Domestic Homicide Review Report:

Adult A

Born: 15th January 1973

Died: 5th June 2014

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Tony Blockley
Director: Johnston and Blockley Ltd

Date: 11th December 2015

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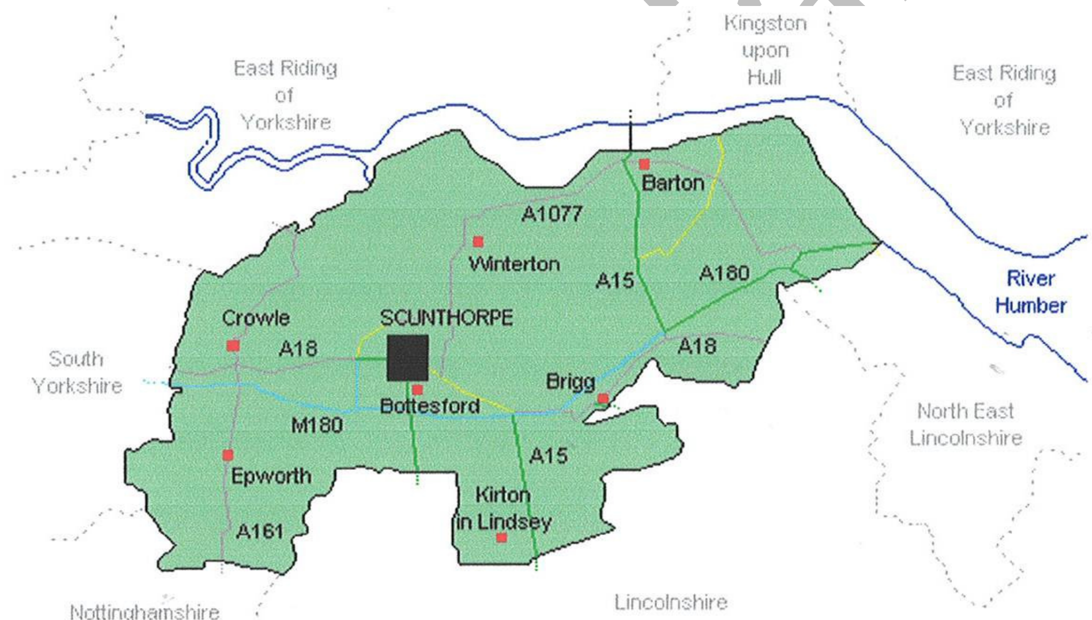
1 Preface

1.1 North Lincolnshire covers an area of approximately 85,000 hectares on the southern side of the Humber estuary. The authority includes a large agricultural area that encompasses small market towns and villages, as well as a substantial urban area that includes the town of Scunthorpe.

1.2 North Lincolnshire has a population of 168,372 people in both urban and rural communities (ONS: May 2014). The urban areas of Scunthorpe, Bottesford and Barton are the major employment and service centres and accommodates over half of the total population.

1.3



1.4 North Lincolnshire consists of 17 Wards and 101 Lower Super Output Areas. There are three parliamentary constituencies in Scunthorpe, Brigg and Goole and Cleethorpes (which covers Barton), each returning one elected Member of Parliament.

1.5 The region of North Lincolnshire is contained within the Humberside Police force which covers the 3 other local Authorities of North East Lincolnshire, Hull and East Riding.

1.6 Strategic governance for domestic abuse and linked issues to the national and local agenda is coordinated through Safer Neighbourhoods, which leads into the Community Safety Partnership for North Lincolnshire.

1.7 Domestic abuse services for North Lincolnshire are split into two services providing support and advice. The Independent Domestic Violence Advisors (IDVAs) are provided through the 'It's My Right Service' and these are collocated into partnership agencies including Humberside Police, Children's Services and recently the

Safeguarding Team at Scunthorpe General Hospital. For non-high risk victims there is the Amber Project providing assistance and advice. There are drop-ins provided by both services around the North Lincolnshire area. There is a Women's Centre called The Blue Door that provides facilities into domestic abuse support alongside substance misuse assistance and running wellbeing courses including the Freedom Programme.

1.8 Any referrals to the Multi Agency Risk Assessment Conference (MARAC) are through the MARAC Coordinator and with direct links into the It's My Right electronic system. Referrals into the service are completed and allocated within a 48-hour window from receiving the information.

1.9 The number of Domestic Abuse incidents reported to Humberside Police in 2014/15 was 2,547, down from 2,696 the previous year. The current half-year figures of 1,367 indicate that the downward trend is likely to be reversed. The number of domestic violence offences has increased from 765 in 2013/14 up to 798 in 2014/15 (4%).

1.10 The number of referrals to the MARAC during 2014/15 was 424, an increase of 55% over the previous year (272). Cases returning to MARAC increased from 28% in 2013/14 to 33% in 2014/15. It is expected there will be a similar number of referrals during 2015/16.

1.11 The Community Safety Partnership (CSP) is leading the Domestic Violence Homicide Review (DHR) process in line with Home Office guidance.

1.12 **DV Services within North Lincolnshire**

1.13 Below is a summary of the Domestic Violence services within North Lincolnshire together with a brief resume of their development.

1.14 **Homegroup Ltd**

1.15 Since January 2011 there has been a small commissioned service by Safer Neighbourhoods to provide housing management of the women's refuge to complement the larger floating support contract. Prior to that the contract was for support and housing management for the women within seven self-contained houses, which was commissioned by Adult Services.

1.16 **Sanctuary Carr Gomm**

1.17 This service provided floating housing support for male and female victims of domestic abuse between 2008 and 2011, and was commissioned by Adult Services.

1.18 **It's My Right**

1.19 This service began with one IDVA in 2005 and now employs three. It is funded by Safer Neighbourhoods with some support from Home Office match funding. It provides the high-risk service for male and female victims of domestic abuse aged 16 or above who are referred into the MARAC or attend any of their local drop

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ins/women's centres. During the last 12 months, a Young Persons IDVA (supporting young adults aged 13 to 19) has been employed with the help of funding from Safer Neighbourhoods and Public Health Outcomes Fund.

1.20 **Amber Project – Homegroup Ltd**

1.21 Since January 2011, there has been a standard to medium floating support service providing advice and drop-ins to male and female victims over the age of 16. It is now commissioned by Safer Neighbourhoods having originally been through Adult Services in North Lincolnshire Council.

1.22 **The Blue Door – Grimsby and Scunthorpe Rape Crisis**

1.23 This Women's Centre opened in August 2013. Some of 'It's My Right' staff are located in the same building. It provides holistic advice and support for women experiencing any type of difficulty including domestic abuse and substance misuse. There are also other Women's groups and partner agencies working within the centre including the counseling and rape crisis element of the service.

1.24 The circumstances that led to the Domestic Homicide Review

1.25 Around 9.35pm on the 5th June 2014, Humberside Police and the Ambulance service were called to an address in Scunthorpe. There they found Adult A. He had been stabbed.

1.26 Adult B was found beside Adult A. She was arrested on suspicion of assault.

1.27 Adult A was taken to Scunthorpe General Hospital where he was pronounced dead. A post-mortem examination revealed that he died as a result of a single stab wound to his chest.

1.28 Adult B was charged with Adult A's murder. She appeared at Sheffield Crown Court and after a trial, was convicted of the offence. The trial Judge Mr. Justice Globe told Adult B that Adult A's premature and violent death had caused *"ongoing pain and anguish to his close family, particularly his father"*

1.29 Adult B was sentenced to life imprisonment. She must serve at least 14 years before being eligible for parole.

1.30 On 18th June 2014, North Lincolnshire Safer Neighbourhood Partnership received formal notification from Humberside Police that Adult A had died.

1.31 On 24th June 2014, North Lincolnshire Safer Neighbourhoods Partnership determined that Adult A's death appeared to fall within the criteria of the Multi-Agency Statutory Guidance for the conduct of domestic homicide reviews' issued under Section 9(3) of the Domestic Violence, Crime and Victims Act (2004) in that Adult's death was caused by: *'a person to whom she was related or with whom she was or had been in an intimate personal relationship'*

1.32 The Consideration Panel decided that a domestic homicide review should be conducted. The Chair of North Lincolnshire Safer Neighbourhoods Partnership

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ratified the decision on 14th June 2014. On 26th June 2014 notice was given to the Home office of the intention to carry out a domestic homicide review.

1.33 On 16th June 2014 all agencies were asked to undertake a review of their records to identify any relevant contact they may have had with Adult A and Adult B. They were also asked to seal the records.

1.34 Scope of the Review

1.35 It is believed that Adult A and Adult B had been in a relationship since January 2013. Both had been in other relationships in which there was evidence of domestic violence and abuse having taken place

1.36 The scope of the review was set from 1st January 2010 until 5th June 2014, so that details of those previous relationships could be included.

1.37 The reason for their inclusion was to ascertain whether there had been any patterns of behaviour that may have been relevant to this Domestic Homicide Review. The panel felt that the time scale was appropriate to ensure relevant information was recorded.

1.38 However, if any agency felt there was relevant information outside the time period under review it was agreed that the information should be included in their Individual Management Reviews (IMRs). The IMR is an individual agency analysing their involvement with Adult A and Adult B. It examines each interaction and critically analyses them to identify best practice to enable learning for the future.

As well as the IMR's, each agency provided a chronology of interaction with the identified individuals including what decisions were made and what actions were taken. The IMRs considered the Terms Of Reference (TOR), whether internal procedures were followed, whether on reflection they were considered adequate, arrived at a conclusion and where necessary, made a recommendation from the agency perspective

1.39 Terms of Reference

1.40 The purpose of the review is to:

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

- Clearly identify what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result

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

- Prevent future domestic homicides through the improvement of service

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responses for all victims of domestic abuse, and their children, through improved intra or inter-agency working

The review will address:

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

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

- Whether Adult A had experienced abuse in previous relationships in North Lincolnshire or elsewhere, and whether this experience impacted on his likelihood of seeking support in the months before he died

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

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

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

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

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

1.41 The rationale for the review process was to ensure agencies are responding appropriately to victims of domestic violence by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with the aim of avoiding future incidents of domestic homicide and abuse.

The review identified the following general areas for consideration:

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1.42 **Family engagement**

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

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

1.43 **Legal Processes**

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

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

1.44 **Research**

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

1.45 In order to reach a view on whether the death could have been predicted and/or prevented, each IMR author was asked to include information on and analysis of all the following issues specific to this case:

1.46 **Diversity**

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

1.47 **Multi agency responsibility**

- Was the victim (Adult A) subject to a Multi-Agency Risk Assessment Conference?

- Was the perpetrator (Adult B) subject to Multi Agency Public Protection Arrangements?

- Was the perpetrator subject to a Domestic Violence Perpetrator Programme?

- Did the victim have any contact with a domestic violence organisation or helpline?

- Was either the victim or the perpetrator a 'vulnerable adult'?

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

1.48 Individual agency responsibility

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

- What were the key relevant points/opportunities for assessment and decision making in this case in relation to the victim and perpetrator?

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

- Was the impact of domestic violence on the victim recognised?

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

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

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

None identified

1.50 Other DHRs in the region or nationally which are similar, and the availability of relevant research

None have been identified at the time of writing.

1.51 Methodology

This overview report has been compiled from and analysis of the multi- agency chronology, the information supplied in the Individual Management Reviews (IMRs), supplementary reports, interviews conducted as part of the IMR and overview report process, consideration of previous reviews and findings of research into various aspects of domestic abuse and with the help and support of family members.

1.52 In preparing the overview report the following documents were referred to:

- The Home Office multi-Agency Statutory Guidance for the conduct of Domestic Homicide reviews
- The Home Office Domestic Homicide Review Tool Kit Guide for Overview Report Writers
- Call an End to Violence Against Women and Girls – HM Government (November 2010)

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- Barriers to Disclosure – Walby and Allen, 2004.
- Home Office Domestic Homicide Reviews – Common themes identified and lessons learned – November 2013.
- Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence, 2006.
- 'If only we'd known': an exploratory study of seven intimate partner homicides in Engleshire - July 2007
- Agency IMR's and Chronologies

1.53 Participating Agencies

The following agencies were asked to give chronological accounts of their contact with Adult A and Adult B prior to Adult A's death:

- Humberside Police
- It's My Right Service
- Children's Services
- NLaG
- Housing Advice Team
- RDaSH
- Stonham/Homegroup
- National Probation Service (On behalf of the Humberside Probation Trust)

1.54 Each agency was required to report the following:

- A chronology of interaction with Adult A, his family and/or Adult B
- What action was taken and analysis of those actions
- Whether internal procedures were followed and if those procedures are appropriate in light of the death of Adult A
- Conclusions and recommendations from the agency's point of view

1.55 DHR Panel Chair/Overview Report Author

North Lincolnshire SNP requested Johnston and Blockley Ltd to fulfill both roles.

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

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1.57 **The DHR Panel**

The CSP agreed the formation of the overview panel comprising of agencies that had had contact with Adult A and Adult B during the period under review, and some that did not, including a representative from a specialist Domestic Violence Service.

1.58 The DHR Review Panel consists of:

Name	Organisation
Tony Blockley	Independent Chair and Overview Author
Stuart Minto	North Lincolnshire Council - SN
Debbie Winning	North Lincolnshire Council - SN
Carol Ellwood	Humberside Police
Sarah Glossop	NHS North Lincolnshire CCG
Wendy Proctor	RDaSH
Clare Robinson	RDaSH/The Junction
Stephenie Price	It's My Right
Wendy Haigh	Stonham/Homegroup
Nick Hamilton-Rudd	National Probation Service (reviewing Humberside Probation Trust)
Craig Ferris	NLaG

In addition, the IMR Report authors are:

Name	Organisation
Debb Pollard	NHS North Lincolnshire CCG
Alexa Watson	National Probation Service (On behalf of the Humberside Probation Trust)
Wendy Haigh	Stonham/Homegroup
Wendy Proctor	RDaSH
Carol Ellwood	Humberside Police
Michael Griffiths	NLaG
Dr Jaggs-Fowler/Deborah Pollard	NHS North Lincolnshire CCG
David Ricketts	Housing Advice Team – NLC
Karen Whitby	Adult Services NLC
Dave Basker	Children's social care

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1.59

Parallel processes

1.60 **Inquest / Criminal Investigations**

There was a thorough police investigation into the circumstances of the death of Adult A resulting in the murder trial. Adult B was found guilty of murder and was sentenced to life imprisonment with a minimum term of 14 years before she can be considered for parole.

1.61 Although the death of Adult A was referred to the Coroner, no inquest will take place because all the evidence and information about his death was aired during the murder trial.

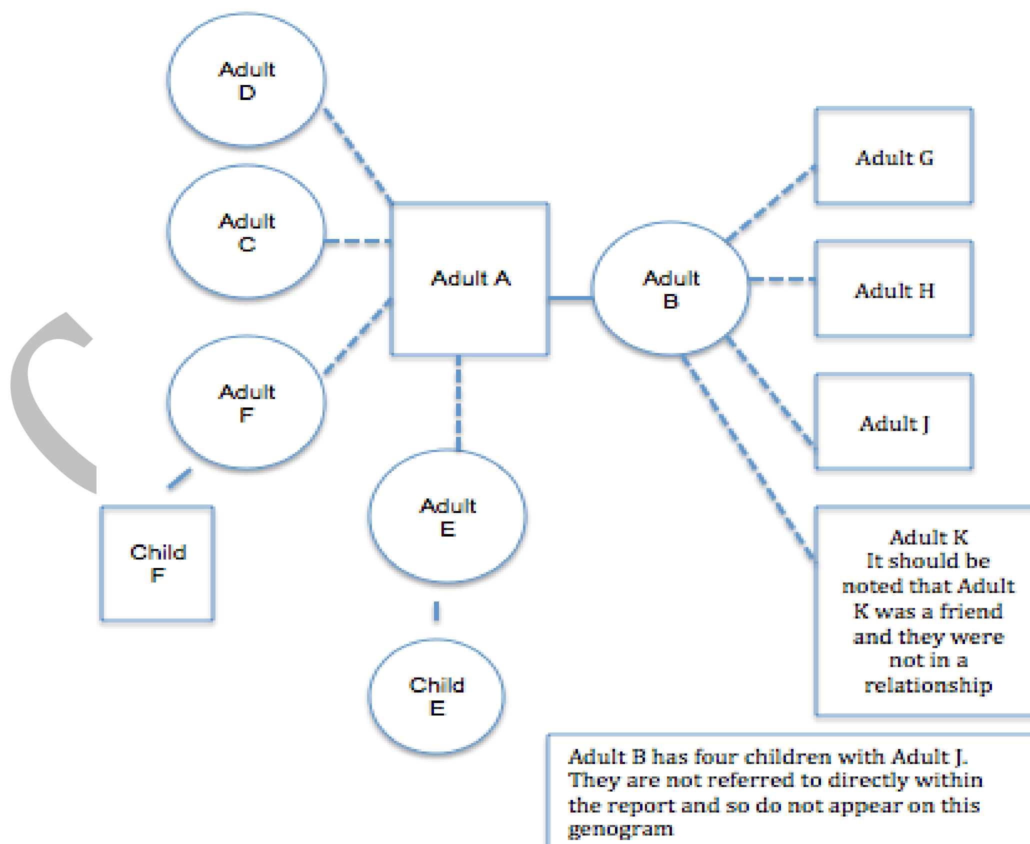
1.62 **The involvement of family members**

Family members were invited to participate in the review process. Adult A's father and two sisters were written to but did not respond to the letters.

Adult B has been written to in prison and has participated in the DHR process. Her mother was also asked to participate but she has not responded.

1.63

Family composition (Of those referred to in the review)



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

1.65 Adult A's father, Adult A's two sisters, Adult B and her mother were contacted after the trial to inform them of the DHR process. Whilst the panel acknowledges this was not strictly within the Home Office guidelines, it was felt appropriate, after consultation with the Police Senior Investigating Officer, to delay the notification and invitation because many of the family were likely to be called as witnesses during the criminal proceedings.

1.66 Family Involvement

The DHR Panel would like to extend its sincere condolences to Adult A's family and although they have chosen not to take part in this review the panel have tried to consider all aspects of Adult A and Adult B's relationship to have a greater understanding of what happened and how services can improve to avoid such a tragedy in the future.

1.67 Letters have been sent to Adult A's father and two sisters, who have chosen not to take part in this review. Adult B was written to in prison and agreed to be interviewed by the review Chair. She also contacted her mother to ask whether she would participate, but she declined to do so. A summary of the interview with Adult B can be found below.

1.68 **Interview with Adult B in prison**

1.69 Adult B said her childhood memories were of her parents fighting one-another physically and of her mother suffering emotional abuse from her father. She recalled her mother shouting and having 'black eyes'. She thought that sort of behaviour was normal. She said she would often try to protect her brother by taking him into a bedroom and covering his ears up.

1.70 She said that when she had been in the relationship with Adult G, she had attempted to commit suicide by setting fire to clothes in the bedroom of their house (Adult B and Adult G's house)

1.71 She added that when she was dealt with for the arson through the criminal justice system, she was not offered any support or even asked why she had committed the offence. She said the police focused on the arson and did not consider the abuse she was suffering.

1.72 Adult B described how controlling Adult G had been throughout their relationship, for example how he wouldn't give her a key to the flat they shared. Adult G used the key as a form of blackmail by insisting that if she weren't back home by a certain time, he would not let her in.

1.73 She said her self-confidence was extremely low around that time and recounted an

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incident on Christmas day morning when the batteries had been taken out of a doll that had been bought as a present for her daughter by Adult G. On the same day Adult G didn't turn up for dinner and Adult B had to go to her mother's house at the last minute.

1.74 Adult B now recognises that Adult G's behaviour towards her was abusive, but she says she did not consider that at the time because she loved him. She added that Adult G particularly took advantage of her after the death of her father when she was emotionally vulnerable.

1.75 She said that even had she had realised she was in an abusive relationship with Adult G, she would not have known how or where to report it. She added that she increasingly felt isolated from her family.

1.76 After her father died, she started to drink more and various agencies became involved with her. She said that in her opinion, Children's services knew she was suffering abuse but because it was emotional abuse rather than physical, their focus was on the children and that her needs were ignored.

1.77 She said that she felt trapped because had she reported the abuse she was suffering, Adult G would have 'kicked her out' and she would have been homeless. An impossible challenge for her was in providing a bond or a deposit that was required before she could move anywhere else.

1.78 Adult B made a point of saying that the provision of accommodation for victims like her would remove the main barrier to reporting abuse.

1.79 She said she had known Adult A for a number of years and that she had ignored advice from a friend not to see him. She had been attracted to him because he was 'good looking', smart and charming. He would open doors for her; take her out for meals and he had money.

1.80 Adult B said that when she first met Adult A, she was still getting over the relationship with Adult G. She did not want to rush into anything, but Adult A put love notes under her door, which she thought, was 'sweet'. She said that he made her feel good.

1.81 Initially, they only saw each other at weekends and they would go out for a drink. It was after about six weeks that he first stayed over.

1.82 Adult A told her that he knew someone who could arrange for her to get a flat from a landlord who did not require a bond or a deposit. One day, Adult A surprised her by producing the keys to the flat saying they could sort the tenancy agreement out at a later date. She gave notice at the bedsit she had moved into and moved in with Adult A.

1.83 Adult A took her rent money but it became apparent to her that he never paid the landlord. After a few weeks together, Adult A started drinking with the neighbours, which caused problems between them.

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1.84 After about three months, Adult B asked Adult A why he had stopped going to work. He broke down and told her he had lost his job. From that time onwards, he began to drink more. She would often find miniature bottles in the flat. On one occasion she challenged him and he hit her and grabbed her by the throat. She thought it was a 'one-off' incident so she did not report it. She said she felt sorry for him because he had lost his job.

1.85 Adult B said neighbours took an electric fire from the flat and sold it. When she challenged them she was assaulted. (This could be the incident in March 2013, when Adult B said several people had assaulted her after she had complained about noise).

1.86 Adult B had wanted to ring the police but Adult A told her not to as she would be arrested. (Adult A and Adult B were subsequently arrested for theft of the fire in February 2013 and charged with the offence of theft in September 2013).

1.87 As a result of the arrest she was evicted. Adult B told the HR department at work and she was able to find another flat a short time later where she lived on her own. Adult A followed her from work one day and discovered where the flat was. He then got into a fight with another tenant and the landlord evicted Adult B.

1.88 She then stayed with her mother who was unwell. Adult A kept coming to the house and Adult B had to tell him to 'clear off'. He consistently rang the house phone and Adult B's mother eventually had to turn it off.

1.89 He persisted in his attempts to re-kindle the relationship and eventually they moved into a flat together.

1.90 She said that Adult A would wait for her outside her work and he wouldn't leave her alone; she had no opportunity to meet friends. Adult A kept telling her that she could not call the police because she had a 3 year supervision order for the arson offence and a conditional discharge for the theft of the fire.

1.91 Adult B said she began to drink to 'block things out'. She had moved five times in 18 months and did not know what to do. She was allocated a Domestic Violence worker (IDVA) who she was able to talk to. Adult B went to stay with a friend who would also meet her when she finished work so as to protect her.

1.92 Adult B said she began to feel she had 'turned the corner', but Adult A kept turning up at her work. Security staff there was aware of him and had at least once made him leave the premises. She said that on one occasion Adult A had assaulted the security guards and the police had been called. (There is no mention of such an incident in the police IMR).

1.93 **Comment**

1.94 Adult B was specifically asked about any barriers that may have prevented her reporting abuse and what agencies could have done to intervene and support her. She said she had been to see her GP and had discussed her depression and that she was the victim of domestic violence. She stated that the GP never referred her

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to any services. (The GP records are limited and this review has been unable to verify what Adult B has said).

1.95 Housing was a key issue for Adult B. She was in arrears with her rent so was unable to get accommodation through North Lincolnshire Housing. She was also unable to go into a refuge because she was working.

As part of this review it was established that as she was working she would have had to contribute monies for access to the refuge, she felt she was unable to do so.

2 The Facts

2.1 At 10.45am on Thursday 5th June 2014, Adult A withdraws cash from a cash machine close to his address. He then bought a large bottle of cider before walking in the direction of his flat.

2.1 Between 11.30am and 12.00pm, Adult A and Adult B left Adult A's flat and went to a nearby cash point where Adult B withdrew £140. They went to a local off-licence and Adult B bought two large cans of lager, which they both drank. (Adult B was at Adult A's flat)

2.3 Whilst they were drinking the alcohol it is claimed by Adult B that she told Adult A she was leaving the relationship. In the early afternoon Adult A and Adult B went to another off-licence; they were seen holding hands and it is believed they bought more alcohol.

2.4 Adult A and Adult B then went to Witness 1's address and he described both Adult A and Adult B being unsteady on their feet. He said that Adult A was 'emotional'. Witness 1 heard Adult A repeatedly tell Adult B that he 'loved her'. At this time Witness 2 was also in the address.

2.5 During their stay they drank more alcohol and Adult A accused Adult B of cheating on him. Adult B denied the accusation and attacked Adult A, punching him and scratching his face; Adult A did not retaliate. Later that afternoon Adult A and Witness 1 purchased more alcohol and then returned to Witness 1's address.

2.6 According to Witness 1 and Witness 2, Adult A and Adult B argued most of the afternoon but Adult A did not show any aggression towards Adult B. Later that evening, all four of them went to a local chinese takeaway and purchased food before walking back to Adult A's address. Whilst they were waiting at the takeaway, Adult A gave Witness 2 a kiss. This was seen by Adult B who argued with Adult A.

2.7 Later that evening, whilst at Adult A's address, a further argument took place between Adult A and Adult B. Witness 1 and Witness 2 both say that Adult B was arguing with Adult A and demanding to know how he had got scratches on his face. Adult A repeatedly told her that she had caused them, which she denied, and this apparently infuriated her.

2.8 At some point Adult B 'flew' at Adult A and tried to put her hands around his throat. In the melee a knife block and knives were knocked off the kitchen worktop. Adult A

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fell to the floor and was sitting with his back to the units, legs outstretched. Adult B was kneeling in front of him. Adult A did not defend himself or attack Adult B. Witness 1 took two knives off Adult B before she got a third one and stabbed Adult A.

2.9 An ambulance was called for and the Humberside police also arrived. All three were arrested. (When it became clear that Witness 1 and Witness 2 were only witnesses, they were released). The ambulance took Adult A to hospital but sadly he had died of his injuries.

2.10 A post-mortem examination revealed that Adult A had died as a result of a single stab wound to his chest.

2.11 During later interviews with the police, Adult B said she had been afraid of Adult A and that she had been defending herself. She gave several conflicting accounts to the interviewing officers of what had happened.

2.12 This was something the Judge later commented upon at her murder trial. He rejected her claims of self-defence and said that Adult A had posed no threat towards her.

2.13 The Judge also rejected most of Adult B's claims that Adult A had been violent towards her, although he accepted that there had been a couple of previous incidents. When describing her use of the knife, the Judge said,

> "*You knew what you were picking up…You made a conscious decision to pick it up and use it. You reacted in drunken temper to abusive, drunken insults by pushing* [Adult A] *to the floor, falling to the floor yourself and then picking up three knives, one of which you used to stab him while he lay defenceless on the ground. You gave little or no thought to what the consequences were going to be. The probability is that you did not have any intention to kill.*"

2.14 The Judge acknowledged that Adult B had shown *"immediate remorse"* but also commented about her attempts to distance herself from the truth of her actions.

2.15 As mentioned previously, Adult B was found guilty of murder and sentenced to life imprisonment. She must serve a minimum period of 14 years before eligibility for parole.

2.16 **Backgrounds of Adult A and Adult B**

2.17 **Adult A**

2.18 Adult A was 41 when he died. He was born in Scunthorpe, North Lincolnshire, in 1973. His father still lives in Scunthorpe, but his mother passed away in 2010. He was the youngest of three children, having two elder sisters.

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2.19 Adult A never married but had several relationships with women during his adult life. He had a son, Child F to a relationship with Adult F in the early 1990's. This relationship did not last long, and Adult A did not see or have contact with his son for many years.

2.20 In the late 1990's, Adult A had a relationship with Adult E for about three to four years. They have a daughter together, Child E, who was born in 1999.

2.21 Adult A had been in contact with Child E until he met Adult B in mid 2013

2.22 After separating from Adult E, Adult A went to live with his parents. Following the death of his mother in 2010, Adult A began to drink alcohol excessively. He steadily declined, in terms of self-esteem and confidence. He stopped working regularly, and became more alcohol dependent.

2.23 Adult A stayed with his father until early 2013, when he met Adult B. From then onwards, Adult A had had little contact with his father and his siblings.

2.24 **Adult B**

2.25 Adult B was 38 when she murdered Adult A. She was born in Scunthorpe and lived there all her life.

2.26 She has four children from a previous relationship with Adult J. None of the children lived with her and she did not have any parental responsibility towards them.

2.27 She had several other relationships, each of which involved an element of domestic violence, sometimes as both victim and perpetrator. Issues with alcohol misuse have dominated her adult life.

2.28 She worked locally and had done so for about three years. Her work colleagues did not socialise with her.

2.29 Adult B had been seeing an Independent Domestic Violence Advocate (IDVA), since early February 2014, as a result of a referral made to the Crisis Team by the Police Domestic Violence Unit.

3 Chronology

3.1 The following chronology of events is intended to provide an overview of Adult A and Adult B's engagement with services. Greater detail will be provided in the individual agency analysis section of this report.

3.2 Throughout the entire period of the review Adult A attended his GP with health issues associated with extensive alcohol consumption. None of the appointments were associated with domestic violence.

3.3 It should be noted that Adult B's employers have not been identified within the review.

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3.4 **January 2010**

3.5 Police were called to a report of a male (Adult C) and a female (Adult B) fighting and that children were outside crying. Adult B was found to have self harmed by slashing her wrists. The information provided was that Adult B had been drinking and become upset following the recent death of her father.

3.6 **February 2010**

3.7 Adult B's children were placed in the care of their maternal grandparents. This was after Adult B and another partner, Adult G, had an altercation. Adult B smashed a mirror and used the glass to cut her wrists. Humberside police notified Children's Services who conducted a Child Protection Investigation.

3.8 **May 2010**

3.9 Adult G alleged that Adult B had stolen from him and used the money he got for the goods to buy alcohol.

3.10 Humberside police attended an incident involving Adult A, who had been harassing Adult C. Adult A had left the premises before the police arrived.

3.11 Adult G called police after Adult B had come home drunk. An argument had ensued. Adult B had left the property prior to the police getting there.

3.12 Adult B self harmed by injecting insulin. Following a short stay in hospital she said she had no more thoughts of self harm and she was discharged

3.13 Adult C called police to report that Adult B was harassing her

3.14 **August 2010**

3.15 Adult B called the police to report that Adult G had assaulted her and that she had a knife. The police found the allegation to be untrue; Adult B had barricaded herself into a bedroom and had then set a pile of clothes alight. Adult B was arrested and charged with arson. A referral was made to North Lincolnshire Women's Refuge for emergency accommodation.

3.16 Adult C called the police to report harassment by Adult A. Adult A was arrested. Following this incident Adult C made a further report of harassment against Adult A

3.17 'It's My Right' Service made contact with Adult B and offered support which she accepted. A referral application was made for a refuge space, but this was turned down because of Adult B's arrest for arson.

3.18 Humberside police were called to an incident where Adult A had been verbally abusive towards Adult C.

3.19 Adult B attended Grimsby magistrate's court on the charge of arson.

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3.20 September 2010

3.21 Adult A was arrested for breach of bail by contacting and harassing Adult C.

3.22 Adult B saw her GP reporting stress. The GP records state (she) *'did set fire to the house because she wanted to die and reach her dad.'* and that it was a *'cry for help because her ex partner was abusing mentally - stopped her seeing her family and locked her in'.* (It should be noted that these records are minimal and do not contain much detail. There is no record of what action the GP undertook following this disclosure however it does not appear a referral was made to any mental health services.)

3.23 Adult A appeared before Scunthorpe magistrate's court in relation to the harassment of Adult C and sentence was postponed until 1st October 2010.

3.24 Humberside police were called to an incident where Adult A had a verbal argument with Adult D

3.25 October 2010

3.26 Adult B was sentenced to a 3 year Community Order with 3 years Supervision and Residence Requirements for the term of the Order for the offence of arson. She was inducted onto the 'women's programme' managed through the Humberside Probation Trust. (There are a number of entries for the Humberside Probation Trust ensuring Adult B maintained her attendance on the programme and on occasions are required and did issue warning letters for non-attendance.)

3.27 Adult A appeared at Scunthorpe Magistrates Court for offences of harassment and was sentenced to a Community Order with supervision requirement and unpaid work.

3.28 February 2011

3.29 Following a GP appointment Adult A was diagnosed with 'chronic alcoholism' and advised to self refer to 'The Junction' (Alcohol and drug services within Scunthorpe.) (There are no records that indicate Adult A did self refer.)

3.30 March 2011

3.31 Adult A was referred from the Humberside Probation Trust, as he was due in court for harassment and a breach of a non-molestation order against Adult C.

3.42 Adult A attended his Alcohol Treatment Requirements (ATR) comprehensive assessment appointment and disclosed that he was consuming 2 litres of 7.5% cider and 2 cans of 4.4% lager daily and had withdrawal symptoms if he does not drink.

3.43 Later in the month Adult A attended a further appointment with an alcohol treatment worker and stated he was drinking up to 4 litres of strong cider over a 4-hour period on a daily basis

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3.44 **July 2011**

3.45 Adult A reported to his alcohol treatment worker that he had reduced his alcohol intake and '*feels like he has turned his life around due to the number of losses he has had through drinking.'*

3.46 **October 2012**

3.47 Adult B signed delegated Parental Responsibility for her children who were now formally voluntarily accommodated in Local Authority care.

3.48 **February 2013**

3.49 Adult A and Adult B were arrested for theft of an electric wall mounted fire at Adult B's accommodation. They were formally charged with the offence in September 2013.

3.50 **March 2013**

3.51 Several people assaulted Adult B (possibly 8 – 12) when she went to a neighbours address to complain about noise and nuisance. She was admitted to hospital for overnight observations.

3.52 **May 2013**

3.53 Following a GP appointment for an alcohol related issue, Adult A was admitted to Scunthorpe General Hospital. He was seen by Drugs & Alcohol Services and admitted that he had consumed 48 units of alcohol daily since December 2012. He said he wanted to stop drinking.

3.54 **September 2013**

3.55 Adult A was arrested for causing damage to a pub window whilst drunk.

3.56 Adult B appeared before North Lincolnshire Magistrates court where she was made subject of a Conditional Discharge in relation to the theft of the fire in February 2013

3.57 **November 2013**

3.58 A member of the public reported that Adult A and Adult B were arguing in the street. During the argument Adult A had placed his hands around Adult B's throat.

3.59 **December 2013**

3.60 Police were called to an incident involving Adult A and Adult B who were fighting in the street; both had been drinking.

3.61 **January 2014**

3.62 Humberside Police received Information from her employers that Adult B had bruising on her arms. Following a risk assessment, a MARAC referral was made in

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relation to Adult A and to Adult B.

3.63 **February 2014**

3.64 An off-duty police officer reported that a verbal argument was taking place between Adult A and Adult B

3.65 **March 2014**

3.66 At a MARAC meeting, police said that intelligence suggested that Adult A was becoming increasingly abusive towards Adult B. Adult B had said that she wanted to engage with an IDVA, but when the IDVA tried to contact her there has been no response. The case was to be reviewed at the next meeting to allow the IDVA to liaise with Adult B's employer and to make contact with Adult B and manage her safety.

3.67 Adult B was contacted via her work place and stated she did not need support at that time

3.68 At a further MARAC meeting Adult B was discussed and due to her non-engagement the case was archived.

3.69 **May 2014**

3.70 Adult A was seen by the crisis team in Scunthorpe General Accident and Emergency due to his suicidal thoughts. Adult A had been drinking and stated he wanted to die as he was feeling *'bereft after losing mum approx. 1 year ago. Breakdown in relations with previous partner, due to reliance on alcohol. Does not work feels if he could get support for alcohol withdrawal could get life back together.'*

3.71 A member of the public reported that that Adult A and Adult B were arguing at Adult B's address

3.72 **2nd June 2014**

3.73 Adult B's work place contacted 'It's My Right Service' and asked to speak to an IDVA. The caller stated that Adult B was *'in a mess.'* Adult B spoke to the IDVA and stated that Adult A was harassing her at home and at work. The IDVA agreed to meet with Adult B and collected her a short time later.

3.74 During the face to face meeting Adult B reported a number of incidents relating to Adult A and that she felt isolated from her friends and was not allowed to go anywhere without him. She recalled an incident at Christmas 2013 when Adult A had assaulted her and she had escaped through a window. She also said that Adult A walked her to and from work, uses her cash card and takes her mobile phone.

3.75 Adult B stated that she had now moved and that Adult A did not know where she was. The IDVA expressed her concerns for Adult B's safety, but Adult B reassured her she would be okay. Housing options were discussed

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3.76 **3rd June 2014**

3.77 Adult B reported to the police that Adult A was physically and verbally abusing her.

3.78 **4th June 2014**

3.79 Adult B reported to the IDVA that Adult A was continuing to harass her and that she was *'feeling low and struggling at the minute.'*

3.80 The IDVA referred Adult B back into MARAC

3.81 **5th June 2014**

3.82 Adult A was murdered and Adult B was arrested.

4 Analysis of involvement

In this section, agency practice is analysed and evaluated against policy and procedure through the IMRs. Further analysis will take place in the next section of this report directly relating to the review Terms of Reference.

4.1 Humberside police

4.2 **Summary of Adult A's relationships prior to the one with Adult B**

4.3 Adult A had relationships with Adult's C and D as follows. The dates are estimates only and are based on agency records.

4.4
- Adult A and Adult C – March 2009 and August 2010

4.5
- Adult A and Adult D – September 2010

4.6 **Adult A and Adult C – outside the scope of the review**

4.7 There were four domestic violence incidents between Adult A and Adult C between March 2009 and December 2009. The first three, (March, June and July) were verbal altercations. Adult A had either left the property or area prior to police arrival, or when seen by police he and she were given advice. There is an indication that Adult A and Adult C are in an 'on-off' relationship during this time.

4.8 On 31st December 2009, Adult C assaulted Adult A by hitting him on his head with a rolling pin. Adult C was arrested, interviewed and later cautioned for assault.

4.9 **Adult A and Adult C – within the scope of the review**

4.10 On 4th July 2010, Adult C reported that Adult A was harassing her through text messaging. The information stated that the couple has been separated for over a year and that they had been in an *'on-off'* relationship.

4.11 A SPECSS (**S**eparation/child contact issues/Stalking, **P**otential barriers to seeking help, **E**scalation of violence, **C**hildren related issues including pregnancy, **S**uicidal.

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Includes attempts/threats of suicide or homicide, **S**exual Assault) risk assessment was completed which highlighted that the couple no longer lived together. The assessment indicated a ‘medium risk’. The rationale was recorded as *‘male appears to be very jealous and it appears to be getting gradually worse the more the female distances herself from him. She has admitted that she may be giving off the wrong signals at times in the past. (They are not current partners).’*

4.12 Attempts were made to locate and speak with Adult A, but these were unsuccessful. Adult A attended a police station the following day and was issued with a harassment warning. At this time and in the circumstances the warning was the only legal remedy available.

4.13 A secondary risk assessment by the Domestic Violence Coordinator also identified *‘medium’* as the appropriate assessment.

4.14 On 27th July 2010, Adult C reported further harassment by Adult A. A risk assessment was completed and assessed as medium. Within the assessment it was recorded that they only lived around the corner from each other; that they had recently ended a 12 month ‘on-off’ relationship and that there were previous incidents of domestic violence between the couple that had not been reported to the Police

4.15 Adult A was not located at this time.

4.16 A secondary risk assessment by the Domestic Violence Coordinator identified medium as the correct assessment.

4.17 On 16th August 2010 Adult C reported a further incident of harassment by Adult A. A risk assessment was completed and recorded as medium. The form details that Adult C was ‘constantly being harassed’ by Adult A.

4.18 Adult A was arrested by a specialist domestic violence officer on 18th August 2010 and was interviewed about all the complaints of harassment.

4.19 Whilst Adult A was in custody, the full circumstances were reviewed by an Evidence Review Officer and a decision was made that Adult A would be issued with another harassment warning as there was insufficient evidence to prosecute him. Primarily the decision was made because Adult A had stated in interview that he didn’t realise his actions amounted to harassment.

4.20 On 21st August 2010, Adult C reported further harassment by Adult A. It occurred when Adult C was driving past the home address of Adult A and appeared to have been a chance meeting rather than an intentional one.

4.21 A Police Officer completed a risk assessment and assessed it as standard. It is clear that the officer conducting the assessment was not aware of the previous incidents and so this affected his assessment. Full information should be available when conducting risk assessments.

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4.22 On 26th August 2010, Adult C reported that Adult A had been verbally abusive. The police completed a detailed risk assessment, which acknowledged that there had been two previous harassment warnings. The assessment stated '*the offender is continuing without abatement.'* The risk assessment was graded as medium.

4.23 Adult A was arrested the same day and was charged with harassment. He was released on conditional bail to appear at court in September. The bail conditions were that Adult A should not communicate directly or indirectly with Adult C.

4.24 **Note**: *This imposition of bail conditions on release was standard practice at that time and was used by police to restrict offenders and offer a degree or protection to victims and witnesses.*

4.25 *Since then, legislation has been introduced to protect victims of domestic violence. They are known as Domestic Violence Protection Notices (DVPN) and Domestic Violence Protection Orders (DVPO).*

4.26 A secondary risk assessment was completed by the Domestic Violence Coordinator, which encompassed an assessment of the risks associated with the incidents on 16th August 2010 and 21st August 2010. The assessment highlighted the ongoing harassment as well as the arrest of Adult A; that Adult A was on conditional bail and that Adult C was being proactive with regards to her safety. The assessment remained as medium.

4.27 On 1st September 2010, Adult C reported further harassment by Adult A in clear breach of his bail conditions. He was arrested and charged and appeared before Scunthorpe Magistrates Court where a successful application for a remand in custody was made.

4.28 The police did not record a risk assessment, which represents a missed opportunity.

4.29 On 9th September 2010, Adult A appeared before the court and was released on conditional bail. In October 2010 the court dealt with all the matters relating to Adult A and he was given a Community Order with Supervision requirement for unpaid work.

4.30 **Adult A and Adult D**

4.31 11th September 2010, two days after Adult A's release from custody, Adult D reported a domestic incident. When police officers arrived, Adult A had left the property. The incident was recorded as a verbal argument.

4.32 Unsuccessful attempts were made to locate Adult A. The police conducted a risk assessment of standard. The assessment shows that Adult A had only been seeing Adult D for two weeks (one of which he was in custody).

There is an assumption that it was Adult A involved in the incident, although this was never confirmed. If it had been confirmed that it was in fact Adult A then the police could have considered using their powers under the Domestic Violence Disclosure Scheme.

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4.33 The Domestic Violence Coordinator who agreed with the earlier assessment as standard risk completed a secondary risk assessment. On review and given the previous history of Adult A there would be an expectation that this risk should have been medium.

4.34 It is acknowledged that had this incident occurred in 2015, Police could have considered utilising their powers under the new Domestic Violence legislation.

4.35 **Summary of Adult B's relationships prior to the one with Adult A**

4.36 The following relationships have been identified between Adult B and Adult's G, H and J. The precise dates are not known and have been estimated based on agency knowledge.

4.37
- Adult B and adult J – March 2001 and March 2003

4.38
- Adult B and Adult H – December 2004 and August 2007

4.39
- Adult B and Adult G – September 2009 and August 2010

4.49
- Adult B and Adult A – March 2013 and June 2014

4.41 **Previous relationships outside the scope of the review – Adult B**

4.42 **Adult B and Adult J**

4.43 There are 3 recorded domestic violence incidents between Adult B and Adult J. The case summary on each indicates that there were verbal altercations between the couple during which property was damaged and that Adult J was the perpetrator. There was no evidence of physical violence being used by either party two of the incidents were resolved by one party leaving the property.

4.44 **Adult B and Adult H**

4.45 There were 11 recorded domestic violence incidents between Adult B and Adult H. The case summaries on each indicate that Adult H was the perpetrator and that either one or both parties were drunk at the time of the incidents.

4.46 In February 2006, Adult H and Adult B were both arrested for assault on each other following a domestic violence incident; Adult B received a caution and there was no criminal justice outcome in respect of Adult H.

4.47 A significant number of the incidents are verbal altercations, but there was also physical violence inflicted upon Adult B. In 2007, Adult H had held a knife held to her throat. Police records show that advice was given although the exact details are not known, the original incident log for this has since been destroyed in line with policy.

4.48 **Adult B and Adult G**

4.49 There was one domestic violence incident between Adult B and Adult G in September 2009. Both had consumed a lot of alcohol and an argument had taken

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place between them as a result of Adult B's children being removed by Children's Social Care.

4.50 No physical violence took place and both parties were given advice.

4.51 **Previous relationships within the scope of the review**

4.52 **Adult B and Adult G**

4.53 On 20th February 2010, the police were called to a domestic related incident involving Adult B and Adult G. When they arrived only Adult B and two of her children were there. Adult B had been drinking and had slashed her wrists. She explained that she had done it because of the recent death of her father.

4.54 Adult B went to hospital with a neighbour and another neighbour looked after the children. A referral about the children was made to the social care Emergency Duty Team.

4.55 Following concerns raised by nursing staff, the police gathered further information that was shared with the Public Protection Unit.

4.56 A SPECSS domestic violence risk assessment was completed and assessed as medium risk. The rationale for the assessment was recorded that *'Female today was a risk to herself, children are fine, and FPU (Public Protection Unit) made aware regarding children.'* This is in line with the policy at the time. (Humberside Police now uses the DASH - **D**omestic **A**buse, **S**talking and Harassment and **H**onour Based Violence - risk assessment).

4.57 Ten days later, the police Domestic Violence Coordinator completed a second risk assessment. The risk was recorded as high although there was no referral to MARAC.

4.58 Following the review it was felt by the IMR author that the secondary risk assessment was medium and not high, and the disparity in the recording is a typing error. If the case had been risk assessed as high this would have resulted in a referral to MARAC in line with the MARAC procedures in place.

4.59 On 17th July 2010, Adult B came home drunk and a verbal argument followed between her and Adult G. Adult G contacted Humberside police, however Adult B had left the address when they arrived. Attempts were made to locate Adult B, but she was not found.

4.60 A SPECSS risk assessment was completed but all the questions were answered with *'n/a'*. It is not clear why limited information was recorded on the risk assessment. The incident was recorded as standard and the rationale was, *'no violence, just words spoken in drink.'*

4.61 The incident was assessed by a domestic violence supervisor, who agreed with the original assessment and referred the incident to Children's social care. The referral

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also mentioned other domestic violence incidents. This was good practice.

4.62 **Note:** *The process for referrals to Children's Social Care has changed since 2010. Humberside Police have a small team of dedicated staff within Social Services premises that share information and undertake Child Protection Decision making with Children's Social Care an a daily basis.*

4.63 *Further work has also been undertaken in 2015 with all four Local Authorities in the Humberside police area sharing information of children living in households or present during domestic violence incidents with Children's Social Care.*

4.64 On 11th August 2010, Humberside police were called to an incident involving Adult G and Adult B. Adult G was alleged to have had a knife and Adult B had locked herself in the bathroom.

4.65 When officers arrived Adult G was outside the property. He was arrested and searched, but no knife was found. Adult G said to officers *'You best go in there, she's trying to set fire to the house.'* Adult G was de-arrested, as the evidence to support the initial decision to arrest was no longer present.

4.66 Officers forced entry into a bedroom where Adult B had barricaded herself, and found it to be full of smoke with a pile of clothing on the bed that was alight.

4.67 Adult B refused to leave the room saying, '*I want to die.'* She was forcibly removed and was then arrested.

4.68 A domestic violence risk assessment was completed and assessed as medium. The rationale was recorded as '*Adult B is understood to have mental health issues which lead to self-harm and tonight's incident. Both parties are stated to drink heavily and constantly leaving potential for further incidents.'*

4.69 The Domestic Violence Coordinator reviewed the incident and increased the risk to high. The rationale was recorded as *'Due to severity of the crime of arson. The victim is suffering mentally and resorted to committing the offence. Victim has previously made self-harm attempts. Information that the offender has used a knife.'*

The practice of independently reviewing risk assessments should be seen as good practice

4.70 Adult B was charged with arson. While she was still in custody, the Domestic Violence Coordinator made the necessary arrangements and offered Adult B emergency housing, which she accepted. This should also be viewed as good practice. A further referral was made to Children's Social Care.

4.71 During a court appearance in 22nd October 2010 Adult B pleaded guilty and was sentenced to a Community Order for three years with a Supervision requirement.

4.72 Following the initial assessment, the Domestic Violence Coordinator, who reduced the risk from high to medium, undertook a further review. The rationale was recorded as – *'Reduced as Adult B is still keeping away from Adult G. Adult B has*

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been referred to Domestic Violence Caseworker and is now living at the [redacted] *where she can be supervised.'*

4.73 There is no record of any support being made or offered to Adult G. When Adult G made a statement to the, he indicated that he was going to seek a civil order in respect of Adult B through his solicitor. There is no record within police systems to indicate whether a civil order was ever applied for.

4.74 Adult G was the victim of domestic violence and the failure to engage with him represented a missed opportunity.

4.75 **Relationship between Adult A and Adult B**

4.76 On 2nd March 2013 a theft report was made to Humberside police. Adult A and Adult B were arrested and were charged later in the year. They appeared before Scunthorpe magistrate's court in October 2013 and were given a conditional discharge.

4.77 On 15th November 2013, a member of the public reported an argument taking place between Adult A and Adult B. During the argument, Adult A had placed his hands around Adult B's throat. When the police attended, Adult B told them that Adult A had removed his hands when she had asked him to, and that she did not want any further action. This was the first recorded incident of domestic violence between Adult A and Adult B.

4.78 A DASH risk assessment was completed and assessed as medium risk. Not all the questions on the assessment were answered although it is recorded that there was no report of restricted breathing (when the hands had been placed around the victims throat), that Adult A was a heavy drinker, that Adult B wanted to end the relationship and that Adult A walks Adult B to work and says who she can see. Adult B had also stated that she did not feel vulnerable.

4.79 Specifically recorded on the assessment is *'Today he put his hands on my throat and squeezed but stopped when I said.'* The Officer took Adult B to a relatives address.

4.80 The Domestic Violence Coordinator who undertook an extensive amount of research and contact with partner agencies completed a secondary risk assessment. It identified that no formal crime complaint had been created and that no contact details for Adult B had been entered although her work place details were recorded. The Domestic Violence Coordinator made contact with her workplace and details of support agencies were passed to Adult B. This should be seen as good practice.

4.81 The assessment remained as medium although it is clear there were a number of high-risk predictors within the incident. (Hands around the throat, separation, controlling behaviour and previous offending history of Adult A).

4.82 On 30th December 2013 an off duty Police Officer reported that Adult A and Adult B were fighting in the street. It is not believed that the officer knew who either of them was.

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4.83 The police attended and spoke with Adult A and Adult B. They accepted they had been arguing and said it was about a recent burglary at their address which had been reported to the police.

4.84 Both had been drinking alcohol and a check on local CCTV did not reveal that any offences had been committed.

4.85 A risk assessment was completed and assessed as 'standard'. The assessment recorded the answer 'no' to the following question, '*Has **** every attempted to strangle/choke/suffocate/drown you?'.* This was amended by the administration staff inputting the assessment details on to the Humberside police computer system to '*no ticked – hands around throat on 15/11/2013.'*

4.86 On 14th January 2014, the police received information that the relationship between Adult A and Adult B was becoming more abusive and controlling. The information was recorded within the Police intelligence system and stated that Adult B had been seen with bruising on her arms while at work.

The Officer who dealt with the incident on 30th December supplied this information; the information was not inputted onto the Police intelligence system until 14th January 2014. This is a significant piece of information and should have been recorded promptly to inform future assessments.

4.87 The Domestic Violence Coordinator did not complete a secondary risk assessment relating to the incident on 30th December until 6th February 2014 by which time the information dated 14th January was also in police systems. The delay is due in part to the delay (2 weeks) of the submission of the original risk assessment, the volume of incidents and that the assessment was originally graded as standard and so was not dealt with immediately. This assessment increased the risk to Adult B from standard to high.

4.88 The Domestic Violence Coordinator e-mailed Adult B's place of work: '*I am aware that [Adult B] has been given all our contact numbers if she wanted to talk with us, do you think she would talk with us or if not a support person who is not police. I am under the impression that her work are supporting her into moving etc??'*

4.89 An e-mail response was received saying the information would be passed to Adult B. The Domestic Violence Coordinator continued to use this point of contact in the workplace for further contact with Adult B and should be seen as good practice. A referral to Children's Social Care was also made in accordance with the Humberside police policy.

4.90 Adult B was referred to a MARAC (Multi Agency Risk Assessment Conference) and the case was allocated to an Independent Domestic Violence Advocate (IDVA). This is good practice and in accordance with the MARAC procedures in place in 2014. Following the referral to the MARAC and prior to the case being heard, a referral was made to the Domestic Violence Caseworker – this is also good practice.

4.92 The child protection record for the incident records that the children of Adult B were in long-term care although Adult B was having supervised contact with them.

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It has become clear to this review that the Domestic Violence Coordinator had a clear level of understanding of the potential risks in the case. The Officer made contact with Adult B's work place, external partners and correctly re-assessed the risk from standard to high. The overall handling of the case was excellent.

4.93 On 5th March 2014, a MARAC meeting was held about Adults A and B. Adult B had not given consent to share information but the Chair determined that it should be shared against her wishes in line with the requirements of Section 115 Crime and Disorder Act 1998.

4.94 It was acknowledged that there were already several actions underway in relation to Adult B and the case was referred back to the MARAC at the end of March 2014. One action was raised at the meeting, which was for the Domestic Violence Caseworker to make further contact with Adult B.

4.95 On 26th March 2014 a further MARAC meeting was held where Adult A and Adult B were discussed. The IDVA had made contact with Adult B at her place of work and Adult B had said she did not require any support, but that she had contact details of the caseworker. The final outcome of the MARAC meeting is recorded as '*nothing from any other agencies present, the risk remains as the relationship is ongoing and support has been refused, the case will be archived today.'*

4.96 On 23rd May 2014, Adult A reported that he has having problems with his neighbours; during the initial call to Humberside police he had said that he was going to kill himself if no one attended.

4.97 Adult A went to a local gym and complained about the neighbours to members of the gym. A member of the gym called Humberside police to report the incident on behalf of Adult A. During that call Adult A was advised to attend at Scunthorpe Police Station to progress the complaint.

4.98 Adult A did not go to the Police Station and due to the fact that he had threatened to kill himself, enquiries were made by the police to locate him and check his welfare.

4.99 The local area was searched and mental health services were contacted who confirmed that they had seen Adult A four days earlier and that he had disclosed his ongoing problems with the neighbours. Adult A had been given advice about accessing mental health services.

4.100 On 24th May 2014, Adult A made another call to Humberside Police and when they attended, both Adult A and Adult B spoke of their ongoing problems with their neighbours, specifically about music being played too loudly at all hours of the day. Adult B stated she was afraid to leave the property and both of them stated the problems were affecting their mental health.

4.101 Police officers visited the neighbours and gave them advice regarding their behaviour. Adult A was given advice about contacting mental health services. Adult A confirmed that he had recently seen mental health services who had advised him that if he was still in the same frame of mind he could attend at the hospital and ask to be seen again.

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4.102 There was no mental health referral made by Humberside Police to mental health services

4.103 The officers notified the local Neighbourhood Policing Team of the ongoing problems with the neighbours and requested the team monitor the situation. This should be seen as good practice.

4.104 On 27th May 2014, a member of the public reported an argument between Adult A and Adult B. When the police arrived, only Adult B was there. She told them there had been a verbal argument and that Adult A had gone to the chip shop. Adult B refused to disclose any further information.

4.105 Adult B admitted that she was drunk. She kept repeating herself and stated she just wanted to go to bed as she was at work the following day. Only limited information was recorded within the risk assessment, specifically the answer *'No'* was recorded against the question, '*Has the current incident resulted in injury? (please state what and whether this is the first injury)'*

4.106 Officers did not see Adult A and there had been little information provided by Adult B. There was no evidence that any violence had taken place. The risk assessment indicted medium risk and the rationale referenced that there had been previous domestic violence between the couple, the property is shared tenancy and both parties were in drink.

4.107 The Domestic Violence Coordinator conducted a secondary risk assessment and agreed with the initial assessment of medium risk. The Domestic Violence Coordinator shared details of the incident with the IDVA, who informed the Domestic Violence Coordinator that further contact would be made with Adult B at her work.

4.108 The management of the incident and subsequent information sharing is good practice and demonstrates good inter-agency working.

4.109 On 3rd June 2014, Adult B contacted Humberside police and said, *'I have just been physically and verbally assaulted by my ex-partner, I am on the* [redacted] *project.'* Adult B also stated that Adult A was outside the property where she was staying, which was not their home address. This is the first indication to Humberside police that the relationship between Adult A and Adult B had ended.

4.110 Recorded on the incident log is the previous police involvement and that the couple had previously been identified as high risk and that the case had been archived at MARAC in March 2014.

4.111 The police officers recorded the following, '*Have attended at the address and we have spoken to both parties – appears to have been chance meeting by both parties and they have been advised.'*

4.112 Further information was that the meeting between Adult A and Adult B had been in an off-licence, that both parties had been drinking alcohol and there had been no physical violence between Adult A and Adult B and that during the incident, friends of Adult B had intervened.

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4.113 Adult B had requested that officers speak to Adult A and that her friends were going to stay with her that evening. She was advised to contact the police if Adult A caused any further problems.

4.114 Recorded on the police incident log is, '[Adult A] *has been given words of advice to ignore* [Adult B] *and not engage with her if he sees her again*'.

4.115 No DASH risk assessment was submitted at the time, but following the death of Adult A two days later, the officers were asked to provide a risk assessment for the incident, which they did.

4.116 The lack of a risk assessment meant that officers were unable to identify risk to Adult B and they either did not have the previous information relating to MARAC or did not recognise the importance of it.

Separation is a key risk factor within domestic violence and this does not appear to have been recognised.

This should be seen as a missed opportunity.

4.117 One of the risk assessments completed by the officers after Adult A's death recorded the risk as medium, with the comment, *'Ex couple live separately at this time and no violence has been offered on this occasion, verbal only.'* The one completed by the other officer other provided a detailed risk assessment but no risk grading or rationale was made.

4.118 The risk assessments mention that Adult B had told the officers that Adult A was trying to contact her at work and that she wanted him to stop. Adult B had also stated that she has regained some control since leaving Adult A.

4.119 During the incident there had been no suggestion that there had been a physical altercation or that the risk to Adult A or Adult B had increased.

4.120 **Note:** *At the time of this incident it was Humberside police policy that when incidents of domestic violence had occurred and attending officers had not submitted a Domestic Violence Form, an e-mail was sent to the officers requesting a form to be submitted within seven days. If, after seven days the Domestic Violence Form was still not received then the Domestic Violence Coordinator would undertake a secondary risk assessment based on the previous history and information from within the incident log. No further follow up action would be taken with the Officers.*

4.121 *The policy changed at the beginning of 2015. It now states that where Officers do not submit a Domestic Violence Form, even after e-mail notification, it is brought to the attention of a supervisor, and then ultimately an Inspector.*

4.122 *This policy change was made following two Child Protection Serious Case Reviews within the Humberside police area. The Force Policy Lead monitors compliance of the Policy for Domestic Violence. The completion of Domestic Violence Forms is embedded throughout the current training being delivered to all front line staff.*

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4.123 National Probation Service (reviewing the Humberside Probation Trust)

4.124 On the 1st June 2014 as part of the Government's Transforming Rehabilitation Reforms, Humberside Probation Trust ceased to operate. The delivery of Probation Services was transferred to two new organisations, the National Probation Service (NPS), a public sector delivery directorate of the National Offender Management Service (NOMS) and the Humberside, Lincolnshire, North Yorkshire Community Rehabilitation Company (HLNY CRC) a private sector organisation.

The NPS is responsible for the management of offenders assessed as presenting a high risk of serious harm, the management of Approved Premises, the management of those offenders meeting the criteria for MAPPA eligibility, services to Courts and the delivery of sex offender treatment programmes. The HLNY is responsible for the management of those offenders assessed as presenting a low and medium risk of serious harm and the delivery of interventions such as unpaid work, accredited offending behaviour programmes and a range of additional interventions targeted at addressing offending behaviour. Both organisations work in strong partnership to deliver Probation Services and to reduce the risk of harm and re-offending in the community.

4.125 The Humberside Probation Trust had limited involvement with both Adult A and Adult B. On 26th August 2010, Adult B appeared at North Lincolnshire Magistrates Court in relation to the offence of arson on 11th August 2010.

4.126 On 10th September 2010, Adult B appeared at Grimsby Crown Court for the offence of arson and later a pre-sentence report was produced.

4.127 *A pre-sentence report can be requested by a Court to assist in determining the most suitable method of dealing with an offender. It includes an assessment of the nature and seriousness of the offence, the impact on the victim and an offender and risk assessment.*

4.128 As part of the pre-sentence report process, a domestic abuse check was requested from Humberside Police. Six incidents were identified for Adult B including the offence of Arson. Adult B was identified as the offender in four of them and as a victim in the other two.

4.129 Only the arson incident involved an element of physical violence. The others consisted in the main of verbal altercations.

4.130 A psychiatric report in relation to Adult B was received from her solicitors in advance of a court appearance on 22nd October 2010. The pre-sentence report stated:

4.131 '[Adult B] *appears before the Court today for sentence in respect of an offence of Arson - Recklessly Endangering Life committed on 11 August 2010. Witness statements detail how* [Adult G] *and* [Adult B] *went to a local Public House at approximately 5pm on 11 August 2010. They had intended on going for a meal but had a few drinks instead. They moved on to The Berkley Public House where they remained, drinking more alcohol, until the couple were asked to leave the premises as they were arguing. The arguments continued on the way home and* [Adult B]

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started hitting [Adult G], *slapping and punching him. He told her to walk on the other side of the road until they reached their home address. On arrival at the flat*, [Adult G] *states that the defendant "went mad". Once inside she broke some glasses by throwing them against the wall. She said something similar to "I'm going to burn the house down" and ran off towards the bedroom.* [Adult G] *followed her and told her "not to be daft". He tried to access the bedroom but was unable to do so, assuming that* [Adult B] *had barricaded herself in the room.* [Adult G] *noticed the smell of burning and immediately contacted emergency services. He left the flat and stood with other residents who had also vacated their properties. The victim of this offence is* [Adult G], *the defendant's then partner. I have been given no information to suggest that* [Adult G] *is vulnerable. Crown Prosecution Service documents indicate that some of* [Adult G's] *clothes were charred and burnt. The bedroom carpet was also damaged during the fire, as were the quilt and bedding. It is my assessment that the main causal factors in* [Adult B's] *offending behaviour are cognitive deficits, relationship difficulties, alcohol use and emotional well-being.* [Adult B] *is in agreement with this assessment and recognises that she needs to address these issues in order to reduce the risk of further offending".*

4.132 Within the risk assessment of the Pre-Sentence Report, Adult B is assessed as presenting a 'Medium Risk of Serious Harm to Public', and a 'Medium Risk of Serious Harm to Self'.

4.133 There is no reference to any assessed risk to partners, her mother or children, despite there being evidence to the contrary as reflected in her index offence.

4.134 The definitions of Risk of Serious Harm levels, as defined by the National Offender Management Service (NOMS) are as follows:

4.135

- ***Very High Risk of Serious Harm*** *(there is an imminent risk of serious harm. The potential event is more likely than not to happen imminently and the impact would be serious);*
- ***High Risk of Serious Harm*** *(there are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious);*
- ***Medium Risk of Serious Harm*** *(there are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse);*
- ***Low Risk of Serious Harm*** *(current evidence does not indicate likelihood of serious harm).*

4.136 There are no records that suggest that a Spousal Assault Risk Assessment (SARA) was undertaken to support the risk assessment. Its purpose is to assist criminal justice professionals predict the likelihood of domestic abuse. The SARA Guide defines spousal assault as:

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'…any actual, attempted, or threatened physical harm perpetrated by a man or a woman against someone with whom he or she has, or has had, an intimate sexual relationship'.

4.137 The Guide discusses the target population for completion of the assessment in the following way:

"Our definition of spousal assault is inclusive. It is not limited to acts that result in physical injury; it is not limited to relationships where the partners are or have legally been married; it is not limited by the gender of the victim or perpetrator; and it is not limited by the ethnicity of those involved. Therefore, the SARA is intended for use with all offenders. The basic risk factors for spousal violence appear to be stable across contexts. However, we recognise that the nature and dynamics of risk might be influenced by culture, gender, sexual orientation and so forth. For example, being a victim of family violence as a child or adolescent (SARA Item 6) might be a more common and important risk factor for certain populations e.g. female or aboriginal offenders – than for others".

4.138 SARA Assessments must always be completed in relevant cases at the pre-sentence report stage.

4.139 On 20th October 2010, a Safeguarding (Risk to Children) Register on the case record of Adult B was made – the entry states:

'*Registered due to previous police caution for child cruelty.* [Adult B] *left her children in the care of her partners son, who subsequently left them alone in the house'.*

4.140 An additional comment was added by the probation officer stating:

*'Continue to monitor this area in light of [*Adult B's] *history of self harm and the nature of this offence'.*

4.141 On 22nd October 2010, Adult B appeared at Grimsby Crown Court and was sentenced to a 3 year Community Order with 3 years Supervision and Residence Requirements for the term of the Order. She attended her induction with the Humberside Probation Trust on 26th October 2010

4.142 Throughout 2010 and the beginning of 2011, Adult B attended her Probation appointments and the relevant workshops.

4.143 On 7th December 2010, Adult B's allocated probation officer was having trouble contacting her. The probation officer contacted her allocated social worker expressing concerns that she was not living at the address stipulated by her Offender Manager.

4.144 The social worker said she had heard that Adult B was living with male friend. She added that Adult B had not seen her children for 3 months and that Children's social care was having difficulty contacting Adult B.

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4.145 In April 2011, Adult B attended the Women's group that was run by the Humberside Probation Trust and said she now had a job

The attendance at the Women's group was not specifically mandated as part of her Court order. However, where the Offender Manager directly instructs an offender under their supervision to attend appointments this becomes a mandatory instruction and therefore one which if not attended can be enforced through the Court.

4.146 On 31st May 2011, a phone call was received from Adult B's aunt who stated that Adult B was living with a man (believed to be Adult G).

4.147 On 14th September 2011, a telephone call was received by the Humberside Probation Trust from a social worker that said Adult B had left her address and that the social worker did not know where she was. She wanted to speak to her about the care of her children. This demonstrates a good working relationship and exchange of information between the Humberside Probation Trust and children's social care.

4.148 On 15th September 2011, Adult B failed to attend the Women's Group and a 'first warning' letter was issued. Her absence was recorded as being unacceptable in accordance with national standards and expected practice

4.149 On 21st September 2011, Adult B confirmed that she had moved address due to issues with other residents (not domestic violence related) and she provided a new address.

4.150 The Humberside Probation Trust made several visits to see her but she was not in.

4.151 On 8th November 2011, a home visit was made and both Adult B and Adult K were there. Adult K said he understood what offences Adult B had been convicted of and had an awareness of the associated risks. Adult K confirmed that he was happy for Adult B to live at his address. He was advised to contact the Humberside Probation Trust if he had any concerns.

4.152 During December 2012 and January 2013, Adult B's probation officer attempted to contact the children's care social worker on three separate occasions via email. The social worker did not respond.

4.3 On 14th August 2013, an arrest Incident for Adult B was recorded relating to the theft of a fire at her accommodation. During an appointment on 16th August, Adult B explained that her neighbour had entered her room, assaulted her and had stolen the fire. The fire had been returned within a week. During this same meeting she identified Adult A as being her partner and stated they were now engaged. There is no record that enquiries were made as to who Adult A was or that a renewed risk assessment was undertaken following receipt of the information.

4.154 On 13th September 2013, Adult B attended a planned appointment, after having attended Scunthorpe Police Station about the theft of the fire. Adult B stated that Adult A had admitted receiving money for the fire.

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4.155 On 18th September 2013, information was received that Adult B had been charged with the theft of the electric fire and was to appear in court in October 2013.

4.156 On 17th October 2013, Adult B appeared before North Lincolnshire Magistrates Court and was found guilty of the theft of fire and was given a Conditional Discharge.

4.157 On 17th February 2014, an entry was made on Adult B's records indicating that she was a victim of domestic violence. A risk register was recorded and it was noted that she was due to be discussed at the North Lincolnshire MARAC on 5th March 2014.

4.158 On 5th March 2014, a MARAC Meeting Summary Entry was recorded which stated that Police Intelligence suggests Adult A is becoming increasingly abusive towards Adult B. Adult B had stated that she wanted to engage with an IDVA, but when the IDVA tried to contact her there had been no response.

4.159 On 26th March 2014, the case management system recorded that a MARAC meeting had been told that an IDVA had made contact with Adult B but she had declined support. The case had therefore been archived.

4.160 **Rotherham, Doncaster and South Humber NHS foundation Trust (RDaSH)**

4.161 **Involvement with Adult A**

4.162 **Episode 1**

4.163 Adult A was briefly admitted to Great Oaks acute adult inpatient unit in January 2010 after an overdose of Paracetamol following a relationship breakdown. Adult A self - discharged shortly after he arrived on the ward, the same day and stated that he had no suicidal thoughts and that he did not want follow up from services.

4.164 On 2nd March 2010 the Humberside Probation Trust referred Adult A to The Scunthorpe Community Alcohol Services. Adult A was due in court for harassment and breach of a non-molestation order against a previous partner (Adult C). A Comprehensive Assessment appointment was made for a week later as part of an Alcohol Treatment Requirement (ATR). Adult A disclosed a high level of alcohol consumption and was deemed suitable for an ATR.

4.165 Adult A was required to attend his appointments, as part of a court agreement but was a frequent non-attender. He missed four appointments and cited childcare issues or attendance at job interviews as a reason. Adult A was given a verbal warning by Humberside Probation Trusts regarding his attendance.

4.166 In May 2011, Adult A told the Community Alcohol Service worker (CAS) that he had not consumed alcohol for four weeks and was generally feeling better. He stated that he would be more focused and use the ATR programme to his benefit.

4.167 Later in May 2011, Adult A reported that he was still abstinent from alcohol and had a job. There was concern expressed from Adult A on the effect of increased cash and the effect on his drinking levels. The CAS reviewer discussed Antabuse as a medication treatment to support Adult A with his attempts to reduce his alcohol

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consumption.

4.168 Adult A failed to attend the programme for a number of weeks and was reminded of the requirements of the court order. Adult A was seen again in July 2011, where he reported a binge drinking session to the CAS counselor but indicated that he was abstinent.

4.169 Adult A had lost his job, but things appeared to improve again and in August 2011, Adult A stated that he had not been drinking for a four-week period.

4.170 At the end of August 2011, Adult A failed to attend the programme and when he did attend in September 2011 he was reviewed by the CAS worker, Adult A stated he was abstinent; his ATR was now complete and a planned discharge was arranged. As part of this process Adult A was informed that he could access support from CAS Direct Access service with a self - referral if he needed to.

4.171 Adult A was formally discharged at the CAS Multi - Disciplinary team meeting on 9th September 2011.

4.172 **Episode 2**

4.173 In May 2013, Adult A was admitted to Scunthorpe General Hospital with abnormal liver results where he underwent detoxification treatment. Adult A had recently started living with Adult B and was keen to quit alcohol. The Scunthorpe General Hospital Alcohol Liaison Nurse referred Adult A to the Community Alcohol Service (CAS).

4.174 Following his discharge, attempts were made to contact Adult A but he was no longer at his known address and did not answer his mobile phone. Two appointment letters were sent but Adult A did not attend.

4.175 Following an arrest for criminal damage in September 2013, Adult A was seen and assessed by CAS. Adult A reported that he had been living with his partner Adult B for the last year since his discharge from CAS. However, it would appear his drinking had increased since his relationship started; he had an assessment score under the CAS assessment tool (AUDIT) of 36 as a high level dependent drinker.

4.176 **Note:** *Alcohol Use Disorders Identification Test (AUDIT) was developed by the World Health Organization (WHO) as a simple method of screening for excessive drinking and to assist in brief assessment. It can help in identifying excessive drinking as the cause of the presenting illness. It also provides a framework for intervention to help hazardous and harmful drinkers reduce or cease alcohol consumption and thereby avoid the harmful consequences of their drinking*.

4.177 Adult A reported very heavy drinking up to 5 bottles of wine a day and stated that he had self- discharged from hospital following an admission for liver disease and did not stay for tests as requested. Adult A reported being physically unwell at this point and was experiencing tremors.

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4.178 During an assessment with CAS on 20th September 2013, Adult A reported an increase in arguments between him and Adult B related to his drinking. Adult A stated that his relationship with Adult B over the preceding year had a negative effect on his drinking, which had increased.

4.179 He stated there were more arguments with Adult B related to his increased alcohol use but he did not report any physical abuse between himself and Adult B. This assessment should have included as per policy that the issue of possible domestic abuse was addressed at this stage. The policy clearly states that if there are concerns about domestic abuse then the questions should be asked about the person's safety. Though there was no report or evidence of physical harm to Adult A this was an opportunity to check on the level of escalation of arguments and the impact on adult A. There was nothing in the notes to indicate this was addressed at this point and could have been something as simple as a welfare check or advice regarding domestic abuse services.

4.180 Adult A's problems were identified as largely due to his alcohol intake and he was referred to CAS for a comprehensive assessment to support him to re – engage and receive appropriate support.

4.181 From the records there does not appear to have been an assessment relating to domestic violence

4.182 Adult A was offered, and agreed to a comprehensive assessment on 1st October 2013 but did not attend. A home visit was made but was unsuccessful and enquiries were made with Scunthorpe General Hospital in case he had been admitted there. Another appointment on 8th October 2013 was made and a letter sent to Adult A; he did not attend.

4.183 On 8th January 2014, Adult A was discussed at the Scunthorpe CAS management team meeting. It was agreed that Adult A would be discharged; this was completed on 10th January 2014.

4.184 On 19th May 2014 Adult A presented at Scunthorpe General A&E department with suicidal ideation and was referred to the Crisis Team.

4.185 A duty social worker from the crisis team saw Adult A who was heavily intoxicated (reading of 135 on breathalyser). As a consequence Adult A was unable to be assessed as the policy states that an assessment cannot be carried out safely if the person is intoxicated.

4.186 The crisis for Adult A appeared to be situational and related to the fact that Adult A had told Adult B that their relationship was over.

4.187 The social worker contacted Adult B by phone and Adult B stated that she had changed her mind and Adult A could return home. This appeared to have an immediate positive affect on Adult A who stated that he no longer felt suicidal and left the department to return home shortly afterwards.

The notes indicated that this was a matter of a welfare check as to whether Adult B

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had a place to stay not a discussion as to his mental state and suicidal ideation. Adult A immediately changed his mind about his suicidal thoughts when realising he was being allowed to go home to Adult B. However, it should be clear that Adult A was not assessed at this point. Adult A did not report any issues of domestic abuse at this point to the attending staff.

4.188 Adult A was clear that he did not want any follow up support. This was the only contact that Adult A had with the Crisis Team.

4.189 **Involvement with Adult B**

4.190 Adult B's involvement with services during the identified period was minimal though she had been involved with the Scunthorpe Junction Drug and Alcohol services during 2005 to 2006.

4.191 Adult B was referred from North Lincolnshire and Goole NHS Foundation Trust (NLaG) A&E to the Crisis Team Rotherham, Doncaster and South Humber NHS foundation Trust (RDaSH) on 21st February 2010 following an alleged overdose. Adult B had presented in accident and emergency following a domestic incident that Humberside Police were aware of and had attended

4.192 Adult B was drunk and stated she was suicidal and had taken an overdose. It transpired that the alleged overdose had been taken over a week ago.

4.193 The duty Crisis Team worker was bleeped but Adult B left the A&E department before the assessment could take place.

4.194 There was concern for Adult B's children who had been taken to a neighbour's house.

4.195 As a result of Adult B leaving the department without assessment, liaison was made with Humberside Police who stated they would make efforts to trace her and if found return her if she was willing to attend.

4.196 The Crisis team attempted to contact Adult B later that day but there was no response. As there were no further welfare concerns from Humberside Police, there was no more input from the Scunthorpe Crisis Team

4.197 This should be seen as effective and good inter-agency practice, drawing together the agencies in order to seek an effective resolution in support of Adult B.

4.198 Adult A and Adult B were discussed at MARAC on 26th March 2014 but there was no action for the Scunthorpe Community Alcohol Service as Adult A had been discharged at that point.

4.199 **Northern Lincolnshire and Goole NHS Foundation Trust (NLaG)**

4.200 There were several attendances where Adult A presented with injuries and complaints. Generally they were for alcohol related matters and there was a

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significant lack of engagement thereafter. Adult A also had a record of repeated visits to the accident and emergency department where he self-discharged before treatment against medical advice.

4.201 Involvement with Adult A prior to the review period

4.202 On 12th July 2009, Adult A was admitted to Scunthorpe General Hospital (SGH) accident and emergency department following a suicide attempt. He was reported to have taken excessive amounts of paracetamol following early morning drinking and that he had domestic problems. A place was secured for him at a Mental Health establishment.

4.203 On 13th December 2009, he arrived at SGH stating that he had been assaulted by his wife (Adult C) who was in police custody.

4.204 Involvement with Adult A within the review period

4.205 On 22nd July 2010, Adult A attended SGH accident and emergency department claiming that he had been assaulted by being punched and kicked around the head. No details were provided and it was established there was no loss of consciousness, but there had been vomiting and he had consumed a significant quantity of alcohol. Following treatment Adult A was discharged.

4.206 On 25th October 2010 Adult A failed to attend a Gastroenterology appointment and a new appointment was sent.

4.207 Adult A attended SGH accident and emergency department on 21st May 2013, complaining of epigastric pain, which had continued for two weeks. It was noted that his eyes were going yellow; he was quite anxious and stated that he was drinking a bottle of wine a day. He discharged himself against medical advice.

4.208 Adult A had been to the GP for abdominal pain on the 28th May 2013 and been referred to the SGH Medical Assessment Unit but had failed to attend. He then attended on the 30th May 2013 and was admitted. He stated that he had been drinking four bottles of wine per day since December 2012. Before that one bottle for about 20 years and he was scared that he was going to die.

4.209 Following his admission Adult A was seen by the Alcohol Liaison Nurse the following day when he stated he did not want to drink again. On the 2nd June 2013 Adult A discharged himself, against advice and before all tests were completed.

4.210 On 14th March 2014 Adult A attended SGH accident and emergency department with black stools, which he had for two months. He also had a scalp wound that may have been caused following an assault by Adult B. He complained of headache but self discharged.

4.211 Whilst Adult A's head wound was noted, medical staff focused on his gastric symptoms and not the cause of the injury. This was a missed opportunity.

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4.212 On 3rd May 2014, Adult A was found unresponsive and collapsed in Scunthorpe. He vomited alcohol three times, complained of abdominal pain, chest pain and a cough. He stated that had not drunk for three years previously; this was clearly false information. Once Adult A felt better, he self discharged.

4.213 On 17th May 2014, Adult A arrived at SGH accident and emergency department having consumed a large quantity of alcohol stating he wanted to die. He stated he was *'still bereft after losing his mum approximately one year ago.'* He also stated that he was experiencing a breakdown in relations with his previous partner (Adult B) due to his reliance on alcohol. He did not work but said that if he could get support for alcohol withdrawal he could get his life back together. The Mental Health Crisis Team attended Adult A and a referral was made to alcohol services.

4.214 During this admission there appears to have been no consideration of a risk assessment for him or Adult B

4.215 On 2nd June 2014, Adult A was transported into SGH accident and emergency department after being found in the street having consumed large quantities of alcohol. He stated that he taken a quantity of paracetamol and further stated that he would do so again if he went home. Following tests it was established that his claims were not as he said and he was discharged after being provided with a drink of coffee.

4.216 On 5th June 2014, Adult A arrived at SGH accident and emergency department with 'multiple stabbings' that were fatal.

4.217 **Involvement with Adult B within the review period**

4.218 On 24th July 2010, Adult B arrived at SGH accident and emergency department having injected herself with approximately 100 units of Novomix 30 insulin. As she was not a known diabetic this matter was dealt with as an intended overdose.

4.219 Doctors established that she was feeling low when she self injected; there was no loss of consciousness; she was with her partner at the time (Adult G). He had tried to stop her and then later called an ambulance. Adult G was diabetic and used Novomix

4.220 The following morning, Adult B stated that she had no more thoughts of self harm and was becoming non compliant with her treatment plan. Following discussion with doctors she agreed to participate in the tests.

4.222 A short time later Adult B wanted to self-discharge because she was due to start a new job the following day. During consultation with the doctor Adult B said that she did not know whether she wanted to kill herself, but she was not keen to see the Mental Health Crisis team that day and would prefer to see the GP the following day.

4.223 Adult B was discharged and a letter was sent to the GP requesting urgent follow up.

4.224 On 2nd March 2013, Adult B attended SGH accident and emergency department stating she had been assaulted by a neighbour resulting in small superficial

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lacerations to her right eyebrow and scratches to her face and under her left eye. She had been drinking.

4.225 On 4th March 2013, Adult B re-attended SGH accident and emergency department and referring to the assault on 2nd March, she reported upper abdominal pain radiating to her back, including rib pain.

4.226 Adult B provided more information about the assault and stated that she went to her next-door neighbours where she was assaulted by between 8 and 12 unknown people, sustaining injuries to her face and cheek. Adult B said she had been kicked all over but suffered no loss of consciousness. (Adult B had not reported any pain to her back or abdomen when in accident and emergency department two days earlier). Adult B was admitted to a Ward to rule out any unseen damage. She was discharged on 6th March 2013.

4.227 From the records reviewed it appears Adult B's discharge letters may have gone to the wrong GP as the names and addresses on the accident and emergency department form and discharge letter are different.

4.228 It appears that the doctor in charge of Adult B's initial assessment/treatment was skeptical of the explanation of her injuries; the overall response and treatment from the organisation was comprehensive. The doctor notes that Adult B "claimed" she did not know the people who assaulted her and highlights in block capitals that there was "NO BRUISING" to Adult B. This lack of any symptoms is noted throughout the examination. No loss of consciousness; no pain; and no vomiting.

4.229 The doctor would have been mindful of the abortive hospital visit on the 2nd March 2013 and the taking of drink. Nevertheless, when it came to decisions over investigation and treatment, the matter was referred on to another Team (Surgery) and the initial decision (to oppose a CT Scan) was later reversed and a CT Scan undertaken, which highlighted no abnormalities.

Whilst the medical staff was keen to investigate any physical injury they were not persuaded that they needed to pursue the matter of the alleged assault. Adult B's formal admission to hospital was only because (as the doctor stated) intra-abdominal injury could not "be entirely" ruled out, although again it was punctuated with the comment that all bloods and x-rays were normal.

4.230 The actions of the doctors are reflective of NLaG policy. The Domestic Abuse Guidance for NLaG staff (4th April 2014) states that '…*the police should be contacted if a prospective victim of Domestic Abuse sustains significant injury'*. In this case there was no significant injury, so the doctor did have the discretion to decide not to contact the police.

4.231 However the policy also states that the victims of domestic violence should be believed and although the evidence of assault does not appear strong it is a concern that at the time the overwhelming sentiment of doctors during this hospital episode was skepticism; to the point where no consideration was given to Adult B's current and future safety. In light of organisational developments and this review it is expected that should a similar event occur again more consideration would be given

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to the alleged victims current and future safety. Also as a victim of violence Adult B should have been believed more readily and more direct questioning taken place covering her well-being.

4.234 Recent changes by the Trust highlighting Domestic Violence, training staff, and monitoring outcomes have been made. It is expected that a more vigorous and robust approach will now be taken. Safeguarding teams now have an Independent Domestic Violence Advocate (IDVA) based with them to assist staff to screen high-risk concerns. There are "flags "on the system (A+E and from Feb 2016 on the inpatient system) for MARAC involvement as well as children at risk. Greater attention is given to patients that abscond, patients capacity to make decisions, (self-discharge) and the need to detain patients without capacity for treatment through the Deprivation of Liberty Safeguards process.

Absconding patients are highlighted through internal reporting system, with outcome measures and lessons learnt included as part of the process. Mental Capacity Act Assessments and Deprivation Of Liberty Safeguards (MCA/DOLS) are subject to ongoing review and monitoring through a multi-agency MCA/DOLS process led by North Lincolnshire Council. There has also been training by both the IDVA and Safeguarding Children's Team to ensure that checks are made for children at the address and MARAC.

4.235 **It's My Right**

4.236 Adult B was considered to be a high-risk victim of domestic abuse; 'It's my Right' had no contact with Adult A and had no reason to consider him to be at risk from Adult B.

4.237 On 11th August 2010, the following referral was received from Humberside police:

"Adult B reported that Adult G had assaulted her and was in possession of a knife. She had locked herself in the bedroom. Police attend and Adult G was outside the address, he was arrested on suspicion of assault. Adult B had barricaded herself in a bedroom; she stated that she had set fire to her clothes. Entry was forced, the room was smoke logged & fire took hold of the wooden frame, bed & clothing well alight. Adult B refused to cooperate saying 'I want to die'. She was dragged out of the address & arrested for Arson. Both in drink."

4.238 Additional information contained within the referral stated:

"Adult B needs help re: housing. Adult B has bail conditions against her due to the Arson charge. Adult G was arrested & then de-arrested. Adult B cannot make contact with Adult G or go near to the property"

4.239 Following receipt of the referral an Independent Domestic Violence Advocate (IDVA) attempted to make contact with Adult B, unsuccessfully.

4.240 The IDVA contacted housing and ascertained that Adult B's funding for her emergency accommodation had been stopped. She had spent the weekend there but had not stayed in the accommodation since.

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4.241 On 23rd August 2010, the IDVA made contact with Adult B who stated she was "*staying with a friend*" and confirmed she would like support from IDVA.

4.242 The following day the IDVA undertook an initial assessment with Adult B and accompanied her to housing. The assessment score was below the criteria to meet 'high risk' and so she did not meet the needs required for IDVA support.

4.243 Within the notes the following was recorded:

"[Adult B] *has made two attempts on her life, one being the arson on 11/08/10 and the other was approx. 1 month ago when she took* [Adult G's] *insulin medication…she could not see an end to the abuse and thought the only way out was to end her life…she does not feel suicidal at present. She stated she feels much better for having opened up to professionals and friends*".

4.244 The Housing Advice Team had made a referral to the Refuge for Adult B but it had been declined because of the charge of arson against her.

4.245 It was agreed that the IDVA would accompany Adult B to the Magistrates Court to support her in relation to the arson charge and following that Adult B would be transferred to the providers of floating support for victims of Domestic Abuse (Not high risk). The good practice of the IDVA to delay the transfer until after the ongoing criminal proceedings should be noted.

4.245 In September 2010 the IDVA noted that:

"[Adult B's] *mood is a little low today. She stated she is drinking more alcohol and is not settled in the home she is currently sleeping in. She does not feel she has a drink problem; however we discussed the support available in the local area, i.e. the drop-in at Shelford House (DIP)*".

4.246 A few days later the IDVA reported that:

"*[*Adult B] *is in a much brighter mood having seen her children and mum.*"

4.247 The notes also record that Adult B has declined support from the floating support provider.

4.248 On 7th February 2014, a referral was received via the MARAC coordinator from Humberside police, which stated:

4.249 "*2 reported incidents of violence to the police neither by [*Adult B]. *Further concerns for* [Adult B]. [Adult A] *is becoming more abusive and controlling over* [Adult B]. *He will walk her to and from work, does not let her go shopping on her own and whilst she is at work he will keep her mobile phone with him. Also* [Adult A] *is becoming more physically aggressive and work have noticed bruises on her arms.* [Adult B] *will not make a complaint regarding this and will not allow it to be put into a statement* [Adult B] *is looking to leave [*Adult A] *and move out of the property and has support from her work. The telephone number for the domestic violence team in Scunthorpe has been handed to* [Adult B]. *Also other external agencies contact numbers have*

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been handed to [Adult B] *whilst at the police station. She has also been advised that police presence will be available when she decides to move out of the premises. She should either telephone police or call in at Corporation Road, Scunthorpe to arrange this and a patrol will be tasked when mutually available.* [Adult B] *did not want any action at this time."*

4.250 Following the referral, the IDVA contacted Humberside police and gathered more information. It was established that the safest and agreed form of contact would be through Adult B's place of work. They were aware of the circumstances and were fully supportive of Adult B.

4.251 On 10th February 2014, the IDVA contacted Adult B's place of work and explained her role and involvement and asked for a message to be passed to Adult B to ask her to call, which she did.

4.252 Initial safety planning was undertaken and an initial appointment was made that Adult B failed to attend. Other attempts were made to contact Adult B through work but these were unsuccessful.

4.253 Following a MARAC meeting on 5th March 2014, the IDVA was requested to attempt contact with Adult B again. Adult B's employers confirmed they had spoken to Adult B who no longer wished to access support from IDVA. The case was closed at a MARAC meeting on 27th March 2014

4.254 On 2nd June 2014, IDVA received a telephone call from Adult B's employers. A record of the call states:

"*T/c received from* [redacted] *at* [redacted], *informing me that she has* [Adult B] *with her, who is in a mess. She added that* [Adult B's] *ex partner is causing her problems, and* [Adult B] *would like to speak to me. On speaking to* [Adult B], *she stated that* [Adult A] *is harrassing at home and at work, and asked if I can meet up with her. She informed me that she has been given time off this afternoon, and that she is able to see me straight away."*

4.255 The IDVA then attended Adult B's place of work and took her to the Blue Door Women's Centre. A DASH risk assessment was completed indicating high risk and a referral was made to MARAC.

4.256 Adult B stated she was not depressed or having suicidal thoughts but she was extremely frightened of Adult A and particularly so when he had been drinking. She stated that they had been in a relationship for 17 months and that Adult A was extremely controlling and financially abusive. She said that the Police had been called after she had ended the relationship on 30th May 2014 as he was "*making a nuisance of himself*". Since then he had continued to follow and stalk her.

4.257 Adult B said she was staying with friends. Refuge and non-molestation orders were discussed but as Adult B was in full time employment, she would need to make significant financial contributions to both legal representation and refuge costs. She was not financially able to do so.

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4.258 The IDVA offered to help in making an application for a non-molestation order without legal representation. Adult B agreed to discuss it the following week because she would need to find some money for application fees.

4.259 The IDVA notes stated:

"I advised [Adult B] *that I am concerned about how vulnerable she is at the current time, however [*Adult B] *again told me that her friends will look after her"*

4.260 On 4th June 2014, the IDVA received a further call from Adult B's workplace requesting a call be made to Adult B. Contact was made and Adult B stated she was feeling low and continually being harassed. It was agreed they would talk again later in the day but the IDVA was unable to contact her.

4.261 The following day (and the day before the murder of Adult A), the IDVA made two calls to Adult B and left a message saying she was worried about her. A third call was answered by Adult B who sounded *"upbeat and like she had been drinking."*

4.262 She told the IDVA that she was fine, that she had moved address again because Adult A had found her, and she was fine and was staying with friends.

4.263 **North Lincolnshire Council Housing Advice Team**

4.264 Adult B presented at Housing Advice Team (HAT) on 24th August 2010 to say she was staying with friends. She admitted being in court re arson and the fact that she had substantial debts. As a consequence HAT were to talk with social services to ascertain the relationship with the children and whether Adult B could afford parental responsibility. Adult B was provided with emergency numbers in the event of requiring immediate help.

4.265 On 3rd September 2010 Adult B attended HAT and told them she was still at friends but admitted owing money to loan companies and landlord. A referral was made by HAT to Stonham Housing although it was considered the arson offence would be a barrier. HAT offered to assist Adult B if she was invited to interview and accompany her

4.266 16th May 2011, HAT contacted Humberside Probation Trust and discussed Adult B with them. They reiterated their offer of assistance to Adult B.

4.267 On 24th June 2011 HAT obtained accommodation for Adult B and agreed to pay the bond. Adult B was informed and appeared to be very happy.

4.268 Adult A first presented to the Housing Advice Team (HAT) on 22rd March 2014. He was living in shared accommodation but wanted to move. He said he was single. The service agreed in principle to provide him with a bond guarantee although the criteria for a bond is normally homelessness or threatened with homelessness. The offer of providing the bond should be seen as good practice in the circumstances.

4.269 6th April 2014 Adult A secured an address without the assistance of HAT or the requirement for a bond.

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4.270 On 24th April 2014 Adult B moved into her last address; that accommodation was secured without a bond.

4.271 **North Lincolnshire Clinical Commissioning Group - GP Services**

4.272 The medical records relating to Adult A and Adult B are sparse and inconsistent. The history of the relevant practice is recorded as:

- There were concerns identified about one of the doctors in the practice. This practitioner chose to resign from the performers list.

- The other partner in the practice chose to retire and hence the practice closed.

- The doctor about whom there were concerns has since had restrictions placed upon his practice by the GMC.

4.273 The following is the only available information obtained by the IMR author:

'The GP records over the period of enquiry are generally sparse, and frequently illegible. There is little evidence of the patient being examined over a substantial period of time, and only the occasional blood test being arranged. There is no real evidence of any serious attempt to intervene in respect to the history of alcohol abuse until the diagnosis of chronic liver disease in May 2013. Overall, the evidence from the medical records alone suggests a very unsatisfactory level of medical care between 2010 and the time of [Adult A's] *death in 2014.'*

4.274 **Information about Adult A**

4.275 All the information gathered relates to Adult A's alcohol consumption. There were 16 consultations in 2010, 11 in 2011, 17 in 2012, seven in 2013 and four in 2014, the last being in April 2014. There is no detail in the notes of what was discussed or any inquiry into other relationship matters that may have provided information relevant to this review.

4.276 **Information about Adult B**

4.277 Adult B was registered with the same practice as Adult A and the same issues apply to her records. There were seven appointments in 2010 relating to the bereavement of her father three in 2011, 11 in 2012, two in 2013. There were none in 2014. There is no detail of what was discussed or any inquiry into other relationship matters that may have provided information relevant to this review.

4.278 **North Lincolnshire Children's Services and East Midlands Ambulance Service**

4.279 North Lincolnshire Children's Services also undertook an examination of their records to establish if there was any information relevant to the review. They found none.

East Midlands Ambulance Service also took part in the review and examined their records. They had nothing to add to this review.

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5 Addressing the Terms of Reference

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

- The incident in which Adult A died was not a one off. There had been numerous incidents involving Adult A and previous partners and with Adult B. On the previous incidents Adult A had been identified as a perpetrator.

- Adult B had been involved in several incidents prior to meeting Adult A and she had been identified as a victim and a perpetrator.

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

- There do not appear to have been any barriers to the reporting of abuse by Adult A. However Adult A was identified as a perpetrator and was never considered a victim, albeit Adult A never presented as a victim.

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

- There is evidence of abusive relationships, but as mentioned above, Adult A was identified as the perpetrator. There is no evidence that he was offered support or help.

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

- None were identified within the review. Adult A's lifestyle was such that when he had medical support within accident and emergency departments, he self discharged before support could be offered and against medical advice.
- The review cannot establish if Adult A disclosed anything to his GP and whether there were any opportunities to 'routinely enquire' because the records are not available.

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

- Adult B did have a previous history as both a victim and perpetrator. This was known to agencies.

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

- There were opportunities for intervention and these were taken in respect of Adult B. It has become apparent during this review that at times Adult B

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sought to manipulate the system by providing limited or incorrect information. She had been subject to MARAC arrangements previously but had not accepted the support that was offered. She had been referred into MARAC again, only days before she murdered Adult A.

- There were opportunities for intervention with Adult A but from the review theses were not taken.

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

- Agencies were aware of the domestic abuse by Adult A towards Adult B and supported Adult B. The review has not found any specific training requirements. Adult A was never considered a victim and this will be commented on in the 'learning' section of this review.

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

- There were no quality or diversity issues identified in relation to Adult A or Adult B.

5.9 **Family engagement**

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

- Letters have been sent to all known family members of Adult A and to Adult B. Adult B's mother has been contacted directly by Adult B. Adult B has participated in the review.

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

- The panel decided that North Lincolnshire Safer Neighbourhoods would manage all media and communication matters.

- An executive summary of the review will be published on the Safer Neighbourhoods website (www.saferneighbourhoods.net/domestic-abuse/domestic-homicide-reviews/), with an appropriate press statement available to respond to any enquiries. The recommendations of the review will be distributed through the partnership website, the partnerships operational and strategic domestic abuse groups and applied to any other learning opportunities with partner agencies involved with responding to domestic abuse.

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5.11 **Legal Processes**

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

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

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

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

5.13 **Research**

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

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

Specific documents have also been considered

- The Home Office Multi-Agency Statutory Guidance for the conduct of Domestic Homicide reviews
- The Home Office Domestic Homicide Review Tool Kit Guide for Overview Report Writers
- Call an End to Violence Against Women and Girls – HM Government (November 2010)
- Barriers to Disclosure – Walby and Allen, 2004.
- Home Office Domestic Homicide Reviews – Common themes identified and lessons learned – November 2013.
- Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence, 2006.
- 'If only we'd known': an exploratory study of seven intimate partner homicides in Engleshire - July 2007.

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5.14 **Diversity**

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

- There were no quality or diversity issues identified in relation to Adult A or Adult B.

5.15 **Multi agency responsibility**

Was Adult A or Adult B subject to a MARAC/ MAPPA?

- Adult B was referred to MARAC and had been discharged from the arrangements due to her non-engagement. Adult A was the perpetrator on that occasion. The notes are: *Nothing from any other agencies present, the risk remains as the relationship is ongoing and support has been refused, the case will be archived today.*

- Adult B had been referred to MARAC again shortly before she murdered Adult A. It has become apparent during this review that the information she had provided which had prompted the referral had been false and misleading.

- During the management of the case of Adult B by the Probation Services, she was not subject of, or eligible for case management under MAPPA.

- Adult B was subject of a 3 year Community Order for an offence of Arson, however, she would have had to have been made subject of 12 months imprisonment to be MAPPA eligible. The Ministry of Justice (MoJ) MAPPA Guidance 2012 explains that: "The Criminal Justice Act 2003 provides for the establishment of Multi-Agency Public Protection. Arrangements (MAPPA) in each of the 42 criminal justice areas in England and Wales. These are designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders. They require the local criminal justice agencies and other bodies dealing with offenders to work together in partnership in dealing with these offenders".

5.16 Did Adult A have any contact with a domestic violence organisation or helpline?

- There was no known contact by Adult A

5.17 Consideration should also be given as to whether either the victim or the perpetrator was a 'vulnerable adult'

- Neither Adult A or Adult B were vulnerable adults

The broad definition of a 'vulnerable adult' is referred to in the 1997 Consultation Paper *Who decides?* issued by the Lord Chancellor's Department and contained within the Guidance issued by the Department of Health in their document *"No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable*

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adults from abuse."

"A person who is 18 years of age or over, who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation".

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

- There were no known issues in communication. Often the communication was good and individuals displayed good practice through effective and timely sharing.
- It is unknown whether there was information held within the GP notes that could or should have been shared.

5.19 **Individual agency responsibility**

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

- The work in connection with Adult A and Adult B was consistent with appropriate policies and procedures, apart from the GP that was below the standard required. There is insufficient detail in the North Lincolnshire Council Housing Advice Team's review to determine if the work was consistent with their appropriate policies and procedures.

5.20 Was the impact of domestic violence on the victim recognised?

- Adult A was never considered a victim and this will be commented upon later in this report.

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

- Actions did accord with the assessments and subsequent decisions. Services appropriate to those assessments were offered, however they were not always accepted.

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

- There is evidence that senior managers were aware of the decisions and they were involved where appropriate to do so

6 Overall analysis and lessons to be learned from the review

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6.1 Adult A was identified as a perpetrator and the information provided by Adult B was taken at face value within the incidents of 27th May 2014 and 3rd June 2014 by Humberside police and the 4th June 2014 by It's My Right. Whilst victims should be believed, it is incumbent upon agencies to check that the information is correct. There is nothing to indicate that any checks were made or that attempts were made to speak to Adult A or to engage him with DV services.

6.2 North Lincolnshire have now created a screening tool for male victims to ascertain if they are in fact victims. A recommendation will be made that the tool should be implemented across all agencies in North Lincolnshire.

6.3 There were several occasions when a wider assessment of risk was not undertaken. For example 14th March 2014 and 17th May 2014 when attending NLaG, 20th September 2013 when involved with RDaSH and involvement with Humberside police on 27th May 2014. Adult A and Adult B were perpetrators and were also involved in criminality. Their use of alcohol was extensive and it does not appear that this was considered when examining their behaviour or risk to themselves or others.

6.4 In 2010 an assessment was made by Humberside police that Adult B was high risk; no MARAC referral was made. The review panel acknowledges though that this was in 2010 and since then, guidance, process and policy has changed. It is important that all agencies are aware of their role with high-risk cases and the need to ensure that appropriate referrals to MARAC are made.

6.5 During the incident immediately prior to Adult A's death on 3rd June 2014, Humberside police made no risk assessment. Subsequent assessments indicated that the risk would have been judged to be standard. Consideration should be given to the effects of risk assessments being made in isolation; they should take note of previous risk levels and assessments.

6.6 During engagement with 'It's my Right' in August 2010, two suicide attempts were noted in the records of Adult B. There does not appear to have been any discussion with other agencies or referrals made to mental health services. Organisations should be aware of their limitations and roles and should refer to appropriate specialists where appropriate.

6.7 There were clear opportunities to identify domestic abuse within the accident and emergency department of the hospital during the attendance on 14th March and the 17th May 2014. It is not clear whether these were identified and progressed. The review acknowledges that both Adult B and Adult A were difficult patients, in that they left the hospital before treatment and were reluctant to engage with staff. All agencies should have clear policies to identify signs of domestic violence and abuse and have appropriate policies to manage information and disclosure.

6.8 MARAC is a key element of managing high-risk victims. It is imperative that all agencies involved with individuals who may be subject to domestic abuse attend the meetings. On occasions they may not be able to contribute information but attendance is necessary to ensure that information sharing takes place across all agencies.

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6.9 Adult A was identified as a perpetrator. Nothing has come to light during this review to suggest that any attempt was made to engage with him to address his behaviour. Support was given to Adult B and yet Adult A was largely ignored. It is imperative that managing domestic abuse is seen as an all-encompassing strategy and that all parties are involved.

6.10 As a general learning point there is research identifying the challenges whereby victims are also perpetrators. This also includes where female victims kill the abuser as a response to the abuse but also where they kill the partner as the perpetrator of the abuse; this is discussed by Dutton, 2006; Cercone, et al, 2005 and Dixon and Kevan, 2011. These are not exhaustive texts however a useful starting point.

It would be helpful to give consideration to the impacts and manifestation of violence within these concepts and to establish whether services are able to supply support and recognise the cause and effect of the behaviours and the violence.

7 Conclusions

7.1 There is nothing in the review that indicates the homicide could have been predicted or prevented.

7.2 This review has highlighted the many challenges associated with domestic violence and abuse. Adult A was seen to be the perpetrator and was largely ignored. Accounts by witnesses indicate that Adult B instigated the violence and attempted to provoke Adult A into resorting to violence. There had been no engagement with Adult A so it is not known whether previous claims of violence, intimidation and harassment by him had followed a similar pattern.

7.3 The review has shown that Adult B was able to manipulate services when she felt it necessary to do so. On the day of the murder she spoke to an IDVA and said she was fine, that she had moved address again because Adult A had found out where she was living, but she was fine and was staying with friends. It is now clear that she was actually with Adult A at the time.

7.4 Domestic violence and abuse featured throughout the lives of both Adult A and Adult B. Alcohol abuse also played a significant part in their lives. It is important to recognise the effects alcohol can have within such relationships and the need to consider agency intervention.

8 Recommendations

8.1 **Organisational**

8.2 **Humberside Police**

8.3
- The learning from this case around the submission and detail of Domestic Violence Forms should be included in the Domestic Violence training currently being delivered to all front-line staff.

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8.4 **National Probation Service (on behalf of the Humberside Probation Trust)**

8.5

- Details of domestic abuse history obtained from Humberside Police are routinely recorded in the Non-Disclosure Section of OASys, as well as in the Case Management System in order to ensure that this information is flagged to any member of staff who may need to access the case record. It is a recommended action that this guidance should be issued within the next 3 months.

8.6

- Details of the purpose and requirements to complete Spousal Assault Risk Assessments (SARA) are reissued to all staff to ensure understanding of appropriate use and review of these assessments, to ultimately inform the OASys Risk Management Plan and Sentence Plan.
    - This information has already been cascaded to staff in the Humberside NPS Area on 3rd December 2014 and this guidance remains readily accessible. The outcome would be that SARA assessments are completed as a matter of course in all relevant cases for all identified domestic abuse perpetrators.

8.7

- Home Visit Guidance is reviewed and re-issued to all staff in order to reiterate the importance of home visits and the purpose of them in identifying and addressing risk factors, particularly in child and adult safeguarding cases.
    - This information has already been cascaded to staff in the Humberside NPS Area on 3rd December 2014 and this guidance remains readily accessible. The outcome would be that home visits are undertaken in al, relevant cases in accordance with the local guidance that has been cascaded

8.8

- Guidance to be formally issued to staff to ensure that in all cases where there are concerns regarding arson, that contact is made with Humberside Fire and Rescue where there is a change of address. This is particularly important where such cases do not fall under the remit of MAPPA.
    - It is a recommended action that this guidance should be issued within the next three months

8.9

- Guidance to be issued to staff in relation to the importance of maintaining communications with Children's Social Care in child safeguarding cases, particularly where the Offender Manager is undertaking a review of the risk assessment.
    - This information has already been cascaded to staff in the Humberside NPS area on 3rd December, 2014 and this guidance remains readily accessible

8.10

- Information to be provided to staff in relation to the importance of clear

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and accurate recording on the case record of all offenders in order to ensure that all contacts, and work undertaken are evident to any authorised individual accessing that record.

- It is a recommended action that guidance should be issued within the next three months

8.11

- OASys Risk Assessment Guidance to be reviewed and cascaded to all staff to enhance the quality of such assessments.

  - This information has already been cascaded to staff in the Humberside NPS Area in the form of a Practice Development Event – the required completion date for this was 28th February2015. The outcome of this recommendation would be enhanced qualities of OASys Risk Assessment and Risk Management Plans.

8.12 **Its My Right**

8.13

- Follow up screening for IDVAs when depression or suicidal thoughts are disclosed should be considered.

8.14

- Past case files should be reviewed by newly allocated case workers

8.15

- Programmes should be made are available to enable perpetrators of domestic abuse to address their behaviours

8.16

- A more flexible Freedom Programme for those that work shifts or can attend infrequently should be considered.

8.17 **NLaG**

8.18

- No recommendations were made

8.19 **RDaSH**

- Staff should clearly consider the policy regarding assessment and domestic abuse when assessing service users and relate this to practice. The policy relating to assessment clearly states to consider domestic abuse issues. Staff must record discussions about domestic abuse when there is a reported escalation in arguments in the home and offering advice and support regarding domestic abuse services. It should be noted that' low level 'abuse such as verbal abuse and arguments have been factors in other domestic homicide reviews with no other preceding factors of violence.

- RDaSH will review this policy /practice issue via an internal audit of clinical records that is in place at the moment to ensure staff are considering the current policy and translating that into practice. This will be aligned with further guidance to staff regarding the recognition of male victims in domestic abuse and the recognition of low-level abuse signs such as an increase in

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arguments or verbal abuse.

8.20 **North Lincolnshire Council Housing**

- Lack of a single IT system – even across council departments prevents effective sharing of data and intelligence on those at risk of DV or identified as being likely to offend. Access to the 'Care first' system for HAT would help break down some silo working and assistance in the sharing of intelligence.

8.21
- HAT's ability to assist Adult B was significantly hampered by her past convictions and rent arrears. There should be an agreed process across all departments for being able to specifically assist clients identified as being at risk from DV but with no chance of getting social housing.

8.22 **Safer Neighbourhoods**

8.23
- The recommendations for the Safer Neighbourhood partnership are contained within the individual agency recommendations.
- There is an issue of a single incorporated computer system to allow agencies to ascertain what information is available or where it can be identified and signposted. The recommendation is to examine the feasibility and determine if this is a strategic way forward for the partnership.

8.24 **National**

8.25
- There are no national recommendations from this review, although the learning should be cascaded

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Appendix

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Superintendent Dave Houchin
Chair North Lincolnshire Safer Neighbourhoods Partnership
Shelford House
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Scunthorpe
DN15 6QB

19 May 2016

Dear Supt. Houchin,

Thank you for submitting the Domestic Homicide Review report for Scunthorpe to the Home Office Quality Assurance (QA) Panel. The report was considered at the meeting on 27 April 2016.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. There were some aspects of the report which the Panel felt could be revised, or benefit from further analysis, which you will wish to consider before you publish the final report:

- Please ensure that the executive summary and overview report are aligned;
- The Panel suggested that in general the lessons, where possible, could be reinforced with more evidence;
- The Panel suggested you could consider if there are lessons relating to victims who are also perpetrators, and questioned whether there is an opportunity to increase learning through a discussion on the research around female victims who kill their abuser;
- Please proof-read for typing errors and accuracy. For example, gender pronouns appear to be muddled in paragraphs 1.9.5 and 3.9;
- Please clarify if the statement on the victim not being able to get a place in a refuge due to being employed was challenged and scrutinised.

Regarding the non-publication request, the Panel feel the full report could be published if medical details of the children were either removed or redacted. I would be happy to discuss this with you in more detail.

The Panel does not need to see another version of the report, but I would be grateful if you could include this letter as an appendix to the report.

I would be grateful if you could email us at DHREnquiries@homeoffice.gsi.gov.uk and provide us with the URL to the report when it is published.

The QA Panel felt it would be helpful to routinely sight Police and Crime Commissioners on DHRs in their local area. I am, accordingly, copying this letter to the PCC for information.

Yours sincerely

Christian Papaleontiou
Chair of the Home Office DHR Quality Assurance Panel