take place.

199. The review has found that there were potentially missed opportunities to identify indicators of abuse; to engage with the victim by making routine enquiry about domestic abuse in different settings and by disclosing her partner's prior history as a serial perpetrator of domestic abuse with a history of violence.

200. Despite mental health services supporting the perpetrator for most of his adult life, his diagnosed paranoid schizophrenia was considered to be treatment resistant although it was not known whether he was consistently compliant with prescribed medication. Moreover, his chronic substance misuse may have compounded this apparent

treatment resistance and this dual diagnosis undoubtedly presented great challenges to services.

201. We have seen that this final assessment, within the day of the murder, lacked a holistic approach. There appeared to be a lack of professional curiosity about how the perpetrator's history of violence impacted upon risk to others at that time. Having said that, neither Adult Social Care, nor the doctors involved in the assessment were aware of domestic abuse within the perpetrator's current relationship and did not consider him sufficiently ill to lose his liberty and be detained under the Mental Health Act.

202. Ultimately, a robust understanding of domestic abuse and skills in engaging with women experiencing multiple disadvantage may have enabled victim engagement much earlier in her life. Likewise, a robust understanding of how domestic abuse perpetrators behave, may have led practitioners to have been more professionally curious about the perpetrator's history of violence and the risk that he may have been seen to pose towards his current partner. Whilst there is no doubt that local agencies have been taking greater responsibility for training their staff to understand and respond to domestic abuse, the legislation on coercive control will help us all to understand better the insidious nature of domestic abuse and the need to look below the surface of what is presented to us.

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8. Action Plans

Domestic Homicide Review: Adult C

Under Section 9 of the Domestic Violence Crime and Victims Act 2004

Action Plan

Overview Report Action Plans						
Recommendation 1: Routine Enquiry Safer Telford and Wrekin should seek assurance that all health services in their area have implemented policies, pathways and staff training to support routine enquiry in domestic abuse.						
Ref	**Action**	**Scope**	**Target date for completion**	**Desired outcome of the action**	**Monitoring arrangements**	**How will success be measured?**
1.1	NHS Providers to ensure that front line staff are aware of and implement Domestic Abuse policies and pathways and TWSP DA training to be reviewed an updated.	Local	March 2021	Services have implemented policies, pathways and staff training	Policies shared by health services in September 2019: CCG Domestic Abuse policy for staff and guidelines; RJAH Domestic Abuse policy and procedures; November 2019: update from Shropshire Community Health Trust	Monitoring by Telford and Wrekin Safeguarding Partnership (TWSP) and Domestic Abuse thematic sub-group TWSP Multi-Agency Case File Audit

Recommendation 2: Multiple Disadvantage Safer Telford and Wrekin should seek assurance from agencies that services and pathways are trauma and gender informed and flexible enough to effectively engage with women facing multiple disadvantage, using the principles of the national Women's Taskforce on Mental Health as a guide.						
Ref	**Action**	**Scope**	**Target date for completion**	**Desired outcome of the action**	**Monitoring arrangements**	**How will success be measured?**
2.1	Review and develop specialist services and support and implement comprehensive multi agency pathways for both victims and perpetrators and children and young people affected by Domestic Abuse	Local	March 2021	The My Time Perpetrator Programme 18 month pilot commenced in April 2021 will also work with the victims of domestic abuse including those facing multiple disadvantage. Through Home Office Funding Richmond Fellowship will be working with CYP between the ages of 5 – 18 years who are victims of domestic abuse and of which the adult perpetrator is engaged in the 'My Time' programme. The model will work with CYP using trauma informed practice, creative play, and resilience work for up to 24 weeks of holistic support (including post programme	Contract monitoring of commissioned services jointly with Council, PCC and provider. T&WC Directors monthly DA meetings and CSP	Number of individuals who have successfully completed programme ultimately reducing the number of child protection cases involving domestic abuse.

				intervention), structured through a care plan, with underlying principles to reduce the impact of DA on CYP, through increasing protective factors, decreasing risk domains and introducing coping strategies where appropriate. Through the Home Office funding the My Time programme will be extended to include BAME and same sex abuse		

Recommendation 3: Dedicated Domestic Abuse Training Safer Telford and Wrekin should seek assurance from its agencies that dedicated time and opportunity is provided by each of its agencies for Domestic Abuse training, in order that practitioners are able to understand Domestic Abuse, coercive control, its' impact upon victims and become skilled in responding safely and effectively.						
Ref	**Action**	**Scope**	**Target date for completion**	**Desired outcome of the action**	**Monitoring arrangements**	**How will success be measured?**
3.1	Domestic Abuse Training offer to be updated to ensure it informs the work of practitioners	Local	March 2021	Richmond Fellowship delivering training with front line staff to support referral into the My Time programme.	Contract monitoring of commissioned services jointly with Council, PCC and provider.	Increased uptake of domestic Abuse Training.
		Local	March 2021	Forming part of our commissioned Domestic Abuse Community Support Service, Citizens Advice delivered training to local community organisations, on signs and impaction of DA. This training was supported by people with lived experience. The service has also developed the Domestic Abuse Community Ambassador Programme, which continue to raise the awareness of Domestic Abuse, through	Contract monitoring	Increased uptake of domestic Abuse Training.

				programmes such as Working with WM Women's Aid and Shropshire Domestic Abuse Service as volunteers, to develop hairdresser programme to raise awareness of domestic abuse. Domestic Abuse forum has been established to share good practice and training		
		Local	March 2020	Safeguarding Partnership Domestic Abuse Training reviewed and updated in March 2020.	Telford and Wrekin Safeguarding Partnership Adult review, Learning and Training Sub Group	Monitoring training update and feedback.

Recommendation 4: Dual Diagnosis Safer Telford and Wrekin should work with local commissioners to consider whether there is sufficient flexibility within current commissioned arrangements to enable assertive outreach services to proactively re-engage with service users with dual diagnosis.						
Ref	**Action**	**Scope**	**Target date for completion**	**Desired outcome of the action**	**Monitoring arrangements**	**How will success be measured?**
4.1	Review and develop specialist services and support and implement comprehensive multi agency pathways for both victims and perpetrators and children and young people affected by Domestic Abuse	Local	March 2021	Richmond Fellowship is a mental health charity and works with Aquarius as part of the Recovery Focus which includes mental health and substance misuse. This informs the work of the My Time perpetrator programme and Telford Stars the local drug and alcohol provider.	Contract monitoring	Collaborative working to support individuals through care planning and support.
			June 2021	On 28th June 2021, T&W implemented the Family Safeguarding Model. This is a model of child protection, working with families where substance misuse, mental health or domestic are factors impacting upon the welfare of children. It enables a multi-disciplinary whole	Family Safeguarding Partnership Board, Children's Services Performance Board	The right support will be provided to families at the right time enabling children to remain in the care of their families where it is safe to do so – this will be evidenced through feedback and evaluation and performance data.

				family response through direct assessment and support from specialist adult practitioners and sharing of knowledge and skills across disciplines.		

Recommendation 5: Domestic Violence Disclosure Scheme Safer Telford and Wrekin should ensure that the Domestic Violence Disclosure Scheme, including both the Right to Ask and Right to Know, is well known by agencies and the public alike.						
Ref	**Action**	**Scope**	**Target date for completion**	**Desired outcome of the action**	**Monitoring arrangements**	**How will success be measured?**
5.1	Develop practitioner's knowledge on the dynamics of domestic abuse on the whole family and provide them with the appropriate training and resources to support the family	Local	March 2021	Practitioners are able to understand domestic abuse, coercive control, its impact upon victims and become skilled in responding safely and effectively Awareness raised within the community – community engagement. Telford and Wrekin White Ribbon campaign/ social media engagement Adult Safeguarding Week event on 21 November 2019, focussing on Domestic Abuse, primarily in older people	Monitor impact of training Monitor impact of White Ribbon Action Plan Evaluation of Adult Safeguarding Week event on Domestic Abuse	Feedback and evaluation

Recommendation 6: Safer Telford and Wrekin should ensure that mental health services and Adult Social Care Services have sufficient access to records, to enable informed Mental Health Act assessments to be undertaken.						
Ref	**Action**	**Scope**	**Target date for completion**	**Desired outcome of the action**	**Monitoring arrangements**	**How will success be measured?**
6.1	Approved Mental Health Professionals to have sufficient access to mental health records	Local	March 2021	Informed Mental Health Act assessment by Adult Social Care and Mental Health services	TWSP Safeguarding Adult Review sub-group	AMHPs are using RIO on a regular basis as required to underpin their Mental Health Act Assessment

Individual Agency Action Plans						
Midlands Partnership NHS Foundation Trust						
No^{o}	**Recommendation**	**Key actions**	**Evidence**	**Key outcomes**	**Lead officer**	**Target date for completion**
1	MPFT Safeguarding Team should review their arrangements for raising awareness of and responding to incidents of domestic abuse to ensure that this meets the need of all of the people that we serve	MPFT Safeguarding team should review their arrangements for raising awareness of and responding to incidents of domestic abuse	Safeguarding team to review training offer and the support offered to frontline practitioners to be assured that incidents of domestic abuse are identified and responded to appropriately	When carers and families come in to contact with MPFT and domestic abuse is identified they are offered an appropriate and timely response by a skilled and supported practitioner	Head of Strategic Safeguarding, Midlands Partnership NHS Foundation Trust	March 2021 Completed 1 March 2019
Sanctuary Housing						
No^{o}	**Recommendation**	**Key actions**	**Evidence**	**Key outcomes**	**Lead officer**	**Target date for completion**
1	Consideration of installation of CCTV recording equipment at an earlier stage	Area Manager and Housing Officer to discuss all possible remedies during Anti-social behavior case reviews	React system will be updated with case review notes to record consideration of all remedies and the recommendations which have been agreed	Relevant and targeted Anti-social behavior tools and powers will be deployed at an earlier stage, with the benefit of more robust evidence gained from CCTV footage	Operations Manager, Sanctuary Housing	March 2021 Completed 1 December 2019
2	Ensure a multi-agency approach is considered and	Area Manager and Housing Officer to	React system will be updated with	A multi-agency approach will be	Operations Manager,	March 2021

	initiated at an early stage in cases where substance misuse and /or mental health issues are prevalent	discuss if a multi-agency approach is relevant during Anti-social behavior case reviews. Such case reviews must be fully documented to evidence decision making. In these circumstances, an understanding of the key contacts within partner agencies will be obtained to ensure communication regarding areas of concern and potential risk	case review notes to record consideration of multi-agency approach, in addition to all interactions with partner agencies	sought in all cases which we feel would benefit from the cooperation/ intervention of partners to achieve a positive outcome	Sanctuary Housing	Completed 1 December 2019
3	Ensure all interactions related to the case are recorded on relevant housing management systems	Housing Teams to be reminded of the requirement to update systems timeously and to link related cases to ensure relevant notes are recorded appropriately. Area Managers to ensure, through regular spot checks, that all interactions are properly recorded	Spot checks by Area Managers will reveal weaknesses in the recording of cases which will be addressed with immediate effect	Robust recording of all contact and relevant information to support the effective management of anti-social behavior cases	Operations Manager, Sanctuary Housing	March 2021 Completed 1 December 2019
4	Refresher training for management and staff regarding Sanctuary's	Area Managers to ensure Sanctuary's approach to anti-	Team meeting action points and HR system	Anti-social behavior cases will be managed effectively and in strict	Operations Manager,	March 2021

	approach to Domestic Abuse, safeguarding and anti-social behaviour case management	social behavior practices are reinforced during a future team meeting with emphasis on meticulously recording all interactions. Targeted formal Anti-social behavior training will be provided if deemed necessary	records will evidence this	accordance with Sanctuary's policy and procedures	Sanctuary Housing	Completed 1 December 2019
Telford & Wrekin Council: Adult Social Care						
No^{o}	**Recommendation**	**Key actions**	**Evidence**	**Key outcomes**	**Lead officer**	**Target date for completion**
1	Read access to RIO for Adult Social Care staff and read only LAS access to mental health staff	Discussions have taken place between organisations and approval in principal	When systems are made available	Front-line staff from both mental health and adult social care are able to consider all available records when making assessments or decisions regarding a shared service user	Service Delivery Manager: Community Casework and Adult Safeguarding, Telford & Wrekin Council	March 2021 (Completed February 2019) Approved Mental Health Practitioners (AMHP's) employed by the Council now have full access to health care records kept by the Midlands Partnership Foundation Trust (MPFT) on the Rio electronic care record. This is a small dedicated

						group of AMHP's who access these health records for a very specific purpose to support them in completing statutory assessments under the Mental Health Act. Access to the Council's electronic social care records system (LAS) for all MPFT mental health workers is a much wider and more complex recommendation, with challenging implications around information governance, consent, data protection, funding, and licensing requirements. Ongoing work to progress the sharing of social care records with health partners has since been super ceded by a broader initiative across the

						Health and Social Care economy through joint working with our Health partners in developing an Integrated Care Record. (ICR). The ICR for Adult Social Care has now worked through the issues and requirements identified, and The Council will be launching access of 'selected' data to Health partners who are signed up to the ICR including MPFT from summer 2021. Those partners who have also signed up to the ICR will also share 'selected' data from their own Systems and therefore the benefit to the County's clients and Professionals will be much greater than that of one system sharing access to records.

2	Further guidance and support to staff on the application of Professional Curiosity through any intervention	A workshop with all Adult Social Care staff has been undertaken. Best practice guidance and application of Professional Curiosity completed	Workshop attendance and development of Best Practice guidance	Front line staff undertake more holistic and person-centred assessments which will be reflected in their Professional Summaries and risk assessments, strengthening practice and enabling greater multi-agency working	Principal Social Worker, Telford & Wrekin Council	March 2021 Completed 1 December 2018
		Curiosity Checklist issued to all staff and accessible through the Adult Social Care policy page			Principal Social Worker, Telford & Wrekin Council	March 2021 Completed 1 December 2018
		Further and refresher Professional Curiosity training provided			Principal Social Worker, Telford & Wrekin Council	March 2021 Completed 1 December 2018
3	Domestic Violence training	All staff to undertake this training course	Joint training commissioned by Telford & Wrekin Council and Shropshire Council	All front-line staff have greater awareness of domestic abuse, skills in identifying and responding to domestic abuse	Principal Social Worker, Telford & Wrekin Council, in line with Locality Team Leaders	March 2021
Shropshire, Telford & Wrekin Clinical Commissioning Group						
No^{o}	**Recommendation**	**Key actions**	**Evidence**	**Key outcomes**	**Lead officer**	**Target date for completion**
1	Raise awareness with GP practices around the documentation of	To share via the GP electronic newsletter and to raise as a	GP newsletter	Improved record keeping and recording	Named GP for Safeguarding, Shropshire,	March 2021

	conversations in respect of 'ask the question'	topic at the next available GP Adult Safeguarding Leads Forum			Telford & Wrekin Clinical Commissioning Group	Completed July 2020 The Forum for Lead Safeguarding GPs conducted in December 2019 was based on Domestic Abuse, with a representative from West Mercia Women's Aid. A Forum event for both Shropshire, Telford & Wrekin Lead GPs was held in July 2020 with 2 speakers, including one from Shropshire Domestic Abuse Service to discuss the referral pathways and actions by frontline GPs
2	To raise awareness of West Mercia Women's Aid	Additional training date to be identified for the GP Safeguarding Leads, to be provided by West Mercia Women's Aid service	Domestic Abuse added on to the Forum agenda	Raised awareness of the local primary support group in respect of domestic abuse – supported by audit of number of referrals via GP's practices, using West Mercia Women's Aid	Named GP for Safeguarding, Shropshire, Telford & Wrekin Clinical Commissioning Group	March 2021 Completed July 2020 The Forum for Lead Safeguarding GPs conducted in December 2019 was based on

				data as a baseline comparator		Domestic Abuse, with a representative from West Mercia Women's Aid. A Forum event for both Shropshire, Telford & Wrekin Lead GPs was held in July 2020 with 2 speakers, including one from Shropshire Domestic Abuse Service to discuss the referral pathways and actions by frontline GPs
3	a) CCG to raise awareness with GP practices about routine enquiry for patients who have a history of substance misuse and also on separation when domestic abuse was known in that relationship; b) CCG to raise awareness with GP practices about the importance of seeing patients on their own when concerns about abuse have been identified; c) CCG to reinforce the need for GP's to document who has attended with the patient and detail	To share learning points with GP practices via GP Safeguarding leads for dissemination within practices	Adult Safeguarding GP audit, to include specific Domestic Abuse questioning	Evidence of measurable positive impact of learning through record keeping and practice staff awareness	Named GP for Safeguarding, Shropshire, Telford & Wrekin Clinical Commissioning Group	March 2021 Completed July 2021 Questions of clinical practice including during encounters with patients will be recirculated in a briefing, to be sent to GPs, along with the briefing derived from the MACFA on Domestic Abuse recently concluded in July 2021.

	conversations that could be used for evidential purposes to secure protection for domestic abuse victims; and d) CCG seek evidence of the impact of recent and ongoing practice development with GPs and practice staff					
4	CCG to provide ongoing monitoring of the need for the commission of the IRIS programme	Ongoing audit and training provision to ensure that the local practices are well versed in the event of suspected Domestic Abuse	Adult Safeguarding GP audit Inclusion within GP Safeguarding Leads Forum agenda	Evidence of consideration and referrals into Domestic Abuse Pathway	Named GP for Safeguarding, Shropshire, Telford & Wrekin Clinical Commissioning Group	March 2021 Completed The Shropshire, Telford & Wrekin CCG has ongoing training and update processes planned as part of the advice and support to General Practice as an alternative to the IRIS programme. Domestic abuse is one of the key priority sub-groups for the Safeguarding Partnerships in both local authorities, and further advice and guidance for GPs includes the use of Domestic Abuse pathways to act as a guide for frontline staff is

						being reviewed. As in STWCCG recommendations 1-3, the briefing notes will be circulated along with further information, including RCGP guidance for Domestic Abuse from SafeLives, and the DASH checklist with information on actions according to local procedures