DOMESTIC HOMICIDE REVIEW

Overview Report – Independent Author Robert Nesbitt

Executive summary

Report into the death of 'Mrs.Z'

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INTRODUCTION:

This is the executive summary of the Domestic Homicide Review that followed the tragic death of Mrs. Z a resident of Leicester, who was killed as a result of domestic abuse by her husband Mr. Z on the 13th November 2012; the couple had two children, these are referred to as 'C1' and 'C2' to protect their identity.

Our deepest condolences are sent to the family of Mrs. Z.

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

The review has considered agencies contact and involvement with Mr. Z (perpetrator) and Mrs. Z (victim). The full report providing further detail and analysis of agencies involvement is available at http://www.saferleicesterpartnership.gov.uk;

1 THE REVIEW PROCESS:

1.1 This summary outlines the process undertaken by a Leicester DHR panel in reviewing the murder of Mrs. Z. Mr. Z was found guilty of manslaughter May 2013 and was sentenced to 4 years imprisonment; this was later reduced to 2 years as Mr. Z pleaded guilty to manslaughter.

1.2 The DHR began on February 2013 and initial contact was made with all agencies that potentially had contact with Mrs. Z, Mr. Z and the children prior to the point of Mrs. Z death. As the case was subject to criminal proceedings, a decision was made to suspend this review until these were concluded; this was recommenced May 2013 and was concluded within a 6 month time-frame following the trial.

1.3 The Independent Author wrote to Mr. Z and extended family informing them of the DHR review and inviting them to participate within the process. Letters in Farsi were sent to family members. Notification was also made to the Families Liaison Officer [Leicestershire Police] and the children's social worker who was supporting the children to settle with extended family members, but Mr. Z and wider family members did not wish to participate.

2 TERMS OF REFERENCE;

2.1 **The terms of reference for the review were to:**

- Review the involvement of each individual agency, statutory and non- statutory, with Mrs Z' and 'Mr. Z' between August 2006 and 13th November 2012.
- Summarise the involvement of agencies prior to November 2012.
- This timeframe was agreed for the review due to 2006 being the year which an initial trawl of records indicated had arrived in the UK from Afghanistan to join her husband living in Leicester.
- Provide a chronology of their involvement with Mrs. Z' and 'Mr. Z.' during the time period. Search all their records outside the identified time periods to ensure no relevant information was omitted.

- Provide an individual management review if necessary: identifying the facts of their involvement with Mrs. Z.' and 'Mr. Z', critically analysing the service they provided in line with the specific terms of reference; identifying any recommendations for practice or policy in relation to their agency.

In order to critically analyse the case, the terms of reference required specific analysis by the panel of the following:

- Communication and co-operation between different agencies involved with the couple.
- Opportunity for agencies to identify and assess domestic abuse risk.
- Agency responses to any identification of domestic abuse issues in relation to 'Mrs. Z'.
- Organisations access to specialist domestic abuse agencies.
- The training available to the agencies involved on domestic abuse issues
- Review the care and treatment, including risk assessment and risk management of the couple in relation to their primary and secondary mental health care.

For the panel to:

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

2.2 Agencies and individuals who produced written reports supporting the DHR review:

Agency Name	Involvement Type	Time Period	Involvement with member of family
Leicester College	Education Language classes	2006 - 2012	'Mrs. Z'
Leicester College	Language Classes-ESOL	2001-2012	'Mr. Z'
GP Practice	Health/Treatment	03/11/12 – 04/0912	'Mrs. Z'
City Council Housing Dep't	Repairs/Re-location	01/02/08 – 05/12	'Mrs. Z' [1] 'Mr. and Mrs Z' [2]

Schools	Children's Education		All
Accident and Emergency	Injury [Minor]	06/11/12	'Mrs. Z'
General /Maternity Hospital	Maternity inpatient Outpatient	06/07 and 05/10 2006 - 2009	'Mrs. Z' All
Urgent Care Centre Primary Healthcare – Out of Hours Service	Health/Treatment/Minor Injuries.	2009 -2011 01/10/10	Parents and Children 'Mrs. Z'
Health Visitor	Health promotion and early intervention to all children 0-5 years	09/07/07 – 09/07/12	'Mrs. Z' and Children.
Police	Criminal Investigation/Protection/Prevention	24/04/08 11/07/11	[1] Mr.Z and Mrs.Z [2] Mr.Z

2.3 There were fifteen 'nil contact' returns were received from local agencies to the request for information on involvement with family. A number of Agencies/Departments provided information to the narrative chronology but had limited involvement the panel agreed for a factual summary to be submitted.

- Leicester City Council - Safer Communities Department - No involvement but in attendance to provide specialist input into the panel.

- Leicester City Council - Child Social Care and Safeguarding - No involvement with family but in attendance to assist with providing 'the voice of the children'.

- United Kingdom Border Agency - Home Office [To establish dates of arrival of family members]

- Safe Project - Leicester City - No involvement but in attendance to provide specialist domestic violence knowledge.

- Leicester Urgent Care Centre - Leicester. Primary healthcare out of GP hour's service. Their contact indicates no concerns/information identified regarding care or safety of the children or of 'Mrs. Z' being at risk or subject to domestic abuse.

- The Children's School -Involved with family in regards to the children's education - No concerns/information identified regarding care or safety of the children or of Mrs. Z' being at risk or subject to domestic abuse.

- Hospitals on the periphery of Leicester/Leicestershire where residents of Leicester City/Leicestershire may access. No contacts identified

2.4 Agencies who submitted an Independent Management Review to the process provided:

- Chronology of interaction with victim, perpetrator or children
- A report of their involvement according to terms of reference for the review
- Conclusions and recommendations from agency's point of view.

3 KEY ISSUES ARISING FROM THE REVIEW:

3.1 Background

Mr. Z came to the UK from Afghanistan and settled in Leicester. Mr. Z claimed asylum at the Dover Port in April 2001. In December 2001 he was granted exceptional leave to remain and in 2008 he was awarded British Citizenship. Mr. Z had local employment as a taxi driver. He spoke both Farsi (Persian) and English.

3.2 Mrs. Z In 2006 applied for entry to the UK on the basis that her husband lived in this country. A visa was granted for 2 years and she arrived later that year in the UK. In 2008 she applied for indefinite leave to remain, which was approved. The couple's children were born in Leicester [2007 and 2010]. Mrs. Z first language was Farsi (Persian); when she arrived in the UK she spoke only limited English, but was keen to improve her language skills and enrolled at Leicester College to study English. Mrs. Z was the main carer for the couple's children.

3.3 At 2.21 p.m. on Tuesday 13th November 2012 the Leicestershire Police received a 999 call reporting that a male had killed his wife. On arrival at the home 'Mrs. Z' was found in the downstairs bathroom, having received fatal stab wounds and a murder investigation was commenced.

3.4 Later that day 'Mr. Z' walked into a police station in Borough London accompanied by a relative and admitted to the killing of his wife. He was arrested, interviewed and charged with the murder of 'Mrs. Z'. He appeared at Leicester Magistrates Court on the 16th November 2013 and was remanded into custody.

3.5 The couple's two children 'C1' and 'C2' are now cared for by family members.

3.6 The criminal trial heard that Mrs. Z in the months before she died formed a relationship with another man, who she was in regular contact with by telephone. Mrs. Z was reported to have made enquiries about divorce proceedings. The family was trying to organise a home swop outside of the area, but the court heard on the day of the fatal incident that the house exchange had fallen through.

3.7 Police Report shows that during the period of Mrs. Z and Mr. Z relationship that there only one occasion on 11th July 2011 that could be considered a possible 'missed opportunity' for intervention and of signifying that 'Mrs. Z' may have been subjected to domestic abuse from her husband some 14 months prior to her death.

3.8 A 999 call (believed to have been made by Mrs. Z) was made on the 11th July 2011 at 8.52 p.m. to the police from the family's home address in Leicester:

- The caller was crying and mentioned that her husband was in the house; she then put the phone down.
- An intelligence search identified an owner living at an address in Leicester [the family home], there was no history relating to this address and the name 'Z' [Family surname]. There was an attempt to contact the caller again.
- The incident was given a priority requiring attendance.
- The attending officer updated the incident stating there was no answer at the door and the flat was in darkness.
- A call taker tried calling the mobile phone but it went through to voicemail again. At 00:57am on the Tuesday 12th July 2011 the incident was reviewed by the Force Control Room team leader and deferred until morning.
- At 8:26am on the 12th July 2011 the incident was updated. The male at the address told an officer who attended the location that his wife wanted the

ambulance service "as their 3 year old daughter had fallen off the bed and needed treatment". The attending officer accepted this explanation and the incident closed.

- There were no other issues and the incident was recorded as an abandoned call and closed.

3.9 The following observations and comments are made by the police in relation to the seriousness and priority that domestic abuse is considered by the Leicestershire police coupled with the systems, resources and procedures now in place to respond effectively and as part of a multi- agency approach.

- Action, which the review notes, that the call handler reacted appropriately and in accordance with the required force policies and procedures.

- In 2010 the 'domestic abuse, safeguarding adults, honor based violence and forced marriage (DASH) check list commenced as the single domestic abuse risk assessment model officially superseding the SPECSS model; all officers in the Leicestershire Constabulary have undertaken mandatory training in using this procedure .

- The implementation of a Comprehensive Referral Desk (CRD) brings together the Child Abuse Referral Desk, Adult Referral and Co-ordination Team, MARAC Co-coordinators, Child Protection Case Conference Coordinators, Child Sexual Exploitation Coordinators and Domestic Abuse Referral Officers (DARO). The aim of the unit is to "protect the lives of the vulnerable and those exposed to domestic and child abuse by the effective co-ordination of multi-agency resources to risk'. The purpose of bringing together this safeguarding specialism is to more readily and efficiently identify risk to the most vulnerable and share information with partner agencies more effectively".

3.10 In September 2012, to further support protecting the lives of the vulnerable and reduce repeat victimisation, Contact Management issued a briefing guide 'Identifying and Managing Vulnerability' throughout the 'journey' of an incident'. This provided a new structured call taking approach based upon the National Decision Making Model and is used across all police forces in the UK.

3.11 In reviewing the incident notified to the police on the 11th July 2011 it is noted:

- There is no substantiated evidence as to identity of the caller.

- It was not clear why the caller was distressed.

- No intelligence of previous concerns at this address notified to the police.

- Had the police been aware that the family had moved from a previous address in Leicester they would have the intelligence of an incident in which 'Mr. Z' was wounded during an altercation with a 'relative' on the 24th April 2008. The risk assessment focused on the assault between 'Mr. Z' and the 'relative was appropriate and completed in accordance with the SPECSS assessment tool however the assault between 'Mr. Z' and 'Mrs. Z' was not recognised'.

- The statements made to the police at the time both record that 'Mr. Z' 'pushed his wife in the face with his hand' and that this took place in front of their daughter who was crying.

- There was a further disclosure that 'Mr. Z' would 'get angry' in the home and

described how he would leave the home to calm down.

- There are also noted contradictions in relation to how the statements tally with the police officers records.

- A number of different spellings are associated with the family surname.

3.12 Leicestershire Police stated: "In reviewing this decision more could have been done to satisfy or support the explanation being given to the officer, the ambulance service could have been contacted for example to establish if there was a call made to them or whether the family had taken their child to hospital for treatment. Conversely the fact that the house was in darkness and there had been no reply to knocking on the door when officers attended in the early hours could also lend support to what was being said. As referred to earlier the family had moved from [address1] to [listed current address] meaning no direct link to the intelligence held at [address1]. However, had that link been there then it would have related to the wounding incident between 'Mr. Z' and a ['relative'] four years earlier but would not have indicated any domestic abuse issues between 'Mr. Z' and 'Mrs. Z' [the deceased].

3.13 All other agencies who had contact with Mrs Z, Mr. Z and children or other family members reported there were no identified issues of concern. The family was provided with "universal" health visiting services, as there were no identified needs that would warrant any targeted visiting patterns. There were no incidents or disclosures of domestic violence made by any family member, nor any children safeguarding concerns raised to the agencies involved.

3.14 The review panel could only establish from unconfirmed reports in the police IMR of the possibility, that the incident, requiring the police to attend the home of 'Mr. Z. and Mrs. Z' may have been of domestic abuse.

4 CONCLUSIONS:

4.1 Nothing was known or identified to those agencies as such to require:

- Mrs. 'Z' being directly approached and/or enquiries made as to whether she was experiencing or had experienced domestic abuse, or

- Information/concerns/observations from services in direct contact with 'Mrs. Z' and her family, that she may be subject to domestic abuse requiring concerns to be referred to an agency with a duty to investigate with or without the permission of 'Mrs Z, or.

- Information regarding concerns/observations/witnessed (by) from the family members, neighbours, or by any third party source to require any agency or person to make further enquiries and/or share that information

4.2 This review has not identified any known and substantiated incidents of domestic abuse such as require or recommend action(s) that an agency or agencies should take to improve practice, systems and interagency working.

5 RECOMMENDATIONS:

Whilst the review has no specific recommendations to make in relation to this case, agencies acknowledge their continued responsibilities in assessing that their systems and requirements are robust and functional in the prevention and management of domestic abuse.

5.1 Agencies continue to scrutinise how they support and promote interagency arrangements and responsibilities, this remains an ongoing high priority. An action plan has been developed to support ongoing quality improvement areas locally, which is attached to the report, Appendix 1

4. Glossary

CRD	Comprehensive Referral Desk
CSP	Community Safety Partnership
DAIO	Domestic Abuse Investigation Officers
DARO	Domestic Abuse Referral Officers
DHR	Domestic Homicide Review
ESOL	English for Speakers of other Languages. Courses include speaking, reading, writing and listening and cover spelling, grammar and punctuation.
FLO	Family Liaison Officer
IDVA	Independent Domestic Violence Advocate
IMR	Individual Management Review
LPU	Local Policing Unit
LSAB	Leicester Safeguarding Adult Board
OVR	Overview Report

Appendix 1 Action plan

Remaining Focused on Quality Improvement	Scope of rec.	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Progress
1. *Agencies acknowledge their continued responsibilities in assessing that their systems and requirements are robust and functional in the prevention, identification and management of domestic abuse*	Local	• *Agencies participate in the development of DA strategy* • *Agencies sign up to the DA strategy*	DVDG / SLP	• *Agencies agree DHR action plan* • *Agencies agree commitment to development of next DA strategy* • *Agencies sign new DA strategy*	Feb 14 Mar 14 Aug 15	Planning session held in February, draft strategy expected end of august 2015. Slight delays to timescale
2. *Agencies continue to scrutinise how they support and promote interagency arrangements and responsibilities*	Local	• *Agencies maintain a document control log of all interagency agreements relating to DA they are a signatory to*	DVDG / SLP	• *Agencies submit list of all agreements* • *DVDG compiles "Issues" log and reviews at each meeting*	Apr 14 Jun 14	Audit completed There is a standing agenda item of victim voice on the Domestic Violence Delivery Group.
		• *Delivery monitors engagement of agencies, works to resolve problems and highlights any persistent difficulties*	LSAB	• *Delivery group and LSAB monitor agencies attendance at multi-agency meetings.* • *Executive leads are informed if any concerns arise*	Ongoing	Board meeting minutes evidence that partnership engagement is consistently reviewed.
3. *To reach out and engage with individuals and communities who may either be isolated and/or lack awareness of how to seek assistance*	Local	• *Delivery group engages with New Arrivals Strategy Group (NASG)* • *Commissioners assess equality impact*	DVDG / SLP	• *DVDG agrees members to sit on NASG* • *DVDG invites NASG member to join* • *NASG and other*	Mar 14 Mar 14 Apr 14	Agreed and attending Achieved Achieved

		assessments and performance against ongoing plans • *Delivery group leads and co-ordinates communications activity* • *Agencies provide figures to evidence whether service recipients reflect local community* • *Delivery group track access and engagement of key services over time*		*relevant groups are identified to input into forthcoming awareness raising campaign plans* • *Agencies provide service user data* • *DVDG analyses service data on demographics* • *Data informs DA strategy*	Jul 14 Sep 14 Oct 14	Achieved Achieved Achieved
4. *Agencies to consider a regular programme of service audits to quality assure their policies and procedures. This should cover levels of awareness of indicators of abuse, the required risk assessment and risk management of domestic abuse, access to training, ability to apply policies and procedures both as single agencies and in supporting joint working*	Local	• *Agencies to assess whether future training needs audits can take into account this level of detail, and on what frequency such information can be obtained*	DVDG / SLP	• *DVDG requests information from partner agencies* • *DVDG agrees improvement plan*	Mar 14 Sep 14	Audit completed Partnership Agreement in effect for SVDG and DVDG
		• *Delivery group to collate such data, assist in the analysis and assist in the response to need arising from such data*	Delivery Group	• *Multi-agency adult safeguarding procedures to support response to DV locally.*	April 2015	Launch of revised adult safeguarding procedures 1st April 2015.
				• *SAAF audit of agencies policies, training, procedures to support DV response*	November 2014	Audit progressed

DOMESTIC HOMICIDE REVIEW

Overview Report into the death

of Anaya

Report produced by

Robert Nisbet

Independent Review Chair

The panel sends its' condolences to the family of Anaya

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1. Introduction

1.1 This Domestic Homicide Review seeks to understand the circumstances surrounding the tragic death of Anaya aged 27 years, who was the victim of a homicide on the 13th November 2012. Maalav, husband was found guilty of manslaughter on 31st May 2013. All those involved in this review wish to extend their sympathy to the family of Anaya. In order to protect the identity of those involved, the victim will be known as Anaya, the husband as Maalav, and the children in the family as 'C1' and 'C2'.

1.2 This review has been conducted in accordance with statutory guidance under Section 9 of the Domestic Violence, Crime and Victims Act 2004. This provision came into force on 13th April 2011. This report of a domestic homicide review examines agency responses and support given to Anaya, a resident of Leicester prior to the point of her death on 13th November 2012. The review considers agencies contact/involvement with Anaya and Maalav from April 2001-November 2012.

1.3 At 2.21p.m. on Tuesday 13th November 2012 the Leicestershire Police received a 999 call reporting that a male had killed his wife. On arrival at the home Anaya was found in the downstairs bathroom, having received fatal stab wounds and a murder investigation was commenced.

1.4 Later that day Maalav walked into a police station in Reading accompanied by a relative and admitted to the killing of his wife. He was arrested, interviewed and charged with the murder of Anaya. He appeared at Leicester Magistrates Court on the 16th November 2012 and was remanded into custody.

1.5 The couple's two children 'C1' [male born 2010] and 'C2' [female born 2007] are now cared for by family members.

1.6 The Leicester Safeguarding Adults Board, who undertake domestic homicide reviews on behalf of the local Community Safety Partnership (known locally as the Safer Leicester Partnership), commissioned the review following the death of Anaya.

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

1.8 This report document outlines the circumstances of the case, the findings of the review and an overview of the recommendations made by the domestic homicide review panel.

1.9 During the time period in which the review was conducted it became apparent that no agency involved with the family or directly with Anaya had any prior concerns that she may have been at risk of or subject to domestic abuse. Anaya, together with members of her family had regular contact with a number of agencies in regards to routine matters and/or receiving services informed by that agencies function, role and responsibilities.

1.10 Known prior contact with the police by Maalav and Anaya', whilst not evidencing unequivocal information as to prior incidents of domestic abuse, will be specifically detailed in this report.

1.11 This 'Overview Report ' serves to:

- Summarise the key facts of the case and the sequence of events.

- Summarise the key facts, key decisions and whether any breeches or the absence of policy or procedures required by those agencies and professional who had prior contact with the victim and their family occurred.

- Whether any noted decisions or actions taken without adherence to those policies and procedures operational at the time, may have significantly influenced a change in the course of events that led to the death of Anaya, had they been implemented.

- Identifies examples of good practice and notes if and what systems need to improve.

- Outlines in the conclusions if there are any lessons to be learnt from the review.

- Details both recommendations from individual agencies and from the Review Panel.

2 Criminal Proceedings:

2.1 Maalavs trial concluded in 2013 he was found guilty of manslaughter and sentenced to 4 years imprisonment, which was then cut down to 2 years as Maalav pleaded guilty to manslaughter. Maalav's defense team argued that Maalav did not intend to murder his wife and that at the time of the stabbing he had diminished responsibility due to Adjustment Disorder.[1]

2.2 Sentencing, the Judge said :

"It's clear on the evidence you had a happy marriage and were a good, placid and kind husband. All that changed two months before you killed your wife and I accept the changes in your life caused you distress and reduced you to a state recognised by doctors in this case as an adjustment disorder."

3. Background Information:

3.1 **Maalav** came to the UK from Afghanistan and settled in Leicester. Maalav claimed asylum at the Dover Port in April 2001. In December 2001 he was granted exceptional leave to remain and in 2008 he was awarded British Citizenship. Maalav had local employment as a taxi driver. He spoke both Farsi (Persian) and English.

3.2 **Anaya** In 2006 applied for entry to the UK on the basis that her husband lived in this country. A visa was granted for 2 years and she arrived later that year in the UK. In 2008 she applied for indefinite leave to remain, which was approved. The couple's children were born in Leicester [June 2007 and May 2010]. Anaya first language was Farsi (Persian); when she arrived in the UK she spoke only limited English, but was keen to improve her language skills and enrolled at Leicester College to study English. Anaya was the main carer for the couple's children.

3.3 The criminal trial heard that Anaya in the months before she died formed a relationship with another man, who she was in regular contact with by telephone. Anaya was reported to have approached a number of professionals and agencies enquiring about divorce proceedings. The family were trying to organise a home swop outside of the area, but heard on the day of the fatal incident they heard that this had fallen through.

[1] An adjustment disorder (AD) (sometimes called exogenous, reactive, or situational depression)[1] occurs when an individual is unable to adjust to or cope with a particular stressor, like a major life event. Since people with this disorder normally have symptoms that depressed people do, such as general loss of interest, feelings of hopelessness and crying, this disorder is sometimes known as situational depression.

4. Contact with family and 3rd parties.

4.1. In June 2013 a letter was sent to Maalav for the purposes of seeking his participating in the review. The letter was also copied to the prison's Governor and translated into Farsi, this being Maalavs' first language.

4.2 Prior to this, Maalavs' solicitor was written to explaining the requirement for the review and in seeking their support in encouraging Maalav to contribute and agree to a meeting with the review chair to be accompanied by an interpreter. The solicitor informed the review chair that they would be advising their client not to assist in the review.

4.3 In September 2013 the Review Chair was contacted by the children's social worker in Reading, to inform that social services were in the process of assessing the longer-term plans and options for permanency of the children's care. Proceedings were listed with the Family Court for a full hearing to be conducted later this year. [Revised listing February 2014]

4.4 With the additional pressures being placed upon the family members caring for the children, the review panel was requested not to seek direct contact with them prior to the Family Court hearing. It was agreed for the review chair to write to family members seeking their participation in the review, but to defer any meeting until the Family Court proceedings were concluded.

4.5 Letters in Farsi were sent to family members, accompanied by a form to return to indicate whether they would be supportive of participating in the review. Notification was also made to the Families Liaison Officer [Leicestershire Police] and the children's social worker in Reading who had existing rapport with the family.

4.6. To date the review panel has not received any reply or information directly or from any third party to indicate if family members would be supportive of a meeting in order to contribute to this review.

4.7 Consideration was given by the DHR review to contacting 3rd parties known to the family, although known contacts were limited. There were two tutors who knew Anaya from the years she attended Leicester College during 2008/09 to access courses to help improve her English language; they reported that there were no indications of any problems or issues within the marriage when Anaya attended the college. On occasions when Anaya visited housing offices, or when housing maintenance people attended the family home to carry out repairs; the workers have no recollection of the family. Health visitors and nursery nurses who visited the home, under normal child health programme contacts had no concerns.

5. Review process and timescales

5.1 This report outlines the process undertaken by the domestic homicide review panel in reviewing the murder of Anaya.

5.2 The Leicester Safeguarding Adults Board were notified of the incident by Leicestershire Police and completed a trawl exercise to understand which agencies were involved with the family prior to the point of death, findings from the trawl were gathered into a report and presented to the Adult Review and Learning Group who made a recommendation for a DHR to be commissioned, this was subsequently agreed on the 28th December 2012 by the chairs of the Leicester Safeguarding Adults Board and Community Safety Partnership (locally known as Safer Leicester Partnership).

5.3 During the trawling exercise, it was noted that Maalav first moved to the UK in April 2001, therefore the review panel agreed this would be the timescale in which the review would begin.

5.4 The LSAB commissioned an Independent Author and Chair to lead the Domestic Homicide Review. Robert Nisbet has the following qualifications Ba (hons) sociology, post-graduate diploma social work, diploma in criminology, CQSW, Diploma Mental Health, MA film studies. Registered Social Worker qualified in 1979. Robert has varied professional experience and held posts in child protection, learning disabilities and for the past 20 years in mental health services. Formally worked for Department of Health East Midlands and worked as Lead for MCA & Deprivation of Liberty Safeguards and Community Offender programmes. Robert has worked for East Midlands Adult Safeguarding Board.

5.5 The Independent Chair and Author was supported in the DHR by a panel who met on 3 separate occasions to agree the terms of reference; review the reports from agencies and to review the overview report. The panel members were selected to bring a range of expertise and perspectives relevant to the circumstances of the review. In appointing to the panel, the Chair ensured there was no conflict of interest and that the panel members did not have direct line management responsibilities for workers who had been involved with Anaya or Maalav

DHR Panel Members
Independent Panel Chair
Leicester Safeguarding Adult board Manager
Head of Adult Safeguarding Leicester City CCG
Detective Inspector Leicestershire Constabulary
Head of Service, Community Safety Leicester City Council
Domestic Violence Support Services – SAFE
Head of Service, Leicester City Council Housing
Service Manager, Leicester City Children's Services

5.6 The review of Anaya's homicide began with a panel meeting on the 6th February 2013. Following a request from the Leicestershire Police and advised to the Home Office, the decision was made by the review panel to suspend the review from February 2013 until criminal proceedings, including the trial of Maalav, were completed.

5.7 Maalav's trial was concluded on the 24th May 2013 and he was found guilty of manslaughter and sentenced to 4 years imprisonment.

5.8 Post the trial the review panel reconvened and met on two further occasions.

5.9 The agencies responsible for providing details of their involvement, through chronologies of contact and individual management reviews were as follows:

- University Hospitals Leicester – Accident and Emergency Department and Community Midwifery
- Leicestershire Partnership Trust - Health Visiting Services
- Leicestershire Police
- Leicester City Councils Housing Department,
- General Practitioner/Health Centre [Family Registered with], and
- Leicester College.

5.10 Other Agencies/Departments gave information to the narrative chronology but given their limited involvement/non-involvement the panel agreed there was no need for an individual management review.

- Leicester City Council - Safer Communities Department – No involvement but in attendance to provide specialist input into the panel.
- Leicester City Council - Child Social Care and Safeguarding – No involvement with family but in attendance to assist with providing 'the voice of the children'.
- United Kingdom Border Agency - Home Office [To establish dates of arrival of family members]
- Safe Project – Leicester City – No involvement but in attendance to provide specialist domestic violence knowledge.
- Leicester Urgent Care Centre – Leicester. Primary healthcare out of GP hour's service. Their contact indicates no concerns/information identified regarding care or safety of the children or of Anaya being at risk or subject to domestic abuse.
- The Children's School –Involved with family in regards to the children's education – No concerns/information identified regarding care or safety of the children or of Anaya being at risk or subject to domestic abuse.
- Hospitals on the periphery of Leicester/Leicestershire where residents of Leicester City/Leicestershire may access. No contacts identified.

5.11 In addition 17 other agencies were contacted as part of the initial scope. Fifteen 'nil contact' returns were received, with 2 'no returns'.

5.12 Leicester Safeguarding Adults Board Office provided the administration and coordination support for this review.

5.13 The findings of DHRs are confidential in nature. Information released to the panel for the purpose of the DHR is available only to participating officers/ professional and their line managers (agencies mentioned above). The panel will release material created for the purposes of the panel with the expressed permission of contributing agencies to the police information governance lead and the coroner should this be requested.

5.14 Upon finalising this overview report copies were circulated to, members of the panel and contributing IMR authors, members of the Leicester Safeguarding Adults Board's Adult Review and Learning Group, along with the chair of the LSAB and the chair of the Community Safety Partnership.

6. Involvement of local agencies:

6.1 **Police IMR:** Paragraph 1.10 of this report advised**:** 'Known prior contact with the police by Anaya and Maalav, whilst not evidencing unequivocal information as to prior incidents of domestic abuse, will be specifically detailed in this report'.

6.2 For the purposes of clarifying this statement it is important to summarise the relevant information contained in the Police's IMR submitted to the review panel. This information was discussed further by review members at their meeting of the 3rd June 2013 and attended by the police as members of the review panel.

6.3 Assumptions might be made that an incident attended by the police on 11th July 2011 could be considered a 'missed opportunity' for intervention and of signifying that Anaya may have been subjected to domestic abuse from her husband some 14 months prior to her death.

6.4 Further that if a closer investigation and follow up had been carried out with 'due diligence' Anaya may have been identified at a much earlier point of time of being at risk of domestic abuse from her husband.

6.5 In summary the relevant facts of the 999 call believed to have been made by Anaya on the 11th July 2011 from the family's home address in Leicester are as follows:

- A 999 call was received from a distressed female Leicestershire Police at 8:52pm on Monday 11th July 2011.
- The caller who was crying and mentioned her husband was in the house; she then put the phone down.
- An intelligence search identified an owner living at an address in Leicester [the family home], there was no history relating to this address and the name 'Z' [Family surname].
- There was an attempt to contact the caller again.
- The incident was given a priority requiring attendance and arrival within 60 minutes. At 10:16pm it was noted that there were 22 queued incidents and all officers were committed to other incidents.
- Officers were dispatched to the address at 00:09am Tuesday 12th July 2011. At 00:43am the attending officer updated the incident stating there was no answer at the door and the flat was in darkness.
- A call taker tried calling the mobile phone but it went through to voicemail again. At 00:57am on the Tuesday 12th July 2011 the incident was reviewed by the Force Control Room team leader and deferred until morning.
- At 8:26am on the 12th July 2011 the incident was updated. The male at the address told an officer who attended the location that his wife wanted the ambulance service 'as their 3 year old daughter had fallen off the bed and needed treatment'. The attending officer accepted this explanation and the incident closed.
- There were no other issues and the incident was recorded as an abandoned call and closed.

6.6 The writer of the police's IMR interviewed the officer who had attended the incident. The officer "had no recollection of the incident or any further details written as a pocket note book entry".

6.7 In reviewing the information detailed in the IMR the following observations and comments are made by the police in relation to the seriousness and priority that domestic abuse is considered by the Leicestershire police coupled with the systems, resources and procedures now in place to respond effectively and as part of a multi- agency approach.

- In respect of domestic abuse, there is a policy document in existence that is regularly

updated. The policy states that 'Leicestershire Police will take positive action to protect the victim and any children present from further harm when domestic abuse occurs'.

- With regard to the actions of a call taker they; "Assign a resource to all abandoned 999 calls where domestic abuse is suspected (i.e. due to what is overheard and relevant history etc.). Every effort must be made to re-contact the caller before assigning a resource in order that critical information is obtained and an assessment of any risk to officers is made"

- Action, which the review notes, that the call handler reacted appropriately and in accordance with the required force policies and procedures.

- In 2010 the 'domestic abuse, safeguarding adults, honour based violence and forced marriage (DASH) check list commenced as the single domestic abuse risk assessment model officially superseding the SPECSS model; all officers in the Leicestershire Constabulary have undertaken mandatory training in using this procedure[2].

- The Leicestershire Police Strategic Policing Plan 2010 – 2013 states 'Tackling violent crime in our communities continues to be a key priority for the Constabulary'.

- "Domestic Abuse Investigation Officers (DAIO) are trained detective constables now offering a force response and managed by a Detective Inspector and two Detective Sergeants, their expertise in the field of domestic abuse is used to improve services and work more directly with first response officers and provide a direct link to Multi Agency Public Protection Arrangements and Multi Agency Risk Assessment Conferences (MARAC)".

- "The implementation of a 'Comprehensive Referral Desk' (CRD) brings together the Child Abuse Referral Desk, Adult Referral and Co-ordination Team, MARAC coordinators, Child Protection Case Conference coordinators, Child Sexual Exploitation coordinators and Domestic Abuse Referral Officers (DARO). The aim of the unit is to "protect the lives of the vulnerable and those exposed to domestic and child abuse by the effective co-ordination of multi-agency resources to risk'. The purpose of bringing together this safeguarding specialism is to more readily and efficiently identify risk to the most vulnerable and share information with partner agencies more effectively".

- In September 2012, to further support protecting the lives of the vulnerable and reduce repeat victimisation, Contact Management issued a briefing guide 'Identifying and Managing Vulnerability' throughout the 'journey' of an incident'. This provided a new structured call taking approach based upon the National Decision Making Model and is used across all police forces in the UK.

- Procedures and Requirements in cases where there is a known/or indications of the potential for 'repeat incidents of domestic abuse:

    - Repeat offences at locations will be flagged to LPUs daily on the third occasion within a year
    - Repeat offences where it is the fifth occasion in a year will be reviewed by a DAIU Supervisor
    - If it is a high-risk case after being reviewed by an Enhanced DASH Risk Assessor the DAIU Dept. will own it.

[2] **DASH - Domestic Abuse, Safeguarding adults, Honor based violence and forced marriage** - is an evidence based risk identification and assessment model designed specifically to identify risk to an adult victim of domestic abuse and improve decision making increasing the likelihood of a victim being responded to appropriately and therefore correctly addressing the risks faced.

- The DAIU team is here to manage high risk perpetrators and to support LPUs in tackling domestic abuse

- Safer Neighbourhood Teams and partners should work together to tackle serial domestic violence perpetrators and protect victims of multiple offences/incidents.

- If you suspect (HBV) honour based violence or (FM) forced marriage then you must contact the DAIU

6.8 In reviewing the incident notified to the police on the 11th July 2011 it is noted:

- There is no substantiated evidence as to identity of the caller.

- We do not know the specific reason why the caller was distressed.

- There had been no intelligence of previous concerns at this address notified to the police.

- Had the police been aware that the family had moved from a previous address in Leicester they would have the intelligence of an incident in which 'Mr. Z' was wounded during an altercation with a 'relative' on the 24th April 2008. The risk assessment focused on the assault between 'Mr. Z' and the 'relative was appropriate and completed in accordance with the SPECSS assessment tool[3] however the assault between 'Mr. Z' and Anaya was not recognised'.

- The statements made to the police at the time both record that 'Mr. Z' 'pushed his wife in the face with his hand' and that this took place in front of their daughter who was crying.

- There was a further disclosure that 'Mr. Z' would 'get angry' in the home and described how he would leave the home to calm down.

- There are also noted contradictions in relation to how the statements tally with the police officers' records.[4]

- A number of different spellings are associated with the family's surname.

6.9 In undertaking the IMR the Leicestershire police have stated: "In reviewing this decision more could have been done to satisfy or support the explanation being given to the officer, the ambulance service could have been contacted for example to establish if there was a call made to them or whether the family had taken their child to hospital for treatment. Conversely the fact that the house was in darkness and there had been no reply to knocking on the door when officers attended in the early hours could also lend support to what was being said. As referred to earlier the family had moved from [address1] to [listed current address] meaning no direct link to the intelligence held at [address1]. However, had that link been there then it would have related to the wounding incident between Maalav and a ['relative'] four years earlier but would not have indicated any domestic abuse issues between Maalav and Anaya [the deceased].

[3] **SPECSS Assessment Tool** - **S**eparation, **P**regnancy, **E**scalation, **C**ultural issues, **S**talking, **S**exual assault) Designed to enhance prevention work by frontline police officers;

[4] **Leicestershire Police IMR Report for DHR Dated 08/04/2013 provided to the DHR Panel 03/06/13**: *Whilst statements clearly record that Maalav 'pushed' Anaya in the face whether the term is misinterpreted through translation is not clear as it could mean hit or slap however the action would amount to an assault and that should have been acted on in a positive manner. There are however opposing indicators. The officer dealing with Anaya at the hospital recorded in his pocket note book 'A' and 'M' - a peaceful relationship', his recollection for writing this was in response to what she had told him whilst at the hospital and, in the closing paragraph of Maalavs' statement, it is recorded that 'he has a good relationship with his wife and she does with him'.*

7. Conclusions and recommendations from the review:

7.1. The review panel finds that no agency or person failed to comply with the required protocols and procedures regarding having relevant knowledge of previous risk. Such that may have subsequently contributed to the prevention of Anaya' death, committed by her husband at their home in Leicester on the 13th November 2012.

7.2. The review panel could only establish unsubstantiated information from the police's previous contact with the family as to a possibility that her husband may have subjected Anaya to domestic abuse.

7.3. There is no information from any other service or source contacted as part of the review to inform of a previous history of incidents or concerns relating to Anaya as being subjected to domestic abuse from her husband.

7.4. The review has made every effort within its authority and means to seek contact with the perpetrator, victim's close family members and 3rd parties. The perpetrator and family have not indicated that they wish for 'their voice' to be included in the review.

7.5. The panel notes the necessity of engaging with people who are 'newly arrived' to the city of Leicester for many reasons including study, economic migration, to seek asylum or other personal or professional matters. The panel referenced the need to ensure domestic violence services are promoting their services in a way which will reach out to everyone. The SAFE project in Leicester have recently translated their literature into Farsi as part of this review which was, previously not available and plan to create literature in a variety of other languages as a learning point from this review.

7.6. The SAFE Project and the police in September 2013 launched a joint campaign to raise awareness of domestic violence services available in Leicester with the aim of providing a coordinated response to domestic abuse so that agencies can offer the best support available to victims and families.

7.7. There has been no evidence of previously known and substantiated incidents of domestic abuse such as to require or recommend action(s) that an agency or agencies should take to improve practice, systems and interagency working.

7.8. All agencies working in partnership are mindful of their continued responsibility to quality assure their services to ensure that they are robust and functional in the prevention and management of domestic abuse.

7.9. In addition it is important to note that a community's population and ethnography can change overtime and in some circumstances quite rapidly. This requires for commissioners and providers of services to ensure that changing needs are actively considered and responded to.

8 Key findings

8.1 The review panel could only establish from unconfirmed reports in the police's IMR of the possibility, but not substantiated, that the incidents requiring the police to attend at the home of Maalav and Anaya may have been of domestic abuse.

8.2 No prior risk indicators of actual or potential for domestic abuse had been notified to those agencies that had regular contact with Anaya, her children or other family members.

8.3 Simply, nothing was known or identified to those agencies as such to require:

- Anaya being directly approached and/or enquiries made as to whether she was experiencing or had experienced domestic abuse, or

- Information/concerns/observations from services in direct contact with Anaya and her family, that she may be subject to domestic abuse requiring concerns to be referred to an agency with a duty to investigate with or without the permission of Anaya, or.

- Information regarding concerns/observations/witnessed (by) from the family members, neighbours, or by any third party source to require any agency or person to make further enquiries and/or share that information

9 Conclusions

9.1 The review panel finds that no agency or person failed to comply with the required protocols and procedures regarding the prevention of domestic abuse.

9.2 The review panel finds that no agency or person failed to comply with the required protocols and procedures for the management of domestic abuse if required to do so.

9.3 The review panel finds that no agency or person, failed to comply with the required protocols and procedures if and when it is identified that a person[s] **not** living in the household of a known perpetrator of domestic abuse continues to remain at risk.

9.4 The review panel could only establish 'soft information', unsubstantiated from the police's previous contact with the family, as to a possibility that Anaya **may** have been subjected to domestic abuse by her husband.

9.5 In considering 'Circumstances of Particular Concern', outlined in the Home Office's Guidance[5] and as to whether such were applicable or evident preceding the death of Anaya**,** we can find no information to inform our findings that they were.

9.6 The review has made every effort within its authority and means to seek contact with both the perpetrator and the victim's close family members. They have not directly advised whether they would wish for their 'voice' to be included in the review.

10. Recommendations

10.1 This review has not identified any substantiated incidents of domestic abuse that required recommendation(s) for an agency or agencies to improve practice, systems and interagency working.

11. Remaining focused on quality improvement

11.1 Whilst informing that the review has no specific recommendations to make in relation to this case, agencies acknowledge their continued responsibilities in assessing that their systems and requirements are robust and functional in the prevention and management of domestic abuse. Further that their commitment to ensuring that singularly and together, agencies

[5] **Home Office:** *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews'* [Revised Version August 2013]. HMSO

continue to scrutinise how they support and promote interagency arrangements and responsibilities, remains an ongoing high priority. Through audit and scrutiny gaps can be identified and pre-emptive action taken.

11.2 The Leicester Interagency Domestic Violence Strategy 2009 - 2014 informs of the continued need ... "to work together to prevent domestic violence and to provide support and protection to anyone affected by domestic violence, with an underpinning commitment to equality, evidence based practice and partnership working" [Page 4].[6] In doing so it recognises that "amongst all ethnic groups there can be a high tolerance of domestic violence. For both new and established communities in Leicester there can be tolerance of domestic violence and a desire to keep such matters within the private, family or community sphere. There can be specific language and immigration barriers". The panel has requested the Community Safety Partnership to reflect on this as part of the wider learning from this review.

11.3 The SAFE Project in Leicester[7] has since strengthened their programme of outreach events in Leicester College specifically with the ESOL[8] students. SAFE have recently translated their literature into Farsi, which previously had not been available. The SAFE Project and the police in September 2013 launched a joint campaign to raise awareness of domestic violence services available in Leicester. They aim provide a co-ordinated response to domestic abuse so that agencies can offer the best support available to victims and families.

11.4 Whilst not directly relevant to this case, agencies may consider a regular programme of service audits to quality assure their policies and procedures. This should cover levels of awareness of indicators of abuse, the required risk assessment and risk management of domestic abuse, access to training, ability to apply policies and procedures both as single as single agencies and in supporting joint working.

11.5 In addition it is important to note that community, population and ethnography can change overtime and in some circumstances quite rapidly. This requires for commissioners and providers of services to ensure that the changing needs of new communities are actively considered and responded to.

[6] A copy of the strategy can be found here: http://citymayor.leicester.gov.uk/EasysiteWeb/getresource.axd?AssetID=102794&type=full&servicetype=Attachment

[7] The Safe project is a domestic violence service commissioned by Leicester City Council until 2015 which provides support to people living in Leicester who are experiencing or who are at risk of domestic violence. http://www.safedvs.co.uk/ Performance of Integrated Specialist Domestic Violence Services 1/9/12 – 31/12/12 http://www.safedvs.co.uk/files/ART93_Performance%20of%20LCC%20Integrated%20Specialist%20Domestic%20Violence%20Services%20FINAL%20Q3%20Year%20One.pdf

[8] ESOL: English for Speakers of other Languages. Courses include speaking, reading, writing and listening and cover spelling, grammar and punctuation.

12. Glossary

CRD	Comprehensive Referral Desk
CSP	Community Safety Partnership
DAIO	Domestic Abuse Investigation Officers
DARO	Domestic Abuse Referral Officers
DHR	Domestic Homicide Review
ESOL	English for Speakers of other Languages. Courses include speaking, reading, writing and listening and cover spelling, grammar and punctuation.
FLO	Family Liaison Officer
IDVA	Independent Domestic Violence Advocate
IMR	Individual Management Review
LPU	Local Policing Unit
LSAB	Leicester Safeguarding Adult Board
MARAC	Multi-agency Risk Assessment Conference
OVR	Overview Report
SPECSS	An assessment tool - Separation, Pregnancy, Escalation, Cultural issues, Stalking, Sexual assault) Designed to enhance prevention work by frontline police officers.
SAFE	The SAFE project is based in and provides support to people living in Leicester that are experiencing or who are at risk of domestic violence. All of the services help women, men and young people regardless of age, ethnicity, disability, sexual orientation, religion and social class and includes those with or without children. The project consists of a helpline, outreach, SAFE home and IDVA services that together provide a holistic service that fits around client needs. The SAFE services form an integral and fundamental part of delivery of Specialist Integrated Domestic Violence Services in Leicester. SAFE works in partnership with the Jenkins Centre, which will provide opportunities for people to change their abusive behaviour and the Living Without Abuse Family Service. SAFE carries out its work as part of Domestic Violence Services 'Working together to build lives free form violence' and is commissioned by Leicester City Council until 2015. SAFE regularly visit organisations to talk about the work they carry out across the city.

13. Appendix A: terms of reference

The terms of reference for the review were to:

- Review the involvement of each individual agency, statutory and non- statutory, with Anaya and Maalav between August 2006 and 13th November 2012.
- Summarise the involvement of agencies prior to November 2012.
- This timeframe was agreed for the review due to 2006 being the year which an initial trawl of records indicated had arrived in the UK from Afghanistan to join her husband living in Leicester.
- Provide a chronology of their involvement with Anaya and Maalav during the time period. Search all their records outside the identified time periods to ensure no relevant information was omitted.
- Provide an individual management review if necessary: identifying the facts of their involvement with Anaya and Maalav, critically analysing the service they provided in line with the specific terms of reference; identifying any recommendations for practice or policy in relation to their agency.

In order to critically analyse the case, the terms of reference required specific analysis by the panel of the following:

- Communication and co-operation between different agencies involved with the couple.
- Opportunity for agencies to identify and assess domestic abuse risk.
- Agency responses to any identification of domestic abuse issues in relation to Anaya
- Organisations access to specialist domestic abuse agencies
- The training available to the agencies involved on domestic abuse issues
- Review the care and treatment, including risk assessment and risk management of the couple in relation to their primary and secondary mental health care.

For the panel to:

- Ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case.

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence including their children.

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

- Apply these lessons to service responses including changes to policies and procedures as appropriate; and

- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

Appendix B: Matrix for the main agency contact

Agency Name	Involvement Type	Time Period	Specific Family Member/All Family Members	Information re Possible Domestic Abuse Concerns – YES/NO	Number of Face to Face Contacts	Comments	Language Communication Difficulties Noted in IMR
Leicester College	Education Language classes - ESOL	2006 - 2012	Anaya	NO	ALL	Academic Years. Completed 2 courses. Last class attended 29/10/12	*"Staff has confirmed that Anaya had sufficient capability and contact with staff and fellow students to have raised any issues and to have accessed the College's support services".* [9]
Leicester College	Language Classes- ESOL	2001-2012	Maalav	NO	ALL	Academic Years. Completed 5 courses	N/K
GP Practice	Health/ Treatme nt	03/11/12 – 04/0912	Anaya	NO	5		NO
City Council Housing Dep't	Repairs/Re-location	01/02/08 – 05/12	Anaya [1] Maalav and Anaya [2] Unspecified [5]	NO	8		NO
Schools	Children's Education		All	NO			N/K
AandE	Injury [Minor]	06/11/12	Anaya	NO	3	Seen by 3 clinicians	NO
General /Maternity Hospital	Maternity inpatient Outpatient	06/07 and 05/10 2006 - 2009	Anaya All	NO	N/K Outpatient X8		NO
Urgent Care							

9

Entry level 2 Key Stage Two (10 to 11 year olds) is able to hold a simple conversation on familiar topics and facts. Gives a basic description. Creates sentences of more than five words and uses link words such as 'and' and 'but'.

Centre Primary Healthcare – Out of Hours Service	Health/ Treatment/ Minor Injuries.	2009 -2011 01/10/10	Parents and Children Anaya	NO NO	3 1		NO
Health Visitor	Health promotion and early intervention to all children 0-5 years	09/07/07 – 09/07/12	Anaya and Children.	NO	9	Note: Maalav also attended some of the appointments/present at visit	*'No one can recall the family with clarity in order to comment on Anaya's understanding or communication skills'*
Police	Criminal Investigation/ Protection/ Prevention	[Contact 1] 24//04/08 [Contact 2] 11/07/11	[1] Maalav and Anaya [2] Maalav	YES	2	See Section 5 of the Overview Report and Summary.	NO

Appendix C Action plan

Remaining Focused on Quality Improvement	Scope of rec.	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Progress
1. *Agencies acknowledge their continued responsibilities in assessing that their systems and requirements are robust and functional in the prevention, identification and management of domestic abuse*	Local	• *Agencies participate in the development of DA strategy* • *Agencies sign up to the DA strategy*	DVDG / SLP	• *Agencies agree DHR action plan* • *Agencies agree commitment to development of next DA strategy* • *Agencies sign new DA strategy*	Feb 14 Mar 14 Aug 15	Planning session held in February, draft strategy expected end of august 2015. Slight delays to timescale
2. *Agencies continue to scrutinise how they support and promote interagency arrangements and responsibilities*	Local	• *Agencies maintain a document control log of all interagency agreements relating to DA they are a signatory to*	DVDG / SLP	• *Agencies submit list of all agreements* • *DVDG compiles "Issues" log and reviews at each meeting*	Apr 14 Jun 14	Audit completed There is a standing agenda item of the victim's voice on the Domestic Violence Delivery Group.
		• *Delivery monitors engagement of agencies, works to resolve problems and highlights any persistent difficulties*	LSAB	• *Delivery group and LSAB monitor agencies attendance at multi-agency meetings.* • *Executive leads are informed if any concerns arise*	Ongoing	Board meeting minutes evidence that partnership engagement is consistently reviewed.
3. *To reach out and engage with individuals and communities who may either be isolated and/or lack awareness of how to seek assistance*	Local	• *Delivery group engages with New Arrivals Strategy Group (NASG)* • *Commissioners assess equality impact assessments and*	DVDG / SLP	• *DVDG agrees members to sit on NASG* • *DVDG invites NASG member to join* • *NASG and other relevant groups*	Mar 14 Mar 14 Apr 14	Agreed and attending Achieved Achieved

		performance against ongoing plans • *Delivery group leads and co-ordinates communications activity* • *Agencies provide figures to evidence whether service recipients reflect local community* • *Delivery group track access and engagement of key services over time*		*are identified to input into forthcoming awareness raising campaign plans* • *Agencies provide service user data* • *DVDG analyses service data on demographics* • *Data informs DA strategy*	Jul 14 Sep 14 Oct 14	Achieved Achieved Achieved
4. *Agencies to consider a regular programme of service audits to quality assure their policies and procedures. This should cover levels of awareness of indicators of abuse, the required risk assessment and risk management of domestic abuse, access to training, ability to apply policies and procedures both as single agencies and in supporting joint working*	Local	• *Agencies to assess whether future training needs audits can take into account this level of detail, and on what frequency such information can be obtained*	DVDG / SLP	• *DVDG requests information from partner agencies* • *DVDG agrees improvement plan*	Mar 14 Sep 14	Audit completed Partnership Agreement in effect for SVDG and DVDG
		• *Delivery group to collate such data, assist in the analysis and assist in the response to need arising from such data*	Delivery Group	• *Multi-agency adult safeguarding procedures to support response to DV locally.*	April 2015	Launch of revised adult safeguarding procedures 1st April 2015.
				• *SAAF audit of agencies policies, training, procedures to support DV response*	November 2014	Audit progressed

Addendum to the DHR report: Information that arose from criminal trial

Maalav's' trial at Leicester Crown Court was concluded on the 24th May 2013 and he was found guilty of manslaughter and sentenced to 4 years imprisonment. Taking into consideration time spent in prison on remand it is anticipated that Maalav will be eligible to be considered for supervised release in mid-2014.

Sentencing, Judge Michael Pert QC, said: 'It's clear on the evidence you had a happy marriage and were a good, placid and kind husband. All that changed two months before you killed your wife and I accept the changes in your life caused you distress and reduced you to a state recognised by doctors in this case as an adjustment disorder' .

The court heard evidence that Anaya had a few days before her death asked her husband for a divorce. In addition the court heard that Maalav believed his wife to be having another relationship and referenced that for several months there had been a noticeable change in her Behaviour. Anaya was reported to have been making and receiving numerous text messages from a person not identified to the court, but believed to be someone she had met whilst attending a course at a local college.

It is noted that Anayas' sister whilst giving evidence in the trial of Maalav for causing the death of his wife, informed the court that during a stay with her in October her sister had mentioned 'divorce 'in a light hearted way'.

In a later telephone conversation with Maalav he stated 'they were having problems'. Anaya had said [we presume a separate telephone call with her sister] 'it was all his [Maalav's] fault. "She said that he had pushed her down the stairs. The Barrister for the defence dismissed this assertion that Anaya had previously been subject to domestic abuse, accusing the sister of "lying about the push in a bid to get her client found guilty of murder".

The sister's partner in giving evidence to the court that Maalav had contacted him by telephone upset, saying his wife wanted a divorce…that there had been an argument and resulted in him beating his wife and pushing her downstairs'. Maalav told the court that he 'denied assaulting her, saying she had fallen accidentally and he had taken her to hospital to be checked over'.

The IMR submitted by the University of Leicester Hospitals confirmed that Anaya attended alone at the A and E department on the 6th November 2012. She received treatment for a fracture to her left wrist.

Contacts Family Members as Part of the Domestic Homicide Review.

A letter was sent to Maalav at the commencement of the DHR advising him of the purposes of the review.

In June 2013 a further letter was sent to Maalav for the purposes of seeking his participating in the review. The letter was also copied to the Governor at HMP Leicester and translated into Farsi, this being Maalav's first language.

Prior to this, Maalav's solicitor was written to explaining the requirement for the review and in seeking her support in encouraging Maalav to contribute and agree to a meeting with the review chair to be accompanied by an interpreter.

The solicitor responded by e-mail to the review chair, dated the 12th June informing: "We will not be advising our client to take part in this process. He is too fragile and currently on medication. There were no agencies involved with this family prior to the incident. There is no history of domestic violence in this case".

In September 2013 the Review Panel Chair was informed by the children's social worker in Reading, that due to the likely supervised release of Maalav from prison being mid-2014, proceedings at the Family Court had been discontinued. The plan had been for a 'Special Guardianship Order' by the Court so as to enable the children to remain living with the deceased's sister and her partner at their home in Reading. Longer term plans and options to enable permanency for the children's care were required to be reassessed with a listed hearing in November 2013. Applications for care orders on the children were likely to be applied for. The hearing has now been deferred until February 2014.

Letters in Farsi were sent to family members in Reading, accompanied by a form to return to indicate whether they would be supportive of participating in the review or not. Copies were sent to the Victims Liaison Officer [Leicestershire Police] and the children's caseworker in Reading. To date we have not received any reply or information from any third party to indicate if family members would be supportive of a meeting in order to contribute to this review.

It is noted that Anaya's sister whilst giving evidence in the trial of Maalav for causing the death of his wife, informed the court that during a stay with her in October her sister had mentioned divorce in a light hearted way'.

In a later telephone conversation with Maalav he stated 'they were having problems'. Anaya had said [we presume a separate telephone call] with her sister] 'it was all his [Maalav's]. "She said that he had pushed her down the stairs. The Barrister for the defence dismissed this assertion that "Anaya' had previously been subject to domestic abuse, accusing the sister of "lying about the push in a bid to get her client found guilty of murder". The sister's partner in giving evidence to the court that Maalav had contacted him by telephone upset, saying his wife wanted a divorce…that there had been an argument and resulted in him beating his wife and pushing her downstairs'. Maalav told the court that he 'denied assaulting her, saying she had fallen accidentally and he had taken her to hospital to be checked over'.

The IMR submitted by the University of Leicester Hospitals confirmed that Anaya attended alone at the A and E department on the 6th November 2012. She received treatment for an un-displaced fracture to her left wrist.

Section 6: Agency IMR submissions to DHR panel; identified no previous incidents of domestic violence within the family or concerns.

6.10 **Leicester Partnership Trust**: Health Visiting IMR Report: the family received visits from Health Visitors and Nursery Nurses according to routine child health programmes, in respect of both children in the family. Anaya wanted to improve her English speaking and was supported by the health visitor service to enroll onto a local college course. Anaya was also referred to local Sure Start Centre, to help her to meet and socialise with mothers in the local community. There were no concerns raised to the service from family members or from other agencies in relation to any domestic violence.

6.11 **Leicester City Council Housing Division IMR report**: Maalav & Anaya lived in council properties since 2.2008. Anaya attended housing office in 2010 and was seen during a home visit by a housing officer the following month. Maintenance staff visited the property during 2011 and 2012 to conduct house repairs. There were no concerns raised from family members or from staff who visited the family.

6.12 **General Practitioner IMR Report:** Anaya registered with the local surgery in 2010; she and the children attended GP appointments for minor illness issues. There were no disclosures of domestic violence within the home. Maalav did not attend the surgery for any significant health problems; there were therefore no opportunities to identify any health-related issues with Maalav in the months before the death of Anaya. At the trial it was identified that he was suffering from adjustment disorder when he committed this crime.

6.13 **United Hospitals of Leicester IMR report**: provided maternity care to Anaya during her pregnancies and early post-natal period. Maternity Services reported no concerns being raised during their contact with Anaya. Before 2011 pregnant women were not routinely asked about domestic violence within booking arrangements; however this has now changed and routine enquiry is now made when women book for maternity care.

6.14 On 6.11.12 Anaya attended the hospital emergency department at UHL; she provided an explanation that she had fallen down the stairs. There were no disclosures of any domestic violence during Anaya contact with staff working within the Emergency Department. Anaya attended the department on own and was seen by a nurse, doctor and radiographer so had opportunities within privacy of the department to talk about any concerns raised. Anaya was treated for an un-displaced fracture to her left wrist which was splinted and she was then discharged home. Information was shared with GP following discharge according to normal procedures. Anaya received appropriate medical attention.

DOMESTIC HOMICIDE REVIEW

Overview Report – Independent Author Kate Galoppi

Executive summary

Report into the death of 'Adult K'

Table of Contents

INTRODUCTION:

This is the executive summary of the Domestic Homicide Review that followed the tragic death of Adult K resident of Leicester, who was killed as a result of domestic abuse by her son on the 16th of July 2013. Adult K was married, the husbands identity is protected within the report. .

Our deepest condolences are sent to the family of Adult K.

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

The review has considered agencies contact and involvement with Adult K victim and her son (perpetrator). The full report providing further detail and analysis of agencies involvement is available at http://www.saferleicesterpartnership.gov.uk;

1 THE REVIEW PROCESS:

1.1 This summary outlines the process undertaken by a Leicester DHR panel in reviewing the murder of Adult K. At the criminal trial Adult K's son pleaded guilty to murder, early in 2014; he received a twenty one and a half year sentence.

1.2 The Safeguarding Board Manager contacted 40 agencies to establish local contact with the family members; the trawl of information covered the period July 2008-July 2013, following the Death of Adult K. The Domestic Homicide Review process began with an initial meeting on 27th January 2014 of involved agencies.

1.3 Family, friends and work colleagues were considered by the panel to be integral to the review process to help build a picture of Adult K's life. In line with the Domestic Homicide Review guidance the husband, son (perpetrator) and daughter of Adult K were contacted and asked if they wished to contribute to the review, and receive a copy of the final report. However, the family declined the offer to contribute to the review, and advised that they 'wished to move on'. The panel gave careful consideration to following this line of enquiry further, but they concluded that the family wishes should be respected.

2 TERMS OF REFERENCE;

2.1 **The terms of reference for the review were to:**

- Review the involvement of each individual agency, statutory and non- statutory, with Adult K' and her Son between 2011 and 16th July 2013.
- Summaries the involvement of agencies prior to July 2013.
- Provide a chronology of agency involvement with Adult K and her Son during the time period.
- Search all their records outside the identified time periods to ensure no relevant information was omitted.
- Provide an individual management review if necessary: identifying the facts of their

involvement with Adult K.' her Son', critically analysing the service they provided in line with the specific terms of reference; identifying any recommendations for practice or policy in relation to their agency.

In order to critically analyse the case, the terms of reference required specific analysis by the panel of the following:

- Communication and co-operation between different agencies involved with the couple.
- Was the Adult K's death 'isolated incident' or were any warning signs meaning the incident was preventable or predictable.
- Opportunity for agencies to identify and assess domestic abuse risk.
- Agency responses to any identification of domestic abuse issues in relation to 'Adult K'
- Quality of oversight and supervision of staff engaging with the victim and perpetrator was this deemed adequate.
- Organisation's access to specialist domestic abuse agencies.
- The training available to the agencies involved on domestic abuse issues
- Review the care and treatment, including risk assessment and risk management of the Adult K's Son in relation to his primary and secondary mental health care.

For the panel to:

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

2.2 Agencies and individuals who produced written reports supporting the DHR review:

Agency Name	Involvement Type	Time Period	Involvement with member of family
Leicester City Council housing Department	Social housing provider	2001-2013	Adult K and Husband
University Hospitals Leicester	Patient records	2012 -2013	Adult K's Son
Health Care Centre	Primary care agency	2012 -2013	Adult K GP

2.3 A trawl of agencies information [1] was sent on 21st August 2013 with a ten day deadline 5th September 2013 for response. All agencies complied with the request, but a significant number of those agencies submitted nil returns, as they had no contact with Adult K, her son or her husband. Leicester City Council - Safer Communities Department - there was no direct involvement but supported the DHR panel representing specialist domestic violence services.

2.4 Agencies who submitted an Independent Management Review to the process provided:

- Chronology of interaction with victim, perpetrator or children
- A report of their involvement according to terms of reference for the review
- Conclusions and recommendations from agency's point of view.

3 KEY ISSUES ARISING FROM THE REVIEW:

3.1 Background

There was limited agency involvement prior to the death of Adult K; there was also no reported history of domestic violence by members of this current household in Leicester, prior to the murder and therefore no key "warning signs". The family GP's were the only professionals who had substantive contact with Adult K's son and Adult K prior to this incident; the son was diagnosed and treated for depression and headaches. The review panel wished to highlight the GP involvement with the family as exemplary in the medical support provided.

4 CONCLUSIONS & RECOMMENDATIONS

4.1 The role of a DHR is to consider whether the homicide appears to be an 'isolated incident' or whether there were any warning signs meaning the incident was preventable or predictable. This should include whether the deceased had experienced

[1] For a list of those agencies 'trawled' please see Appendix B of the main report The full report providing further detail and analysis of agencies involvement is available at http://www.saferleicesterpartnership.gov.uk;

domestic abuse within her family dynamics, and whether these were known about by agencies; and whether agencies were aware of the alleged perpetrator having any previous history of abusive behaviour or substance misuse to suggest any indication that he was capable of such an act.

The answer to these questions in the case of the murder of Adult K is no. The information provided by agencies identified there were no reports of domestic abuse between Adult K and her son; and no suggestion that Adult K's son was capable of committing this act. The review panel concluded that this murder was not predictable and could not have been prevented.

Given these findings there are limited recommendations arising from this DHR for local agencies on lessons learned on supporting victims of domestic violence, as this appeared to be an isolated incident. However, the panel would like to recommend that whenever anger management issues are identified a follow up question is always asked as to how this is impacting on the family; and a routine enquiry about domestic violence is followed by practitioners, and embedded in practice. It is proposed that a local resource be developed that encapsulates this recommendation.

A factor that featured in this review was that Adult K's son was witness of domestic violence as a young child; between his mother and an ex-partner. Leicester has raised awareness of learning from National and Local DHR's within a joint conference delivered by SAFER Leicester Partnership and the Local Safeguarding Boards, November 2014. This included the phenomenon of mothers and grandmothers killed by their sons; and the impact on children of witnessing DV within a home

To conclude, sadly this horrific murder of a mother by her son is one which could not have been predicted or prevented. The panel however wanted to emphasise the good practice points in working with the son of Mrs K when anger management was an identified issue, the following actions across agencies are being taken forward, see appendix 1 for full action plan.

- A local general practice resource is developed that includes prompts to explore the impact of anger management behaviour on the family, to disseminate good practice arising from this review.
- Routine enquiry into domestic violence is embedded within general practice whenever anger issues are identified.
- Importance of routine enquiry on impact on family members when anger is identified as a problem has been emphasised to local agencies.
- Share learning to staff from National and Local Domestic Homicide Review's- workshops held within Joint Safeguarding Conference held November 2014.

4. Glossary

DHR	Domestic Homicide Review
DCI	Detective Chief Inspector
LSAB	Leicester Safeguarding Adults Board
CSP	Community Safety Partnership
SLP	Safer Leicester Partnership
LSCB	Local Safeguarding Children Board
MCA	Mental Capacity Act
DoLS	Deprivation of Liberty Safeguards
DV	Domestic Violence
GP	General Practitioner
DVIRP	Domestic Violence Integrated Response Project (known as FreeVA – 'Free from Violence and Abuse' from August 2013)
LWA	Living Without Abuse
WALL	a non-profit-making organisation affiliated to Women's Aid
EMAS	East Midlands Ambulance Service
MIU	Minor Injuries Unit
SSAFA	Soldiers, Sailors, Airmen and Families Association
LCC	Leicester City Council
YOS	Youth Offending Service
LASBU	Local Anti-Social Behaviour Unit
CAFCASS	Children and Family Court Advisory and Support Service
UHL	University Hospitals of Leicester
LPT	Leicestershire Partnership Trust
FLO	Family Liaison Officer
DOB	Date of Birth
IMR	Individual Management Report / Internal Management Review (used interchangeably)
OVR	Overview Report
PHQ-9	a nine item depression scale of the Patient Health Questionnaire for assessing and monitoring depression
ABH	Actual Bodily Harm
ED	Emergency Department
DVD	Digital Versatile Disk
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference
NSPCC	National Society for the Prevention of Cruelty to Children
NHS	National Health Service

Appendix 1 Action plan

Recommendation	Action to take	Lead Agency	Key milestones to take enacting the recommendation	Target Date	Agency Progress
It is noted that the self help guide used by the GP was developed by another area. We recommend a local resource is developed that includes prompts to explore the impact of behaviour on the family	Review what self- help guides are used across Leicester by GPs for discussing depression and anger management with a patient. If appropriate develop standardised local self help guide(s) adapted from best practice models.	Leicester CCG	Circulate help guide amongst group of local GPs Comments received from local GPs local guide developed and signed off for use March 2015 self help guide in circulation	January 2015 Sept 2015	Draft proposal outlining an adapted version of the IRIS model, developed in partnership (Head of Adult Safeguarding CCG, Head of Community Safety and the DV coordinator from LCC) submitted to the CCG. CCG working with Jenkins centre to produce a resource to support GPs
A routine enquiry into domestic violence is embedded within general practice whenever anger issues are identified.	GP engagement plan, with specific tools and practice documents as necessary	Leicester CCG	GP engagement in DVDG action plan GP and IDVS link people identified Joint Safeguarding Conference includes relevant workshops Comments received from GPs and local IDVS on self help guide on anger Review need for additional actions April 2015 review report on routine enquiry following identification of anger issues and general referral levels from GPs into IDVS	April 2014 June 2014 Nov 2014 February 2015	Draft proposal outlining an adapted version of the IRIS model, developed in partnership (CCG, CSP, DV LCC) submitted to the CCG CCG working with Jenkins centre to produce a resource to support GP's.

Recommendation	Action to take	Lead Agency	Key milestones to take enacting the recommendation	Target Date	Agency Progress
Emphasis to agencies importance of routine enquiry on impact on family members when anger is identified as a problem	Review strategy and action plan	Community Safety (LCC)	Review information collated. Review Report drafted Draft Strategy ready 31/3/15 inter-agency domestic violence and sexual violence strategy is signed off by partners including city council; LSAB; LSCB; Police; NGOs; CCG with live action plan for annual delivery	August 2015	Planning session held 26th Feb. Draft Strategy expected end August 2015
Share learning from Domestic Homicide Review	Hold X2 workshops on lessons learnt from DHRs and SCRs at the joint safeguarding board and domestic violence delivery group conference on the 4th November 2014 aimed at frontline professionals, students and academics.	(LSAB) Strategic Plan for 2013/14.	Presentation drafted and key interactive questions to be asked of the audience by the workshop facilitator to be agreed by the Adult Review and Learning Group. September 2014. Evaluation forms to be completed post event by attending delegates. Evaluation forms to be reviewed and comments made in the workshops. Feedback from workshop provided to November ARLG meeting	04/11/14	 Learning Lessons.pptx Completed Discussion from workshops summarised for ARLG - WB 10.11.14

Safer Leicester Partnership
Working together for a safer City

Leicester Safeguarding Adults Board
WORKING IN PARTNERSHIP TO KEEP ADULTS SAFE

DOMESTIC HOMICIDE OVERVIEW REPORT

REPORT INTO THE DEATH OF Adult K

Report produced by Kate Galoppi,
Independent Report Writer

Date 21/05/2014

Version Control

1	Initial draft by the overview report author shared with the panel for comments	21st May 2014
2	Second draft incorporating the panels comments and suggested changes and shared with the Adult Review and Learning Group	2nd June 2014
3	Final draft incorporating the Adult Review and Learning Groups comments, ready for sign off by the Community Safety Partnership Chair and the LSAB Chair.	13th June 2014
4	Final report incorporating amendments requested by the chair of the CSP and the chair of the LSAB. In readiness to send to the Home Office DHR Quality Assurance Panel	20th June 2014
5	Updated report in response to feedback from The Home Office	13th October 2014

The overview report author would like to thank the LSAB Board manager, panel members and those professionals and agencies who contributed and supported the completion of this review.

The panel wish to formally express their condolences to Adult K's family on the loss of Adult K and note that whilst the family did not wish to formally contribute to the review; the panel utilised information contained within other agencies' documents respectfully and appropriately to provide a true reflection of Adult K's life and the events which led up to her life ending.

CONTENTS

1. INTRODUCTION

A. Purpose

1.1. This report of a domestic homicide review examines agency responses and support given to Adult K, a resident of Estate 1, (age 50 years) Leicester prior to the point of her death on 16th July 2013.

1.2. The review considers agencies contact/involvement with Adult K and the perpetrator (Adult K's son, age 21 years), from 5th August 2011- 16th July 2013.

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

B. Timescales

1.4. This review began on 25th October 2013 and was concluded on 3rd June 2014. Reviews, including the overview report, should be completed, where possible, within six months of the commencement of the review.

1.5. The Leicester Safeguarding Adults Board (LSAB) office was notified of the incident on the 18th July 2013 by the DCI for Safeguarding from Leicestershire Police. A trawl for information by agencies[1] was sent on 21st August 2013 with a ten day deadline 5th September 2013; all agencies complied with the request, but a significant number of those agencies submitted nil returns, having had no contact with Adult K, her son or her husband.

1.6. The scoping period of the initial trawl for information covered a 5 year period; local agencies were asked to provide information on family members dating back to July 2008. The agencies that identified an involvement with family members were then asked to provide a full chronology, and/ or an Internal Management Report (IMR) dependent on their involvement.

1.7. The information obtained during the trawl was compiled into a summary report and presented to the LSAB's Adult Review and Learning Group on the 8th October 2013 where a recommendation was agreed to commission a DHR into the case. This request was made to the chair of the LSAB and the chair of the Community Safety Partnership (known locally as Safer Leicester Partnership). The DHR was agreed on the 25th October 2013.

1.8. The review was halted on the 30th October 2013 at the request of the Senior Investigating Officer, due to the on-going criminal process which was required to take precedence over the DHR review panel. This request was respectfully complied with by the DHR panel, which was disbanded until 27th January 2014 when the panel formally held its first panel meeting.

[1] For a list of those agencies 'trawled' please see Appendix B

1.9. During the course of the review, the panel has met two times.

C Methodology

1.10. This DHR review follows the process outlined in the publication 'domestic homicide review local procedures' published on the 15th April 2013 by the Leicester Safeguarding Adults Board in conjunction with the Safer Leicester Partnership and the Local Safeguarding Children Board.[2] These local procedures are based on the methodology for statutory DHRs as outlined in 'Multi-agency statutory guidance for the conduct of domestic homicide reviews' published by the Home Office in April 2011, and revised in August 2013.

D. Confidentiality

1.11. The detailed findings of each review are confidential. The detailed information informing this overview report is available only to participating officers/professionals and their line management.

E. Dissemination

1.12. (List of recipients to be inserted once agreed with the media group) have received copies of this report.

[2] For a copy of these procedures please visit http://www.leicester.gov.uk/LCSAB

2. EXECUTIVE SUMMARY

A. The review process

2.1. This summary outlines the process undertaken by the Leicester Safeguarding Adults Board Domestic Homicide Review Panel in reviewing the murder of Adult K. (aged 50 years) .The Leicester Safeguarding Adults Board completes Domestic Homicide Reviews on behalf of the local Community Safety Partnership, known locally as the Safer Leicester Partnership (SLP). This process is outlined in local domestic homicide review procedures[3].

2.2. Adult K was murdered in the early hours of 16th July 2013, by her son (aged 23 years), in their family home; they were home alone. In a horrific attack, Adult K's son using a kitchen knife, stabbed Adult K repeatedly - some 50 plus times. Adult K died of blood loss and haemorrhaging.

2.3. Criminal proceedings have been completed. Adult K's son was sentenced in Leicester Crown Court early 2014. Adult K's son pleaded guilty to murder and was sentenced to a life sentence, with a minimum term of 21 and half years.

2.4. The Safeguarding Board Manager contacted 40 local agencies to establish local contact with the family members; the trawl of information covered the period July 2008-July 2013, following the Death of Adult K. The Domestic Homicide Review process began with an initial meeting on 27th January 2014 of involved agencies.

2.5. Agencies and their representatives who participated in this Domestic Homicide Review were:

- Leicester City Council Housing Department, Area Manager.
- Leicestershire Police Domestic Abuse Unit, DCI Safeguarding Lead
- Leicester Clinical Commissioning Group, Head of Adult Safeguarding, MCA and DoLS
- Health Care Centre 1, GP Partner and GP of Adult K
- University Hospitals of Leicester, Head of Safeguarding
- Leicester City Council Community Safety Department, domestic violence Coordinator and Head of Community Safety
- The Leicester Safeguarding Adults Board, Board Manager

2.6. Agencies identified through the trawling process to have had contact with the victim and/ or perpetrators were asked to give chronological accounts of their contact with the victim prior to her death. Where there was no involvement or insignificant involvement, agencies advised accordingly. Each agency's report covers the following:

- A chronology of interaction with the victim and/or their family;
- what was done or agreed;
- whether internal procedures were followed;
- and conclusions and recommendations from the agency's point of view.

[3] A copy of the local procedures can be found on this website: http://www.leicester.gov.uk/your-council-services/social-care-health/adults/staying-safe/lsab/domestic-homicide-reviews/ referencing page 3 paragraph 1.3

2.7. Of the 40 agencies who were contacted within the initial trawl; the majority of local agencies/teams responded as having had no contact with the victim, perpetrator or children; these agencies are identified in appendix B. The trawl period covered the timeframe July 2008 – the date of death, however agencies were also requested to review their records further back and note anything of significance for information.

2.8. 3 local agencies had some level of involvement with the victim. These were: Leicester City Council Housing Department (broken down into i) housing options, ii) income management and iii) tenancy management/ neighbourhood housing office); University Hospitals Leicester (UHL); the family GP: Health Care Centre 1.

2.9. The information provided by UHL and LCC Housing is of no relevance to the events that led to the death of Adult K; however for completeness the chronologies provided by these organisations are captured in this report. The last record of contact by UHL is 09.01.2013, where Adult K's son did not attend a follow up neurology appointment and was discharged. The last record of contact made by LCC housing was on 04.03.2013; when Adult K and her husband became joint tenants of the property.

2.10. The police had no contact with Adult K between the agreed scoping dates.

2.11. Family, friends and work colleagues were considered by the panel to be integral to the review process to help build a picture of Adult K's life. In line with the Domestic Homicide Review guidance the husband, son (perpetrator) and daughter of Adult K were contacted and asked if they wished to contribute to the review, and receive a copy of the final report. However, the family declined the offer to contribute to the review, and advised that they 'wished to move on'. The panel gave careful consideration to following this line of enquiry further, but concluded that the family wishes should be respected.

2.12. In the absence of the family involvement the review panel were provided with a set of comprehensive police documentation including police witness statements; these were used as background information for the family.

2.13. The panel considered whether it would be appropriate, to make direct contact with the work colleagues of Adult K or the perpetrator. The panel chair was provided with the police witness statements obtained from work colleagues; when these were reviewed, it was felt the transcript information adequately fulfilled the requirements, so direct contact with work colleagues was not needed.

B. Key issues arising from the review

2.14. A key issue arising from this review is the limited involvement of agencies prior to the death of Adult K; there was also no reported history of domestic violence by members of this current household in Leicester, prior to the murder and therefore no key "warning signs". The family GP's were the only professionals who had substantive contact with Adult K's son and Adult K prior to this incident; the son was diagnosed and treated for depression and headaches. The review

panel wished to highlight the GP involvement with the family as exemplary in the support provided.

C. Conclusions and recommendations from the review

2.15. The role of a DHR is to consider whether the homicide appears to be an 'isolated incident' or whether there were any warning signs meaning the incident was preventable or predictable. This should include whether the deceased had experienced domestic abuse within her family dynamics, and whether these were known about by agencies; and whether agencies were aware of the alleged perpetrator having any previous history of abusive behaviour or substance misuse to suggest any indication that he was capable of such an act.

2.16. The answer to these questions in the case of the murder of Adult K is no. The information provided by agencies identified there were no reports of domestic abuse between Adult K and her son; and no suggestion that Adult K's son was capable of committing this act. The review panel concluded that this murder was not predictable and could not have been prevented.

2.17. Given these findings there are limited recommendations arising from this DHR for local agencies on lessons learned on supporting victims of domestic violence, as appears to be an isolated incident. However, the panel would like to recommend that whenever anger management issues are identified a follow up question is always asked as to how this is impacting on the family; and a routine enquiry about domestic violence is followed by practitioners, and embedded in practice. It is proposed that a local resource be developed that encapsulates this recommendation.

2.18. A factor that has featured in the review that Adult K's son was exposed to domestic violence as a young child, between his mother and ex-partners when he lived in Derbyshire. Adult K separated from these relationships and moved the family to Leicester, where she married her current husband and there was then a period of stability within the home. There were two occasions when police responded to domestic incidents within the home. Within Leicester we are raising awareness of key themes arising from National and Local DHR's which will include the phenomenon of mothers and grandmothers killed by their sons; impact on children of witnessing DV within a home, within a joint conference delivered by SAFER Leicester Partnership and the Local Safeguarding Boards, November 2014.

2.19. To conclude, sadly this horrific murder of a mother by her son is one which this DHR is of the view could not have been predicted or prevented. The lessons learned from this review are the importance of routine enquiry into domestic violence being embedded within general practice whenever anger issues are identified. The panel would like to emphasis to local agencies the importance of routine enquiry on impact on family members when anger is identified as a problem, the local DV strategy and action plan will be reviewed to ensure that this is progressed.

3. LEICESTER DOMESTIC HOMICIDE REVIEW PANEL CONCLUDING REPORT

A. Introduction

3.1. This concluding report is an anthology of information and facts from three agencies, all of which were potential support agencies for Adult K. They are:

- Leicester City Council Housing Department
- University Hospitals Leicester
- Health Care Centre 1

B. The facts

Overview of the Local Authority Housing Service chronology

3.2 History of involvement: 17th September 2001 Adult K's husband (prior to their marriage) became the sole tenant of Address 1. On the 4th March 2013 Adult K's husband and Adult K became joint tenants of Address 1. Other than these records there was no other recorded involvement of the family with LCC Housing until after the death of Adult K.

3.3 Adult K moved from Derby to Leicester in 2008. There was no contact with local authority housing services in Leicester until Adult K commenced a joint tenancy with her husband 04.03.2013. A chronology of involvement was provided by LCC Housing as part of the panel's review of the domestic homicide of Adult K, Estate 1, Leicester, aged 50 years. Adult K is a White British female, who was a known tenant of LCC, occupants of the household were Adult K, her husband and her son.

3.4 Further contact has taken place with Adult K's husband following his wife's death by LCC Housing to offer support, which has included changing the locks to the property; and exploring future housing options. It should be noted that LCC Housing has been very supportive and sympathetic to Adult K's husband's situation, and continue to support him with the future of his tenancy. Discussions are taking place with him about downsizing and supporting a move out of the area. Whilst this is out of normal housing policy the team are trying to support Adult K's husband the best way that they can, given his circumstances. The LCC Housing support provided to Adult K's husband was highlighted as good practice by the review panel.

Overview of the NHS chronologies and IMR reports

3.5 A chronology of involvement was provided by University Hospitals Leicester (UHL). An IMR was not required as there was limited contact.

3.6 On 23rd August 2012 hospital records detail an outpatient appointment for the perpetrator with neurologist following GP2's referral further to a history of cluster headaches. A letter following the contact was sent to GP2, which communicated the plan to offer a follow up appointment.

3.7 On 9th January 2013 hospital records show that the perpetrator did not attend the follow up neurology appointment; he was therefore discharged from hospital. A letter was sent to GP2. All further UHL records relate to contact after the murder. On the 16th July the perpetrator was brought to UHL Emergency Department by the police with lacerations / wrist injuries. The wounds were treated with a recommendation made for further treatment. The perpetrator was later discharged back into police custody and information was shared with HMP Leicester regarding further medical treatment.

3.8 Hospital records 2011-13 for Adult K's husband are summarised as outpatient and hospital stays for a routine orthopaedic procedure.

3.9 An IMR was provided by the GP1, Health Care Centre 1, based on the electronic medical records of the victim, the victim's husband, and the perpetrator. Medical records for Adult K and her son were also obtained from Derbyshire as part of the information gathering process by GP1.

3.10 The IMR covers the period between August 2011 and July 2013, and was presented to the review panel at its meeting of 28th April 2014. The review panel heard that overall the family were healthy independent individuals, and they were all known to the GP surgery but had not had significant contact.

3.11 The IMR report contains reference to health appointments for Adult K between the dates of 3rd April 2012 and 10th December 2012, where Adult K was seen in the surgery for routine appointments. Given the routine nature of these physical health appointments it was the view of the panel that it was neither relevant nor appropriate during these consultations to enquire about the patient's home life or relationships.

3.12 Adult K's son attended the surgery on 5th July 2011 accompanied by Adult K. Adult K was very upset and distraught with her son's behaviour; which was described as him getting angry and hitting walls in the home until his knuckles bleed. Adult K blamed herself for "bad parenting" when he was young and reported that he was bullied at school, but she wanted him to know that she loved him. The perpetrator was not cooperative for GP1 to carry out formal PHQ9[4], but did not display any symptoms of psychosis[5], and reported that his sleep and appetite both okay. GP1 observed the perpetrator to be low in mood and socially isolated. In response she provided him with her personal email address and gave him a self-help guide for depression and encouraged him to make further contact.

3.13 GP1 confirmed that the depression guide was provided due to his presenting symptoms, given the level of time required by the patient to complete the guides

[4] A PHQ9 is a type of Patient Health Questionnaire. "9" is the depression module which uses scoring against criteria/questions to evaluate depression and is validated for use in primary care.

[5] Psychosis is a mental health problem that causes people to perceive or interpret things differently from those around them. This might involve hallucinations or delusions http://www.nhs.uk/Conditions/Psychosis.

it is not helpful to provide more than one in any consultation. The depression self help guide provides a clear explanation of negative thoughts/cycles and how these can be transformed into positive actions and changing feelings. It was noted from Police transcripts that the perpetrator found the self-help guide a useful tool. It should be noted that as there was no known previous pattern of domestic abuse within this family by local agencies. The provision of the self help guide was a proactive act by the GP1 and has been highlighted by the panel as best practice.

3.14 On 26th July Adult K's son returned to see GP1, and did report having completed the self help guide. He explained that he did not want counselling, and reported he was dealing with his anger management problems himself. He reported a history of migraines / cluster headaches. GP1 prescribed migraleve, which is a medication that treats severe headaches.

3.15 The next recorded contact with Adult K's son was by GP2, 21st May 2012, again he presented for help with headaches. Between this date and 24th August 2012 GP2 records show a further 8 contacts relating to his presentation, and resulting health interventions for headaches[6].

3.16 The analysis provided through the IMR clearly states that there was no record of domestic violence, injuries or violence in the electronic records. The anger management problems that were discussed in consultations contained no indication or suggestion that the anger was directed towards Adult K or anyone else, Adult K was not asked by the GP about the impact of her son's behaviour on her directly. The perpetrator's anger management was brought to the attention of the GP by his mother; in this context the panel viewed Adult K as a concerned mother, not as a victim of this behaviour.

3.17 GP1 confirmed that they had regular contact with Adult K's husband for treatment of an existing workplace injury. During these consultations he often spoke of how happy he was in his relationship, and Adult K at times accompanied him. GP1 described a loving, devoted, and stable couple. GP1 also stated that during these consultations there was opportunity for Adult K's husband to raise any concerns he had regarding Adult K's son in relation to anger, and any violence towards the family. Indeed, given his clear devotion to Adult K, GP1 felt that if he had thought she was under threat he would have disclosed this. It was further commented by Health Care Centre 1 that even following the death of Adult K, her husband has continued to be seen, and has not at any point suggested that there was anything that could have led him to suspect Adult K's son was capable of murder.

3.18 The IMR confirms that no other information was known, nor was any concerns raised from other sources when the family lived in Leicester, regarding any issues of domestic violence, or other violence in the home.

3.19 The IMR provides assurance that all staff within Health Care Centre 1 receives regular clinical supervision, and safeguarding training is provided and regularly

[6] It was noted by the panel that the perpetrator saw two GPs at Health Care Centre 1; this was explained by GP1 to the panel as GP1 only works in the surgery part time which is why the perpetrator would have seen alternative doctors when attending the surgery.

reviewed.

3.20 The conclusion of the IMR is that Health Care Centre 1 followed best practice in record keeping, and displayed innovation in offering a range of access methods to patients, as in the case of the personal email address of GP1. There were no missed cues to suggest that domestic homicide would ensue.

Overview of Derbyshire and Leicestershire Police reports

3.21 Within the initial trawl for information it was identified that Adult K was previously known to Derbyshire Police, when she lived there with her children. This includes offences regarding non-school attendance of her children; and incidents of a domestic nature with an ex-boyfriend.

3.22 In December 2005 police were called by Adult K, she requested the police attend the family home to remove an ex-boyfriend following an argument; she explained they were in the process of separating. Police responded, there were no visible signs of injury nor was a complaint made by Adult K of any offences against her ex-boyfriend. The police officer accompanied the ex-boyfriend to the train station, but he returned to the address following this and was then arrested.

3.23 In April 2006 Adult K's daughter aged 17 years rang the police and alleged during an argument that her mother had pushed her against the door. The police attended the house and spoke to the daughter of Adult K who explained that the argument with her mother arose because a violent ex-boyfriend (who lived away from the family) had earlier that day gained access to the house and had argued with Adult K's son, who was aged 14 years at the time. No complaints were made to the police officer against the ex-boyfriend or Adult K and there were no visible injuries. The police escorted the ex-boyfriend to the train station but he later returned to the address and was then arrested. A form 621 was completed (which was replaced by the Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH assessment) in 2011 within Derbyshire's saferderbyshire.Domestic Abuse strategy. The incident was not deemed to be of a serious nature by the officer.

3.24 All written records pertaining to police incidents from 2005-2006 have been destroyed according to current police data retention procedures. The Adult Review Panel made a decision; based on initial scoping of information and the different record retention periods across involved agencies, for the terms of reference for the DHR review to commence in 2008.

3.25 There are no Police reports from Leicestershire Police for either Adult K or Adult K son whilst they lived in Leicester.

The murder investigation

3.26 Crime Unique Reference Name (URN): Operation Ribbon dealing with the murder of Adult K.

Police records regarding the murder investigation.

3.27 The circumstances surrounding the death of Adult K are that on the evening of 15th July, and through to the morning of 16th July, the date of the murder, both Adult K and her son were at their home address and no one else was present. Adult K's husband was away with his work, as a long distance HGV driver. When the perpetrator was interviewed by Leicestershire Police he reported that he returned home after work, watched DVDs, drank alcohol, ate, and then drank alcohol again. He said that he remembered the DVD stopping and the next thing being in the bathroom covered in blood.

3.28 It is established that at about 02:00 the perpetrator went into Adult K's bedroom where she was asleep in her underwear (as usual). The perpetrator used a kitchen knife and stabbed Adult K repeatedly in the head and neck. Adult K sustained in the region of 52 stab wounds and died of blood loss and haemorrhaging.

3.29 Witness statements, and transcripts from the court state there may have been an argument between Adult K and her son prior to the event, regarding his cannabis use.

3.30 At 0711 hours on Tuesday 16th July Leicestershire Police were requested to attend Address 1 following a report by Adult K's father in law, of a male having stabbed his mother. Police attended and were met at the property by Adult K's father in law who advised that Adult K was upstairs. Adult K was found lying in front of the bedroom door on her back with her feet behind the door. Her body was covered in blood, and the floor appeared to be saturated in blood. The forensic evidence shows defence wounds consistent with Adult K curling up in the foetal position trying to protect herself. A Police officer at the scene attempted chest compressions. Paramedics attended and life was pronounced extinct at the scene.

3.31 Adult K's daughter (brother to the perpetrator) received 3 telephone calls from her brother in the early hours of 16th July. In his first contact he asked his sister if he could go to her home, in Derbyshire, as he had been in a fight, and that he had cut his hands. The second telephone conversation, around 3am, lasted a lot longer, for 1 hour and 40 minutes. In this conversation the perpetrator reported he had been drinking vodka, and smoking cannabis, he told his sister that the fight was more serious. During this phone conversation his sister asked about their mother (Adult K), and he said she was asleep in her room. In the 3rd call around 6.36 am the perpetrator said it was Adult K he had been in a fight with. He said that they had been in an argument about his cannabis use; and that their mother had slapped him around the face. His sister thought this unlikely. The perpetrator then said he thought their mum was dead. He checked her pulse, and confirmed over the phone that she was dead. His sister then contacted Adult

K's husband to tell him about the phone call, and he asked his father to go to the property to check Adult K was okay. Adult K's father in law found Adult K slumped on the bedroom floor, surrounded by blood, and called the police to attend the property.

3.32 Following the event the perpetrator visited the care homes where he works as a chef. On route he visited a garage and purchased cigarettes, the attendant noticed blood on his hands and blood where he was standing. At his work, he spoke to a number of colleagues and said he had been in a fight with his step-father. He was observed by colleagues to smell of alcohol. He disclosed to one colleague that he didn't know what had happened but that it was really bad, and that he might have stabbed his mum or step-father. Further to this disclosure and in discussion with the perpetrator the care home staff called the police. On 16th July 2013 Adult K's son was arrested for the murder of his mother.

3.33 A witness statement provided by a man who lives on the St. Matthews estate details him hearing a female voice in the early hours of the 16th July, screaming "please don't do it"; the man was walking near to Address 1 at the time the incident happened but did not realise the significance of this at that time and therefore this information was unreported until police enquiries was made after the incident.

3.34 The murder investigation shows that there was no police involvement with the family in the time that they had resided in Leicester, which was from 2008. Prior to then the Adult K's family lived, and were from Derbyshire.

3.35 Upon the review panel obtaining background information from the FLO in relation to Adult K; it was noted that her early life was traumatic and sad; she came from a large family and was placed in care by her parents. At the age of 15 she met her first husband (father to the perpetrator and his sister) who was older than her by 12 years; this relationship was described as abusive. Adult K's son had no relationship with his father from the age of 3 and has no desire to pursue this as an adult. Adult K went onto a second relationship which was also described as abusive. However when Adult Ks son was 14 his mother met her current husband; they are noted by Adult K's husband, family members and GP1 as being a very loving and happy couple.

3.36 The perpetrator, lived with his mother and her husband, and was described as being a silent lodger – with limited interaction. There is nothing to suggest an abusive relationship between Adult K's son and his mother and stepfather, and the perpetrator was best man at the wedding of Adult K and her current husband. The only contentious issue between them was that her son smoked a small amount of cannabis (light user) in his room which Adult K and her husband were not happy about and requested he did this outside of the family home.

3.37 The perpetrator had no social network other than through social media. He worked as a chef in two care homes for the past 3.5 years, and got on well with the other staff, but did not have a relationship with them outside of work. Through his online network he had a different persona, a confident alter-ego. He was known to his online friends with an alternate name. He was interested in a character Dexter, from a TV series that involved killing with knives. The perpetrator presented himself to his online friends with a fictional background

different to that of his real life; this included portraying himself as having a different family. He had told an online friend that his mother had died when he was young and that he lived with his dad and stepmother before his father left him behind to live with his stepmother and her new partner. The panel queried the perpetrator's understanding of his real life circumstances; noting that he had applied for a bank account which was rejected this was due to the type of account requiring a minimum income of £500,000 per annum. Adult K's son also told his friends he was moving to Wales to be near them however his situation suggests he was not a position to move out of his parents' house. The perpetrator admitted during psychological assessment of fantasising about having special powers and that he imagines he is in TV series he watches.

3.38 Around 3-4 months before the perpetrator committed the act of murder there were two incidents causing tension between Adult K and her son. Adult K had put a photo online of her son online which made him very angry that he had been 'out-ed' as he had tried hard to stay anonymous and as a result of this incident he defriended his mother as well as a host of other friends. Secondly, the perpetrator had declared on Facebook that he had changed his name via Deed poll. The name he is noted to have used is in reference to the TV serial, Dexter, and an online friend who had the surname the perpetrator adopted '. His mother wrote on his Facebook wall 'you'll always be <real name> to me' – this was another tension.

3.39 The perpetrator was sentenced to a life sentence by the Judge at Leicester Crown Court, early 2014. The court heard evidence from a psychological report and a forensic psychiatric assessment, neither of which found support for diminished responsibility. In his summing up of the case the Judge described the attack as one of appalling savagery.

C. Analysis

3.40 Through the trawling process, and the subsequent submission of information it can be deemed that there was only routine contact with the family medical practice.

3.41 The references to domestic violence between Adult K occurred with a previous partner when she lived in Derbyshire, 2003 and 2006 respectively. Adult K separated from this abusive relationship and moved to Leicester in 2008[7]; married and moved into the flat as a joint tenant in 2013.

3.42 The involvement of GP1 has been identified by the panel as exemplary, and the panel wish to highlight the approach that was observed as best practice. GP1's offer to the perpetrator of her personal email address demonstrated innovation in attempting to engage and encourage access to help and support. From the medical records, the IMR and presentation to the panel, the panel were confident that there had been no cues or disclosure of information to GP1 or GP2 that could have suggested there was domestic violence, and that Adult K was at risk. Therefore, the panel is of the opinion that GP1 and GP2's was appropriate and

[7] 5 years is a standard initial scoping period set by the Adult Review and Learning Group for adults when conducting trawls for Adult Reviews and DHRs (with a caveat which states if information is known prior to the 5 years, this must be stated on the trawl response). The review panel chose not to go back further with the exception of requesting the GP to obtain records for Adult K from birth.

that the practice acted in accordance with their set procedures and guidelines. Anger management issues were identified but there is no information to suggest that this was directed towards Adult K. However, as anger management is more likely to be disclosed than domestic violence, the panel recommend that agencies reinforce to professionals the importance when anger management is disclosed; a follow up question is asked as to how this affects the family.

D. Conclusion/lessons learnt

3.43 The review panel, after thorough consideration, believes that under the circumstances agency intervention would not have prevented the victim's death, given the information that has come to light through the review.

3.44 The information available to the review panel suggests that there were no recorded incidences of domestic violence and abuse between the victim and the perpetrator. This is conclusive.

3.45 This is a tragic story of a horrific murder of a mother by her son. However, the panel have concluded that in this case there was no opportunity to prevent this death, with limited agency involvement, and no reported incidents of domestic violence occurring within this family whilst they lived in Leicestershire, within the scoping period. Whilst anger management issues for the perpetrator were identified by GP1, there was no suggestion that this was directed towards his mother, and the approach offered by GP1 was absolutely appropriate. Although there was no suggestion of violence towards Adult K, there is no recording of any attempted exploration of how the perpetrator's anger might have impacted on the family, and on review of the self-help guide this was found to be absent. As anger management is more likely to be disclosed than domestic violence the panel wish this to be reinforced to staff working within agencies.

3.46 The scoping period across local agencies for the review originally went back 5 years, which was shortened to 2 years upon reviewing initial agency involvement. The panel did hear through police evidence that Adult K had a sad history, and that her first marriage, and second relationship were both unhappy. The panel heard that the perpetrator had witnessed domestic violence within the home when he was a younger child. However Adult K positively separated from this abusive relationship and moved to Leicester, married her current partner and moved in with him. There were no reports to the police of any DV or wider incidents occurring with family members whilst they lived in the Leicester area.

3.47 Whilst the panel is of the opinion that this sad and tragic death was not preventable or predictable, and that there is no causal link between the perpetrator's childhood exposure to domestic violence and the murder of Adult K; given the significant number of women – mums and grandmothers, killed by sons ("counting dead women campaign"[8]) the panel recommend that this phenomena is included within the joint DV and Safeguarding Conference being held within Leicester City, November 2014.

[8] A News article by Nia, a London based DV charity: http://www.niaendingviolence.org.uk/perch/resources/kettlemag-how-karen-ingala-smith-is-breaking-the-silence-kettlemag-march-2014.htm

3.48 A literature review completed by the overview report author identified a number of publications describing behaviour change in children who have witnessed or experienced abuse, and go on to display fear, inhibition and depression as well as high levels of aggression and anti-social behaviour; children's abusive behaviour was most frequently directed towards mothers, friends or siblings. (EIF 2014 publication[9]; CAADA 2014 Children's insight report[10]). Of note is a Canadian resource[11]. This identifies how the impact of domestic violence between mother and her partners can harm the mother/child bond; the research goes on to suggest that children go on to have a negative view of their own lives and fantasise about having a different or better family. These behaviours were all exhibited in this case. The learning from this review will be included in the workshop being delivered to staff working in local agencies (statutory and independent) at the joint DV and Safeguarding Conference November 2014; on lessons learnt from both local and national Serious Case Reviews (SCR's) and Domestic Homicide Reviews.

E. Recommendations

3.49 The panel is in agreement that sadly this death was not preventable or predictable. The ability to make recommendations from this review is limited due to the lack of involvement of agencies with the family. The panel heard from 3 agencies, 2 of which were simply a record of just one or two contacts pertaining to access to services. The most significant contact was with the Health Care Centre. GP1 heard that the perpetrator had anger management issues. Whilst the panel is of the view that this was dealt with in the correct manner, the panel would like to recommend that where anger management issues are disclosed, this is explored further by probing as to how this is affecting the family. The self-help guide for depression given to Adult K's son was developed from another NHS area, this was reviewed by the overview author and a "prompt" to make further enquiry was not present. It is therefore proposed that a local guide(s) is scoped and developed which incorporates this to be used within health settings.

3.50 A feature of this review is the son/ perpetrator childhood exposure to domestic incidents within the home. Whilst no recommendations arising from this are to be translated into organisational procedures, local learning opportunities will be used to raise awareness and share learning. A conference is planned aimed at all professionals sharing the learning from DHRs both nationally and locally. This event and other learning mechanisms will raise this issue, along with other key learning.

3.51 It is recommended by the panel that this overview report is shared with the Leicester Safeguarding Adults Board and the Community Safety Partnership (and its Domestic Violence Delivery Group) to note its contents prior to wider dissemination.

[9] Early Intervention in Domestic Violence and Abuse – published 2013

[10] Children's Insights Dataset 2011-2013 appendix to 'in plain sight' research and policy reports – published 2014

[11] Little eyes, little ears: how violence against a mother shapes children as they grow –published 2007

APPENDIX A - TERMS OF REFERENCE FOR THE CASE

1. PURPOSE

The purpose of the Domestic Homicide Review is to:

1.1. Ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case.

1.2. Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence and abuse, including their children (where applicable).

1.3. Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on and what is expected to change as a result.

1.4. Apply these lessons to service responses including changes to policies and procedures as appropriate; and

1.5. Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

2. TERMS OF REFERENCE

In addition the following areas will be addressed by the Review Panel through the submissions of Individual Management Reviews:

2.1. The review should address whether the domestic incident in which Adult K died appeared to be an 'isolated incident' or whether there were any warning signs meaning the incident was preventable or predictable.
This should include:

2.1.1. Whether the deceased had experienced domestic abuse within her family dynamics, and whether these were known about by agencies.

2.1.2. Whether agencies were aware of the alleged perpetrator having any previous history of abusive behaviour or substance misuse to suggest any indication that he was capable of such an act?

2.2. The Review Panel need to understand:

2.2.1. What agencies the victim and perpetrator were involved with and what was known by these agencies.

2.2.2. Whether these agencies followed their policies, procedures and guidelines when engaging with the victim and/or perpetrator. If this was not what workers reason for deviation from procedure was and whether it was appropriately documented?

2.3. The Review Panel should establish how effective the following areas were carried out by agencies with the victim and/or perpetrator (where applicable):

- Information gathering and analysis
- Completion of assessment(s)
- Decision making, planning and reviewing.

And to what extent was the exchanges of information were appropriate, sufficient and effective:

- Within the agency

Between the agency and other partner agencies/ organisations

2.20. The Review Panel need to establish whether oversight and supervision of staff engaging with the victim and/ or perpetrator was deemed adequate.

2.21. The Review Panel should consider whether there were opportunities for agency intervention in relation to domestic abuse regarding the deceased and the alleged perpetrator that were missed. This should also include consideration of agencies promotion of services and values and presence of domestic violence services in Leicester during the scoping period. On reflection at the time of the incident, could there have been any perceived barriers to accessing agencies services and support

2.4. The Review Panel should consider whether family, friends and work colleagues wish to participate in the review and if so whether they were aware of any domestic incidents or concerns, prior to the homicide or whether anyone attempted to approach agencies for help/advice/assistance on the subject and the outcome

2.5. The Review Panel should consider whether there are important events outside of the scope dates that are relevant and worthy of inclusion in the final report which have been found out during the course of the Review through trawls/IMR submissions.

2.22. The Review Panel should reflect if there are any examples of exceptional practice found during the course of this Review which should be noted.

3. Membership of DHR Panel/ Requests for IMRs

Following an initial trawl the agencies identified which were involved in the case and specialised identified for advice and guidance have been outlined below:

Organisation/ Specialist Area	**Panel Member**	**Chronology / IMR Writer**
Leicester City Council - Housing Services - Community Safety	 Area Manager Head of Service	 Chronology needed N/A
Leicester City Clinical Commissioning Group	Head of Adult Safeguarding, MCA and DoLS	N/A
General Practice	GP1	IMR needed
Leicestershire Police	DCI for Safeguarding	N/A
University Hospitals of Leicester	Head of Safeguarding	Chronology needed

Domestic violence specialist	Domestic Violence Coordinator for Leicester	N/A
Board Office	Board Manager	N/A coordination role
Independent Overview Report Writer/ Chair	Kate Galoppi	OVR required

4. Timescales of Review

2.23. As per the government guidance for DHRs, this review should be completed within 6 months. It is agreed that the date of the Chair of the CSP being briefed on the case and providing consent to commission a DHR was the 25TH October 2013. Therefore the projected review date should be completed and submitted to the home office no later than the 25th April 2013, provided there are no delays or requests to pause the review.

2.24. It is the responsibility of the Board Manager to keep the review on schedule and to note any foreseen deviations to the agreed timeline to the chair of the CSP.

2.25. Upon reviewing the trawling content, the scoping period agreed for the review is August 2011- July 2013.

APPENDIX B –AGENCY TRAWL LIST

Health organisations	Response
1. University Hospitals of Leicester	Y
2. Leicestershire Partnership Trust	O
3. East Midlands Ambulance Service	N
4. Out of Hours Service CNCS	N
5. George Elliot Hospital	N
6. Derbyshire Community Health Services	N
7. Fielding Palmer Minor Injuries Unit	N
8. Melton Mowbray Minor Injuries Unit	N
9. Market Harborough Minor Injuries Unit	N
10. Rutland Minor Injuries Unit	N
11. Urgent Care Centre LRI	N
12. Loughborough Walk-in Centre	N
13. Oadby 8-8 Centre	X
14. SSAFA Care Walk-in Centre	N
15. NHS Direct	X
16. Family GP 'Health Care Centre 1'	Y
Local authority	
17. Adult Social Care	N
18. Children Social Care	O
19. Housing Services (income management)	Y
20. Housing Services (housing options)	Y
21. Housing Services (tenancy management – neighbourhood housing office)	Y
22. Youth Offending Service	N
23. Customer and Access (includes education services)	N
24. Planning and Commissioning	N
25. Neighbourhood Services (includes community centres, libraries and museums)	N
26. The Leicester Anti-Social Behaviour Unit (LASBU)	N
27. Connexions	X
28. Adult Skills and Learning	N
Domestic violence services	
29. Sanctuary Housing	N
30. Foundation Housing (East Midlands Housing Association)	N
31. SAFE Project	N
32. DVIRP (now known as FreeVA)	N
33. WALL (Women's Aid)	N
34. Action Homeless	N
35. Living Without Abuse	N
Other	
36. Leicestershire Police (includes MARAC and MAPPA)	O
37. Leicestershire Probation	N
38. NSPCC	X
39. CAFCASS	N
40. Leicester College	N

Key

N = nil return from agency

X = no response received

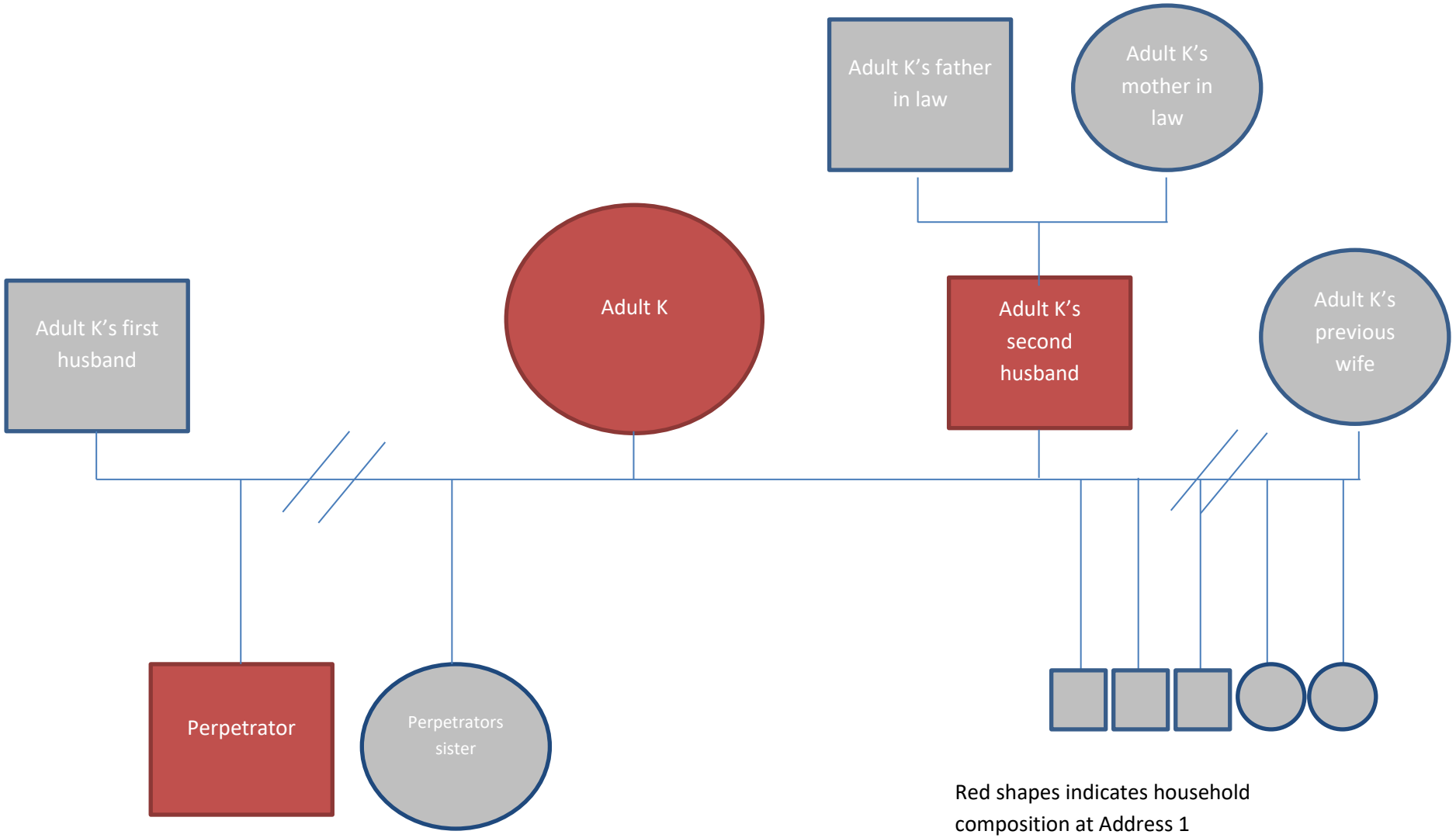
Y = one or more individuals known

O = known but outside of scoping period or not of relevance to include in the review

APPENDIX C- GLOSSARY OF TERMS AND ABBRIVIATIONS

ABH	Actual Bodily Harm
CAFCASS	Children and Family Court Advisory and Support Service
CSP	Community Safety Partnership
DCI	Detective Chief Inspector
DHR	Domestic Homicide Review
DOB	Date of Birth
DoLS	Deprivation of Liberty Safeguards
DV	Domestic Violence
DVD	Digital Versatile Disk
DVIRP	Domestic Violence Integrated Response Project (known as FreeVA – 'Free from Violence and Abuse' from August 2013)
ED	Emergency Department
EMAS	East Midlands Ambulance Service
FLO	Family Liaison Officer
GP	General Practitioner
IMR	Individual Management Review
LASBU	Local Anti-Social Behaviour Unit
LCC	Leicester City Council
LPT	Leicestershire Partnership Trust
LSAB	Leicester Safeguarding Adults Board
LSCB	Local Safeguarding Children Board
LWA	Living Without Abuse
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference
MCA	Mental Capacity Act
MIU	Minor Injuries Unit
NHS	National Health Service
NSPCC	National Society for the Prevention of Cruelty to Children
OVR	Overview Report
PHQ-9	A nine item depression scale of the Patient Health Questionnaire for assessing and monitoring depression
SLP	Safer Leicester Partnership
SSAFA	Soldiers, Sailors, Airmen and Families Association
UHL	University Hospitals of Leicester
WALL	a non-profit-making organisation affiliated to Women's Aid
YOS	Youth Offending Service

APPENDIX D – GENOGRAM



Red shapes indicates household composition at Address 1

APPENDIX E - ACTION PLAN

Recommendation	Scope of recommendation	Action to take	Lead Agency	Key milestones to take enacting the recommendation	Target Date	Date of completion and outcome
It is noted that the self help guide used by the GP was developed by another area. We recommend a local resource is developed that includes prompts to explore the impact of behaviour on the family		Review what self help guides are used across Leicester by GPs for discussing depression and anger management with a patient. If appropriate develop standardised local self help guide(s) adapted from best practice models.	Leicester CCG	Circulate help guide amongst group of local GPs Comments received from local GPs local guide developed and signed off for use	January 2015 March 2015	March 2015 self help guide in circulation
A routine enquiry into domestic violence is embedded within general practice whenever anger issues are identified.		GP engagement plan, with specific tools and practice documents as necessary		GP engagement in DVDG action plan GP and IDVS link people identified Joint Safeguarding Conference includes relevant workshops Comments received from GPs and local IDVS on self help guide on anger Review need for additional actions	April 2014 June 2014 November 2014 February 2015 April 2015	April 2015 review report on routine enquiry following identification of anger issues and general referral levels from GPs into IDVS

Emphasis to agencies importance of routine enquiry on impact on family members when anger is identified as a problem		Review strategy and action plan	Community Safety (LCC)	Review information collated. Review Report drafted Draft Strategy ready	31/10/14. 30/11/14 1/2/15	31/3/15 inter-agency domestic violence and sexual violence strategy is signed off by partners including city council; LSAB; LSCB; Police; NGOs; CCG with live action plan for annual delivery
Share learning from Domestic Homicide Review	Workforce Development	Hold X2 workshops on lessons learnt from DHRs and SCRs at the joint safeguarding board and domestic violence delivery group conference on the 4th November 2014 aimed at frontline professionals, students and academics.	Forms part of the Leicester Safeguarding Adults Board (LSAB) Strategic Plan for 2013/14. To be undertaken by the Adult Review and Learning Group and reported on in the next annual report.	Presentation drafted and key interactive questions to be asked of the audience by the workshop facilitator to be agreed by the Adult Review and Learning Group. September 2014. Evaluation forms to be completed post event by attending delegates.	04/11/14	Evaluation forms to be reviewed and comments made in the workshops. This to be fed into the ARLG and the LSAB.

DHR 3

Domestic Homicide Review Executive Summary Report

Subject of the report: "Rabia"
Month of death: January 2014

INDEPENDENT CHAIR AND AUTHOR OF THE REPORT:
ADRIAN SPANSWICK, RGN, RHV, MA.

Safer Leicester Partnership
Working together for a safer City

TABLE OF CONTENTS

1. THE REVIEW PROCESS

1.1 This summary outlines the process undertaken by the Safer Leicester Partnership's Domestic Homicide Review (DHR) Panel in reviewing the homicide of "Rabia", who was a resident in Leicester.

1.2 Pseudonyms have been in used in this review for the victim and perpetrator (and other parties as appropriate) to protect their identities and those of their family members.

1.3 The victim: "Rabia". Age at the time of her death: 34 years.

1.4 The perpetrator: Ahmed. Age at the time of the time of the offence: 44 years.

1.5 The perpetrator's disabled brother: Shahid. Deceased by the time of the murder.

1.6 Criminal proceedings were completed in June of 2015 and the perpetrator was found guilty. He was sentenced to life imprisonment for the murder of Rabia, with a requirement to serve a minimum prison term of 22 years.

1.7 The DHR process began in January 2014 when local agencies were contacted and asked to confirm whether they had involvement with the victim, the perpetrator and their family members prior to the point of death.

1.8 Eight of the thirty agencies contacted, confirmed contact with the victim and/or perpetrator and were asked to secure their files.

2. CONTRIBUTORS TO THE REVIEW

Multiple services within Leicester City Council (Adult Education, Adult Social Care, Housing, Libraries).

Leicestershire Police.

Leicestershire Partnership Trust.

University Hospitals of Leicester NHS Trust.

The Home Office.

Local provider of Black and Minority Ethnic services.

Independent Consultant, with experience in psychiatry and systemic therapy.

3. THE REVIEW PANEL MEMBERSHIP

Name of Panel member	Role/job title	Agency represented
Mina Bhavsar	Head of Adult Safeguarding	Leicester City Clinical Commissioning Group
Stephanie McBurney	Domestic and Sexual Violence Team Manager	Safer Leicester Partnership
Jenny Williams	Partnership and Strategy Manager	Leicester City Council Adult Social Care
Philip Akiens	Supported Residents Care Team Leader	Leicester City Council Adult Social Care
Sarah Statham	Property Lettings Team Manager	Leicester City Council Housing
Sharon Hames	Specialist Nurse	Leicestershire Partnership Trust
Jonny Starbuck	Detective Chief Inspector, Serious Crime Unit	Leicestershire Police
Claire Weddle	Domestic Violence Services Manager	Women's Aid Leicester
Lindsey Bampton	Leicester Safeguarding Adults Board Officer	Leicester Safeguarding Adults Board

3.1 The Panel met a total of five times and were consulted by e-mail on the final draft of the reports in July 2018.

4. TERMS OF REFERENCE FOR THE REVIEW

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

4.2 To establish how professionals and agencies carried out risk assessments, including:

4.3 Whether risk management plans were a reasonable response to these assessments.

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

4.5 To identify whether services involved with Ahmed were aware of the circumstances of Rabia's presence in the home and whether connections were made and information shared between these services in order to establish a full picture of the wider family's vulnerability and risks.

4.6 To establish whether agencies involved made routine enquiries about domestic violence when working with these adults, whether relevant procedures were followed and if any opportunities were missed.

4.7 To establish whether Ahmed and Rabia's social needs around housing, benefits and caring responsibilities were adequately supported by local agencies.

4.8 To establish whether the mental health needs of Ahmed were supported and managed appropriately by local agencies.

4.9 To establish if there were any barriers experienced by Ahmed, Rabia or family / friends that prevented them from accessing support, including how their wishes and feelings were ascertained and considered.

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

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

4.12 To establish how effectively local agencies and professionals worked together.

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

4.14 To identify any areas of good practice.

5. SUMMARY CHRONOLOGY

5.1 Rabia was born and lived in Pakistan until she came to the UK on a student visa in May 2010. Her family continued to live in Pakistan. After moving to the UK and before her arranged marriage, Rabia lived with family friends in the Midlands. Information obtained by the Panel describes Rabia as a clever well-educated woman who was regarded as polite and hardworking, and able to stand up for herself. She was seen as someone who wanted to make more of her life. She taught herself English and hoped to pursue a career in nursing. She is described as caring, kindly and "never lost her temper".

5.2 Ahmed lived in another part of the East Midlands in his parents' home until 2009 when he moved to live in Leicester. He had a brief first marriage in 1991.

Ahmed's mother, Rehana, lived with him until her death in the family home the same month that Ahmed and Rabia first met (February 2011). Ahmed was described as behaving aggressively towards paramedics treating his mother at the time of her death and was asked to leave the room to let the paramedics get on with their work. Later that same month (February) he was seen in a local Emergency Department feeling "suicidal" after his mother's death. General practice records describe this being regarded as a "bereavement reaction".

5.3 That same month (February 2011) Rabia first met her future husband, Ahmed. She moved to live with his family shortly before the couple married in a religious ceremony in May 2011. This was after Ahmed's mother died.

5.4 After the religious ceremony, Rabia and Ahmed married in a civil/ legal ceremony in June 2011. Around that time Rabia got a job working at a local nursing home and became the primary earner for the family. At that time Ahmed's brother, was living in the family home and being cared for in respect of long-standing mental health and physical health problems. Ahmed had had varying levels of caring responsibilities for Shahid over a number of years and assessments of Shahid refer to Ahmed suffering carer stress that impacted on his life.

5.5 Between February 2011 and Rabia's death, the Panel learned of five occasions when Shahid mentioned to support staff situations that indicated potential for harm/ abuse but retracted the comments straight away on each occasion. These concerns were documented and discussed by his Intensive Community Support Team (ICST) worker, Community Psychiatric Nurse and Adult Mental Health Social Work Team. They were seen within a complex context involving: repeated retractions by Shahid; the nature of his mental health problems (which included "paranoia"); and discussion with family members. One incident involved Shahid saying that he was frightened because Rabia was crying and he didn't know what was going on at home. On this occasion Shahid was described as very preoccupied with Rabia and scared of going home in case something happened. The ICST worker phoned Ahmed and his response was that he and Rabia had an argument and Shahid had overheard it. When Shahid returned home Rabia opened the door and indicated that she was fine. Other incidents involved allegations that Ahmed had hit Shahid, assaulted him, pushed him, and/ or shouted at him.

5.6 Shahid remained with the family until his death from physical illness in December 2012. Ahmed had to cope with the loss of his brother coupled with the impact that had on family finances in respect of benefits and housing.

5.7 In 2013 Ahmed was referred from the GP to the IAPT service with anxiety and depression thought to be related to the deaths of his mother and brother and subsequent financial problems. In May 2013 he was seen four times by an

IAPT counsellor and in June he missed two appointments. Also in May-June 2013 he had two interviews with the local authority related to investigations for possible benefits fraud: at these he was accompanied by a student social worker. At the second interview he was described as forgetful and confused when answering simple questions. He was referred to the Fit for Work (FFW) service. The IAPT service assessed Ahmed as at minimal risk of harm to self or others and noted fears that he might lose his partner and house, also that he would like to be referred to a care home as he felt he would be unable to look after himself if his wife abandoned him.

5.8 In July 2013 Rabia and Ahmed attended a fifth IAPT appointment together. Ahmed reported feeling worse and unable to cope. It was thought that he was unable to engage with talking therapy due to high levels of stress and anxiety and the case was closed to IAPT with the suggestion of regular GP appointments to review medication and risk issues. Crisis advice was also given. At that time Ahmed was described as reporting fleeting thoughts of suicide with no plans or intentions to act on the thoughts. A week later he saw his GP and was given a 13 week sickness certificate for anxiety and depression.

5.9 In September 2013 Ahmed telephoned Property Lettings to refuse the offer of a flat, stating that he needed a ground floor flat not a first floor flat as offered. He told them that he suffered from a depressive condition that sometimes affected his concentration.

5.10 In early October 2013 Ahmed saw a Mental Health Therapist at the GP surgery and was again referred to FFW. He was assessed as having no thoughts of harm to self or others at that time. Later the same month Leicester City Council Housing service offered Ahmed a ground floor flat, and he accepted the offer. Rabia was then on a spousal visa and had no recourse to public funds, so Ahmed was the sole applicant. She had, however, applied for indefinite leave to remain in October 2013.

5.11 In early November 2013 Ahmed was reviewed by a Mental Health Therapist at the GP surgery and reported no improvement. He expressed the fear that his wife would leave him and showed no evidence of harm to self/ others. He saw the Therapist twice more later that month and then missed an appointment. He reported being confused, depressed and anxious and was again referred to FFW.

5.12 In early December 2013 Ahmed attended for FFW assessment. The assessment was followed up by five phone calls: four (the last being on 8 January 2014) went unanswered, but the third on 23 December 2013 was answered with the information that he was away for Christmas.

5.13 On 16 December 2013 Ahmed did not attend an escorted viewing of the new property and did not contact Housing. Consequently the housing application was suspended.

5.14 In mid December 2013 Rabia was granted indefinite leave to remain in the UK.

5.15 Towards the end of December 2013 Ahmed's anti-depressant medication was changed following a telephone contact with the surgery.

5.16 One week into January 2014 Ahmed saw a Mental Health Therapist at the surgery and was still low in mood. He was assessed as having no thoughts of harm to self/ others.

5.17 The following day Rabia was stabbed to death at the family home. Ahmed was seen in the Emergency Department of a local hospital after ingesting anti-freeze.

5.18 Ahmed was subsequently convicted of Rabia's murder and it emerged in court that the Police had evidence that he had been researching methods of killing his wife and himself for a number of months prior to the murder.

6. KEY ISSUES ARISING FROM THE REVIEW

6.1 Despite the best efforts of this review to find out, it must be acknowledged that, to local services (with the exception of the GP) Rabia remains 'anonymous'. Health and social care professionals did engage with Ahmed. In this context Rabia was seen, not as an individual in her own right but as a support to her husband. At no time was Ahmed, even the day before Rabia's death, seen as a risk to her by the professionals involved with him.

6.2 The Panel was unaware of what Rabia's life was like after she relocated to the UK and married Ahmed. Efforts to engage neighbours, friends, her employer and family members proved to be unsuccessful.

7. CONCLUSIONS

7.1 Rabia showed incredible strength by coming to a foreign country, caring for a brother-in-law with complex needs. Rabia had no rights until she was granted leave to remain in the UK in December 2013. Despite this, Rabia learnt English, studied and found work. It appears she had aspirations for her life. It must be noted that she made no disclosure to professionals or colleagues as far as we are aware from information provided to this review.

7.2 This review concludes that agencies had only limited contact with Rabia. There has been no evidence to suggest that agencies were aware of any abuse within the relationship. In addition, there is no evidence to suggest that opportunities were missed, or that policies related to domestic abuse were not followed.

7.3 The review has highlighted the importance of continuing the important work of reaching out to individuals who are new to Leicester (and new to the UK) to ensure that they are aware of the support services available to them despite any lack of recourse to public funds.

7.4 It is unclear how much the family were aware of any abuse suffered by Rabia. The role that employers, neighbours and friends can play is important. They require confidence to approach the services which could help.

7.5 No action was taken by those who were aware of the abuse to attempt to stop the abuse, or to seek outside intervention from agencies in Leicester City.

8. LESSONS TO BE LEARNED

8.1 The review has highlighted the importance of continuing the important work of reaching out to individuals who are new to Leicester (and new to the UK) to ensure that they are aware of the support services available to them despite any lack of recourse to public funds.

9. RECOMMENDATIONS FROM THE REVIEW

9.1 Improve awareness of domestic abuse services available to individuals in Leicester City. Specifically:

- Individuals who have no recourse to public funds
- Individuals new to Leicester City
- Individuals also new to the United Kingdom

9.2 Improved awareness in Leicester City for friends, community and family of how to refer concerns confidentially if required, and encouragement to do so, where Domestic Abuse is known or suspected.

DHR 3

Domestic Homicide Review Overview Report

Subject of the report: "Rabia"
Month of death: January 2014

INDEPENDENT CHAIR AND AUTHOR OF THE REPORT:
ADRIAN SPANSWICK, RGN, RHV, MA.

Safer Leicester Partnership
Working together for a safer City

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1. INTRODUCTION

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

1.2 This Review has been conducted in accordance with statutory guidance under section 9(3) of the Domestic Violence, Crime and Victims Act (2004). It was commissioned by Safer Leicester Partnership (SLP) in conjunction with Leicester Safeguarding Adults Board (LSAB).

1.3 Rabia arrived in the United Kingdom from Pakistan in 2010. Rabia was killed by her husband Ahmed, when he attacked her in their home with an axe and a knife. This Domestic Homicide Review examines agency contact/involvement with Rabia and her husband over a 3 year period, from February 2011 until her death in January 2014.

1.4 The purpose of a DHR is to:

a) establish what lessons are to be learned regarding the way in which local professionals and organisations work individually and together to safeguard victims;

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

c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

e) contribute to a better understanding of the nature of domestic violence and abuse; and

f) highlight good practice (Home Office, 2016).

1.5 This report is about the murder of Rabia, who was 34 years old and lived in Leicester prior to her death, at the hands of her husband in 2014.

1.6 The Review panel wishes to express its' condolences to the family, friends and associates of Rabia.

2. ESTABLISHING THE REVIEW

Timescales

2.1 The Adult Review and Learning Group (an LSAB sub-group) were notified of the homicide on 15th January 2014 and, following an initial trawl to ascertain which partner agencies had involvement with the key individuals involved in the case, made a recommendation to commence a review. Subsequently, Leicestershire Police requested that the review process be halted until the conclusion of the murder trial. The murder trial concluded in June 2015, when Ahmed was sentenced to life imprisonment for the murder of Rabia, with a requirement to serve a minimum term of 22 years.

2.2 On 25th June 2015 the Interim Manager of the Leicester Safeguarding Adults Board (LSAB) contacted the Home Office clarifying the need to undertake a review when initial information implied that there was no domestic violence prior to the homicide known to any agency. The Home Office response concluded that:

> '*…. there should be a Domestic Homicide Review (DHR) in this case as the definition has been met and there has been a criminal trial*'.

Confidentiality

2.4 Panel members operated within the Leicester Safeguarding Adults Board 'Domestic Homicide Reviews: Local Procedures' (LSAB, 2013).

2.5 To protect the identity of the victim, the perpetrator, and family members, pseudonyms have been used throughout this review.

2.5.1 The victim: Rabia, aged 34 years at the time of her death.

2.5.2 The perpetrator: Ahmed, aged 44 years at the time of the offence.

2.5.3 The perpetrator's disabled brother: Shahid.

Terms of Reference

2.6 The following Terms of Reference were agreed by the Panel:

- To review whether practitioners involved with Rabia and Ahmed were knowledgeable about potential indicators of domestic violence and aware of how to act on concerns about a victim or perpetrator.
- To establish how professionals and agencies carried out risk assessments, including:
- Whether risk management plans were a reasonable response to these assessments.

- Whether there were any warning signs of serious risk leading up to the incident in which the victim died that could reasonably have been identified, shared and acted upon by professionals.
- To identify whether services involved with Ahmed were aware of the circumstances of Rabia's presence in the home and whether connections were made and information shared between these services in order to establish a full picture of the wider family's vulnerability and risks.
- To establish whether agencies involved made routine enquiries about domestic violence when working with these adults, whether relevant procedures were followed and if any opportunities were missed.
- To establish whether Ahmed and Rabia's social needs around housing, benefits and caring responsibilities were adequately supported by local agencies.
- To establish whether the mental health needs of Ahmed were supported and managed appropriately by local agencies.
- To establish if there were any barriers experienced by Ahmed, Rabia or family / friends that prevented them from accessing support, including how their wishes and feelings were ascertained and considered.
- To identify whether more could be done locally to raise awareness of services available to victims of domestic abuse.
- To consider how issues of diversity and equality were considered in assessing and providing services to Ahmed and Rabia (protected characteristics under the Equality Act 2010 age; disability; race; religion or belief; sex; gender reassignment; pregnancy and maternity; marriage or civil partnership).
- To establish how effectively local agencies and professionals worked together.
- To establish whether domestic violence policies, protocols and procedures (including risk assessment tools) that were in place during the period of review were applied and whether they were fit for purpose.
- To identify any areas of good practice.

Methodology

2.7 The review considered agencies' contact/involvement with the victim and perpetrator from 10/02/2011 to 15/01/2014, which covers the entire period of their relationship. The LSAB asked a total of 30 local agencies (including a number local Specialist Domestic Violence services within Leicester) if they had had involvement with key family members. Where they had such involvement, the agencies were instructed to secure their records.

2.8 24 of the 30 agencies responded.

2.9 The following 16 agencies responded as having had no contact with either the victim or the perpetrator:

- WALL- Women's Aid Leicestershire Limited
- Sanctuary Housing
- Rutland Memorial Hospital
- FreeVA - Freedom from Violence and Abuse
- LWA- Living without abuse
- Market Harborough Minor Injuries Unit
- Melton Mowbray Minor Injuries Unit
- Medical Practice 1
- Action Homeless
- SAFE Project (East Midlands Housing Association)
- Youth Offending Service
- Oadby and Wigston Walk-in-Centre
- George Elliot Hospital Urgent Care Centre
- Soldiers', Sailors', Airmen and Families Association Medical Centre
- Central Nottinghamshire Clinical Services
- Probation

2.10 The following 9 services responded with information indicating some level of involvement with either the victim or perpetrator:

Agency	Services with involvement	Nature of involvement
Leicester City Council	Housing	Ahmed: housing applications + revenues and benefits
Leicester City Council	Adult Social Care	Ahmed: carer's assessment
Community Services	Adult Education College	Rabia: ESOL course
Leicester City Council	Library Services	Ahmed & Rabia: used local library service
Police	Crime Unit	Investigation of Rabia's murder
Leicestershire Partnership Trust	Improving Access to Psychological Therapy (IAPT) Services	Ahmed: assessment and talking therapy for stress and depression
University Hospitals Leicester NHS Trust	Medical Appointments	Ahmed attended Emergency Department (ED) with suicidal thoughts.
Home Office	UK Border Agency	Rabia: Application for

		Leave to Remain as a Spouse of a Settled Person
Medical Practice 1	General Practitioner	Ahmed & Rabia: Appointments with the family doctor

2.11 Members of the Panel were identified from senior positions in their agency to quality check agency information submitted and commit their agency to any single or multi agency recommendations identified. The Panel decided not to include library or adult education services as their information provided background information only. The agencies that supported this DHR were:

- Leicester City Council Adult Social Care
- Leicester City Council Housing
- Leicestershire Police
- Leicester City Clinical Commissioning Group (CCG)
- Leicester City Community Safety
- Leicestershire Partnership NHS Trust (LPT)
- WALL- Women's Aid Leicestershire Limited (Specialist Domestic Abuse Service)

2.12 Agencies were asked to provide chronological details of any contact with both adults prior to the death of Rabia. Where there was no involvement or insignificant involvement, agencies informed the LSAB office accordingly.

Parallel Processes

2.13 There were no single agency internal serious incident reviews or mental health reviews conducted on this case.

The Family's engagement with the Review process

2.14 Rabia's family lived in Pakistan; there were no family members living within the UK. When Rabia came to England, she stayed with a family in the Midlands. She was regarded by this family as their daughter and, as such, they were the point of contact for the Family Liaison Officer throughout the Police criminal investigation. This family were in regular contact with Rabia's family in Pakistan. However, they did not wish to comment or contribute to this review.

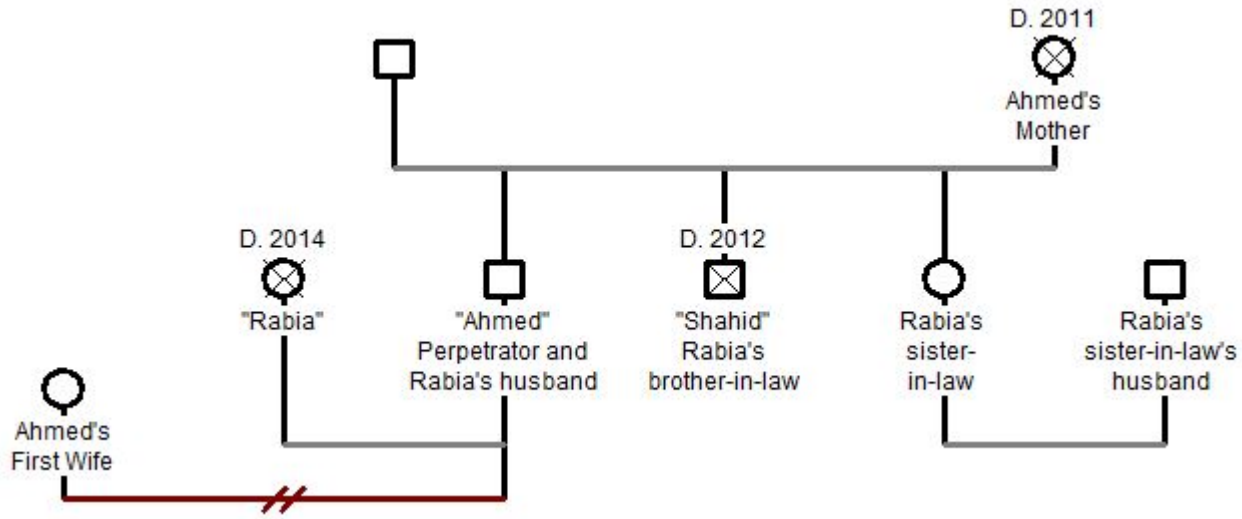
2.15 The LSAB interim Board Manager wrote to family members and close family contacts to seek their engagement with the DHR process. Unfortunately, none of them wished to provide any input into this review.

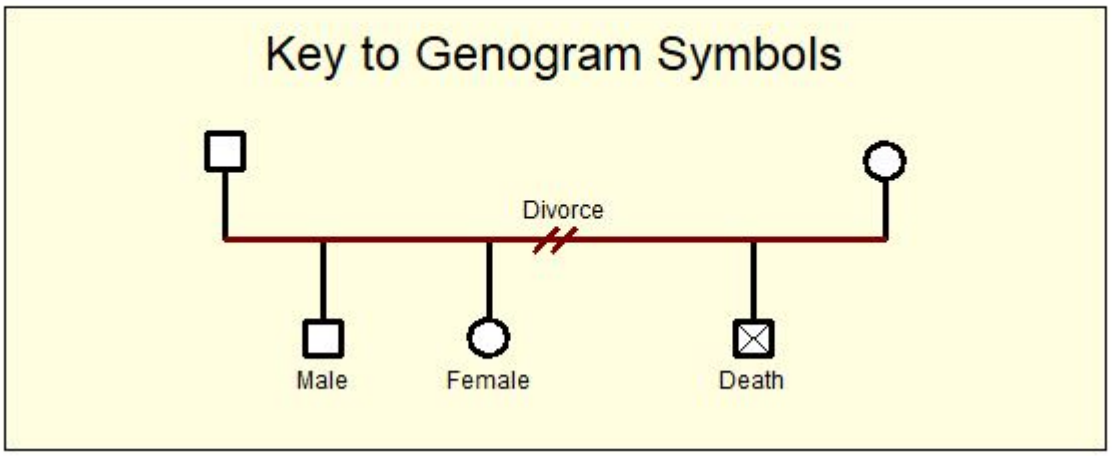
2.16 This has impacted on this report's ability to understand Rabia as an individual, in the context of her arrival to the UK until her death in 2014. In addition, no photograph of Rabia was available.

2.17 The input into this review has thus depended on information supplied by agencies represented on the panel, and as a result lacks a holistic perspective.

3. SUMMARY

Genogram





Rabia's life from 1979 to 2014

3.1 Rabia was born in Pakistan in 1979. She moved to Leicester from Pakistan following an agreement for an arranged marriage. Rabia arrived in the UK in May 2010. Although Rabia knew very few people when she came to the UK, she quickly set about making the most of her new life, teaching herself English and working hard to pursue a career in nursing.

3.2 Ahmed had lived in Nottingham but then moved to Leicester in 2009, as he had previously lived in overcrowded conditions in his parents' home. Ahmed moved into a Housing Association property in 2010, following assistance from Leicester City Council's Housing Services. Ahmed's mother died in February 2011.

3.3 Rabia and Ahmed met in February 2011. They lived together from the beginning of May 2011 and were married in an Islamic ceremony later the same month.

3.4 A formal legal ceremony took place in June 2011. There were no children within the relationship.

3.5 Ahmed's adult brother Shahid, who was in need of ongoing care due to a variety of health conditions, lived in Ahmed's home.

3.6 A number of individuals appear to have known that Rabia was subjected to abuse:

- **Physical abuse** – Rabia was subject to physical assault.
- **Psychological abuse** – Rabia was seeking to remain a resident in the UK although, as her immigration status remained unconfirmed, she had the potential to be sent back to Pakistan. It is possible that this was used as threat to ensure she complied with Ahmed's wishes and his terms in relation to their marriage.
- **Exploitation** – Ahmed sought, through premediated acts, to manipulate Rabia's isolation from her family and her status in seeking to legally remain in the United Kingdom.
- **Financial abuse and in, relation to his brother, material abuse** – Ahmed sought to control the family finances (misappropriation of benefits could not be fully ruled out).

3.7 In the six months before Rabia's death, Ahmed made internet searches on the ways in which he could kill her.

3.8 Indefinite leave for Rabia to remain in the United Kingdom was granted by the UK Border Agency mid-December 2013.

3.9 Less than a month later, early in January 2014, Rabia was killed by Ahmed, when he attacked her in their home with an axe and a knife. The Crown Prosecution Service summary of the case was reported as follows:

'Ultimately, her desire to make something of herself was too much for him and he planned to kill her. He conducted over a hundred internet searches about how to kill, what prison would be like and what weapons he could use, eventually attacking her in their home with an axe and a knife. His defence in court was that he had momentarily lost control, so pleaded not guilty and took the case to trial. After the entire prosecution case had been heard and Ahmed had given evidence and been cross-examined in court, the Judge ruled that he could not use the defence of momentary loss of control. Without a defence in law, he had no option but to plead guilty to murder'.

3.11 In June 2015, Ahmed was sentenced to life in prison, with a requirement for him to serve a minimum term of 22 years.

4. CHRONOLOGY

4.1 The scope of the review agreed by the Panel was from 10/02/2011 to 15/01/2014.

Information outside scope of the review

4.2 **13/01/2010**: Initial records of carer's assessment Adult Social Care identified Ahmed was the primary carer for his brother Shahid (same address).

4.3 **01/05/2010:** Rabia moved to Leicester from Pakistan following agreements for an arranged marriage to Ahmed. Rabia (Pakistan National) arrived in the UK on an Entry Clearance Visa, which was valid from 12/05/2010 to 20/01/2012.

Information within scope of the review

4.4 In total Rabia had 13 contacts with her GP in regard to health appointments, the majority of which were for routine health issues. Rabia saw the GP in relation to tiredness in November 2012. She was subsequently seen on three occasions for a course of B12 injections given by the Practice Nurse (December 2012 and January 2013). Her last appointment with her GP was in September 2013 with 'right heel' pain.

4.5 In regard to information within the scope of this review, key information from the chronology assembled from local agencies' records is as follows:

February 2011 - Ahmed's mother died in the family house. Ahmed was said to be behaving in an aggressive manner towards paramedics in the house at the time. Ahmed was asked by them to leave the living room as he was very distressed and not allowing them to do their work.

10/02/2011: Rabia and Ahmed met.

18/02/2011 - Ahmed presented at the local Emergency Department (ED) feeling suicidal following his mother's death.

03/05/2011 - Ahmed - Seen by GP – Ahmed presented to the surgery following a blunt injury to the right foot 10 days previously. It is documented by the GP (now retired from the practice) that the patient hit his foot against the door (no further information was documented by GP in regard to the context of the injury). Ahmed's foot was examined and he was prescribed anti-inflammatory medication and an x-ray was requested.

06/05/2011 - Rabia and Ahmed start to live together

17/05/2011 - Rabia - Seen by GP

21/05/2011 - Rabia and Ahmed married (Islamic ceremony)

31/05/2011 - Rabia - Seen by GP

02/06/2011 - Rabia - Telephone Contact with GP

10/06/2011 - Rabia and Ahmed marriage (legal ceremony)

20/06/2011 - When the Intensive Community Support Team (ICST) [who provide low level mental health provision] worker for Shahid (Ahmed's brother) visited on this day, Ahmed was waiting in the street with Shahid when he arrived. As the ICST worker walked away with Shahid, Shahid told him that he was frightened because Rabia was crying and he didn't know what was going on at home. They talked as they went to Abbey Park as part of the support that day. Whilst they were at Abbey Park, Shahid was very preoccupied with Rabia and said he was scared of going home in case something happened, but did not elaborate on events at home. Because of the uncertainty, the ICST worker phoned Ahmed during the visit to ask what had happened. The response from Ahmed was that he and Rabia had had an argument and that was all, but his brother had overheard it. The mobile was passed to Shahid whereupon Ahmed reassured Shahid that things were okay at home. Once at home Rabia opened the door; she was smiling and directed reassurance to her brother-in-law by telling him she was fine.

24/06/2011 - Rabia - Seen by GP

27/06/2011 - The ICST worker visited. Shahid was upset when he arrived and said that he didn't want to talk to anyone anymore. It emerged that the Community Psychiatric Nurse (CPN) had suggested that he complete certain basic tasks for himself, like emptying the ashtray. Because Shahid had refused to do any of the tasks, Ahmed had told his brother that he would tell the ICST worker about this. Shahid responded by saying that he was going to tell him that Ahmed hit him. Rabia told the ICST worker that her brother-in-law always says things of this nature and that even when Ahmed politely asks him to do something, he responds by saying Ahmed hit him or shouted at him. The support continued and once the ICST worker was out and alone with Shahid he repeatedly asked if the Police were going to come and arrest him. Despite reassuring Shahid that the Police were not going to arrest him, he would not settle and only calmed down towards the end of the support time.

14/07/2011, 02/09/2011, 11/10/2011 and 10/11/2011 - Rabia seen by GP

12/01/2012 - Contact made by Adult Social Care to arrange further carer assessment of Ahmed.

03/02/2012 - Rabia - Seen by GP.

06/02/2012 – Ahmed: Carer assessment completed by Adult Social Care.

15/02/2012 and 06/03/2012 - Rabia seen by GP.

04/05/2012 - The ICST worker visited as part of support arrangements. As part of that supportive visit Shahid claimed that Ahmed hit him and pushed him. Later on during the support, however, he retracted his allegations and said that it was okay and that Ahmed had done nothing. In denying the

allegations he said he was upset because he had been asked by Ahmed to do things, such as washing, dressing and eating and that this made him angry.

19/06/2012 - During a Community Care Assessment being completed by the Adult Mental Health Social Work Team, but with support from the ICST worker, Shahid made reference to being shouted at and hit by Ahmed. He immediately retracted the statement and said he was joking. The ICST worker reported that Shahid will continually say that Ahmed has hit him. He had also made the same allegation at his sister's home, but she claimed then that he was making things up as she had been there all day and at no time did Ahmed hit or shout at their brother.

16/08/2012 - Further carer assessment by Adult Mental Health Team (as the allocated team for brother). Provision of carer personal budget.

30/11/2012 - Shahid had been experiencing some more severe examples of his deteriorated mental health, including getting up in the early hours of the morning, asking about appointments, not eating properly, getting agitated and paranoid about what the TV was telling him. Ahmed reported to the ICST worker that he felt the voices were getting worse for his brother. On a supportive walk in the community Shahid told his ICST worker that Ahmed assaulted him, but immediately retracted the statement saying he was joking. When they returned home Ahmed stated that his brother had also told day service staff that he had assaulted him and these staff had asked him about this matter.

26/12/2012 - Shahid died of natural causes.

31/12/2012 - Ahmed visited by Adult Social Care (ICST) [provide low level mental health provision] – The ICST worker visited Ahmed. He offered condolences and spoke about his brother for a short while. Ahmed was very positive about things and seemed to have accepted his brother passing away. Ahmed said he would arrange for the return of the bed, wheel chair and commode. Ahmed said 'he will start to look for a job as a home carer'.

07/01/2013 - Ahmed (seen by GP1) – History: is coping after brother passed away looking for care home work as has vast experience taking care of his elderly mother (dementia; Type 2 Diabetes Mellitus) and brother with mental health schizophrenia, lymphoma and type 2 Diabetes Mellitus. Plan: requests a private letter stating he was carer for his family to support job applications, advised fee. Patient will inform me if still needs it. Depression screening using questions – feels well in himself.

02/02/2013 - Telephone Call with Ahmed by Adult Social Care (ASC) Duty Worker (09:20hrs) Telephone call between ICST worker and ASC Duty Worker. The ICST worker informed the ASC Duty Worker that he had spoken to Ahmed and that he is ok and dealing with grief better than he did when he lost his mother. ICST worker said he will go and see Ahmed on Friday and will discuss with him all the items that he needs to return in relation to Assistive

Technology. The ASC Duty Worker informed the ICST worker that she was very grateful for all the hard work that he had done with this family not just his brother. The ASC Duty Worker said she would speak to Ahmed today.

02/02/2013 - Telephone Call with Ahmed by Adult Social Care Duty Worker (09.30hrs). The duty worker spoke to Ahmed about what led up to his brother passing away and confirmed that he did speak to ICST worker. "Ahmed does acknowledge that it is very difficult for him and it is still at the early stages of the grieving process". Ahmed asked if the ASC Duty Worker would write him a reference as he now would like to work as a carer. The ASC Duty Worker informed him that she would need to ask her manager first and then let him know. She said "I will be in touch next week and reminded him that ICST worker will visit on Friday" (note: no evidence in record to support if visit took place as planned or not).

12/02/2013 - Acknowledged within Adult Social Care Record that the Assisted Technology Equipment still required collection.

08/03/2013 - Ahmed (seen by GP1) Attended with brother [additional details of this brother are not known to the panel] – very stressed poor sleep not eating not self-caring and gets very worked up when he has to go to BA (Benefits Agency Office) cannot fill forms and making mistakes so BA office advised to see GP. Examination: stressed not making eye contact – brother doing all talking had recent bereavement reaction has not got fully over it. Diagnosis: Stress and adjustment reaction following bereavement, feel he needs some time off work [details of this work are not known to the panel] so that he can sort his affairs out. Plan. Medication for 3 for 4 weeks for stress reaction.

11/03/2013 - Ahmed seen by GP3. Heavy head, eyes burning, lack of concentration. Feels like he is stressed with paper work and finances. Brother died recently. When busy feels fine, poor sleep. Stress reaction. Advised that this will improve as sorts out paperwork and financial situation. Asked about tablets – advised can have but as stress reaction counselling would be good option (GP acknowledged patient seeing someone re finances).

26/04/2013 - Ahmed (seen by GP3) Brother died December 12. Feeling anxious ++, lacking motivation, low mood, was a carer for his brother so bit of a shock since his death, started work last night doing night shift, not coping, very anxious about going in, not sleeping well. Examination: looked anxious+. Prescribed antidepressants.

29/04/2013 - Ahmed (Telephone call to Ahmed by GP3). Still very stressed, anxiety symptoms – palpitations, sweating. Actions: try beta blocker, refer to counselling.

30/04/2013 - Ahmed (seen by GP3) Still very stressed, palpitations with sweating, not sleeping well. Antidepressant for anxiety and depression. Diagnosis: Anxiety state and depression. Patient health questionnaire

completed – Q. Thoughts that you would be better off dead, or hurting yourself in some way? N/A (answer recorded in GP record). Plan: Increase beta blocker gradually. Refer to IAPT.

01/05/2013 - Ahmed seen by Open Mind Service (Session 1), referral from GP3 with anxiety and depression. Mood low most of the time. Fears he might lose his partner and house. Risk: minimal risk to self and other at the moment. No thoughts of self-harm or suicide reported currently. No past history of any suicidal attempts or DSH (Deliberate Self-harm). No risk to/from others noted. Patient Goals – finding it hard to cope with financial difficulties and would like help with employment. Does not think talking therapy will help with his problems and is looking for practical support. Plan: Discussed a few options with him that he could be referred to Fit For Work service – not sure but has agreed to the referral. Does not feel confident to go to job centre to discuss his options. Wants quick fix for his problems which therapist discussed with him that Open Mind can't offer. Would like to come back next week to discuss treatment options.

08/05/2013 - Ahmed seen by Open Mind Service (Session 2). No change in mood and stress level. Worrying constantly about his interview with the council on Friday this week. He is fearful that his partner would abandon him and he would not know where to get money from. Feels like hiding him-self and escape from these problems. Looking for quick solutions. He wants someone to go with him to places as he is not able to think properly and was wondering whether he is eligible for a support worker. Requested patient to discuss with GP3. Another session planned for next week to review.

13/05/2013 - Ahmed attended meeting with Local Authority, accompanied by Social Work Student on placement with the Improving Access to Psychological Therapy (IAPT) service, as he was being investigated for benefit fraud. The outcome of these interviews was communicated to GP3.

15/05/2013 - Ahmed seen by Open Mind Service (Session 3). Patient confirmed had meeting with Local Authority. Felt quite nervous in interview. Social work student present that he found quite helpful. Case ongoing, anxious re outcome. He says he wants support worker or a social worker to look after him as does not feel in right state of mind to make decisions. He would like to be referred to a care home as feels he would not be able to look after himself if his wife also abandons him, which is his fear at the moment. Advised to book appointment with GP to look at option of being referred to Psychiatry. Offered another appointment in two weeks. No risk to self or other noted currently.

15/05/2013 - Ahmed - Note in GP record (GP3). Has seen counsellor today, requesting to be referred to psychiatry. Action: to refer urgently. GP telephoned patient (no context of telephone call).

20/05/2013 - Ahmed (seen by GP3). Came with wife, ongoing stress/anxiety symptoms, not much better. Noted on antidepressant. Refer to crisis team as not coping.

21/05/2013 - Ahmed seen by Crisis Team for assessment, requested by his GP because of his depression and anxiety. Ahmed was assessed with wife present. Assessment concluded that Ahmed was not a risk to himself or others and home treatment was not indicated. Advice offered. Outcome of assessment went to Ahmed's GP.

29/05/2013 - Ahmed seen by Open Mind Service (Session 4). Anxiety and stress still same. Not much change in circumstances. Not heard from local authority for next interview date for ongoing benefit fraud case. Confirmed referred for psychiatry – waiting for appointment. Advice given – patient reluctant to make any changes. Discussed that session are of no use if he does not want to change. Agree to go for walk and practice breathing exercises. Another session booked next week.

05/06/2013 - Ahmed – Did Not Attend Appointment Open Mind Service.

10/06/2013 - Ahmed (seen by GP3) Has been seen at Bradgate Unit, Dose of antidepressant increased by GP3. Ongoing financial problems/ stress.

12/06/2013 - Ahmed – DNA Appointment Open Mind Service.

12/06/2013 - (Second Contact with Local Authority) Ahmed attended meeting with Local Authority, accompanied by Social Work Student on placement with the IAPT service, as he was being investigated for benefit fraud. The outcome of these interviews was communicated to the GP, which described Ahmed as forgetful and confused when answering simple questions at the second interview.

01/07/2013 - Letter from GP to housing department confirming Ahmed has severe anxiety and depression for 6 months, has attended surgery several times and is being supported by counsellor at surgery. From the GP records it appears that a private letter was requested by Ahmed from the GP on 26/06/2013).

03/07/2013 -Rabia and Ahmed attended Ahmed's Open Mind Service (Session 5). Ahmed insisted that his wife sits in on session. He stated he is feeling much worse since the last session. Kept repeating himself how he is feeling stressed following his brother's death and that he is not able to cope. He has had interview under caution with the Department for Work and Pensions (DWP) and Local Authority and is awaiting their decision now. Worried about consequences. Seeks reassurance from his wife continually throughout the day. His wife [Rabia] tells me [Open Mind Practitioner] that he starts to cry if she does not offer him reassurance. Suggested to wife not to offer any reassurance as it might be maintaining his problem with worry. Ahmed does not seem to be making any changes since sessions started. It

seems that he is not able to engage with talking therapy at this point due to high level of stress and anxiety. Therefore it was agreed with Ahmed and Rabia to close case for now. Suggested to them to keep regular appointments with GP for review of his medication and risk issues. In terms of risk, he does report fleeting thoughts of suicide but denies any intent or plan to act on these thoughts. Crisis advice given to them.

10/07/2013 - Ahmed (seen by GP3) Medication issued to patient. Unfit to return to work. Condition: Anxiety and depression. Duration of sickness certificate 13 weeks.

19/07/2013 - Ahmed – Echocardiogram.

29/07/2013 - Ahmed seen GP surgery by GP4. Palpitations

19/08/2013 - Ahmed seen GP Surgery by GP4. Cardiac 12 Electrocardiogram (ECG). ECG report satisfactory. No further action.

25/09/2013 - Ahmed – Blood Test.

05/09/2013 - Application for housing: Ahmed telephoned Property Lettings to refuse the offer of a flat (stating that he did not realise it was a first floor flat needed a ground floor flat). He advised housing that suffers from a depressive condition which sometimes affects concentration.

05/09/2013 - Rabia - Seen by GP: Right heel pain (last contact with health professional. Rabia did have a GP appointment booked the day after her death – reason not known).

08/10/2013 - Ahmed seen at GP surgery, Mental Health Therapist (IAPT – Open Mind Service). Again referred to the Fit For Work (FFW) service (Note: IAPT and FFW link closely together and service users cross over between both services. FFW prepares individuals with mental health issues to return to the work environment through building confidence, improving outlook and hopefully improving the individual's mental health. This is not a service provided by Leicestershire Partnership Trust). Overviewed family situation (caring for mother and brother) and brother's death, financial situation re benefits. Complains unable to cope. Patient well presented. No anxiety – calm. Appeared subdued. Demonstrated good eye contact. Concentration good – relevant focusing on financial issues, no thoughts of harm to self/others, no thought disorder, no perceptual abnormalities – cognitively intact, good insight – will see 5/52.

10/10/2013 - Ahmed seen GP surgery by GP3. Medication issued to patient. Anxiety and depression noted as condition. Unfit to return to work. Duration of sickness certificate 8 weeks.

18/10/2013 - Leicester City Council Housing service made an offer to Ahmed for ground floor accommodation.

21/10/2013 - Leicester City Council Housing service determines that Rabia was not eligible to be a joint applicant for the tenancy due to her being on a spousal visa and having 'no recourse for public funds' in regard to housing application. Therefore Ahmed was made sole applicant for housing application.

28/10/2013 - Ahmed accepts offer of new ground floor flat property in Leicester.

29/10/2013 - Ahmed (seen by GP4). Burning sensation both eyes. Diagnosis: allergic conjunctivitis. History: feeling drowsy, attributes to antidepressant. Would like to try different medication, also often low mood - pressure from family to look for work. No suicidal ideas. Receiving counselling. Examination: Good eye contact, well kempt, keeps on repeating above history. Plan: Eye drops prescribed.

05/11/2013 Ahmed seen by mental health therapist at GP surgery, no improvement. Did not go to fit for work appointment as forgot, has been sent further appointment. Feels wife will leave him as he has no job again, advised to break problems down. Well presented, good eye contact, not tearful, accurate and appropriate thought content. Keeps on suggesting why strategies to improve situation would not work. No psychotic features, no thoughts harm to self/ others – says he has to phone GP this pm to change antidepressant but will not be able to afford purchase script. Advised that he should discuss this with adult social care, given details for Grey Friars. Will review 3/52.

08/11/2013 - Ahmed (seen by GP5). Review of antidepressant medication. Plan: change of medication.

12/11/2013 - Ahmed – Attended for seasonal influenza vaccination.

12/11/2013 - Rabia spoke to housing property letting team for an update; property not yet ready.

18/11/2013 - Ahmed seen in surgery by the Mental Health Therapist. He reported being confused, depressed and anxious. He was difficult to engage. He was again seen by the same member of staff on 25/11/2013, who agreed again to refer him to Fit For Work [FFW] Service (service which provides advice and support to adults with benefit issues). On 26/11/2013 Ahmed's case was reviewed with a clinical supervisor who confirmed referral to FFW.

26/11/2013 - Ahmed - DNA Mental Health therapist appointment.

04/12/2013 Ahmed attended for assessment within FFW project. Referred to the National Careers service for advice on presentation of CV. Spoke to Ahmed on 13/12/2013 to follow up and encourage him. Further telephone contacts made to Ahmed on a further 5 occasions (17/12/13 and 20/12/13) which were not answered.

11/12/2013 - Escorted viewing for flat in Leicester organised by Property and Lettings team. Applicants did not attend for escorted viewing of the flat.

16/12/2013 - Message left for Ahmed to contact housing.

18/12/2013 - Permission for Rabia to remain in the United Kingdom was granted by the UK Border Agency [indefinite leave to remain].

18/12/2013 - Housing application suspended.

19/12/2013 - Ahmed – telephone call from GP practice to Ahmed's mobile: follow-up call following recent alteration to his antidepressant medication. GP left voicemail

23/12/2013 - Telephone call by FFW worker, answered by relative who said Ahmed was away for Christmas.

24/12/2013 - Telephone call from Ahmed to GP: Resulting in change of Ahmed's anti-depressant medication. Medication transferred over few days ago – Patient feels less drowsy.

07/01/2014 - Ahmed seen GP surgery, Mental Health Therapist. Agreement of care plan – patient still low in mood. No psychotic features, no thoughts harm to self/ others – adherent to medication.

07/01/2014 - Ahmed contacted housing department by telephone saying that he had not received the offer letter, or any messages left. Housing Department advised application suspended for no reply. Ahmed advised to call Housing Options.

07/01/2014 and 08/01/2014 - Further telephone calls made by FFW worker, but calls were not answered. Weekly calls were part of Ahmed's FFW plan. It was confirmed by FFW service, that it is standard practice for contact to be attempted in planned telephone session for 3 consecutive appointments.

08/01/2014 - Ahmed stabs Rabia to death at the family home.

4. ANALYSIS OF INFORMATION KNOWN TO AGENCIES AND INDIVIDUALS

Contacts with Adult Social Care

5.1 The information provided by Adult Social Care (ASC) noted that Ahmed had had varying levels of caring responsibilities in relation to his brother Shahid for a number of years. Assessments of Ahmed refer to a degree of carer strain and noted the impacts of his caring responsibilities on his life. A Carer's Assessment was completed in February 2012 and options for residential respite were being explored. During this period Shahid received very regular contact from ICST and attended Day Support.

5.2 Additional to the case recording information the ASC reviewer was able to talk to the ICST worker about 5 occasions where Shahid mentioned situations that might have indicated potential for harm or abuse, but then retracted the statements straight away. There were a number of low level concerns (as documented) that were discussed between the ICST worker, CPN and Adult Mental Health Social Work Team. These professionals considered the statements within the context of the consistent retractions by Shahid, the nature of his mental ill-health (which resulted in a level of paranoia) and discussions at the time with family, who would testify that they had not witnessed any mistreatment.

Author's Comment:

5.3 ***It could be argued that the social care professionals involved should have identified the patterns of low level concern and tested these against the Safeguarding processes in place at that time (2012). However, whether any of these would have met the safeguarding threshold is unlikely in this case. Leicester City Council introduced 'Safeguarding Adult Thresholds Guidance (April 2013) and subsequently adopted Leicester, Leicestershire and Rutland-wide in November 2015. Although the guidance was not available to practitioners at the time of involvement with Shahid, it does identify the positive changes in practice locally to support practitioner decision making since 2012.***

Perpetrator Perspective: Feedback from Prison Visit

5.4 As part of the Review process, the Panel Chair and Author of the Review visited the perpetrator in prison. Ahmed stated that he had been a carer for over 20 years of his life. He provided care for both his mother and brother. He described caring as "hard". He explained that he had promised his mother that he would care for his brother and not "put him into care". He highlighted that his caring role started when he was 8 years old. Ahmed stated that having to provide care from a young age had a negative impact on his

personal welfare. Ahmed felt he needed help from a social worker at the time of his brother's death. He had lost his place, role and his family and felt that a social worker could have "pushed him along" and helped him sort out financial issues, which later became a debt. He felt that this was due to bereavement and not all due to some sort of benefit fraud. However, the facts known to the panel are that Ahmed was thought to have defrauded his benefit claims, which is broader than the debt issue.

Ahmed's Mental Health Issues (including contact with GP)

5.5 During the scoping period Ahmed was known to mental health practitioners after the death of his brother in December 2012. Specifically, he was known to have developed, over a period of time, as a consequence of his mothers and brother's death, anxiety and depression. His brother's death also resulted in a change of role, with loss of identity as his brother's carer. Subsequently he faced financial problems arising from the loss of benefit, the need to repay overpayments and increased housing costs arising following the death of his brother.

5.6 Ahmed did present with stress and anxiety symptoms to his GP in March 2013 and did start antidepressants in April 2013 as his symptoms deteriorated. Bereavement and financial difficulties would form part of Ahmed's monologue to health practitioners, which was repeatedly acknowledged in the GP record by health practitioners.

5.7 On 20th May 2013 Ahmed was referred by his GP to Leicester Partnership Trust's Crisis Team for an assessment, because of his low mood and anxiety following bereavement and financial difficulties. Having attended the appointment with Rabia, Ahmed was given advice, his anti-depressants were increased and he was discharged from the service. The attendance by Ahmed and Rabia together may have given a picture of unity and support between the couple. There were no issues brought to the attention of health practitioners by either Ahmed or Rabia.

5.8 The GP also referred Ahmed to Leicester City Improving Access to Psychological Therapy (IAPT) Open Mind Service (provision is for 16 years and above for people who live in Leicester City who are feeling stressed, troubled, anxious or depressed). In May 2013 Ahmed attended 4 appointments with IAPT Open Mind Service before missing two appointments in June 2013. On 3rd July 2013 he attended an appointment with Rabia stating that he was feeling much worse. Due to Ahmed being unable to engage in therapy due to high levels of anxiety and stress, it was agreed with Ahmed and Rabia to close the case. However, he was directed to his GP for review of medication and any risk issues.

5.9 More than 3 months later, on 8th October 2013, Ahmed was seen again by Open Mind Service. Previously Open Mind worker had stated the case was to

be closed in July 2013. During this domestic homicide review, the panel asked for it to be established whether or not Ahmed had been seen by a psychiatrist. Although referred to Psychiatry services, the panel were advised that Ahmed was to be referred by the GP to a psychiatrist 'if needed'. On this occasion, standard advice had been given to Ahmed and he was seen by a Mental Health Therapist on 10/10/2013 at the GP Surgery (the facilitators offer flexible advice for non-urgent cases and they liaise with other services). Ahmed's presenting symptoms were low level and he did not display evidence of a risk of harm to himself or others. The symptoms recorded were not considered to require secondary mental health intervention as it appears he was viewed as a low level risk. Thus it was reasonable for him to be seen by a Mental Health Therapist.

5.10 Ahmed also was seen again by the Mental Health Therapist at the surgery on 05/11/2013, but 'no improvement' was noted. It was also highlighted that Ahmed had no psychotic features and no thoughts of harm to self or others. At an appointment with Open Mind IAPT service on 18/11/2013 Ahmed was described as 'confused, depressed and anxious'. Ahmed then failed to attend an appointment with the Mental Health Therapist at the surgery on 26/11/2013. No further contact regarding mental health is noted until 24/12/2013 when Ahmed's anti-depressant medication was 'changed in response to depression symptoms' following a telephone consultation with his GP.

5.11 The last contact recorded with mental health services or his GP by Ahmed was on 7th January 2014 with the Mental Health Therapist. Although Ahmed was in a low mood, he displayed no psychotic features and no thoughts of harm to self and others. He was also noted to be compliant in taking his medication, as prescribed.

5.12 Ahmed murdered Rabia on 8th January 2014 before attempting to kill himself.

Contacts with IAPT (Open Mind) Service

5.13 No coercive or controlling behaviours were observed or reported to exist between Ahmed and Rabia.

5.14 Ahmed did however disclose to his Open Mind counsellor that he was worried that his wife would abandon him and subsequently again highlighted the issue with the Mental Health Therapist in November 2013. This was obviously a concern for Ahmed that his wife may leave him was linked to his finances and not having a job.

5.15 Rabia accompanied her husband to two Open Mind appointments (May and July) and a GP appointment.

5.16 Rabia was also contacted by the Housing department, to obtain an update on the housing application.

5.17 Ahmed was noted by Open Mind service in May 2013 as having cared for his mother who had died in February 2011.

5.18 Ahmed was a carer for his brother for over 20 years; a brother who suffered from schizophrenia, chronic diabetes and lymphoma and who died in December 2012.

5.19 Ahmed was intermittently engaged with his GP, Open Mind services and with medical treatments for anxiety and depression. He also initially engaged with the 'Fitness to Work' service for help with future employment. Ahmed was assessed by the Open Mind (IAPT) and CRISIS mental health team as presenting 'no risk' to self and others. It is also of note that an IAPT (Open Mind Service) bespoke risk assessment is completed during every consultation:

01/05/2013 – Open Mind Service Completed risk assessment – "minimal risk to self and low risk to others at the moment".

20/21 May 2013 (actual date not able to confirm) – CRHT – risk assessment stated "not suicidal and has no plans – No risk identified to others".

03/07/2013 – Open Mind Service recorded "in terms of risk he has suicidal thoughts but denies intent or plans to act on thoughts".

08/10/2013 – recorded as 'no thoughts of harm to self/ others

05/11/2013 - recorded as 'no thoughts of harm to self/ others

07/01/2014 – recorded as 'No psychotic features, no thoughts of harm to self/others – adherent to medication (last contact with health services).

Author's Comment:

5.20 ***Based on the information available to the panel, Ahmed's mental health was low level and appropriately managed within primary care. He did not warrant any significant mental health intervention. This was reaffirmed throughout the DHR process. From the patient's notes Ahmed was in frequent contact with the practice and in addition attended the IAPT Open Mind Service. At no time was he viewed as a risk to others by health professionals.***

Family Finance Issues

5.21 Ahmed and Rabia's finances were impacted upon after the death of his brother. Ahmed highlighted his financial situation with health practitioners frequently during consultations. Ahmed was, until the death of his brother, the primary provider through his benefits. However, Rabia had commenced working full-time at a residential home and was, at the time of her death; ready to take up a new employment opportunity at UHL as a health care assistant (she had aspirations of commencing nursing training).

5.22 Ahmed became subject to an investigation in relation to overpayment of his benefits.

5.23 Rabia subsequently became the primary wage earner.

5.24 Ahmed personally felt that, due to bereavement and loss of benefits, this contributed to him being in debt that led to arguments with Rabia. His income from the benefits and primary role disappeared, whilst Rabia was going out to work and earning money and not fulfilling her role as a wife within the household. Ahmed stated when interviewed, that Rabia worked nightshifts and during the day slept a lot, so he felt left on his own and as a result felt Rabia did not look after him in a way that met his expectations.

Author's Comment:

5.25 ***It appears likely that Ahmed's views on Rabia's 'role as wife within the household' and his perception that she was not fulfilling her role, contributed to the dynamic of power and control within the relationship and underpinned the gender-based violent crime he went on to commit.***

Agencies' Awareness of Domestic Violence Issues

5.26 No previous incidents of domestic violence were known between the couple to police or wider local agencies within Leicester City.

5.27 IAPT service make routine enquires about anger and domestic violence and it is included in their 'Open Mind Demography Form'. Questions included are:

- Does violence or fear of violence (including physical, sexual or emotional violence) affect your health?
- Do you consider this to be Domestic Violence? (Domestic violence/abuse is physical, sexual, emotional or financial violence that takes place within an intimate or family type relationship and that forms a pattern of controlling behaviour. This can include forced marriage and so called 'honour crimes'.

5.28 Ahmed answered 'no' to both of these questions.

Author's Comment:

5.29 ***The standard questions represent good practice. It also needs to be acknowledged that Ahmed was the patient and that there was no reason to further explore any domestic violence issues with his wife.***

5.30 Adult Social Care entry into record (Care First, 09/01/2014) from Team Leader (as the worker for Shahid had raised this case following media reports) made reference to brother's worker being aware of 'marital problems (between Ahmed and Rabia) but no threats involved; no contact made with police or other follow up'. However, this cannot be correlated to any issues of domestic violence within the relationship.

5.31 In addition, it was noted Adult Social Care assessments highlighted relationship pressures (lack of time, strain on relationship), which were due to caring responsibility for brother.

Author's Comment:

5.32 ***Again, no correlation can be made with any issues of domestic violence in the relationship between Ahmed and Rabia.***

Contacts with Leicester City Housing

5.33 Ahmed and Rabia were both engaged with housing services and had received 2 offers of accommodation within Leicester City. The first offer was declined 05/09/2013; the second accepted 28/10/2013.

5.34 In between housing making the two offers, it was found that Rabia was not eligible to receive public funds. This resulted in Rabia being made an occupant on the application and Ahmed being made the sole applicant. In addition, Rabia did contact the Property Letting Team (PLT) for an update on 12/11/2013, but was advised that the property was not ready.

5.35 The offer had progressed to an accompanied viewing of the property that was arranged for the morning of the 16/12/2013 (the PLT left a message on Ahmed's phone and a 1st class letter was sent). Ahmed then failed to attend the appointment and the housing department attempted to contact him by phone, but failed. However, no further contact was received from Ahmed. Thus the PLT suspended the housing application on 18/12/2013 due to no contact and failure to attend the escorted viewing. Housing Options Service (HOS) cancelled the application for this reason.

5.36 Ahmed contacted the PLT to advise that he has had not received the offer letter or any of the answer messages. He was advised to contact HOS to get his application reinstated. No further contact was made by Ahmed after this time.

5.37 If applicants fail to respond to an offer of accommodation, the offer is treated as a refusal. The Property Lettings Team will suspend their application and e-mail Housing Options to cancel the application due to no response. The applicant has 3 months to get in touch with Housing Options if they still wish to remain on the housing register. If they contact within this time, their application will be reinstated. If they do not contact within this time, they would have to re-apply for housing in the future.

Author's Comment:

5.38 ***It is important to consider the potential impact on Rabia of being removed from being a joint applicant for housing, to being an occupant because she had 'no recourse to public funds'. Was it clear to Rabia that despite this, she was still entitled to receive support from other services***

(i.e. domestic abuse services funded by Leicester City Council) should she require them? It is not clear whether it was from the records available.

5.39 ***In regard to Ahmed's mental health, his disengagement from services, evidenced by not turning up for appointments or returning phone calls, may have been an indicator of deteriorating mental health. However, in the absence of contact with health or social professionals, this perspective is not able to be substantiated as they were not aware of Ahmed's depression and treatment.***

5.40 ***Rabia had only limited contact with professionals. Rabia was not on any professionals' radar as an adult in need of support or protection.***

5.41 ***Ahmed was known to services in the context of his 'carer role' but also as a user of services. He was not perceived by agencies as a 'risk' to others.***

Additional information provided to the Panel

5.42 Following a panel meeting in January 2016, further information was provided to the Author and the Safeguarding Adults Board Manager. Once reviewed, key information was subsequently shared with panel members to facilitate wider discussion and it proved to provide a greater insight into Ahmed's and Rabia's relationship, the nature of which was totally unknown to professionals involved or their wider agencies.

5.43 A key feature from this review is the lack of information about who Rabia was. There are no pictures of her reported in the media. Further detail regarding Rabia comes from additional information provided to the panel about her life, visible only to those closest to her and not available from agency records.

5.44 In relation to Ahmed, the additional information complements what is known about him and his immediate family, especially in relation to his mother and the impact of her death upon him.

5.45 The very limited information provided to the panel, in relation to those who came into contact with either Ahmed or Rabia, provides a brief insight into what was happening within their relationship. It has not been possible to seek clarity, or expand upon, the information that presents a series of snapshots of Rabia's and Ahmed's relationship. In addition, the information cannot be matched to the chronology as it has no timescales. The narrative is unsubstantiated as, when contacted, relatives and family declined to be interviewed as part of the DHR process. Some of the additional information that can be shared is summarised below.

5.46 **Rabia the Individual:** Rabia is described as a clever, well-educated lady, who was a polite woman, but who was able to stand up for herself. It is noted that family members did get on well with Rabia. Those that knew her outside of the family describe her as being popular and hard working. She was perceived as someone who wanted to make more of her life.

5.47 **Money Issues:** Rabia became the primary money earner within the relationship. She got a job in June 2011 working at a local nursing home. Rabia is reported as working long hours and, prior to her death, she had accepted a job at a local hospital. In parallel to Rabia getting a job, Ahmed lost all his benefits following the death of his brother.

5.48 **Ahmed's Mental Health:** Ahmed's mental health deteriorated following the death of firstly his mother and then his brother. Ahmed's mental health was a concern to those that knew both him and Rabia.

Author's Comment:

5.49 ***It is not clear whether Rabia would know who to contact for support. It may be reasonable to assume that Rabia may have been fearful of being deported or bringing shame on her family in Pakistan for leaving her marriage. The latter was discussed to some depth by the panel, and there was disagreement around whether this could be assumed based on birth country culture and religion alone. She will have been very aware through her housing application of having no recourse to public funds. This may be the reason for her and other women in her situation not contacting agencies. Therefore, women in similar domestic abuse situation to Rabia may risk their personal welfare in order to retain the right to remain resident in the UK.***

5.50 ***The additional information shared with the panel provides a glimpse into what it was like for Rabia following her marriage to Ahmed. However, Rabia appears to have wanted to contain issues within her marriage within her own private sphere. It is not known why those friends and family who had contact with either Ahmed or Rabia did not report concerns to authorities or support services. Perhaps any concerns noted were not identified as domestic abuse or were seen as a private matter to be kept within the family. Is it widely known that friends and family can raise their concerns with authorities or support services in a completely confidential way? Would having such awareness make a difference?***

5.51 ***If the Author had a chance to meet Rabia he would want to ask her "What stopped you seeking help?". The Author's challenge to the multi-agency partnership in Leicester City is – How can we empower women in violent relationships, to come forward? This has to be considered in the context that Rabia may have been frightened that if she left Ahmed, the only option that she may have felt open to her was a return to Pakistan (as her status to remain in the UK was not resolved until December 2013). What awareness is there of the domestic violence support available to individuals with no recourse to public funds? How can this level of awareness be improved or awareness promoted within our local communities?***

5. EQUALITY AND DIVERSITY

5.1 All nine characteristics that are protected by the Equality Act 2010 were considered by the DHR Panel, and several were found to have relevance to this DHR. These were:

5.2 **Age** – Ahmed was nearly 10 years older than Rabia, and such age gaps have been highlighted in homicide research as a risk indicator.

5.3 **Disability** – The couple cared for Ahmed's disabled brother Shahid. Ahmed saw himself as the primary carer for both his mother and his brother. When they died a year apart, in addition to his grief for the loss of close family members, Ahmed struggled with the loss of his independent income as a carer. He reacted adversely to his perceived loss of identity and role (as he saw it) of "carer", and possibly also saw his marriage to Rabia as a solution to his caring responsibilities.

5.4 **Marital status** – Ahmed and Rabia were married in June of 2011, when he was 41 and she was 32. This was described as an "arranged marriage" and all the indications were that Rabia was content with this arrangement.

5.5 **Ethnicity/Nationality** – Ahmed was born in the United Kingdom. Rabia was born in Pakistan in 1979, and moved to Leicester in May 2010. The panel discussed in great detail, and undertook background research into cultural implications of this on Rabia; discussing the high level of known violence against women in Pakistan and the potential normalisation of this.

5.6 **Religion/belief** - Ahmed was clear when interviewed that what he did was wrong in regards to law, as well as in his Islamic beliefs. Ahmed was clear that murder would be seen as a sin by his religion and that he would be subject to legal sanction (e.g. he was serving a prison sentence), a fact he stated he would now have to live with.

5.7 The Crown Prosecution Service states: "Honour based violence (HBV) can be described as a collection of practices, which are used to control behaviour within families or other social groups to protect perceived cultural and religious beliefs and/or honour. Such violence can occur when perpetrators perceive that a relative has shamed the family and/or community by breaking their honour code".

5.8 The Panel took advice from an independent Domestic Violence consultant with extensive experience of issues of honour-based violence, and in the provision of direct services, primarily to Asian women and their families in the West Midlands. The Panel concluded that, on the basis of the evidence available to it, that the murder of Rabia was not motivated by Ahmed's religious beliefs, or considerations of honour.

5.9 After his conviction he clearly acknowledged that what he had done was against the teachings of his religion. He said he had felt neglected by his wife.

He regarded the time she spent at work as time that she was not able to spend providing him with care and support.

6. TERMS OF REFERENCE, FINDINGS AND KEY LEARNING POINTS

6.1 This section of the report will review the elements set out in the DHR Terms of Reference (TOR) for this case in order to summarise findings and learning points.

7.2 **TOR1: To review whether practitioners involved with Ahmed and Rabia were knowledgeable about potential indicators of domestic violence and aware of how to act on concerns about a victim or perpetrator.**

7.3 **Summary Response:** In information received from the GP Practice, there is no documentation of questions relating to domestic violence. However there is evidence that one organisation was orientated to asking practice questions in regard to domestic violence. The Leicester City Improving Access to Psychological Therapy (IAPT) Open Mind Service include routine enquires about anger and domestic violence on their Open Mind Demography form. However, they can only respond to signs, symptoms and disclosures and this type of actual evidence of harm and abuse was not known to any of the services. Ahmed was the perpetrator (not acknowledged or identified) and not the victim. Rabia, as the victim, was seen by professionals (Language tutor, employer, GP), but did not disclose any marital issues or seek support; indeed she may not have been aware that there was help available for her.

7.4 **TOR2: To establish how professionals and agencies carried out risk assessments, including:**

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

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

7.5 **Summary Response:** No domestic violence and abuse was identified by local agencies. Consequently, risk assessments and risk management plans were not deemed to be necessary. Ahmed was not viewed as posing a risk to Rabia, by the agencies involved.

7.6 From a multi-agency perspective, where Ahmed was known to agencies whom he engaged with, they identified in records that he was neither a risk to harming himself or others. As a result, Ahmed was viewed as not requiring a risk assessment management plan. Ahmed did not avoid agencies. Even the day before Rabia was violently killed, Ahmed was seeking contact with the housing department in regard to his application for new housing accommodation. Rabia was known to agencies (Housing, GP, library services, Language service, her employer), but not as a person in need of safeguarding services).

7.7 **TOR3: To identify whether services involved with Ahmed were aware of the circumstances of Rabia's presence in the home. Whether connections were made and information shared between these services in order to establish a full picture of the wider family's vulnerability and risks.**

7.8 **Summary Response:** Services involved with Ahmed were aware of Rabia's presence in the home, but they were not in possession of information that highlighted any concerns with agencies involved. Rabia was invisible to local services and had no recourse to public funds. Even to her employer, Rabia presented her marriage and relationship as ordinary and uneventful. Her employer noted her as a hard worker, someone with aspiration. However, the abuse Rabia was experiencing was contained within the immediacy of the family home, and was not something her employer, colleagues or local agencies were aware of.

7.9 **TOR4: Did agencies involved make routine enquiry about domestic violence when working with these adults, were relevant procedures followed, were any opportunities missed?**

7.10 **Summary Response:** This has been covered in TOR1: Individual agencies did not know information that was known to non-family members. Ahmed and Rabia, when in contact with agencies, did not disclose domestic violence.

7.11 **TOR5: To establish whether Ahmed and Rabia's needs around housing, benefits and caring responsibilities were adequately supported by local agencies.**

7.12 **Summary Response:** Leicester City Housing Options did work with both Ahmed and Rabia to ensure that their preferred option of a ground floor flat was offered. However, when arranged, Ahmed failed to attend the pre-arranged viewing with the Property Letting Team. Following this failure to engage, the housing application was suspended.

7.13 In regard to benefits, prior to Adult Social Care closing the case it would have been beneficial to Ahmed for someone to have explored with him the impact of his change of circumstances and how he was going to respond to his change of role and loss of carer role. However, this was not part of anyone's formal remit. Ahmed's own perception and one that he projected to services was the image he was a main carer for his brother.

7.14 It is of note that Ahmed's self-image then changed and the benefits that had provided him with a level of financial security ceased. Ahmed then had to repay an overpayment of his benefits and he was also investigated in relation to fraudulent activity. This required him to attend appointments with the Local Authority. In addition, it is of note that the student social worker on placement with the IAPT Open Mind Service did provide Ahmed with support in regard to his discussions with the Local Authority regarding benefits, after the death of his brother (this was not part of an official entitlement for help but was in addition to what would have normally been provided).

7.15 **TOR6: To establish whether the mental health needs of Ahmed were supported and managed appropriately by local agencies.**

7.16 **Summary Response:** Ahmed was referred to the Leicester IAPT Open Mind Service by the GP. This service did provide input to Ahmed to address issues in regard to his anxiety and depression. However, it is unclear if they addressed issues that were significant to Ahmed in regard to his bereavement and loss of his role as a carer. In reality, the records from IAPT Open Mind Service do not give a full insight in regard the care provided or if any issues were highlighted in the consultation by Ahmed. The IAPT service is patient led and Ahmed may not have raised any issues with the service.

7.17 The IAPT service is no longer provided by the Leicestershire Partnership NHS Trust. It was recommissioned in 2016 and transferred to the new provider Nottinghamshire Healthcare Foundation Trust in April 2016. At the point of transfer legacy issues were highlighted in regard to record keeping. Poor quality record keeping was identified informally, on mobilisation of the service on 13/05/16. East Leicestershire and Rutland CCG (ELRCCG) oversee the contract with Nottinghamshire Healthcare Foundation Trust (NHCFT).

7.18 To address the record keeping issues identified the following actions were put in place by NHCFT in 2016:

- Establish regular notes audit within the in line with NHCFT guidance
- To organise local record keeping training for staff
- To organise local record keeping training for staff (this was to address the poor quality of record keeping that was highlighted within the IPAT service at the point of transfer to the new provider).

7.19 If the IAPT service had continued with LPT it would have been subject to a single agency recommendation. However, the issue in relation to the IAPT service was resolved with the awarding of the contract to the new provider (NHCFT) and an action plan being agreed to address the legacy issues. The ELRCCG oversees the quality contract and NHCFT addressed the recording keeping issues within the first year of being awarded the IAPT contract. ELRCCG oversee the contract and have confirmed (July 2018) record keeping issues have been identified as part of the ongoing quality monitoring of the service.

7.20 However, it has been reaffirmed to the panel by the LPT representative (Adult Safeguarding Nurse who is a Registered Mental Health Nurse) that the level of provision within primary care was appropriate to address Ahmed's mental health issues as the care provision he required was low level mental health intervention.

7.21 **TOR7: To establish if there were any barriers experienced by Ahmed, Rabia or family / friends that prevented them from accessing support; including how their wishes and feelings were ascertained and considered.**

7.22 **Summary Response:** In this case, it is of significance to note that individuals in contact with Rabia did, by commission or omission, not support her in accessing the support that she needed. Rabia was a private individual who, from the limited information available, preferred to contain the issues within the family. This could be viewed as the biggest barrier to any offer of intervention. In contrast, it could be proposed that she was not able to act effectively herself to be protected from abuse and neglect, a victim of circumstances that were imposed upon her.

7.23 **TOR8: To identify whether more could be done locally to raise awareness of services available to victims of domestic abuse.**

7.24 **Summary Response:** Within Leicester City, work has been undertaken to raise the awareness of services to those who suffer domestic abuse. However, in this case we do not know how visible the messages were for Rabia.

7.25 What other communication methods were used in any of the public waiting areas e.g. at Rabia's GP practice? Were posters or other methods of communication used to highlight contact numbers of services? This information is not available to the author.

7.26 Even if the information was available, how do we empower women in Rabia's circumstances to seek help and support? How do we convey that they will be listened to and supported by agencies?

7.27 **TOR9: To consider how issues of diversity and equality were considered in assessing and providing services to Ahmed & Rabia.**

7.28 **Summary Response:** This aspect of the review is addressed in Part 6 of this report.

7.29 **TOR10: To establish how effectively local agencies and professionals worked together.**

7.30 **Summary Response:** In regard to the service offered to Ahmed, they were provided to address specific issues, to meet identified health and social care needs.

7.31 There is clear evidence that the housing department considered Rabia as having 'no right to public funds'. The message given to Rabia from her contact with the housing department may have led her to act with caution in future when considering approaching other services? Again, this statement is made without the ability to qualify its content with Rabia from her perspective.

7.32 Rabia was not seen as a care provider for Shahid during any of the carer assessments. Does this reflect a lack of understanding of who provided care? There is no evidence that Adult Social Care engaged with Rabia in relation to home care arrangements for Shahid. It appears that Ahmed's perspective was taken at face value by those involved and was not challenged in relation to him being the sole carer for his brother. From Ahmed's perspective, when

interviewed, he had undertaken caring responsibilities for his brother from an early age and his own life had been constrained by his caring responsibilities.

7.33 **TOR11: To establish whether domestic violence policies, protocols and procedures (including risk assessment tools) that were in place during the period of review, were applied and whether they were fit for purpose.**

7.34 **Summary Response:** In this case there were no known issues by partner agencies in relation to domestic violence in relation to either Ahmed or Rabia. Thus it was not necessary to apply domestic violence policies or procedures because there were no issues known to health and social care practitioners.

7.35 **TOR12: Identify any areas of good practice.**

7.36 **Summary Response:** There were not any areas of outstandingly good practice identified as part of this review.

7. CONCLUSION

8.1 Despite the best efforts of this review to find out, it must be acknowledged that, to local services (with the exception of the GP) Rabia remains 'anonymous'. Health and social care professionals did engage with Ahmed. In this context Rabia was seen, not as an individual in her own right but as a support to her husband. At no time was Ahmed, even the day before Rabia's death, seen as a risk to her by the professionals involved with him.

8.2 The Panel was unaware of what Rabia's life was like after she relocated to the UK and married Ahmed. Efforts to engage neighbours, friends, her employer and family members proved to be unsuccessful.

8.3 Rabia showed incredible strength by coming to a foreign country, caring for a brother-in-law with complex needs. Rabia had no rights until she was granted leave to remain in the UK in December 2013. Despite this, Rabia learnt English, studied and found work. It appears she had aspirations for her life. It must be noted that she made no disclosure to professionals or colleagues as far as we are aware from information provided to this review.

8.4 This review concludes that agencies had only limited contact with Rabia. There has been no evidence to suggest that agencies were aware of any abuse within the relationship. In addition, there is no evidence to suggest that opportunities were missed, or that policies related to domestic abuse were not followed.

8.5 The review has highlighted the importance of continuing the important work of reaching out to individuals who are new to Leicester (and new to the UK) to ensure that they are aware of the support services available to them despite any lack of recourse to public funds.

8.6 It is unclear how much the family were aware of any abuse suffered by Rabia. The role that employers, neighbours and friends can play is important. They require confidence to approach the services which could help.

8.8 No action was taken by those who were aware of the abuse to attempt to stop the abuse, or to seek outside intervention from agencies in Leicester City.

8. RECOMMENDATIONS

Single agency recommendations

9.1 If the Improving Access to Psychological Therapy service had remained within the Leicestershire Partnership Trust, there would have been a recommendation for the service. As the record keeping issues were resolved on the recommissioning of the service to the Nottinghamshire Healthcare Foundation Trust, there are no further single agency recommendations identified.

Multi-agency (partnership) recommendations

8.2 Improve awareness of domestic abuse services available to individuals in Leicester City. Specifically:

- Individuals who have no recourse to public funds
- Individuals new to Leicester City
- Individuals also new to the United Kingdom

8.3 Improved awareness in Leicester City for friends, community and family of how to refer concerns confidentially if required, and encouragement to do so, where Domestic Abuse is known or suspected.

National recommendations

8.4 None

Process learning

8.5 The Safer Leicester Partnership should not commission DHRs on an informal basis without first establishing the facts of the particular case. Since the start of this review process, responsibility for the commissioning of DHRs has now passed fully to the Safer Leicester Partnership. The importance of full chronologies and robust individual management reports is now reflected in its' latest DHR Protocol Guidance.

9. GLOSSARY

Acronym/ Abbreviation	Full title
ASC	Adult Social Care
BA	Benefits Agency
BME	Black Minority Ethnic
CPN	Community Psychiatric Nurse
CPS	Crown Prosecution Service
CRHT	Crisis resolution and home treatment team
CV	Curriculum Vitae
DHR	Domestic Homicide Review
DNA	Did not attend
DSH	Deliberate Self Harm
DSV	Domestic and Sexual Violence
DWP	Department for Work and Pensions
ED	Emergency Department
FFW	Fit for work Service
FLO	Family Liaison Officer
GP	General Practitioner
HO	Home Office
HOS	Housing Options Service
IAPT	Improving Access to Psychological Therapy Services
ICST	Intensive Community Support Team
IMR	Independent Management Report
LGBT	Lesbian, Gay, Bisexual, Transgender
LPT	Leicestershire Partnership Trust
LSAB	Leicester Safeguarding Adults Board
NHS	National Health Service
NHCFT	Nottinghamshire Healthcare Foundation Trust
PLT	Property Letting Team
QA	Quality Assurance
SIO	Senior Investigating Officer
SLP	Safer Leicester Partnership (Leicester's Community Safety Partnership)
SMART	Specific, measurable, achievable, realistic and timely
UKBA	United Kingdom Borders Agency

Leicester Safeguarding Adults Board

WORKING IN PARTNERSHIP TO KEEP ADULTS SAFE

Adult A

Domestic Homicide Review

Executive Summary

Independent Author: Hayley Frame

1. Introduction

1.1. The establishment of a Domestic Homicide Review (DHR) is set out under Section 9 of the Domestic Violence Crime and Victims Act 2004 which came into force on the 13th April 2011.

1.2. Multi-agency statutory guidance for the conduct of DHRs has been issued under Section 9 (3) of the Domestic Violence Crime & Victims Act 2004. Section 4 of the Act places a duty on any person or body named within that section (4) to have regard to the guidance issued by the Secretary of State. The guidance states that the purpose of a DHR is to:

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

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

- Apply these lessons to service responses including changes to policies and procedures as appropriate, and

- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

Persons Covered by the Review

1.3. The principal focus of the Review is the victim Adult A. The other involved adults are the perpetrator, Adult C and his girlfriend Adult B. Adult B is the niece of Adult A. Adult C was found guilty of manslaughter and preventing the course of justice. Adult B was found guilty of preventing the course of justice and preventing the lawful and decent burial of a dead body.

Contributors

1.9. Agencies participating in this Review and commissioned to prepare reports included:

- Leicestershire Police
- Leicester City Council – Children's Social Care
- Leicester City Council – Adult Social Care
- GP practices
- East Midlands Ambulance Service
- University Hospitals Leicester NHS Trust
- National Probation Service
- Leicestershire Partnership NHS Trust
- Leicester City Council – Housing
- Leicester City Council – Antisocial behaviour unit

- Leicester City Council – Education Welfare Service
- Leicester City Council – Youth Offending Service
- SAFE
- New Futures
- East Midlands Homes

2. **The Facts**

2.1. Adult A resided at a flat in Leicester. He lived there with his niece Adult B. Adult B had commenced a relationship with Adult C, a few weeks prior to Adult A's death and Adult C regularly stayed at the address during that time.

2.2. On 21st February 2015, Leicestershire Police formed concerns for the wellbeing of Adult A whose whereabouts were unknown. Later that day, as the situation developed and despite Adult A remaining missing, both Adult B and Adult C were arrested on suspicion of Adult A's murder.

2.3. On 23rd February 2015, Adult A's body was found a few hundred yards from his home. He had received multiple injuries.

2.4. On 24th February 2015, both Adult B and Adult C were charged with the murder of Adult A and preventing his lawful burial. Both were remanded in custody.

2.5. On 22nd September 2015 at Leicester Crown Court, Adult C was convicted of manslaughter and received life imprisonment, Adult B was convicted of perverting the course of justice and preventing the lawful and decent burial of a dead body. She was sentenced to three years imprisonment.

2.6. The HM Coroner recorded a verdict of unlawful killing on 29th September 2015.

3. Summary of key events

Author Comments are in Bold

3.1. On 9th March 2013, police attended Adult A's home address after he called to report that he felt suicidal and had heard rumours that people were calling him a paedophile. The attending officers saw cuts to Adult A's arms and he was conveyed to hospital. Adult A was seen by the Deliberate Self Harm team who noted that the patient's difficulties were secondary to alcohol dependency and social stressors and that he has no mental health needs. Adult A was also seen by the Acute Assessment and Recovery Service in relation to alcohol misuse; Adult A declined their input. Adult A was discharged as his mood was described as stable and he was willing to reduce his drinking.

Adult A was seen by the appropriate services as a result of his self-harm and alcohol misuse.

3.2. Adult A was seen again in the Emergency Department, in the company of Adult B, on 21st March 2013. Adult A was intoxicated and had self-harmed causing a laceration to his forearm. Adult A disclosed earlier to the police that he had self-harmed as a result of being accused by the ex-partner of Adult B that he had sexually touched Adult B and her daughter. Both Adult A and Adult B were described as aggressive and soon left the hospital.

3.3. Adult A returned to the Emergency Department on 24th March 2013, to have the wound on his arm examined. An Adult Mental Health Proforma was completed by an Emergency Department Doctor and Adult A was not deemed to be a current risk to self. Adult A denied suicidal ideation and reported to the Doctor that he was drunk at time of the self-harming incident. The Doctor was unable to suture the wound due to the age of the wound, so it was cleaned and dressed. Adult A was adamant that he did not want to see Deliberate Self Harm team and was discharged.

3.4. On 13th July 2013, Adult B's mother contacted the police as she had information that Adult A had assaulted Adult B. This was later denied by Adult B despite having a large bruise on her arm. The police referred Adult B to Adult Social Care following her having disclosed that she was working as a sex worker. Also on that day a report of antisocial behaviour was made. After this, regular reports continued to be made concerning Adult A, Adult B and various unknown others including reports of drinking and fighting.

3.5. On 21st August 2013, Adult A attended the Emergency Department reporting that he had been assaulted the previous day and had rib pain. He told staff that he was pushed over by a female friend. No abnormalities were noted and he was discharged.

There is no record of any detailed discussion regarding the alleged assault, the name of the perpetrator or liaison with the police.

3.6. An ambulance was called to Adult A on 1st September 2013 who reported that he had been assaulted by a large lady who jumped on his chest. Adult A declined being conveyed to hospital.

Again, there is no record of any detailed discussion regarding the alleged assault, the name of the perpetrator or liaison with the police.

3.7. On 6h September 2013, Adult A attended the Emergency Department complaining of right sided chest pain as a result of a further alleged assault during which he sustained blows to his chest and face. A facial x-ray identified a fracture of left zygomatic arch (cheekbone). Whilst in hospital, Adult A was reviewed by the alcohol liaison nurse but Adult A did not engage and refused community help or support. Adult A denied being alcohol dependent but admitted to excessive drinking of approximately 40 units per week.

Yet again, there is no record of any detailed discussion regarding the alleged assault, the name of the perpetrator or liaison with the police.

3.8. On 28th November 2013, an ambulance was called to Adult A following an assault. Adult A was aggressive and abusive to the crew. A further ambulance was called the next day when Adult A reported that the pain from the attack was increasing. Adult A would not agree to being conveyed to hospital.

There is no record of any detailed discussion regarding the alleged assault, the name of the perpetrator or liaison with the police.

3.9. Adult A saw his GP on 3rd December 2013 and mentioned that he had been assaulted and kicked in the ribs. He was prescribed ibuprofen.

Again, there is no record of any detailed discussion regarding the alleged assault, the name of the perpetrator or liaison with the police.

3.10. On Tuesday 6th February 2014 a Post Office worker reported that Adult A was in the Post Office, Leicester and very upset as he believed money had been stolen from his account. Police officers attended and Adult A was taken back to his home address and completed a statement with the officers. A Police National Computer enquiry, undertaken by the officers whilst still at the address, identified that Adult A was wanted on warrant for failing to attend a court summons the previous day; and so he was arrested. Whilst on his way to the police station, Adult A told officers that he had been diagnosed with cancer and had only three months left to live. He made comments that he no longer wished to live as he was in a lot of pain. Once at the police station, Adult A was seen by a doctor due to the comments he had made and he was considered fit to detain. An adult at risk referral was made for Adult A as he was without money, was very upset by the incident and had made comments of a suicidal nature. The Police in house Adult at Risk Team contacted Adult Social Care and were told that they had previously offered Adult A services in 2011 which he had declined, and so a re-referral was made. As a result of this referral, Adult Social Care left a message to ask for the out of hours GP to visit Adult A and made an unsuccessful attempt to contact Adult A by phone. The GP subsequently spoke with the police as it was felt that it was unsafe

to visit due to history of violence and racism. The GP was reassured by the police that they would visit, which they did do and confirmed that Adult A was safe and well.

This was an appropriate response to Adult A.

3.11. An ambulance was called to Adult A on 21st February 2014. Adult A stated that he had been drinking vodka and brandy for the last two days. He also stated that four days previously he had taken some unknown tablets given to him by the people across the road. He reported that he lived with his niece but as there is only one bed they take it in turns to sleep on the sofa. Adult A was conveyed to the Emergency Department with left sided chest pain. He admitted to having been in a fight earlier sustaining blows to his chest and face. Adult A was referred to the alcohol liaison nurse.

There is no record of any discussion regarding the fight, and who was the perpetrator of his injuries.

3.12. On 28th February 2014, Adult Social Care made unsuccessful attempts to contact Adult A, including a home visit. This was a result of the police referral on 6th February 2014. Adult Social Care spoke to agencies, including his GP who confirmed that he did not have terminal cancer. The case was subsequently closed.

3.13. Adult A was invited to meet with the housing provider on 28th May 2014 to discuss reported antisocial behaviour. Adult A failed to attend, so the property was visited by a housing officer and 2 police officers. Adult A was adamant that Adult B was not living at property, despite her being present. A formal warning letter was sent to Adult A regarding antisocial behaviour and visitors to the property.

3.14. On 30th May 2014, Adult A was conveyed by ambulance to hospital after having fallen due to being intoxicated. He had hit his head as he fell, after having drank 1.5 litres of vodka. Relevant investigations were carried out and Adult A was discharged. Adult A was admitted again on 3rd June 2014, with sudden onset left sided chest pain. He had been drinking to excess all day, no medical problems were detected and he was again discharged.

3.15. A housing officer visited Adult A on 9th June 2014. Adult A stated that Adult B had moved out, despite evidence of women's clothing and make-up being in the flat.

3.16. On 18th July 2014, Adult A was referred to the specialist antisocial behaviour team, however the complainant requested no action be taken against Adult A until they had moved due to a fear of repercussions. The complainant subsequently moved to alternative accommodation and the case was closed.

3.17. On 24th September 2014, Adult A was admitted to hospital with abdominal pain secondary to pancreatitis. He was advised by doctors that his condition was caused by excess alcohol and was advised to reduce to safer drinking levels. Adult A was seen by the alcohol liaison nurse but did not engage and declined offers of support. Adult A was discharged on 27th September 2014.

Attempts were made to support Adult A with his alcohol misuse.

3.18. On 25th December 2014, Adult A reported a number of incidents to the police ranging from someone pointing a gun at his head two weeks earlier to being attacked in the street and stabbed in the stomach. The call handler considered Adult A to be intoxicated and doubted the truth of his reports however having established that he was safe, a scheduled response was agreed and police officers attended the following day. The officers questioned Adult A about the allegations he had made, he said that he had encountered two males in the street on 25th December 2014 who had proceeded to cut him in his stomach area. Adult A was vague about the event and gave conflicting information. The officers viewed the injuries and the clothing he had been wearing at the time and the officers believed the injuries had been self-inflicted. An adult at risk referral was made to the police in house adult at risk team owing to the belief that Adult A had self-harmed. Adult A's GP surgery were also informed of the incident and the GP made telephone contact with Adult A on 2nd January 2015. Adult A denied excessive alcohol intake and any self-harm/suicide ideas.

The referral made by the police plus the contact with the GP are evidence of good practice.

3.19. On 19th February 2015, Adult C spoke with his social worker and informed her that although he would be staying at his residential care home placement from Monday to Friday, he would be spending weekends with his girlfriend Adult B. He stated that she might be pregnant.

This is the only agency record of the relationship between Adult C and Adult B. In mid-January 2015, Adult C was in a relationship with someone else and as such the relationship with Adult B was very recent.

3.20. On 23rd February 2015 information was received by the police to indicate that Adult A had been murdered. Adult B and Adult C were arrested.

4. Analysis

4.1. This review has established that there was no professional knowledge of the connection between Adult A, Adult B and Adult C prior to the domestic homicide. There were no indicators or evidence of Adult A being at risk of harm from Adult C.

4.2. It is clear however that all three individuals had histories of concern, involving alcohol misuse, domestic abuse and mental ill health.

4.3. A number of themes/areas of learning have arisen from the review of this case. These can be summarised in the following headings:

- The correlation between domestic abuse, violence and aggression and alcohol misuse
- Care pathways for mental health and alcohol misuse and engaging the hard to engage
- Recognition of and response to safeguarding concerns
- Responding to historical abuse allegations
- The role of the GP

4.4. Any findings made are highlighted within each theme.

The correlation between domestic abuse, violence and aggression and alcohol misuse

4.5. The review has considered that Adult A was not perceived by agencies as a victim of domestic abuse. Despite numerous alleged assaults, there was overall a failure to recognise indicators of domestic abuse and a lack of professional curiosity with regard to the nature of the assaults. Adult A's lack of engagement with and hostility towards agencies, coupled with his frequent intoxication, led to assumptions being made about his presentation. It has been acknowledged that it is a challenge for professionals to view an aggressor as a victim.

4.6. The review has highlighted that there was an absence of routine enquiries regarding domestic abuse. This was evident in the cases of the GPs and the Emergency Department. The review has also highlighted a lack of awareness of interfamilial domestic abuse which would appear to have been evident between Adult B and Adult A.

Finding: All agency training in respect of domestic abuse must include abuse outside of intimate partner relationships.

4.7. In October 2014, the charity Alcohol Concern wrote a research paper entitled 'domestic abuse and treatment resistant drinkers: a project to learn lessons from domestic homicide reviews'. The research highlighted that in 75% of the cases viewed alcohol played a significant contributory role in the domestic homicides. The majority of these alcohol related homicides involved high risk treatment resistant drinkers. The

Blue Light project is Alcohol Concerns' national initiative to develop alternative care pathways for treatment resistant drinkers who place a burden on public services. The project has developed tools for understanding why clients may not engage, risk assessment tools, harm reduction techniques, and relevant management frameworks. There is merit in embedding these tools within local device delivery in Leicester.

Care pathways for mental health and alcohol misuse

4.8. Concerns regarding self-harm and suicidal ideation whilst intoxicated is a key feature within this case. All three individuals presented in this way on several occasions and their engagement with follow up services was limited.

4.9. The review has established that there is an assumption that until someone's substance misuse is managed and they are deemed stable, that an assessment of their mental health will not be accurate in terms of diagnosis. There is a need to be able to separate intoxication from mental health as it is recognised that alcohol is a depressant and that once sober, a person may behave entirely differently. However in the case of problematic, intractable drinkers, the difficulties may have become entrenched and therefore require a joint, dual diagnosis, approach.

4.10. When a patient is threatening self-harm and experiencing mental health difficulties the referral routes available to GPs can take several weeks to process. In order to refer to the crisis team, the GP would have to see the patient first. The team will then respond within 4 or 24 hours depending upon the clinical need. The crisis team are unable to assess people who are so intoxicated that they cannot be safely assessed. The view of Leicestershire Partnership Trust is that this scenario, or indeed if the patient needed to be seen sooner, would constitute a medical emergency and so the patient should be taken to the Emergency Department where they can be seen and assessed by the Deliberate Self Harm team. The DSH team can then refer for home treatment with the crisis team, ask for a Mental Health Act assessment or arrange informal admission. In reality, the DSH team are equally unable to assess a patient who is intoxicated, leaving the management of that individual with the Emergency Department staff.

4.11. The challenge with this arrangement is that Emergency Departments are not equipped or resourced to manage the demands of intoxicated patients who are expressing thoughts of self-harm. Often patients may leave prior to receiving medical input (missing a crucial window of opportunity to engage the patient) and until that time they can present management issues within the department.

4.12. This review has established that the three individuals involved proved difficult to engage and that in the case of Adult B and Adult A in particular, support services were unable to engage with them effectively.

Finding: The review has considered that there is a requirement for a specific care pathway for the management of acutely intoxicated people. The review has also considered that the provision for adults in acute mental health crisis needs to be reviewed.

Recognition of and response to safeguarding concerns

4.13. The review has established that there were a number of missed opportunities to make safeguarding referrals in respect of the adults involved in this case. Adult A was not perceived as a victim of abuse and assumptions were made about him given his difficult presentation. Adult B's allegations of sexual abuse, her alcohol misuse and ongoing mental health concerns were not responded to robustly. Adult C was perceived as a vulnerable individual yet there was a lack of risk assessment with regard to what this meant in terms of the risks to himself and to the risk he posed others. It is evident that awareness raising in respect of adult safeguarding continues to be essential.

4.14. The review has established that poor compliance by some agencies with adult safeguarding training has been a concern to the LSAB. Assurance has been provided that agencies have a clear framework for adult safeguarding and regular training. Safeguarding training figures are monitored by the LSAB safeguarding effectiveness group. A significant development is that the Director for Adult Services has ensured that adult safeguarding training is now mandatory within adult social care.

Finding: agencies must ensure that adult safeguarding is a key priority within their strategic and operational service planning and ensure that their staff are equipped to make safeguarding referrals.

Responding to historical abuse allegations

4.15. The history of this case indicates that Adult B disclosed and denied on numerous occasions and to many different agencies that she had allegedly been sexually abused by Adult A. These disclosures were seen as a life event rather than a potential crime that required investigation. There was a lack of consideration of any ongoing risks potentially posed by Adult A.

4.16. The local adult safeguarding procedures do not contain any reference to how to manage historical abuse allegations. This is a significant shortcoming. Importantly, no national or statutory guidance is available to guide professionals in dealing with such matters. The local safeguarding children board (LSCB) procedures contain a short chapter entitled historical abuse allegations. This chapter stresses the importance of a high quality organisational response as there is a significant likelihood that a person who abused a child in the past will have continued and may still be doing so, and that criminal prosecutions can still take place despite the allegations being historic in nature. The chapter describes how the disclosure must be recorded, a chronology should be completed and it must be explained to the adult disclosing historical abuse that the information will need to be shared with the police. The chapter lacks any further detailed guidance regarding how such cases should then be managed. There is reference to strategy meetings being held but this appears to refer to alleged perpetrators who are still working with or caring for children.

Finding: Robust procedural interagency guidance must be in place in order to support professionals to manage and appropriately respond to allegations of historical abuse.

The role of the GP

4.17. A factor in this review is the role of GPs when patients lead chaotic lifestyles and are difficult to engage. The three individuals in this case frequently attended Emergency Department but not at a level to trigger hospital frequent attendees procedures. GPs are notified of all attendances at hospital, outpatient reviews and discharges from health services. The GP is therefore the holder of all information pertaining to a patient and is therefore best placed to understand the issues. However whether the GP themselves have capacity to read all of the information they are sent and respond to it is unlikely and as such this questions whether the information sharing is purposeful or actually just adding to a 'central storage record'.

4.18. The CCG Hosted Safeguarding team have recently incorporated themes from DHRs (local and national learning) into face to face safeguarding adults training for GP's. At the last City Protected Learning Time event held in April 2016, this training was delivered to 85 GPs.

Finding: an alert system of frequent attenders at Emergency Departments should be considered within GP practices and efforts made to target those that are hardest to engage.

5. Conclusions

5.1. The time period that brought Adult A, Adult B and Adult C together was brief – just a matter of weeks. Adult B and Adult C had not known of each other before this time and their relationship developed quickly, with Adult C spending time at the flat where Adult B and Adult A lived. Agencies were not aware of the connection between the 3 individuals.

5.2. The DHR panel has considered that Adult C did not appear to pose a risk of significant and serious harm to others. Adult C was not perceived by agencies working with him to be a violent and dangerous individual. In view of this, had the connection between Adult C, Adult B and Adult A been known, this would not have raised concerns regarding any risk posed by Adult C to Adult A.

5.3. The DHR panel has determined that the set of circumstances that led to the death of Adult A were so specific that it could not have been predictable that Adult A would die as a result of such a violent crime. His life appeared to be in danger as a result of alcoholic liver disease and not by any risks posed by those with whom he associated.

5.4. This DHR has identified areas where practice and interventions could have been improved which might have better supported Adult A, Adult B and Adult C. The DHR panel has considered that whilst the learning has led to recommendations for change, changes in practice would not have altered the final outcome for Adult A. The risk to Adult A on the day that he died was not, and could not have been identified, and as such his death could not have been prevented.

6. Changes to practice

6.1. The pathway of care for acutely intoxicated people in the context of a 'possible' mental health problem such as threats of self-harm has been considered by the Local Crisis

Care Concordat group as a priority. The group has agreed that firstly a medical screen is required in the Emergency Department followed by a mental health assessment.

6.2. A pathway has therefore been agreed for acutely intoxicated people who may have a mental health problem to be firstly assessed medically in the Emergency Department and then have a mental health assessment in the Emergency Department within 1 hour of the Emergency Department staff being satisfied that the individual is 'medically fit'. University Hospitals Leicester and Leicestershire Partnership Trust are operationally working closely together under the Leicester, Leicestershire and Rutland Urgent and Emergency Care Vanguard Programme changes to this effect and are also aligning with the newly formed Public Health procured substance misuse services from Turning Point so that appropriate contact can be made, following a mental health assessment, with substance misuse services if required. The proposed model is an outreach model and the expectation is for Emergency Department and Mental Health staff to refer to the substance misuse team to determine an appropriate response in terms of time and location of assessment.

6.3. The local Crisis Care Concordat group are overseeing a programme of work that is fully integrated into the Better Care Together Mental Health Work stream, reviewing all provision for people in mental health crisis. For further details please see: http://www.crisiscareconcordat.org.uk/areas/leicester/

6.4. A regional multiagency sub group comprised of police, health and local authorities, for Individuals with Frequent Needs on a Range of Services has been established, and has the aim of identifying people who have multiple interactions with multiple agencies. The focus of the group will be to improve the long term well-being of vulnerable adults who have frequent needs relevant to multiple service sectors. This can include but is not limited to;

- Poor physical and mental health;
- Risk of self-harm or suicide;
- Drug and alcohol abuse;
- Crime and ASB victimisation or offending, including domestic abuse.
- Extreme social isolation

6.5. The expectation will be that the needs of the person will have been long term and that other multi-agency partnerships are not currently co-ordinating actions or are not able to do so effectively. Through intelligence gathering this will allow the group to identify people who may not meet the need or threshold for certain agency intervention, but collectively through a collaborative approach can have those needs met. The alternative is that there may be a decision to not meet those needs but agree a robust strategy for managing contact with that individual which all agencies are aware of so a consistent approach is adopted by all.

6.6. The group began in November 2015 and has so far met 4 times. There has been a number of cases already which having had a multi-agency input has led to a different pathway being explored which has yielded benefits to organisations but most importantly the individual.

7. **Recommendations**

7.1. The DHR panel endorses the single agency IMR recommendations. Each agency retains responsibility for the implementation of actions arising from their IMR.

7.2. Given the changes in practice identified above, the recommendations arising from this review are few in number, and although they will improve practice going forward, their implementation would not have altered the outcome in this case.

- LSAB to seek assurance that single agency domestic abuse training does not focus purely on abuse within intimate partner relationships and that learning from this DHR is incorporated into domestic abuse training.

- For there to be national and regional guidance regarding the management of historical or non-recent allegations of abuse.

- For routine enquires regarding domestic abuse to be embedded within substance misuse services, in particular alcohol misuse services, given the link between domestic abuse and alcohol.

7.3. In addition, the DHR panel recommends that the learning from this DHR is taken forward by the Domestic Violence Delivery Group of the Safer Leicester Partnership for wider communication and awareness raising.

Leicester Safeguarding Adults Board

WORKING IN PARTNERSHIP TO KEEP ADULTS SAFE

Adult A

Domestic Homicide Review

Independent Author: Hayley Frame

Contents

Appendices

1. Introduction

1.1 The establishment of a Domestic Homicide Review (DHR) is set out under Section 9 of the Domestic Violence Crime and Victims Act 2004 which came into force on the 13th April 2011.

1.2 Multi-agency statutory guidance for the conduct of DHRs has been issued under Section 9 (3) of the Domestic Violence Crime & Victims Act 2004. Section 4 of the Act places a duty on any person or body named within that section (4) to have regard to the guidance issued by the Secretary of State. The guidance states that the purpose of a DHR is to:

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

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

- Apply these lessons to service responses including changes to policies and procedures as appropriate, and

- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

1.3 Hayley Frame, Independent Safeguarding Consultant, was appointed as the independent author. Gwen Doswell, Head of Service, Leicester City Council, was asked to chair the DHR panels. Neither Hayley nor Gwen had any prior knowledge or involvement with the case.

Persons Covered by the Review

1.4 The principal focus of the Review is the victim Adult A. The other involved adults are the perpetrator, Adult C and his girlfriend Adult B. Adult B is the niece of Adult A. Adult C was found guilty of manslaughter and preventing the course of justice. Adult B was found guilty of preventing the course of justice and preventing the lawful and decent burial of a dead body.

Review Period

1.5 The scoping period is from January 2013 until February 2015, (capturing the period when Adult B commenced living with Adult A, Adult C became involved with Adult B and up to the period of Adult A's death).

1.6 A summary of agency involvement from 2004 until the beginning of the scoping period was also requested in order to capture any relevant background information.

Terms of reference:

1.7 The full terms of reference for the Review can be found at Appendix A.

1.8 The following areas were addressed in the Individual Management Reviews and has shaped the analysis of this Overview Report:

a. To review whether practitioners involved with Mr Adult A and Ms Adult B & Mr Adult C were knowledgeable about potential indicators of domestic violence and aware of how to act on concerns about a victim or perpetrator(s).

b. To establish how professionals and agencies carried out risk assessments, (including assessment of the victim's mental capacity to make decisions relating to risks) including:
   - whether the risk management plans were reasonable response to these assessments,
   - Whether risk assessments and management plans of Mr Adult C took account of his early history, including convictions for sexual assaults on minors and assessments of risk made during this period,
   - whether there were any warning indicators of serious risk leading up to the incident in which the victim died that could reasonably have been identified, shared and acted upon by professionals.
   - Whether any of the adults concerned were assessed to be vulnerable adults and whether they would now meet the criteria for an adult at risk as per the Care Act 2014

c. To identify whether services that were involved with Mr Adult A were aware of the circumstances of Ms Adult B's & Mr Adult C's presence in the home and agencies involved with them. Whether connections were made and information shared between these services in order to establish a full picture of the vulnerability and risks arising from the relationship(s).

d. Did agencies involved make routine enquiries about domestic violence when working with these adults and if so were any opportunities missed?

e. To establish whether agencies responded to alcohol dependence and offer appropriate services and support to Mr Adult A and Ms Adult B.

f. At each point of contact with emergency health services for assaults, self-harm and injuries – were enquiries made about domestic violence and procedures followed?

g. To establish whether the mental health needs of adults subject to this review were supported and managed appropriately by local agencies.

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

i. To establish if there were any barriers experienced by Mr Adult A, Ms Adult B or family / friends that prevented them from accessing help; including how their wishes and feelings were ascertained and considered.

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

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

l. To identify whether child sexual abuse allegations, leading to the risk of sexual exploitation, were appropriately managed by local agencies and the transition to adult services.

m. To establish whether adult safeguarding concerns (Adult A, Adult B, Adult C) were recognised by agencies and whether multi-agency safeguarding procedures were followed.

n. To consider whether there were any missed opportunities for a multiagency response to consider the multiple issues of Adult A and Adult B

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

p. To establish whether safeguarding children procedures were properly followed in respect of Ms Adult B's allegations of historical abuse made against Mr Adult A.

q. To establish how effectively local agencies and professionals worked together.

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

s. Identify any areas of good practice

Contributors

1.9 Agencies participating in this Review and commissioned to prepare Individual Management Reviews are:

- Leicestershire Police
- Leicester City Council – Children's Social Care
- Leicester City Council – Adult Social Care
- GP practices
- East Midlands Ambulance Service

- University Hospitals Leicester NHS Trust
- National Probation Service

1.10 Agencies with more limited involvement were asked to prepare summary reports:

- Leicestershire Partnership NHS Trust
- Leicester City Council – Housing
- Leicester City Council – Antisocial behaviour unit
- Leicester City Council – Education Welfare Service
- Leicester City Council – Youth Offending Service
- SAFE
- New Futures
- East Midlands Homes

DHR Panel members

1.11 DHR Panel members consisted of senior representatives from the following agencies:

- Leicestershire Police
- Leicester City Council – Children's Social Care
- Leicester City Council – Adult Social Care
- Leicester City Council – Community Safety
- Leicester City CCG
- East Midlands Ambulance Service
- University Hospitals Leicester NHS Trust
- National Probation Service

2. The Facts

2.1. Adult A resided at a flat in Leicester. He lived there with his niece Adult B. Adult B had commenced a relationship with Adult C, a few weeks prior to Adult A's death and Adult C regularly stayed at the address during that time.

2.2. On 21st February 2015, Leicestershire Police formed concerns for the wellbeing of Adult A whose whereabouts were unknown. Later that day, as the situation developed and despite Adult A remaining missing, both Adult B and Adult C were arrested on suspicion of Adult A's murder.

2.3. On 23rd February 2015, Adult A's body was found a few hundred yards from his home. He had received multiple injuries.

2.4. On 24th February 2015, both Adult B and Adult C were charged with the murder of Adult A and preventing his lawful burial. Both were remanded in custody.

2.5. On 22nd September 2015 at Leicester Crown Court, Adult C was convicted of manslaughter and received life imprisonment, Adult B was convicted of perverting the course of justice and preventing the lawful and decent burial of a dead body. She was sentenced to three years imprisonment.

2.6. The HM Coroner recorded a verdict of unlawful killing on 29th September 2015.

3. Summary of individual agency contact/involvement prior to the scoping period with Adult A and Adult B.

Leicester City Council Children, Young People and Families Directorate

3.1. Adult B was subject to a statement of special educational needs yet attended mainstream school.

3.2. The Youth Offending Service provided services to Adult B from 2004-2007 as a result of her offending behaviour. This included support and guidance and work to reduce her offending. Adult B also did not attend school regularly, and as such the Education Welfare Service was involved. Her mother was prosecuted for Adult B's non-school attendance, and a Parenting Order was made. Work was carried out with Adult B's mother in line with the requirements of Parenting Orders during 2005, to support her to provide clearer boundaries and guidance to Adult B.

3.3. From 2004 until December 2012, Children's Social Care had 10 contact/referrals in relation to Adult B. The first contact was when Adult B, aged 12, came into the office to see a duty social worker and received advice and information. The details of this are unknown. There was a contact from her mother who wanted advice with regard to Adult B's behaviours and the other remaining contacts were from partner agencies in relation to Adult B's daughter, Child A, and Adult B's behaviour as a parent including self- harming and domestic violence issues. There was evidence of information sharing from CAFCASS in relation to historical allegations of sexual abuse and concerns about Adult B's alcohol use during pregnancy. The absence of detailed records for some of these contacts, including the nature of the information from CAFCASS, makes it difficult to judge whether there were missed opportunities to provide Adult B (and/or her mother) with appropriate services. It should be noted that it is unusual for a 12-year-old girl to visit a Children's Social Care office alone to see a duty social worker.

3.4. Targeted Services in relation to Youth Offending also had involvement with Adult B and there were concerns about the parenting she was receiving. The assessment was that Adult B's mother may have been involved in some of Adult B's offending, that this was part of their family culture; and included concerns about financial exploitation of older people who lived locally.

3.5. An important event outside of the scoping period was a referral from the police to Children's Social Care in relation to Adult B in August 2010 when she was alleging sexual abuse by Adult A, both current and historical. In line with procedures this was followed up as a single agency investigation as Adult B was an adult. The working practice was that the police would seek to ascertain during their enquiries whether an alleged perpetrator has any contact with children and refer these children to children's social care. In addition, children's social care would check whether the alleged perpetrator is living with children. In this case, Adult A was not living with children and therefore no further action was taken by Children's Social Care.

Leicester City Council Adult Social Care

3.6. Prior to the dates within scope of this review Adult A had been closed to Adult Social Care (ASC) since March 2011. Prior to the dates within scope of this review ASC had no contact with Adult B.

East Midlands Ambulance Service

3.7. EMAS attended Adult B and Adult A 33 times outside of the scoping period and 22 of these attendances were for medical reasons. One attendance to Adult B related to an episode of domestic violence. This attendance would have occurred prior to the EMAS domestic violence and abuse policy being developed and before domestic violence and abuse education being provided to EMAS staff. The other attendances were to Adult A and relate to self-harm.

University Hospitals of Leicester NHS Trust

3.8. Adult A attended University Hospitals of Leicester NHS Trust on 40 occasions during the review period. On 39 of the 40 occasions he attended the Emergency Department. Of those, he did not require treatment, or he did not wait to be seen, on 10 occasions. Throughout 2004 – 2010 his attendances were not excessive, numbering 12 in total (average 1.5 attendances per year). However, in 2011 there was a sharp increase in the contact between Adult A and the Emergency Department, equalling 11 attendances in the calendar year. Of those he did not to wait to be seen on 4 occasions. It is difficult to know why this increase occurred in 2011, although 3 of those attendances were related to the same injury. In 2012 his attendances had dropped to 4.

3.9. It is apparent that throughout Adult A's attendances that excess alcohol featured on numerous occasions with Adult A disclosing that he relied on alcohol to cope with the death of his daughter in the 1970s and the breakdown of his marriage in 1980. There were several attendances due to physical problems, mostly chest or abdominal pain; likely to have been exacerbated by excess alcohol intake. Adult A had a long history of gastric ulceration due to excess alcohol. On 7 occasions Adult A presented with minor injuries following episodes of self-harm, or expressing suicidal thoughts, although rarely was intent to commit suicide evident within the records. Low mood due to the death of his daughter appears to be a key factor in Adult A's self-harming behaviours. In 2007, Adult A claimed to feel suicidal and also claimed that his sister and niece were accusing him of sexually abusing them. He stated that they were asking him for money to perform sexual acts on him. Adult A was described as being aggressive and hostile towards staff. He was heavily under the influence of alcohol at the time.

3.10. On two occasions Adult A presented with minor injuries as a result of physical altercations between himself and other unknown assailants. On another occasion, in

2011, Adult A attended with a minor head and hand injury after being allegedly hit by a bottle during a fight with his niece.

3.11. On each attendance, the records indicate that Adult A received appropriate and timely physical care and treatment. Where necessary Adult A was admitted to a ward for further investigations, treatment and follow up prior to discharge.

3.12. When Adult A presented due to self-harm, or when expressing suicidal ideation, he was appropriately referred to mental health services, prior to discharge. Several times he declined to be seen and refused to wait for an assessment. On the occasions that he was seen and assessed, it is recorded in the notes that there was no evidence of mental ill health or depression following assessment.

3.13. During the period 2004 – 2015, Adult B attended the Emergency Department on 32 occasions. Of those, she did not require treatment, or she did not wait to be seen, on 12 occasions. Throughout 2004 – 2010 she attended 8 times, averaging 1 attendance per year.

3.14. As in the case of Adult A, it is clear that alcohol was a key factor in Adult B's contact with UHL. She attended the Emergency Department having been drinking excess alcohol in 2006, when she was 15 years old. Standard practice at that time would have been to ensure that she was not allowed to leave unless accompanied by an appropriate adult and to refer to the school nurse and liaison health visitor for information (regarding her risky behaviours) and follow up if appropriate. As the relevant paper records from 2006 are destroyed it is difficult to determine what actions were taken at the time.

3.15. From 2010 it is apparent that Adult B was increasingly consuming excess alcohol. Of relevance outside of the scoping period, was Adult B's attendance at the Emergency Department in December 2010 when she was 19 years of age. On this occasion Adult B was drunk and had been involved in a physical altercation with a friend. She admitted to a lack of judgement due to alcohol and reported that she had been evicted the day before and was living with her mother. Adult B also disclosed to the clerking Doctor that she was being sexually assaulted by her Uncle. The Doctor recorded that it was difficult to assess Adult B as she was intoxicated. Adult B remained in the bedded area of the department until she was more coherent and sober and could be reviewed by a Primary Care Coordinator and mental health services. There is no evidence to confirm whether she was spoken to again about her disclosures.

3.16. In 2011 there was an increase in the contact between Adult B and the Emergency Department equalling 9 attendances in the year. Adult B did not to wait to be seen on the first 2 occasions. Then, in July 2011, Adult B presented with genito-urinary symptoms and disclosed that she had a planned meeting with Police regarding sexual abuse by her Uncle. The Emergency Department Doctor advised Adult B's GP of this in the discharge letter and requested the GP to review and consider 'sexually transmitted infection' and 'vulnerable person' status. There is no evidence that a safeguarding adults or children referral was generated at the time.

3.17. In August 2011, Adult B presented twice with similar physical signs/symptoms but did not wait to be seen by a specialist, despite advice. On both occasions the

Emergency Department Doctor wrote to the GP asking for follow up and consider referral to the appropriate specialist service as an outpatient. In November 2011 Adult B presented with abdominal pain and claimed to be pregnant although a test carried out in the Emergency Department was negative.

3.18. In 2012, Adult B attended the Emergency Department on 3 occasions. In April she complained of spot bleeding in early pregnancy, and in May she attended after consuming excess alcohol, which generated a safeguarding children referral by Emergency Department staff due to concerns about the unborn child.

3.19. Adult B did not attend the Emergency Department again until April 2013. Following that there was another spike in attendances with 8 presentations, although she only waited to be seen on 6 occasions. Alcohol excess again featured in Adult B's attendances and the records indicate that Adult B was becoming more aggressive in her behaviours and was involved in more physical altercations with others / friends. Adult B was also increasingly uncooperative, aggressive and abusive towards staff in the Emergency Department.

Leicestershire Partnership Trust (LPT)

3.20. Adult A had various contacts with LPT through the Crisis Resolution and Home Treatment Team (CRHTT) and Deliberate Self-harm service. On 27th May 2006, Adult A was assessed by an on-call Senior House officer in Psychiatry for deliberate self -harm issues. Adult A denied any suicidal ideation and refused any offer of help for his drinking or otherwise. On 20th June 2007, a further referral was made for Adult A, from the Emergency Department, to the Leicestershire Partnership NHS Trust Liaison Psychiatry for deliberate self-harm issues. Adult A was seen by the deliberate Self-harm team and he reported that he had taken an overdose of morphine and had drunk excess alcohol. There was no psychotic or depressive signs evident and a personality disorder was noted. Adult A was then discharged with no further follow up.

3.21. On 19th May 2010, Adult A was referred by the Emergency Department to the on-call Deliberate Self Harm team. The team attended and found Adult A to be intoxicated and no evidence of mental health problems were found. They could not continue with the assessment until the patient was sober, however, Adult A left hospital prior to being seen by the Deliberate Self Harm team despite having agreed to be seen.

3.22. Adult A was again referred on 5th March 2012 by the Emergency Department however the process was that if the Deliberate Self Harm team attended to see a patient referred to them, and the patient was not medically ready, they would not continue their involvement until the patient was deemed medically fit. The initial referral would be closed, and a new referral required when the patient was medically fit. In this instance, it would appear that the second referral was not made.

Leicestershire Police

3.23. Adult A had numerous convictions dating back to 1962 which include theft, criminal damage, arson, public order and racially motivated offences. Police officers responded to a large number of incidents at his home address with Adult A being

both a victim and offender. In addition there are four vulnerable person reports which all related to Adult A self-harming.

3.24. Adult B has a number of convictions dating from 2004 which include wasting police time, racial harassment, public order, shoplifting, criminal damage, burglary, handling stolen goods and theft. The Police National Computer also shows that she has warning markers for depression, suicide and panic attacks and a heart condition. Outside of the scoping period, police officers have responded to a large number of domestic incidents between Adult B, her brother and her mother. Police reports show that Adult B may have been involved in prostitution since July 2010.

3.25. A significant event outside of the scoping period was on Wednesday 6th June 2007. Adult B's mother, took Adult B and a friend, who was a minor, to Adult A's address and whilst at the address the friend called the police stating that Adult A had indecently assaulted her by digital penetration. All three females provided statements and Adult B also alleged that she too had been sexually assaulted by Adult A by way of inappropriate touching over clothing in the groin and hip areas. Adult A was arrested and denied the offences. Forensic samples were taken from Adult A. The friend later retracted her accusation that digital penetration had occurred. The investigation did not identify any further corroborating evidence or witnesses and due to the conflicting victim and witness accounts a decision was made by the Crown Prosecution Service to take no further action.

3.26. On Saturday 31st July 2010, the police were notified that Adult B had attended hospital with breathing difficulties; and whilst there she disclosed to staff that over the past three years she had been sexually abused on a number of occasions by Adult A. Although Adult B refused to engage with the police or make a formal statement, the Child Abuse Investigation Unit (CAIU) conducted an investigation during which Adult A was interviewed; he denied that any of the events (touching over clothing in the genital area) had occurred and the case was filed without further action.

3.27. On Wednesday 9th March 2011, police officers attended Adult A's address to assist the ambulance service with Adult B, who was at the address with her mother, and had visible injuries. Adult A was arrested on suspicion of assault but was released without charge as Adult B and her mother refused to give statements or make a complaint. A domestic abuse incident form was completed and a risk assessment identified a standard risk.

3.28. On Friday 8th April 2011 police officers attended the home address of Adult A; he had sustained significant injuries and Adult B was arrested on suspicion of assault. The attending officer completed a risk assessment and identified a high risk. Adult A declined to make a complaint and Adult B was advised to speak to a housing officer upon her release.

3.29. On Friday 27th May 2011, police officers attended the home address of Adult A after a report that he had assaulted Adult B. Upon arrival it was established that Adult A had left prior to the officer's arrival. Adult B refused to make a statement of complaint but disclosed that she had also assaulted Adult A during the incident.

National Probation Service

3.30. The NPS contributions to this process are made on the basis of access to legacy records from Leicestershire and Rutland Probation Trust (LRPT). The NPS was not formed as an organisation until June 2014.

3.31. Adult B was subject to a 12 months' Community Order imposed on 1st September 2011 due to Racially Aggravated Harassment and Section 4 Public Order. The pre-sentence report and order supervision were undertaken by LRPT. As part of this order, the Offender Manager completed the following tasks:

- groupwork - cooking on a budget, art therapy, health and harm group
- criminogenic needs addressed - alcohol, association with peers,
- alcohol misuse - reduction in harm
- debt advice including liaison with benefit agencies
- offer to refer for counselling following sexual abuse - Stepping Stones (declined)
- liaison with police and Glenfield Hospital following a sexual assault by an unknown assailant
- referrals made to Leicestershire Cares, the Learning Cafe, REACH (employability)
- provided with the services of a support worker
- given support in working towards her goal of running her own catering business
- support given in completing housing application form

3.32. In 2011, Adult B informed the Offender Manager completing the pre-sentencing report that was being prepared that at the time of the index offence she had been drinking with her uncle with whom she was residing. She also disclosed that her uncle had tried to touch her and used sexual language towards her, and that prior to this, her uncle had sexually abused her. The uncle's name was not recorded. By the time of the report interview Adult B had moved out of her uncle's address and was living with her mother. Adult B stated that she had reported the issues to the police but was not ready to gain support to deal with the abuse. Adult B was referred for counselling during the course of her order but declined the service. In relation to the alleged abuse by Adult A, the Offender Manager supervising the order took Adult B's word that she had reported the matter to the police.

4. Summary of individual agency contact/involvement with Adult C

Although there is significant agency involvement with the three individuals involved in this DHR, there was no information to link them together. Adult C essentially led a separate life and was not known to Adult B or Adult A until a matter of weeks prior to Adult A's death.

Given the fact that there was no agency information to link Adult C, Adult B and Adult A, and that the relationship between Adult C and Adult B had only begun a matter of weeks prior to Adult A's death, this summary of individual agency contact/involvement is in respect of Adult C only and includes involvement both before and during the scoping period.

Education

4.1. As a child, Adult C was made subject of a statement of special educational needs. It indicated that he had special educational needs due to difficulties in the following areas: general physical skills; hand eye coordination; self-help skills; language skills (both understanding and expression); social skills, difficulties with concentration; cognitive skills; literacy and numeracy difficulties. Adult C attended a school for pupils with physical and learning difficulties.

Leicester City Council Adult Social Care

4.2. Adult Social Care (ASC) had involvement with Adult C during and prior to the dates within scope of this review. Adult C was supported by ASC with his finances and had ongoing case management by a Social Worker in the Adult Mental Health Team throughout the period of January 2013 and February 2015.

4.3. The main focus of the support from ASC was around Adult C's finances and management of these. There was also support with Adult C's Housing needs and the difficulties that Adult C had with maintaining a tenancy and moving between addresses. There were several incidents where Adult C appeared to be the victim of theft, robbery and assault.

4.4. In September 2014, Adult C was placed in residential care at Island Place. He had been living in the community prior to this but had lost his tenancy and there were concerns regarding his vulnerability and exploitation by the 'friends' he made.

Leicestershire Partnership Trust (LPT)

4.5. Adult C received care and support from the Leicestershire Partnership Trust Adult Community Mental Health Teams (CMHT) and the Specialist Psychological Therapy Services.

4.6. Adult C's first contact with LPT was in 2001 when he was referred by his GP for an assessment of Asperger's Syndrome. Adult C had been suffering from cerebral palsy since birth and had a diagnosis of learning disabilities during his secondary school years. By then, he had already had various educational psychology assessments and

had been educationally statemented. His diagnosis of Asperger's Syndrome was made in October 2001.

4.7. Although Adult C received ongoing outpatient psychiatric care from the Community Mental Health Team between March 2005 and March 2012, he did not have a primary psychiatric diagnosis of a severe mental disorder. The working diagnosis at the time he was seen in the psychiatric outpatient department was Asperger's Syndrome. Common characteristics include difficulty in forming friendships and communication difficulties.

4.8. The Community Consultant Psychiatrist referred Adult C to the Forensic services of LPT in January 2005 for them to assess him to determine if that service would be better placed to support his needs but the referral was rejected as he did not meet the clinical criteria needed.

4.9. Between July 2005 and August 2011, Adult C was open to the Specialist Psychological Therapy Service for two reasons: firstly, to help manage some of the Asperger's Syndrome associated behaviours using Cognitive Behavioural Therapy and self-help groups' sessions and secondly, for the management of his secondary diagnosis of Post-traumatic stress syndrome which Adult C identified as caused by an alleged sexual abuse at a young age. Adult C was also concerned about the effect of his anger and the difficulties managing this upon his relationships. When Adult C disclosed his concerns about the impact of his anger on his personal relationships in a therapy session, he was not in a relationship; so no immediate risk to others was identified. The purpose of the therapy was to mitigate against the impact of his anger against future partners.

4.10. A specialised therapy called Eye movement desensitizing and reprocessing therapy (EMDRT) was utilized during Adult C's individual therapy. Adult C appeared to have found these therapies beneficial and was able to apply the skills learnt in his daily life to the point where he felt ready to discontinue and his attendance became infrequent. He later verbalized in one the sessions that he did not require further therapy as he had learnt enough skills through therapy to cope with life stressors. Despite this assertion he subsequently requested to be re-referred for further therapy, which was facilitated, however he failed to attend appointments and was subsequently discharged from the service.

4.11. During LPT involvement, Adult C was reviewed by a consultant psychiatrist every 3 months and was also monitored and supported by a member of the Community Mental Health Team (CMHT), every 2-3 weeks. The member of the CMHT supported him with activities of daily living such as shopping, paying bills, housing issues and ensuring that he attends routine medical and non- medical appointments. They would also alert the psychiatrist if there were changes in his mental health that might affect him and others. The multi-disciplinary team involved in Adult C's care made the decision in collaboration with Adult C and his family, that his needs which were related to social factors, would be best met by him living in a residential home. He was subsequently, discharged from LPT in March 2012.

4.12. In cross reference with the adult social care records, it would appear that they were not attendees at this multi-disciplinary meeting. There are social care records in 2012 where Adult C's mother made a request for residential care but this was not deemed

to be the primary option for him. Work took place instead for Adult C to be supported to remain in his tenancy.

4.13. On 12th September 2013, Adult C was assessed by the deliberate self-harm team to determine if he required crisis intervention due to his reaction to social stressors. He had presented at the Emergency Department with thoughts of ending his life by taking some tablets, using a knife and / or running in front of traffic. Adult C reported that he had fallen out with the people he was living with and had been made homeless. He described having no intent to go through with these thoughts and he was prepared to seek help and wanted things to change. Adult C did not present with hallucinations or delusions and there was no evidence of formal thought disorder. He was advised to stay with his sister overnight and then present to the Dawn Centre (homeless hostel for people with mental health issues), the next day. Adult C reported that he preferred to go to the Housing Options instead with the hope that they would provide him with bed and breakfast accommodation. He was informed by the assessor that his social worker would be updated about his assessment and would be referred to the psychiatric outpatient service if need be. It was also suggested that he liaised with his GP if he required anti-depressant to help him with his situation especially as he had indicated that it had helped him previously. He was subsequently discharged as he was not deemed to be clinically depressed, or experiencing any psychotic illness or anxiety. There was no evidence of intent to harm himself.

4.14. On 7th August 2014, Adult C was assessed by the Crisis Resolution and Home Treatment Team following referral by the police. Adult C reported social stressors during his assessment, and that his sister had threatened to put him in a psychiatric hospital. He denied any thoughts of self-harm or harm to others. The assessment concluded that no intervention was needed. Adult C was advised to see his GP and was discharged.

University Hospitals of Leicester NHS Trust

4.15. During the period 2004 – 2015 Adult C attended the Emergency Department on 17 occasions. Of those, he did not require treatment, or he was redirected to a more suitable service, on 4 occasions. Up until 2011, Adult C only attended with minor illnesses / injuries / sprains and no concerns were apparent in the medical records. He was treated appropriately on each occasion and discharged within a few hours.

4.16. In 2009, Adult C was seen at hospital because of an overdose with alcoholic intoxication, for which he was admitted. On 10th July 2009 he was admitted to hospital in Nottingham following an alleged assault where he had been beaten over his head and scalp.

4.17. On 19th July 2011, Adult C was conveyed by ambulance having been found crawling along a street intoxicated. It is recorded on the notes that Adult C was at that time residing in a ‘care home’ for people with mental health difficulties. Adult C could not recall events, had lost his glasses and was struggling to see. Hospital staff contacted the care home prior to discharge and were informed that Adult C was ‘free to leave the home’ at any time, and he was ‘due to move out soon’. Consequently, no further action was taken and he was therefore discharged from hospital with head injury instructions.

4.18. On 12th September 2013, Adult C attended the Emergency Department, conveyed by ambulance. Adult C presented with suicidal thoughts, and had called the Police himself to report that he needed 'sectioning'. He was seen by the deliberate self harm team (see 4.12 above).

Leicestershire Police

4.19. Adult C has convictions for attempted buggery and gross indecency in 2001. The Police National Computer shows that he has warning markers for self-harming, anxiety, depression, deafness, cerebral palsy, post-traumatic stress syndrome, Asperger syndrome and for being suicidal. There are nine vulnerable person reports for Adult C which include three reports of him being a missing person, two calls for assistance, a report from his mother over concerns of exploitation and one for harassment.

4.20. In October 2009, Adult C reported to the police that he had been assaulted by his then girlfriend and her friends; the case was investigated during which Adult C re-established his association with the perpetrators and despite all the appropriate referrals being made to support him he ultimately retracted his complaint.

4.21. On 1st January 2013 the police were contacted as Adult C was making threats to jump from the balcony of his sister's home address. The incident was graded Priority 1 and intelligence checks identified that Adult C had mental health issues and learning difficulties; this information was passed to the attending officer. Police officers arrived and found that the situation was not as reported; Adult C was intoxicated and in an argumentative mood. No offences were disclosed to the officers however to prevent the situation escalating Adult C was taken to his uncle's house for the rest of the night; and was described as calm when the officers left him.

4.22. On 19th August 2013 a member of the public reported a robbery. Police officers attended and established the victim was Adult C; he had been robbed by two males whom he had just met. The attending officers arrested the two suspects who were still at the scene and they were later charged with the offence.

4.23. On 3rd September 2013, the police were informed that Adult C had been assaulted by two males in the street and that it was part of a running feud between neighbours who had attacked Adult C with a bottle. The attending police officers conveyed Adult C, and two witnesses (with whom he lived) to the Police Station in order to obtain statements. The officers were aware that all three required an appropriate adult due to their learning disabilities and mental health. Whilst a statement was being taken from one witness, Adult C left the police station with the other witness. The officers tried to contact them via their mobile phones and visited their address but there was no reply. The investigation was not supported by Adult C and he failed to attend an arranged appointment. The crime was filed as undetected.

4.24. On 12th September 2013, Adult C reported to the police that he had been threatened with violence by his male housemate. As a result of concerns regarding his mental health, Adult C was taken by ambulance to hospital that evening. Police officers attended the hospital to find Adult C had not been assaulted but that he was in a distressed state, he said that he was having difficulties with his 'carers' and that he

wanted to admit himself voluntarily for an assessment of his mental health. Adult C was seen by the deliberate self-harm team. At that time he reported that he was drinking about 8 – 9 cans of lager every 2 days.

4.25. On 14th September 2013, the police officer established that Adult C was safe at a hostel but that he wanted to retrieve his property from the address he had shared with his two housemates; which was facilitated. An adult at risk referral was made to the police in house adult at risk team who viewed the circumstances and concluded that as Adult C was already in receipt of the appropriate care from other agencies further referrals were not required.

4.26. On Sunday 3rd November 2013 a member of staff from a hostel where Adult C was being housed reported that she had received a call from Adult C stating he had been sexually assaulted. Police officers arrived shortly after midnight and ascertained that Adult C had not been assaulted but had agreed to consensual sex earlier in the day with his girlfriend's brother. Later that day Adult C had given his bank card to him and asked him to go to the cash machine to withdraw money but he did not return. Adult C was taken back to his hostel; where both officers and the hostel staff expressed doubts over the validity of the allegations or whether an offence had actually been committed. An adult at risk referral was made however Adult C's social worker had already been informed of events.

4.27. On 7th May 2014, EMAS reported that they had been called to an assault where a male was bleeding from a head injury; the attacker was not believed to be at the scene. Police officers arrived and established that Adult C was the victim, he did not have a head wound but he did have a cut to his hand which required stitches. At the time Adult C was unable to recall any details of the incident and when he was seen later he decided that he did not want any further police action.

4.28. On 31st July 2014, Adult C was accused, along with 2 others, of beating a female over a period of days whilst at a shared address and that Adult C had recorded some of the assaults on his mobile phone. A decision was taken by the CPS that no further action would be taken in respect of these allegations.

4.29. On 6th August 2014, a member of staff from Adult C's support housing reported him missing; information was received that he had taken his clothes and television with him. Adult C was located with two associates and a vulnerable person report was completed. There was a concern that he was being exploited by the two associates but when questioned he did not support this and stated that he was "sofa-surfing" of his own free will.

4.30. However Adult C later reported to the police on 25th September 2014 that he had been assaulted by the two associates over a period of weeks. Adult C was safe at a hostel at the time of the report so an appointment was made to visit him. Adult C gave conflicting accounts to the investigating officer and CCTV opportunities were explored which did not match the events he described. Enquiries were completed however no evidence was found to support the allegation and the crime remained undetected. An adult at risk referral was made, Adult C's social workers were made aware of the allegation and he was given safety advice.

GP

4.31. Adult C registered with a new GP on 13th October 2014. Adult C asked for Sertraline which he was being prescribed for depression and anxiety. The prescription was issued and he was asked to book an appointment prior to his next request for medication. However a medication review was subsequently completed based on patient records rather than face to face contact.

Housing

4.32. Adult C was provided with supported accommodation in 2012 and 10 hours of care per week. This ceased due to Adult C failing to engage and he went on to lose his tenancy as he was failing to engage with the support that was a prerequisite of the tenancy. In addition, Adult C had allowed two associates to move in with him, leading to concerns regarding antisocial behaviour.

4.33. Adult C was rehoused in further supported accommodation but was served with a notice of abandonment of his property of 7th September 2014. On 22nd September 2014, he informed housing options that he was staying with friends who were abusing him. Temporary accommodation was sought.

4.34. Adult C then moved to Island Place, a residential care home on 22nd September 2014. This was intended to be a temporary placement pending exploration of other housing options.

There was no evidence of any association between Adult A and Adult C in the agency case records for Adult C apart from a very brief mention in the adult social care case records on 19th February 2015, where Adult C advised that he would be staying with his girlfriend (Adult B) at the weekends. This was *after* the recorded date of death for Adult A.

5. Summary of key events within the scoping period

NB: This section relates to Adult B and Adult A as Adult C was not known to them until a few weeks before Adult A's death. Information in respect of Adult C has been summarised in the sections above.

Author comments are in bold

5.1. On 1st January 2013, a 999 call was made to the police by Adult B who reported that her partner was preventing her leaving the address with their daughter Child A. The police visited and found Adult B's partner asleep upstairs, and conveyed Adult B and her daughter to a different address. Later that day the partner retrieved Child A from the care of Adult B as she had been drinking alcohol and contacted the police to raise his concerns about Adult B's ability to care for the child. A safeguarding referral and domestic violence report were completed by the police as a result of this incident.

The safeguarding referral made in respect of Child A is evidence of good practice.

5.2. A non–molestation order was subsequently granted to Adult B against her ex-partner. Adult B's solicitor referred her to SAFE, domestic violence support services, but she failed to engage.

5.3. As a result of the concerns in relation to alleged domestic abuse and alcohol misuse, Children's Social Care allocated a social worker to Child A and completed a core assessment of Adult B's parenting. Child A's father applied for a residence order in respect of Child A, which was supported by Children's Social Care and was subsequently granted.

5.4. On 9th March 2013, police attended Adult A's home address after he called to report that he felt suicidal and had heard rumours that people were calling him a paedophile. The attending officers saw cuts to Adult A's arms and he was conveyed to hospital. Adult A was seen by the Deliberate Self Harm team who noted that the patient's difficulties were secondary to alcohol dependency and social stressors and that he has no mental health needs. Adult A was also seen by the Acute Assessment and Recovery Service in relation to alcohol misuse to Adult A declined their input. Adult A was discharged as his mood was described as stable and he was willing to reduce his drinking.

Adult A was seen by the appropriate services as a result of his self-harm and alcohol misuse.

5.5. Adult A was seen again in the Emergency Department, in the company of Adult B, on 21st March 2013. Adult A was intoxicated and had self-harmed causing a laceration to his forearm. Adult A disclosed earlier to the police that he had self-harmed as a result of being accused by the ex-partner of Adult B that he had sexually touched Adult B and her daughter. Both Adult A and Adult B were described as aggressive and soon left the hospital.

5.6. Adult A returned to the Emergency Department on 24th March 2013, to have the wound on his arm examined. An Adult Mental Health pro forma was completed by an Emergency Department Doctor and Adult A was not deemed to be a current risk to self. Adult A denied suicidal ideation and reported to the Doctor that he was drunk at time of the self-harming incident. The Doctor was unable to suture the wound due to the age of the wound, so it was cleaned and dressed. Adult A was adamant that he did not want to see Deliberate Self Harm team and was discharged.

5.7. On 2nd April 2013, Adult B was seen in an area used for street prostitution by New Futures Outreach Workers. Adult B was provided with condoms and advice in respect of alcohol use and the dangers of this when working in prostitution. This was due to Adult B appearing intoxicated.

5.8. On 4th April 2013, Adult B's mother contacted the police to report an argument with Adult B; she wanted Adult B out of the house as she was drunk. The call was recorded as a domestic incident but upon the arrival of officers Adult B accused her mother of slapping her on her back. The assault was recorded as a crime and Adult B was taken to Adult A's address to calm down. The investigation into the assault found that Adult B's mother had tried to get Adult B to leave the premise by placing her hand on her back; Adult B had no injury and would not provide a statement or assist with the investigation and so the crime was filed.

5.9. On 5th April 2013, and ambulance was called to Adult B who had a hand injury. Adult B reported that she had punched a door the day before. Whilst she was in the ambulance, Adult A became abusive and "squared up to staff". The ambulance crew noted that Adult A would not allow Adult B to travel on her own or to answer her own questions. The crew also noted that she taken alcohol. On arrival at the Emergency Department, Adult B refused to enter a cubicle and left without seeing a doctor.

This incident could have prompted a safeguarding referral being made by EMAS in respect of Adult B.

5.10. On 15th April 2013, Adult B reported being beaten and robbed by a male whilst waiting for a friend. She had been pushed to the ground and her mobile phone and £10 was stolen. Adult B denied being there as a sex worker. Police officers attended however during their enquiry Adult B's recollection of events changed a number of times and did not match the evidence from CCTV coverage. The crime was filed as unverified.

5.11. Adult B was seen again by New Futures Outreach Workers on 18th April 2013 in an area used for street prostitution. Adult B appeared intoxicated and advice was given regarding the dangers of this.

5.12. The following day, Adult B attended the Urgent Care Centre after having been allegedly assaulted the previous Monday by an unknown assailant. Adult B was difficult to assess due to the level of intoxication but she was seen to have bruising to the kidney region so was sent to the Emergency Department. Once there, Adult B did not wait to be seen by a doctor.

There is no evidence of liaison with the police or consideration of a safeguarding referral being made in respect of Adult B.

5.13. On 22nd April 2013, at 01.03 hours, Adult B attended the Emergency Department complaining of blood in her urine after being kicked previously in the back. Adult B was accompanied by Adult A. Adult A became loud and was asked to leave by the security staff and became racially abusive. Adult A was subsequently arrested. Adult B did not wait for assessment and left the hospital. As a result of this admission, Adult B's GP tried to contact Adult B and an appointment was arranged at the surgery. Adult B failed to attend this appointment.

The proactive attempt of the GP to see Adult B as a result of her attendance at the Emergency Department is an example of good practice.

5.14. Adult A admitted the offences and was charged. He subsequently appeared in court and was fined.

5.15. Later that day on 22nd April 2013, an ambulance was called to Adult A for pain in his wrists. Adult A reported that he had an altercation with the police the previous night and was handcuffed, since then he has suffered from pain in his wrists.

5.16. Over the next few weeks, an ambulance was called to Adult B on 4 occasions, although none required her to be conveyed to hospital.

5.17. On 3rd June 2013, Adult A attended the Emergency Department with musculoskeletal pain. He smelled strongly of alcohol. No bruising or injuries were seen and he was discharged.

5.18. The police were contacted on 15th June 2013 by Adult B's mother who reported her concerns for Adult B's wellbeing; there was then a further call reporting a disturbance in the street involving both Adult B and her mother. Adult B's mother was concerned that Adult A and Adult B were engaged in sexual activity and that Adult B was working as a prostitute, with Adult A acting as her 'pimp'. Adult B denied the allegations of sexual activity with Adult A but admitted that he was accompanying her to work on the streets and that he was looking after her money. She told officers that Adult A had allegedly tried in the past to "come on to her" but she did not let him; it was the officer's observations that Adult B did not seem concerned by this. Adult B declined to make any statements. Attempts to speak to Adult A were unsuccessful as he was not at home. A vulnerable adult's form was completed in respect of Adult B and referral made to New Futures (prostitution outreach) and Open Hands (a Christian charity) but Adult B failed to engage with them.

The referrals made to support Adult B are examples of good practice.

5.19. On 20th June 2013, Adult B was seen by the police officer back at Adult A's address; Adult A was not at home and Adult B denied that she was living there. The officer returned 10 minutes later and no-one would answer the door.

5.20. On 13th July 2013, Adult B's mother contacted the police as she had information that Adult A had assaulted Adult B. This was later denied by Adult B despite having a large bruise on her arm. The police referred Adult B to Adult Social Care following her having disclosed that she was working as a sex worker.

5.21. Also on that day a report of antisocial behaviour was made. After this, regular reports continued to be made concerning Adult A, Adult B and various unknown others including reports of drinking and fighting.

5.22. As a result of the referral made by the police, Adult Social Care made contact with New Futures. Adult Social Care were unsuccessful in contacting Adult B.

5.23. On the 26th July 2013 the GP for Adult B received a call from Adult Social Care. The social worker reported to her that they were investigating claims made by a third party that Adult B is being assaulted by her uncle whom she was currently living with and that she was also involved with prostitution. The social worker had requested if there was anything in the GP records that would collaborate this information and if there was any underlying health problems. The GP reported that Adult B had not been seen in the GP surgery for some time but had presented to the Urgent Care Centre smelling of alcohol and with alleged physical abuse.

5.24. An ambulance was called to Adult B on 28th July 2013 after she was seen fitting. Her aunt was with her and she also appeared intoxicated. Adult B was wearing clothes that the crew considered inappropriate in that she was wearing leggings, and underwear with a bathrobe and jacket over. Adult B was observed to have bruising to her upper and lower body. The aunt stated that Adult B lived with her uncle who was a registered sex offender and had been allegedly abusing Adult B since she was 12 years of age. She also alleged that Adult A supplied Adult B with alcohol and other substances and then abuses her. The crew approached Adult B about this and she denied it. She refused to be transported without her uncle. She also informed the crew she might be pregnant. The crew completed a safeguarding referral. On arrival at the Emergency Department, Adult B was seen to have bruising to her head, caused during falling. Adult B was treated for alcohol withdrawal and admitted to the Admissions Unit.

The safeguarding referral made by EMAS is an example of good practice.

5.25. The following day Adult B was discharged as she wanted to go home. Advice was given regarding her alcohol use. There are no records of any discussions regarding alleged abuse.

5.26. As a result of information provided by the police and ambulance crew, Adult Social Care decided to open a safeguarding alert in respect of Adult B. Attempts were made to contact the admissions unit but by the time contact was made, Adult B had already been discharged.

5.27. Continued attempts were made to contact Adult B, including two home visits, letters and telephone calls. Despite this no contact was made. It was decided that Adult B's case would be transferred to a locality team for ongoing social work involvement under the Vulnerable Adults Risk Management Policy.

5.28. **The potential risks to Adult B were recognised by Adult Social Care and the** transfer for ongoing social work involvement was a positive step.

5.29. On 4th August 2013, a neighbour of Adult A reported to the police that there had been a forced entry to her property. She reported that the noise from and frequent

visitors to Adult A's flat were having an adverse effect on her and her son. Allegations were made of drug use and prostitution. The City Council Anti-social behaviour unit were notified.

5.30. On 21st August 2013, Adult A attended the Emergency Department reporting that he had been assaulted the previous day and had rib pain. He told staff that he was pushed over by a female friend. No abnormalities were noted and he was discharged.

There is no record of any detailed discussion regarding the alleged assault, the name of the perpetrator or liaison with the police.

5.31. An ambulance was called to Adult A on 1st September 2013 who reported that he had been assaulted by a large lady who jumped on his chest. Adult A declined being conveyed to hospital.

Again, there is no record of any detailed discussion regarding the alleged assault, the name of the perpetrator or liaison with the police.

5.32. On 3rd September 2013 a meeting was held between a police officer and a Housing Officer from Foundation Housing to discuss Adult B living at Adult A's flat. It was agreed that the best outcome was to disrupt the arrangement by issuing a warning letter to Adult A as the tenant and to invite them both to a meeting on 9th September 2013 to discuss the matter. The City Council Antisocial Behaviour Unit was also invited to attend but did not do so as it was felt that the matter did not meet the thresholds of serious and protracted antisocial behaviour. Adult A and Adult B did not attend the meeting but were located on the street near to Adult A's address. They were handed Anti-Social Behaviour Warning letters from the police officer and informed that Foundation Housing would be escalating proceedings to evict Adult A unless the situation changed. Adult B agreed with the police officer that she would move out of the address.

This attempt to disrupt the living circumstances of Adult A and Adult B is an example of creative methods to address the issues of concern.

5.33. On 6th September 2013, Adult A attended the Emergency Department complaining of right sided chest pain as a result of a further alleged assault during which he sustained blows to his chest and face. A facial x-ray identified a fracture of left zygomatic arch (cheekbone). Whilst in hospital, Adult A was reviewed by the alcohol liaison nurse but Adult A did not engage and refused community help or support. Adult A denied being alcohol dependent but admitted to excessive drinking of approximately 40 units per week.

Yet again, there is no record of any detailed discussion regarding the alleged assault, the name of the perpetrator or liaison with the police.

5.34. On 7th September 2013, an ambulance was called to Adult B. On arrival of the crew, Adult B was lying on the bed hyperventilating, semi dressed and exposing her breast. The crew noticed a lot of circular bruising to her arms, hands and legs. They asked if Adult B was clumsy and Adult A replied yes. Adult B continued to expose herself in the presence of the male crew member and Adult A, even though she had been

asked by the female crew member to cover up. The crew on scene completed a safeguarding referral in relation to this attendance. The crew also made contact with Adult B's GP who also made a safeguarding referral. He also expressed in the referral letter previous information received from the social worker suggesting possible physical abuse from her uncle.

The safeguarding referrals made are examples of good practice.

5.35. On arrival at hospital, doctors also noticed faded bruising but Adult B denied that she was being abused. She stated that the bruising was due to her having been in a fight with a girl. Adult B's mother reported that she had concerns about Adult B living with her uncle because of his alcoholism; and she confirmed that Adult B's daughter lived with her. Both Adult B and her her mother disclosed that Adult A would not allow Adult B to leave the flat, was controlling and gave her alcohol. Adult B's mother alleged that Adult A was having sex with Adult B and was coercing her into prostitution. Adult B did not confirm either allegation. Adult B was seen by the alcohol liaison nurse and admitted to drinking to excess. Adult B described the living arrangements with her uncle as suitable but said 'we argue all the time'. She denied any physical or sexual abuse by Adult A when asked. An alcohol detox programme commenced.

5.36. On 12th September 2013, Adult B was seen on the ward by a social worker. Detoxification was progressing well and discharge options were discussed. Adult B agreed to stay with her mother's friend in the short term. Adult B denied experiencing domestic abuse. The social worker recorded that Adult B had capacity to make decisions around discharge and support, and provided her with contact details of various support agencies including women's aid. After review by the alcohol liaison nurse Adult B was discharged, with arrangements made for community follow up support.

5.37. Between 19th September 2013 and 3rd October 2013, an ambulance was called to attend to Adult B on 5 occasions. On 1st October she had been drinking and was seen to have bruising to her legs. The cause of the bruising was not documented.

5.38. On 4th October 2013, the social worker made telephone contact with the friend Adult B was going to reside with after discharge from hospital. The friend stated that Adult B never arrived and went back to reside with Adult A. She was reported to be drunk with 2 hours of discharge. The case was subsequently closed by Adult Social Care.

Given the potential risk that a return to live with Adult A may have posed to both individuals, plus the associated alcohol abuse, it would have been good practice for Adult Social Care to have made contact with Adult B and Adult A and establish their safety.

5.39. On 17th October 2013, Adult A was arrested for an assault upon a female, having punched and spat at her. He later pleaded guilty and was given a community order and a fine.

5.40. An ambulance was called to Adult B on 20th October 2013 for abdominal pain. She stated that she might be pregnant and had started bleeding that morning. She admitted to having drunk a bottle of vodka that day and was uncooperative with the

staff at times. Adult B was conveyed to hospital. Adult B was uncooperative and unwilling to be examined and she left the Emergency Department prior to being assessed.

5.41. On 28th November 2013, an ambulance was called to Adult A following an assault. Adult A was aggressive and abusive to the crew. A further ambulance was called the next day when Adult A reported that the pain from the attack was increasing. Adult A would not agree to being conveyed to hospital.

There is no record of any detailed discussion regarding the alleged assault, the name of the perpetrator or liaison with the police.

5.42. Adult A saw his GP on 3rd December 2013 and mentioned that he had been assaulted and kicked in the ribs. He was prescribed ibuprofen.

Again, there is no record of any detailed discussion regarding the alleged assault, the name of the perpetrator or liaison with the police.

5.43. An ambulance attended to Adult B on 12th December 2013 due to excessive alcohol consumption. Again she was seen to be exposing herself despite being asked by the crew not to do so. Adult B was conveyed to hospital and admitted to the admissions ward. Adult B reported that her alcohol consumption had increased over the past 6 months since splitting with her boyfriend. She was noted to have alcohol hepatitis, kidney injury, sepsis and her condition deteriorated whilst in hospital. Adult B required intensive care due to Type 2 respiratory failure before recovering prior to discharge on 22nd December 2013.

5.44. Whilst in hospital, the ward nurse contacted Adult Social Care and was advised that they had closed the case. The nurse recorded that the call handler was 'unhelpful and did not provide further assistance', so the nurse then found the social worker's direct number in an old set of notes and contacted him directly. The social worker advised that he had been unable to help Adult B as she had refused all previous offers of help and support.

The case had been closed to Adult Social Care without contact having been made with Adult B following her last discharge from hospital. It would have been pertinent to consider whether the case should have been reopened given her current circumstances.

5.45. On 25th December 2013, Adult A called for an ambulance for a medical reason but became aggresive and so the crew left the scene. On 29th December 2014. Adult B called an ambulance reporting that she had fallen backwards and received a head injury 4 days previously.

5.46. On 19th January 2014, Adult B was admitted to hospital following excessive alcohol intake. She was treated for chest and kidney infection and alcohol withdrawal. Whilst in hospital Adult B was diagnosed with acute hepatitis and pyelonephritis. She was discharged on 27th January 2014 as medically fit.

5.47. On Tuesday 6th February 2014 a Post Office worker reported that Adult A was in the Post Office, Leicester and very upset as he believed money had been stolen from his

account. Police officers attended and Adult A was taken back to his home address and completed a statement with the officers. A Police National Computer enquiry, undertaken by the officers whilst still at the address, identified that Adult A was wanted on warrant for failing to attend a court summons the previous day; and so he was arrested. Whilst on his way to the police station, Adult A told officers that he had been diagnosed with cancer and had only three months left to live. He made comments that he no longer wished to live as he was in a lot of pain. Once at the police station, Adult A was seen by a doctor due to the comments he had made and he was considered fit to detain. An adult at risk referral was made for Adult A as he was without money, was very upset by the incident and had made comments of a suicidal nature. The Police in house Adult at Risk Team contacted Adult Social Care and were told that they had previously offered Adult A services in 2011 which he had declined, and so a re-referral was made. As a result of this referral, Adult Social Care left a message to ask for the out of hours GP to visit Adult A and made an unsuccessful attempt to contact Adult A by phone. The GP subsequently spoke with the police as it was felt that it was unsafe to visit due to a history of violence and racism. The GP was reassured by the police that they would visit, which they did do and confirmed that Adult A was safe and well.

This was an appropriate response to Adult A.

5.48. On 7th February 2014, Adult A was sentenced at court to a 12 months Community Order for Assault by Beating and Racially Aggravated Harassment. In terms of the theft incident reported on 6th February 2014, Adult A had initially accused Adult B of the theft but on 10th February 2014 he contacted police to say that it was actually someone else and as there was no CCTV evidence or witnesses, the crime was filed as undetected.

5.49. On the 10th February 2014, Adult B had a consultation with a health professional from Inclusion Health Centre where an alcohol screening test was performed which identified Adult B as having problems with alcohol. Adult B also reported suffered with depression due to not being able to see her one year old daughter who was in the care of her mother. Adult B also reported she had been physically and sexually assaulted by her uncle and this had been also caused her to feel low. Adult B said she was drinking heavily and had done so since she was 20 years of age. She reported she dislocated her thumb as she was assaulted about a week ago on the street. Adult B was then also seen by a nurse on the same day at Inclusion Health Centre and she gave further information to the nurse and stated that she had now started drinking 2 bottles of wine a day. She said she was staying with friends but could not continue to do so, she was in touch with the outreach team who were arranging dormitory accommodation for her. Adult B was treated for a urine infection. She was also introduced to a CPN and was made aware of how to access services for support, including alcohol supports services.

5.50. **There is no evidence of consideration of a safeguarding referral or of liaison** with the police given the allegations of physical and sexual abuse.

5.51.

5.52. On 16th February 2014, Adult B attended the Urgent Care Centre and was then sent to the Emergency Department following an alleged assault that occurred 2 weeks previously, where she was pinned to the ground injuring her right wrist. Adult B was

examined and no injury was noted. Adult B reported that she was thrown out of a car but did not disclose who by. She was noted to smell of alcohol.

There is no record of any detailed discussion regarding the alleged assault, the name of the perpetrator or liaison with the police.

5.53. An ambulance was called to Adult A on 21st February 2014. Adult A stated that he had been drinking vodka and brandy for the last two days. He also stated that four days previously he had taken some unknown tablets given to him by the people across the road. He reported that he lived with his niece but as there is only one bed they take it in turns to sleep on the sofa. Adult A was conveyed to the Emergency Department with left sided chest pain. He admitted to having been in a fight earlier sustaining blows to his chest and face. Adult A was referred to the alcohol liaison nurse.

There is no record of any discussion regarding the fight, and who was the perpetrator of his injuries.

5.54. On 28th February 2014, Adult Social Care made unsuccessful attempts to contact Adult A, including a home visit. This was a result of the police referral on 6th February 2014. Adult Social Care spoke to agencies, including his GP who confirmed that he did not have terminal cancer. The case was subsequently closed.

5.55. Adult A was admitted to hospital on 24th March 2014 due to abdominal pain and a history of gastro bleeding. Adult A had an abdominal X-ray, was reviewed and discharged 2 days later.

5.56. On the 27th May 2014, Adult B had a further alcohol screening test at the GP surgery. Adult B reported that she had been drinking ¾ of a litre of Vodka a day. She was feeling unwell at the time. The GP advised her to consider a referral to the alcohol team which she said she would think about. The GP also arranged blood tests but Adult B failed to attend.

5.57. Adult A was invited to meet with the housing provider on 28th May 2014 to discuss reported antisocial behaviour. Adult A failed to attend, so the property was visited by a housing officer and 2 police officers. Adult A was adamant that Adult B was not living at the property, despite her being present. A formal warning letter was sent to Adult A regarding antisocial behaviour and visitors to the property.

5.58. On 30th May 2014, Adult A was conveyed by ambulance to hospital after having fallen due to being intoxicated. He had hit his head as he fell, after having drank 1.5 litres of vodka. Relevant investigations were carried out and Adult A was discharged. Adult A was admitted again on 3rd June 2014, with sudden onset left sided chest pain. He had been drinking to excess all day, no medical problems were detected and he was again discharged.

5.59. A housing officer visited Adult A on 9th June 2014. Adult A stated that Adult B had moved out, despite evidence of women's clothing and make-up being in the flat.

5.60. Adult B was admitted to hospital on 24th June 2014 with queried pancreatitis. She presented as tearful and anxious and had been drinking excessively. Examination

found that Adult B was medically well. She was agitated and asking to leave so was discharged the same day. The GP then wrote a letter to Adult B asking her to contact the surgery so that a referral could be arranged to the alcohol team for her if she was happy to proceed. Adult B also had an appointment at the surgery on the 30th June 2014. Adult B did not attend the appointment.

The GP's attempts to engage Adult B in accessing appropriate alcohol support is an example of good practice.

5.61. On 18th July 2014, Adult A was referred to the specialist antisocial behaviour team, however the complainant requested no action be taken against Adult A until they had moved due to a fear of repercussions. The complainant subsequently moved to alternative accommodation and the case was closed.

5.62. On 24th September 2014, Adult A was admitted to hospital with abdominal pain secondary to pancreatitis. He was advised by doctors that his condition was caused by excess alcohol and was advised to reduce to safer drinking levels. Adult A was seen by the alcohol liaison nurse but did not engage and declined offers of support. Adult A was discharged on 27th September 2014.

Attempts were made to support Adult A with his alcohol misuse.

5.63. On 25th December 2014, Adult A reported a number of incidents to the police ranging from someone pointing a gun at his head two weeks earlier to being attacked in the street and stabbed in the stomach. The call handler considered Adult A to be intoxicated and doubted the truth of his reports however having established he was safe, a scheduled response was agreed and police officers attended the following day. The officers questioned Adult A about the allegations he had made, he said that he had encountered two males in the street on 25th December 2014 who had proceeded to cut him in his stomach area. Adult A was vague about the event and gave conflicting information. The officers viewed the injuries and the clothing he had been wearing at the time and the officers believed the injuries had been self-inflicted. An adult at risk referral was made to the police in house adult at risk team owing to the belief that Adult A had self-harmed. Adult A's GP surgery were also informed of the incident and the GP made telephone contact with Adult A on 2nd January 2015. Adult A denied excessive alcohol intake and any self-harm/suicide ideas.

The referral made by the police plus the contact with the GP are evidence of good practice.

5.64. Adult B contacted the police on 25th January 2015 to report having being raped by a male she had agreed to have sex with for money. She told the police officers that she had spent the previous night in Leicester city centre drinking with a friend and, after being dropped off at home by a male at 2:00am, she had gone back out to look for clients. Adult A had reportedly accompanied her to 'watch over her'. Adult B left alone with the suspect after agreeing a price for sex and was taken to an unknown address. Adult B stated it was at this address that she was raped.

5.65. Adult B completed a video recorded interview several weeks after the incident. She admitted to having met the suspect on two previous occasions at Adult A's address; and on both occasions she had sex with him for money. She also stated that she

had arranged to meet him through a mutual friend. Whilst a scene was never identified a CCTV trawl was completed. As the investigation progressed, Adult B's account of the event changed from when she first disclosed the rape. Adult B's clothing was seized however she refused to provide forensic samples. The police made contact with New Futures and Adult B's GP following the investigation.

The police contact with support services and the GP are examples of good practice.

5.66. A referral was made to Adult Social Care by the on call GP on 29th January 2015 in respect of Adult B. Concerns were expressed regarding the rape allegation, psychological problems and whether Adult A was her 'pimp'. A safeguarding alert was opened and the case was allocated to the same worker who had attempted to make contact with Adult B in 2013. Despite further attempts being made, the worker was again unable to make contact with Adult B.

5.67. An ambulance attended to Adult A on 3rd February 2015, and it was recorded that Adult A was intoxicated and admitted to having drank a bottle of vodka that day.

5.68. On 4th February 2015, Adult B made an application for housing.

5.69. On the 12th February 2015, Adult B's GP received a phone call from a paramedic who was with Adult B. He said that he knew Adult B well and that she was intoxicated, abusive and threatening self-harm. The paramedic reported that she had been like this for many years and wanted to know what the next step of action should be. The GP advised that Adult B should be taken to a place of safety, the Emergency Department, however if she preferred to be seen at the GP surgery then he would be happy to see her.

When a patient is threatening self harm and experiencing mental health difficulties the referral routes available to GPs can take several weeks to process. The view of Leicestershire Partnership Trust is that this scenario would constitute a medical emergency and so the patient should be taken to the Emergency Department where they can be seen and assessed by the Deliberate Self Harm team. The challenge with this arrangement is that Emergency Departments are not equipped or resourced to manage the demands of intoxicated patients who are expressing thoughts of self-harm.

5.70. The Adult Social Care worker spoke with Adult B on the telephone on 16th February 2015. Adult B stated that she had been raped on a couple of occasions with the last time being in January. She said she had given a DNA test and was waiting for the police to make an arrest. Adult B had a male in the background as she was talking and made reference to the poor housing conditions that Adult A was living in. Adult B also complained about the contact occurring between her daughter and her father, whilst she had no access. The Adult Social Care Worker arranged to see Adult B the next day, but this resulted in no access. The social worker then spoke with the GP, the police and Children's Social Care. The case was then closed.

Again a lack of engagement by Adult B prompted the case to be closed.

5.71. On 19th February 2015, Adult C spoke with his social worker and informed her that although he would be staying at his residential care home placement from Monday to Friday, he would be spending weekends with his girlfriend Adult B. He stated that she might be pregnant.

This is the only agency record of the relationship between Adult C and Adult B. In mid-January 2015, Adult C was in a relationship with someone else and as such the relationship with Adult B was very recent.

5.72. On 23rd February 2015. Information was received by the police to indicate that Adult A had been murdered. Adult B and Adult C were arrested.

6. Family Perspectives

6.1. The family of Adult A were contacted at the outset of the DHR process to ascertain whether they would wish to contribute to the review. No response was received.

6.2. The DHR panel decided that there would be merit in pursuing the contribution of Adult B and Adult C to the review. Adult B chose not to meet with the Independent Author.

6.3. Adult C agreed to speak with the Independent Author, which occurred via video link in the presence of his Offender Manager. Adult C spoke of the difficulties that he has experienced as a result of Asperger's syndrome and named friendships and relationships as being a particular area where he struggled, and did not know how to respond. Adult C felt that he had never received the support that he needed in order to manage his Asperger's syndrome but struggled to identify what support he felt that he needed. Adult C spoke of services withdrawing when he was perceived as doing well, when he felt that he needed ongoing support. Adult C gave the example of social work visits reducing to monthly when he would have preferred to have seen the social worker more frequently. Adult C spoke positively of his time at Island Place care home, reporting good relationships with staff. It is evident that Adult C has learning difficulties and, as described in the agency reports, is vulnerable to exploitation. This has also continued since he has been in prison.

6.4. Adult C stated that he had met Adult B via a friend and that they had been together for 3-4 weeks at the time of Adult A's death. He stated that he would often stay at Adult A's flat and that initially he got on well with Adult A. He described how Adult A and Adult B would sometimes argue but that he never saw any violence between them but stated that they both drank heavily. Adult C stated that he disliked Adult B working as a prostitute but would sometimes accompany her instead of Adult A. He stated that Adult B had told him that Adult A would often walk into the bathroom when she was taking a bath. At first Adult C did not believe Adult B.

6.5. Adult C gave his account of the day that Adult A died. Adult B and Adult A had argued that day and he saw them face up to one another. That day he and Adult B had been drinking and Adult B decided to take a bath, whilst Adult C sat in the bathroom with her. Adult A walked into the bathroom which led Adult C to believe that Adult B was telling the truth and Adult C followed Adult A into the bedroom and was strangling Adult A on the bed, asking him if he was a 'nonce'. Adult C then stated that Adult B handed him a breadknife and he cut Adult A's throat.

7. Relevant Summary of analysis and lessons learned from IMRs when considering the Terms of Reference

Leicester City Council Children, Young People and Families Directorate (pre scope)

7.1. The social worker's risk assessment completed on 2013 was in relation to Adult B's parenting capacity and he assessed that she was vulnerable and that her lifestyle, decision making and parenting capacity was affected by her alcohol misuse. He encouraged her to engage with alcohol services and was aware that she was not engaging with these services. He was concerned about her relationship with Adult A and felt that it was an unhealthy relationship in that it affected her use of alcohol and was a barrier to change.

7.2. With regard to Adult B's allegations of sexual abuse by Adult A, the social worker involved in completing the core assessment did not conclude that she had been sexually abused by Adult A, even on the balance of probabilities. He considered Adult B's allegations in the context of someone who had made various allegations of sexual abuse against different people over time and then changed her accounts. He was aware that there were suspicions that Adult B was a sex worker and he believed that she had been sexually abused in the past and was probably being exploited if she was sex working. During his involvement he gave Adult B opportunities to discuss her history of alleged sexual abuse but she did not want to engage with him. He did not give her any information about services that may have been available to her for support and advice.

7.3. The risk assessment in relation to Adult A was that he was not a safe person to care for a child given his alcohol dependency. The social worker noted that he was vulnerable but did not assess his vulnerability to warrant referral to adult social care as he was presenting as managing in his accommodation with self-caring skills.

7.4. Given the known vulnerabilities of Adult B and Adult A and their inter-dependency and misuse of alcohol, it would have been advantageous for them to have been referred to adult social care. The children's social worker seemed to have made decisions about the referral pathway based on his knowledge of the eligibility criteria. It is understandable that he would not want to raise expectations about what services may be forthcoming from adult social care however he should have taken account of adult social care's responsibilities to assess the level of vulnerability. These decisions meant that adult social care did not have opportunity to provide services to Adult B and Adult A.

7.5. The multi- agency procedures in relation to safeguarding children give clear guidance and protocols for agencies to have a Think Family approach and how to refer adults to adult social care and promote engagement with partner agencies who work with adults. The context is to promote joint assessment and working in families who are caring for a child.

7.6. **Learning:** Children's social care have to ensure that they follow the guidance in relation to non-recent allegations and consider the therapeutic needs of the alleged adult victim and the potential vulnerabilities of the alleged perpetrator. They need to

ensure that their information sharing practices with adult social care are effective and promote best practice.

7.7. The agency must ensure that practitioners in the children's workforce ensure that they take account of the vulnerabilities of adults, not just how they impacts on an adult's parenting capacity and risk to children but also whether that vulnerability means that they need assessment/ services in their own right.

Leicester City Council Adult Social Care

7.8. At the point of referral by the police in February 2014 it does not appear from the case records that Adult Social Care (ASC) were made aware of any concerns regarding domestic violence within Adult A's life. As a result of this, it would not have been deemed necessary for practitioners to act on domestic violence issues. ASC practitioners did not meet with Adult A and thus there would be no opportunity for them to have identified any indicators for domestic abuse.

7.9. At the point ASC received a referral regarding Adult B the concerns raised by the Police mentioned Domestic Violence from Adult B's uncle toward her. Practitioners were unable to contact Adult B and showed a good insight into the risks that Adult B could be in by ensuring that the case remained open and was not closed due to non-contact. The practitioners initiated the LCC VARM policy[1] to ensure that the risks were to be considered despite being unable to contact Adult B.

7.10. The hospital ward confirmed that Adult B had the mental capacity to make decisions and was able to manage her own care needs. A decision could have been made at this point to provide information over the phone and close the case. However, the practitioners showed a good awareness of risks regarding domestic violence by visiting Adult B on the ward. During the initial contact with Adult B on the ward, the social worker showed good awareness of domestic violence by providing Adult B with alternative options for housing and support from specialist domestic violence agencies. Although Adult B denied that there was any domestic violence between herself and her uncle, the social worker continued to offer the information and encourage Adult B to obtain support.

[1] A significant development has been introduced in Leicester called Vulnerable Adult Risk Management (VARM). This is a framework to facilitate effective working with adults who are at risk due to self-neglect, where that risk may lead to significant harm or death and the risks are not effectively managed via other processes or interventions. Self-neglect is determined to be any of the following:

- the inability to care for one's self and/or one's environment
- a refusal of essential services
- a failure to protect one's self from abuse by a third party (where "normal" adult safeguarding processes are not applicable or sufficient).

The VARM guidance sets out a co-ordinated, multi-agency response designed to protect adults deemed most at risk and ensure that any significant issues raised are appropriately addressed. A key aspect of the response is the identification of the agency best placed to engage and the development of holistic support plan via a Support Planning meeting. Having established the Support Plan, the adult at risks' resistance to engagement is be tested by the introduction of the Support Plan by the person or the agency most likely to succeed. If the plan is still rejected, the Support Planning meeting should reconvene to discuss and review the plan. The case should not be closed simply because the adult at risk is refusing to accept the plan.

7.11. During ASC's involvement with Adult C there were no referrals directly relating to domestic violence and there was no link between Adult C and either Adult B or Adult A.

7.12. Throughout the case records for Adult C, there is a pattern evident of Police incidents and concerns raised regarding Adult C's vulnerability in relation to making unwise decisions regarding friendships and being easily led. There is also evidence that Adult C places himself in risky situations and has been assaulted as a result. There are records that indicate when Adult C is in the company of some people he is more likely to commit an offence or increase intake of drugs and alcohol. There appears to be no analysis of risk as a result of these incidents.

7.13. There is reference throughout Adult C's records of him being in a relationship with numerous people. There does not appear to be any work from the practitioner to identify further who these people are in order to identify potential risks to either Adult C or his new partner. It is therefore not evident that Adult C's history regarding assault against children was taken into account or risk assessed. There does not appear to be any risk assessments in place regarding Adult C's apparent vulnerability when he is in destructive friendships and the changes in his behaviour at these times.

7.14. There was not a formal Mental Capacity Assessment for Adult C completed by ASC. Due to the repeated concerns regarding his friendships and the apparent risks, combined with Adult C's Asperger's Diagnosis, it would have been good practice to complete a Mental Capacity Assessment although it appeared the practitioners assumed capacity as stated in the MCA.

7.15. Adult C had been assessed by ASC as a vulnerable adult prior to the Care Act 2014. Since the introduction of The Care Act it is felt that Adult C would have met the criteria for an adult at risk as he had needs for care and support.

7.16. There was no evidence in the records that there were any barriers to Adult A or Adult B that prevented either accessing services. In the records it is clear that practitioners tried to engage with both Adult B and Adult A and they refused to engage with ASC.

7.17. Learning: Where there are concerns about finances or developing unsafe relationships and a diagnosis of Mental Health issues, a Mental Capacity Assessment should be carried out, this was not apparent in the work completed with Adult C as a formal capacity assessment was not completed.

7.18. Repeat concerns raised regarding physical abuse should be recorded together and considered as a time line in order to identify patterns and analyse the risks together, ensuring that apparently isolated or infrequent incidents are viewed in their wider context.

7.19. When considering support to any victim of domestic abuse, where agreed and risk assessed, considerations should be given to support of the perpetrator to help reduce the risks involved.

Leicestershire Police

7.20. During the scoping period, police officers knowledge and understanding of domestic abuse is evident in the fact that completed domestic abuse, stalking and harassment (DASH) risk assessment forms were submitted following all the domestic incidents attended which contained sufficient information for the risk assessment to be made and adult at risk referrals made where necessary. Police officers' decision making was proportionate and appropriate for the incidents they were faced with and the correct referral procedures were followed.

7.21. Leicestershire Police Procedure for Managing Adults at Risk gives guidance to officers when dealing with the victim or the perpetrator. Adult C, Adult B and Adult A were all at more than one point in the scoping period deemed by the police to be adults at risk due to their situation or circumstance.

7.22. When an officer attends an incident involving an adult at risk (where no crime has been committed), a vulnerable adult report is created. Where the victim of a crime is deemed to be vulnerable they are identified by a Q code on the modus operandi page of the crime report. All these incidents are automatically placed into a queue for the Adult at Risk Team Sergeants to risk assess and make decisions about referrals to other agencies, as appropriate.

7.23. Adults at risk are categorised by four tiers of risk based on outcomes:

- Tier 1: resolved through police involvement. Initial recording only (temporarily vulnerable because of their situation or circumstances)
- Tier 2: comprehensive recording on police systems and consideration of multi-agency information sharing and support
- Tier 3: Multi Agency Safeguarding (people who are unable to protect themselves and who are being abused or who are at risk of abuse)
- Tier 4: Critical where if action is not taken there will be grave consequences for the individual and the agencies

7.24. Police officers who attended incidents concerning Adult C, Adult B and Adult A did not raise concerns that they lacked the mental capacity to make decisions regarding their safety.

7.25. Whilst investigating reports that Adult B and Adult A were in a sexual relationship the police officer completed a vulnerable adult referral and attempts were made to disrupt the living arrangements between them which involved a meeting with the housing association. The police officer reported that Adult A would be issued with a warning that would state that Adult B could not stay at the address any longer.

University Hospitals of Leicester NHS Trust

7.26. There is no evidence of any indicators of domestic abuse within the health records relating to Adult C. His attendances were in relation to minor illnesses / injuries and there was nothing to suggest these were as a result of domestic abuse, either as a victim or a perpetrator.

7.27. In relation to Adult A and Adult B, it does appear that there were indicators of domestic abuse on several occasions. There is no evidence that staff completed the

domestic abuse risk assessment which was in use at that time or considered a MARAC referral.

7.28. However, the practitioners involved in this review felt that emergency department staff would not consider domestic abuse in these circumstances because they would not identify a victim / perpetrator scenario. The practitioners also felt that staff, and the public in general, still think of domestic abuse in relation to husband and wife / boyfriend and girlfriend relationships. There remains amongst most staff an image of 'wives' being beaten' when they think of domestic abuse and this does not resonate easily across other family relationships.

7.29. There is no evidence that emergency department staff made routine enquiries about domestic violence when working with Adult A, Adult B or Adult C. Practitioners involved feel that it would be unrealistic to expect staff to routinely ask about domestic abuse due to the number of people they attend to each day. However, where there are potential indicators of domestic abuse then staff ought to be considering it and asking the question.

7.30. On the rare occasions that Adult B and Adult A were admitted to a ward from the emergency department, it is clear that they had mental capacity and were able to consent to /decline treatment.

7.31. Emergency department staff routinely complete a mental capacity assessment as part of their mental health pro forma. This is completed whenever patients present with mental health disturbances, self-harming behaviours or suicidal thoughts/intent. On the occasions where Adult A and Adult B were reviewed and assessed by mental health services they were deemed to have no mental health problems and did not require treatment, it is also recorded that they had mental capacity to be discharged. In relation to Adult C, he was assessed by MH services in September 2013 and deemed safe to be discharged with outpatient psychiatric follow up in view of his low mood. There is no evidence that Adult C lacked capacity to leave hospital.

7.32. The Trust hosts a Frequent Attender Nurse on a part time basis, within the Emergency Department. Part of this role is to consider whether or not an individual might benefit from referrals to other agencies in order to improve outcomes and reduce reliance on the Emergency Department, where relevant. However, the Frequent Attender Nurse would only consider becoming involved once the person has attended and been assessed within the emergency department on more than 10 occasions within a rolling 12 month period. Therefore, in this case none of the individuals met the threshold.

7.33. Although staff complete mandatory safeguarding adults and children training, there is no specific standardised training provision for domestic abuse and violence across the Trust. There is also no commissioned resource for dealing with domestic abuse within UHL. The adult safeguarding team provide some support / advice to staff where concerns are raised but they are not dedicated specialists in this field. An Independent Domestic Violence Advisor (IDVA) is based on a part time basis within the Emergency Department and it is hoped that this provision will improve the service available for victims of domestic abuse. Since October 2015, the IDVA has worked with 192 cases, 52 of which were considered at MARAC.

7.34. **Learning:** Staff did not consider the possibility of domestic abuse between Adult B and Adult A. Staff also have knowledge gaps in the field of adult safeguarding. There is ample evidence that staff working within Emergency Department make IDVA/ MARAC referrals for people who are experiencing domestic abuse as part of an intimate relationship and this demonstrates their general knowledge and awareness. However, they acknowledge that their appreciation of domestic abuse in extended family relationships is less robust, especially when alcohol abuse is a factor. Using the learning from this case review will support staff to understand domestic abuse in the context of wider family members.

East Midlands Ambulance Service

7.35. The IMR found that EMAS attended Adult A for various medical reasons and on review of the Patient report forms Adult A did not appear to have care and support needs. Additionally it was felt that Adult A appeared to have the ability to protect himself. Adult A was sometimes verbally aggressive and threatening towards EMAS staff, he was often reluctant to follow medical advice and on some occasions was seen as a perpetrator of abuse against Adult B. On review of the patient report forms (PRFs) there is no evidence of Domestic Abuse with Adult A as the victim.

7.36. EMAS attended Adult B for various medical reasons and on review of the PRF's Adult B did not appear to have care and support needs. On review of the patient report forms Adult B has been able to seek help when required and it was felt that she appeared able to protect herself from abuse. Adult B was often verbally aggressive and threatening towards EMAS staff on attendance to her.

7.37. There was a missed opportunity to engage with Adult B about domestic violence at the attendance on the 5th April 2013. EMAS attended Adult B for a hand injury from punching a door. Whilst on scene Adult A became abusive to staff, not allowing Adult B to speak for herself and insisting on travelling to hospital with her, this behaviour should have given staff cause for concern. No referral was completed for Adult B however based on the injuries Adult B had and the behaviour of Adult A a referral should have been considered.

7.38. On the attendance on the 28th July 2013, EMAS raised a safeguarding referral due to historic allegation and concerns that the alleged perpetrator, Adult A, was still abusing Adult B however Adult B denied all the allegations. This referral was shared with children social care to ensure they were aware of the historic allegation and also to ensure that Adult B's child was protected.

7.39. On the attendance on the 7th September 2013, EMAS staff did share concerns about domestic violence and abuse following an incident where Adult B had different bruises in different stages of healing and always referred to Adult A to answer questions.

7.40. EMAS missed an opportunity on the 3rd September 2013 and the 12th September 2013 to raise safeguarding referrals for Adult C following an assault. The PRF provides information that he has care and support needs due to his ongoing medical problems and he had been unable to protect himself from abuse as EMAS attended

him twice following assaults. Adult C was also known to be under the community mental health team.

7.41. **Learning:** There is learning within this review in relation to the attendance on the 5th April 2013 to Adult B. The learning is in relation to professional curiosity around mechanism of injury and the way individuals respond on scene. There is also learning identified in relation to the attendance to Adult C. At both of these attendance no referral was raised, the common theme is that Adult C was assaulted in a public place and police were called. EMAS need to highlight to staff that abuse can occur within a public place and that even if police are involved they should still raise a referral to social care.

National Probation Service

7.42. When the Probation Service was working with Adult A, the only person that he disclosed to be living with him, albeit on a temporary basis, was Adult B. Adult C's name was not mentioned in any of the documents pertaining to Adult A's or Adult B's case. There was no evidence in the probation records of Adult A or Adult B being a perpetrator of domestic abuse.

7.43. During the period February 2014 to January 2015 Adult A was offered 25 appointments. He attended 20 of these. Four were made acceptable absences due to hospital admissions. Adult A was offered advice about referrals to adult social care and to the Macmillan nurse service. He did not return any of the paperwork needed for a referral to take place. Adult A was also given the paperwork for a referral to NACRO/SHARP for accommodation support. He did not consider his alcohol consumption to be problematic and in 2014 informed the offender manager that his alcohol consumption was dictated by his income and that he limited his drinking to two days per week. As a consequence of this he did not meet the threshold for an Alcohol Treatment Requirement. It was noted that Adult A appeared satisfied and content with his drinking and had no motivation or desire to alter his ways.

7.44. In 2011, Adult B alleged that she had been sexually abused by her uncle. She told the probation officer that whilst she had reported this to the police "she did not yet feel ready to gain support for the abuse experienced". She described the abuse in terms of him using sexual language and attempting to touch her. Professional curiosity could have led to the identity of the uncle being disclosed, which would have triggered a referral to Children's Social Care and further information gathering from the police. Adult B also disclosed that at the age of 7 years she was raped by the friend of a cousin. Professional curiosity may have led to this person being named and the appropriate follow up action taken.

7.45. **Learning:** The Fast Delivery Report that was prepared for Court on 5th February 2014 in respect of Adult A's offences of Assault by Beating and Racially Aggravated Harassment was requested only 2 days earlier. As neither the offences nor Adult A's known history indicated safeguarding or domestic abuse concerns then under current practice checks would not be made with police or safeguarding services. Had the request been made and the information provided, the allegations of sexual abuse reported by Adult B would have come to light and the case would have been managed in a different way by the probation service in that a qualified probation

officer would have been allocated to Adult A. Because this action was not taken, the potential risk that Adult A posed was not identified and acted upon.

7.46. The NPS are to explore with local Police and safeguarding services whether known persons checks could be resourced for all report cases.

GP practices

7.47. Although Adult A attended his GP surgery, and was asked general questions on wellbeing, he was not asked directly about domestic abuse. The GP practice has discussed whether potentially vulnerable adults should be asked screening questions about threat or history of violence as this can be hidden and not disclosed by the patient. The GP practice has also recognised the need to be aware of patients attending Emergency Departments on a regular basis as Adult A had a history of attending with injuries following assault, self-harm and suicidal ideation which indicated social, physical and mental health concerns that required addressing. It was also recognised that referral for alcohol treatment services would have been appropriate for Adult A and the practice will now screen all new patients for excessive alcohol use and ensure relevant follow up.

7.48. Adult B was seen mainly in the Urgent Care Centres by different doctors and nurses. She attended several times with injuries which she claimed were from assault by strangers, although there is no documentation of possible domestic abuse causing her injuries. There is evidence of GP's making safeguarding referrals in respect of Adult B which is positive practice.

7.49. Adult B rarely attended the GP practice and failed to attend pre-arranged appointments. How to engage patients who are hard to engage is a priority action for the surgery, including developing an alert system when a patient has not attended 3 consecutive appointments.

7.50. Adult C registered with a new GP surgery during the scoping period. He was issued with prescriptions for sertraline (an antidepressant) without a face to face medication review being undertaken. The practice policy is that all new patients on repeat medication are reviewed face to face or on the telephone to determine the ongoing need for the medication and to inform future management. In the case of Adult C, this did not happen. Face to face assessments of newly registered patients are now encouraged, in particular for patients on repeat medications, although capacity issues within the practice have a negative impact upon this.

8. Overview analysis

8.1. This review has established that there was no professional knowledge of the connection between Adult A, Adult B and Adult C prior to the domestic homicide. There were no indicators or evidence of Adult A being at risk of harm from Adult C.

8.2. It is clear however that all three individuals had histories of concern, involving alcohol misuse, domestic abuse and mental ill health.

8.3. A number of themes/areas of learning have arisen from the review of this case. These can be summarised in the following headings:

- The correlation between domestic abuse, violence and aggression and alcohol misuse
- Care pathways for mental health and alcohol misuse and engaging the hard to engage
- Recognition of and response to safeguarding concerns
- Responding to historical abuse allegations
- The role of the GP

8.4. Any findings made are highlighted within each theme.

The correlation between domestic abuse, violence and aggression and alcohol misuse

8.5. The review has considered that Adult A was not perceived by agencies as a victim of domestic abuse. Despite numerous alleged assaults, there was overall a failure to recognise indicators of domestic abuse and a lack of professional curiosity with regard to the nature of the assaults. Adult A's lack of engagement with and hostility towards agencies, coupled with his frequent intoxication, led to assumptions being made about his presentation. It has been acknowledged that it is a challenge for professionals to view an aggressor as a victim.

8.6. The review has highlighted that there was an absence of routine enquiries regarding domestic abuse. This was evident in the cases of the GPs and the Emergency Department. The review has also highlighted a lack of awareness of interfamilial domestic abuse which would appear to have been evident between Adult B and Adult A.

Finding: All agency training in respect of domestic abuse must include abuse outside of intimate partner relationships.

8.7. In October 2014, the charity Alcohol Concern wrote a research paper entitled 'domestic abuse and treatment resistant drinkers: a project to learn lessons from domestic homicide reviews'. The research highlighted that in 75% of the cases viewed alcohol played a significant contributory role in the domestic homicides. The majority of these alcohol related homicides involved high risk treatment resistant drinkers. The Blue Light project is Alcohol Concerns' national initiative to develop alternative care pathways for treatment resistant drinkers who place a burden on public services. The project has developed tools for understanding why clients may

not engage, risk assessment tools, harm reduction techniques, and relevant management frameworks. There is merit in embedding these tools within local device delivery in Leicester.

Care pathways for mental health and alcohol misuse

8.8. Concerns regarding self-harm and suicidal ideation whilst intoxicated is a key feature within this case. All three individuals presented in this way on several occasions and their engagement with follow up services was limited.

8.9. The review has established that there is an assumption that until someone's substance misuse is managed and they are deemed stable, that an assessment of their mental health will not be accurate in terms of diagnosis. There is a need to be able to separate intoxication from mental health as it is recognised that alcohol is a depressant and that once sober, a person may behave entirely differently. However in the case of problematic, intractable drinkers, the difficulties may have become entrenched and therefore require a joint, dual diagnosis, approach.

8.10. When a patient is threatening self harm and experiencing mental health difficulties the referral routes available to GPs can take several weeks to process. In order to refer to the crisis team, the GP would have to see the patient first. The team will then respond within 4 or 24 hours depending upon the clinical need. The crisis team are unable to assess people who are so intoxicated that they cannot be safely assessed. The view of Leicestershire Partnership Trust is that this scenario, or indeed if the patient needed to be seen sooner, would constitute a medical emergency and so the patient should be taken to the Emergency Department where they can be seen and assessed by the Deliberate Self Harm team. The DSH team can then refer for home treatment with the crisis team, ask for a mental health act assessment or arrange informal admission. In reality, the DSH team are equally unable to assess a patient who is intoxicated, leaving the management of that individual with the Emergency Department staff.

8.11. The challenge with this arrangement is that Emergency Departments are not equipped or resourced to manage the demands of intoxicated patients who are expressing thoughts of self harm. Often patients may leave prior to receiving medical input (missing a crucial window of opportunity to engage the patient) and until that time they can present management issues within the department.

8.12. This review has established that the three individuals involved proved difficult to engage and that in the case of Adult B and Adult A in particular, support services were unable to engage with them effectively.

Finding: The review has considered that there is a requirement for a specific care pathway for the management of acutely intoxicated people. The review has also considered that the provision for adults in acute mental health crisis needs to be reviewed.

Recognition of and response to safeguarding concerns

8.13. The review has established that there were a number of missed opportunities to make safeguarding referrals in respect of the adults involved in this case. Adult A was not perceived as a victim of abuse and assumption were made about him given his difficult presentation. Adult B's allegations of sexual abuse, her alcohol misuse and ongoing mental health concerns were not responded to robustly. Adult C was perceived as a vulnerable individual yet there was a lack of risk assessment with regard to what this meant in terms of the risks to himself and to the risk he posed others. It is evident that awareness raising in respect of adult safeguarding continues to be essential.

8.14. The review has established that poor compliance by some agencies with adult safeguarding training has been a concern to the LSAB. Assurance has been provided that agencies have a clear framework for adult safeguarding and regular training. Safeguarding training figures are monitored by the LSAB safeguarding effectiveness group. A significant development is that the Director for Adult Services has ensured that adult safeguarding training is now mandatory within adult social care.

Finding: agencies must ensure that adult safeguarding is a key priority within their strategic and operational service planning and ensure that their staff are equipped to make safeguarding referrals.

Responding to historical abuse allegations

8.15. The history of this case indicates that Adult B disclosed and denied on numerous occasions and to many different agencies that she had allegedly been sexually abused by Adult A. These disclosures were seen as a life event rather than a potential crime that required investigation. There was a lack of consideration of any ongoing risks potentially posed by Adult A.

8.16. The local adult safeguarding procedures do not contain any reference to how to manage historical abuse allegations. This is a significant shortcoming. Importantly, no national or statutory guidance is available to guide professionals in dealing with such matters. The local safeguarding children board (LSCB) procedures contain a short chapter entitled historical abuse allegations. This chapter stresses the importance of a high quality organisational response as there is a significant likelihood that a person who abused a child in the past will have continued and may still be doing so, and that criminal prosecutions can still take place despite the allegations being historic in nature. The chapter describes how the disclosure must be recorded, a chronology should be completed and it must be explained to the adult disclosing historical abuse that the information will need to be shared with the police. The chapter lacks any further detailed guidance regarding how such cases should then be managed. There is reference to strategy meetings being held but this appears to refer to alleged perpetrators who are still working with or caring for children.

Finding: Robust procedural interagency guidance must be in place in order to support professionals to manage and appropriately respond to allegations of historical abuse.

The role of the GP

8.17. A factor in this review is the role of GPs when patients lead chaotic lifestyles and are difficult to engage. The three individuals in this case frequently attended Emergency Department but not at a level to trigger hospital frequent attendees procedures. GPs are notified of all attendances at hospital, outpatient reviews and discharges from health services. The GP is therefore the holder of all information pertaining to a patient and is therefore best placed to understand the issues. However whether the GP themselves have capacity to read all of the information they are sent and respond to it is unlikely and as such this questions whether the information sharing is purposeful or actually just adding to a 'central storage record'.

8.18. The CCG Hosted Safeguarding team have recently incorporated themes from DHRs (local and national learning) into face to face safeguarding adults training for GP's. At the last City Protected Learning Time event held in April 2016, this training was delivered to 85 GPs.

Finding: an alert system of frequent attenders at Emergency Departments should be considered within GP practices and efforts made to target those that are hardest to engage.

9. Conclusions

9.1. The time period that brought Adult A, Adult B and Adult C together was brief – just a matter of weeks. Adult B and Adult C had not known of each other before this time and their relationship developed quickly, with Adult C spending time at the flat where Adult B and Adult A lived. Agencies were not aware of the connection between the 3 individuals.

9.2. The DHR panel has considered that Adult C did not appear to pose a risk of significant and serious harm to others. Adult C was not perceived by agencies working with him to be a violent and dangerous individual. In view of this, had the connection between Adult C, Adult B and Adult A been known, this would not have raised concerns regarding any risk posed by Adult C to Adult A.

9.3. The DHR panel has determined that the set of circumstances that led to the death of Adult A were so specific that it could not have been predictable that Adult A would die as a result of such a violent crime. His life appeared to be in danger as a result of alcoholic liver disease and not by any risks posed by those with whom he associated.

9.4. This DHR has identified areas where practice and interventions could have been improved which might have better supported Adult A, Adult B and Adult C. The DHR panel has considered that whilst the learning has led to recommendations for change, changes in practice would not have altered the final outcome for Adult A. The risk to Adult A on the day that he died was not, and could not have been identified, and as such his death could not have been prevented.

10. Changes to practice

10.1. The pathway of care for acutely intoxicated people in the context of a 'possible' mental health problem such as threats of self-harm has been considered by the Local Crisis Care Concordat group as a priority. The group has agreed that firstly a medical screen is required in the Emergency Department followed by a mental health assessment.

10.2. A pathway has therefore been agreed for acutely intoxicated people who may have a mental health problem to be firstly assessed medically in the Emergency Department and then have a mental health assessment in the Emergency Department within 1 hour of the Emergency Department staff being satisfied that the individual is 'medically fit'. University Hospitals Leicester and Leicestershire Partnership Trust are operationally working closely together under the Leicester, Leicestershire and Rutland Urgent and Emergency Care Vanguard Programme changes to this effect and are also aligning with the newly formed Public Health procured substance misuse services from Turning Point so that appropriate contact can be made, following a mental health assessment, with substance misuse services if required. The proposed model is an outreach model and the expectation is for Emergency Department and Mental Health staff to refer to the substance misuse team to determine an appropriate response in terms of time and location of assessment.

10.3. The local Crisis Care Concordat group are overseeing a programme of work that is fully integrated into the Better Care Together Mental Health Work stream, reviewing all provision for people in mental health crisis. For further details please see: http://www.crisiscareconcordat.org.uk/areas/leicester/

10.4. A regional multiagency sub group comprised of police, health and local authorities, for Individuals with Frequent Needs on a Range of Services has been established, and has the aim of identifying people who have multiple interactions with multiple agencies. The focus of the group will be to improve the long term well-being of vulnerable adults who have frequent needs relevant to multiple service sectors. This can include but is not limited to;

- Poor physical and mental health;
- Risk of self-harm or suicide;
- Drug and alcohol abuse;
- Crime and ASB victimisation or offending, including domestic abuse.
- Extreme social isolation

10.5. The expectation will be that the needs of the person will have been long term and that other multi-agency partnerships are not currently co-ordinating actions or are not able to do so effectively. Through intelligence gathering this will allow the group to identify people who may not meet the need or threshold for certain agency intervention, but collectively through a collaborative approach can have those needs met. The alternative is that there may be a decision to not meet those needs but agree a robust strategy for managing contact with that individual which all agencies are aware of so a consistent approach is adopted by all.

10.6. The group began in November 2015 and has so far met 4 times. There has been a number of cases already which having had a multi-agency input has led to a different

pathway being explored which has yielded benefits to organisations but most importantly the individual. For more information see Appendix D.

11. Recommendations

11.1. The DHR panel endorses the single agency IMR recommendations. Each agency retains responsibility for the implementation of actions arising from their IMR.

11.2. Given the changes in practice identified above, the recommendations arising from this review are few in number, and although they will improve practice going forward, their implementation would not have altered the outcome in this case.

- LSAB to seek assurance that single agency domestic abuse training does not focus purely on abuse within intimate partner relationships and that learning from this DHR is incorporated into domestic abuse training.

- For there to be national and regional guidance regarding the management of historical or non-recent allegations of abuse

- For routine enquires regarding domestic abuse to be embedded within substance misuse services, in particular alcohol misuse services, given the link between domestic abuse and alcohol.

11.3. In addition, the DHR panel recommends that the learning from this DHR is taken forward by the Domestic Violence Delivery Group of the Safer Leicester Partnership for wider communication and awareness raising.

Leicester Safeguarding Adults Board

WORKING IN PARTNERSHIP TO KEEP ADULTS SAFE

Adult A
Domestic Homicide Review
Terms of Reference
V0.1 (DRAFT)

1. The purpose of the Domestic Homicide Review is to:

a. Ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case.

b. Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence including their children.

c. Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on and what is expected to change as a result.

d. Apply these lessons to service responses including changes to policies and procedures as appropriate; and

e. Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

2. Panel members will ensure the DHR fulfils the following requirements:

1. Ensure the review is conducted according to best practice; with effective analysis and conclusions of the information related to the case.

2. Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence, including their dependent children.

3. Identify clearly what those lessons are; both within and between agencies, how and within what timescales they will be acted upon and what is expected to change as a result.

4. Apply these lessons to service responses; including changes to policies and procedures as appropriate; and prevent domestic violence homicide and improve service responses

for all domestic violence victims and their children, through improved intra and inter-agency working.

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

3. In addition the following areas will be addressed in the Individual Management Reviews and the Overview Report:

1. To review whether practitioners involved with Mr Adult A and Ms Adult B & Mr Adult C were knowledgeable about potential indicators of domestic violence and aware of how to act on concerns about a victim or perpetrator(s).

2. To establish how professionals and agencies carried out risk assessments, (including assessment of the victim's mental capacity to make decisions relating to risks) including
   - i) whether the risk management plans were reasonable response to these assessments,
   - ii) whether risk assessments and management plans of Mr Adult C took account of his early history, including convictions for sexual assaults on minors and assessments of risk made during this period,
   - iii) whether there were any warning indicators of serious risk leading up to the incident in which the victim died that could reasonably have been identified, shared and acted upon by professionals.
   - iv) Whether any of the adults concerned were assessed to be vulnerable adults and whether they would now meet the criteria for an adult at risk as per the Care Act 2014

3. To identify whether services that were involved with Mr Adult A were aware of the circumstances of Ms Adult B's & Mr Adult C presence in the home and agencies involved with them. Whether connections were made and information shared between these services in order to establish a full picture of the vulnerability and risks arising from the relationship(s).

4. Did agencies involved make routine enquiries about domestic violence when working with these adults and if so were any opportunities missed.

5. To establish whether agencies responded to alcohol dependence and offer appropriate services and support to Mr Adult A and Ms Adult B.

6. At each point of contact with emergency health services for assaults, self-harm and injuries –were enquiries made about domestic violence and procedures followed?

7. To establish whether the mental health needs of adults subject to this review were supported and managed appropriately by local agencies.

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

9. To establish if there were any barriers experienced by Mr Adult A, Ms Adult B or family / friends that prevented them from accessing help; including how their wishes and feelings were ascertained and considered.

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

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

12. To identify whether child sexual abuse allegations, leading to the risk of sexual exploitation, were appropriately managed by local agencies and the transition to adult services.

13. To establish whether adult safeguarding concerns (Adult A, Adult B, Adult C) were recognised by agencies and whether multi-agency safeguarding procedures were followed.

14. To consider whether there were any missed opportunities for a multiagency response to consider the multiple issues of Adult A and Adult B

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

16. To establish whether safeguarding children procedures were properly followed in respect of Ms Adult B's allegations of historical abuse made against Mr Adult A.

17. To establish how effectively local agencies and professionals worked together.

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

19. Identify any areas of good practice

Family Participation

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

Scoping period

The scoping period is from January 2013 until February 2015, (capturing period when Adult B commenced living with Adult A, Adult C becoming involved with Adult B and up to the period of Adult A death).

The end date will be reviewed in the event that any new information arising from the criminal trial indicates that information needs to be considered post death.

4. Outside of Scoping

4.1. A summary of agency involvement from 2004 until the beginning of the scoping period is requested within the IMR reports in order to capture relevant background.

4.2. If there are important events outside of the scoping dates that are relevant and worthy of inclusion, a summary of those should also be included.

5. Membership of DHR Panel/ Requests for IMRs

Organisation/ Specialist Area	**Panel Member**
Leicester City Council - Children Services - Housing Services - Community Safety	Paul Kitney Helen Bannister Steph McBurney
Leicester CCG: - GP surgeries - Out of hours - SAAF	Mina Bhasvar / Adrian Spanswick
SAFE	Sandra Green
University Hospitals Leicester	Michael Clayton
Leicester Partnership Trust	Di Postle
Leicestershire Police	Jonathan Starbuck
Children's Social Care	Helen Bannister
EMAS	Zoe Rodger
Board Officer	Jackie Wilkinson
LSAB Administrator	
Independent Overview Report Author	Hayley Frame

6. Timescales of Review

6.1. As per the government guidance for DHRs, this review should be completed within 6 months.

6.2. It is the responsibility of the Board Officer to keep the review on schedule and to note any foreseen deviations to the agreed timeline to the chair of the CSP.

Appendix B - Domestic abuse within Leicester

Leicester City Council Commissioned Specialist Domestic Violence and Sexual Violence Provision

Date Covered: April 2014-March 2015

Reaching People

- **2747** Referrals **(1853)**
- **7108 (7894)** calls to the domestic violence helpline (**2464** from public) **(1959)**
- **899 (155)** calls to the sexual violence helpline
- **4911 (963) children and young people** taking part in awareness sessions or support work SVDV

Equality & Diversity

- **25% (48%)** service users **BME**
- **86 (1%)** Identified as **LGBT 40 (1%)**
- **184 (2%)** aged 16-18 **185 (5%)**
- **36** at risk of Honour Based Violence **58**
- **14** Identified as at risk of Forced Marriage **19**
- **1328 (15%)** Noted a Disability **679/19%**
- **6896 (76%) 3237 (92%)** were **women** and **2221 (24%) 304 (8%)** were **male (victim-survivors)**

Risks & Vulnerabilities

- **345 (60%) DV victims had children (552/67%)**
- **130 (25%)** DV victims noted **suicidal thoughts** and/or previous attempts **(198/ 24%)**
- **83 (16%)** DV victims experiencing abuse from **multiple perpetrators (120/15%)**
- **59 (11%)** DV victims in receipt of **community care payments (14/2%)**
- **31 (6%)** DV victims reported problems related to **alcohol use (31/4%)**
- **25 (3%)** DV victims reported problems related to **drugs use (48/6%)**
- **76 (20%)** DV victims known to have involvement with **children and young people's services 110/20%)**

Making a difference

- **899 (96%) Felt safer** post intervention from a specialist DV service **542/89%**
- **184 (86%)** Felt better **able to cope** after support from a specialist SV service **47/85%**
- **188 (85%)**Reported **improved sense of well-being** after accessing a specialist SV service **44/80%**
- **92%** Perpetrators **reported reduction in domestic violence 78%**
- **453** Staff **received training** on domestic violence and sexual violence and **94% improved their knowledge** (94% of 222 completed evaluations from DV training to LCC staff) **353 (no evaluation data held)**

Figures in red denote the comparable performance at Q4 2013/14

Provision	Numbers reached and impact	
	2013-14	**2014-15**
CYP Support and Parent/Carer DV	188 referrals 2745 support hours delivered 244 cases opened 963 CYP accessing service 376.5 creche hours 96% greater understanding 75% engaged (CYP) 92% reduction in DV 90% feel more positive regarding parenting capacity **39% service users BME**	209 3379 315 765 575 97% average 79% average 99% 100% **43% service users BME**
Prevention & Education SV	87 staff trained 9 schools delivering HR programme 1498 CYP completing HR programme	332 56 4146
Safe Home Service DV	706 referrals 706 cases opened 167 homes secured 3 perpetrators accommodated 92% safer at home 89% increased confidence in independent living **59% service users BME**	1055 1055 133 0 100% average 95% average **59% service uses BME**
Victim-Survivor Service DV	7819 people accessing service 13049 telephone support hours delivered 378 counselling sessions delivered 851 intake forms completed 3793 safety plans completed 89% safer following intervention 87% reduction in DV 85% improvement in health and WB 84% engaged **47% service users BME**	7429 20,332 1345 1136 4281 93% average 92% average 93% average 93% average **44% service users BME**
Perpetrator Interventions DV	108 referrals 88% referrals eligible 65 started group modules 309 assessment sessions 145 individual interventions 25 self-referrals 296 partner support 1:1 sessions 78% reduction in DV 87% motivated to change 86% engaged in support plan **31% service users BME**	99 98% 60 320 178 29 273 92% average 88% average 81% average **38% service users BME**
SV therapeutic	273 service users accessed 1156 counselling sessions delivered 93 assessments completed **24% service users BME**	200 (new) 3167 146 **25% service users BME**
SV helpline, outreach and ISVA	155 accessed helpline 63 cases opened 70 outreach sessions delivered **44% service users BME**	899 178 199 **42% service users BME**

NB: sexual violence services only started November 2013

Appendix C –Action Plan

Specifics of action plan to be determined by LSAB.

Recommendation	Scope of recommendation i.e. Local, regional or national	Action to take	Lead Agency	Target Date	Date of completion and Outcome
LSAB to seek assurance that single agency domestic abuse training does not focus purely on abuse within intimate partner relationships and that learning from this DHR is incorporated into domestic abuse training.					
For there to be national and regional guidance regarding the management of historical or non-recent allegations of abuse					
For routine enquires regarding domestic abuse to be embedded within substance misuse services, in particular alcohol misuse services, given the link between domestic abuse and alcohol.					

Appendix D – IFNRS subgroup

Memorandum of Understanding: SPB Board Sub-Group Individuals with Frequent Needs on a Range of Services

The Strategy

This group will encourage a strategy towards vulnerable adults in Leicester, Leicestershire and Rutland that;

- Takes a cross agency, cross locality approach with the needs of the individual being at the core as opposed to the remit of any individual agency or locality;
- Targets a long term improvement in well-being working towards individual independence;
- Targets intervention on the root cause of need(s);
- Shares information appropriately to identify needs and their root cause;
- Is proactive to address needs before they reach a high need or crisis point;
- Coordinates actions across service areas to deliver a more effective, efficient service;
- Engages with the vulnerable adult using a consistent, single point of contact wherever possible;

The Focus

The focus of the group will be to improve the long term well-being of vulnerable adults who have frequent needs relevant to multiple service sectors. This can include but is not limited to;

- Poor physical and mental health;
- Risk of self-harm or suicide;
- Drug and alcohol abuse;
- Crime and ASB victimisation or offending, including domestic abuse.
- Extreme social isolation;

The expectation will be that the needs of the person will have been long term and that other multi-agency partnerships are not currently co-ordinating actions or are not able to do so effectively.

The Actions

The actions the group will take will be:

- To be a 'critical friend' panel which can advise on successful strategies utilising the expertise of the 'expert practitioners' present.

- To offer strategic leadership which encourages flexibility from all relevant partners to adopt the strategy detailed above.

The Membership

The group will be made up of a small 2-3 person strategic panel of representative from the following key partner agencies;

- Police;
- Leicester City, Leicestershire and district local authorities;
- Leicestershire Partnership Trust;
- University Hospitals Leicester;

The strategic panel will be there to chair the meeting and to lead the group towards a cross agency, cross locality strategy for each individual case.

The group will also be made up of 'expert practitioners' from the following areas:

- Crime investigation and policing;
- Fire and household safety;
- Housing law and applications;
- Drug and alcohol services;
- Adult social services;
- Probation Service & Community Rehabilitation Company;
- East Midlands Ambulance Service;
- Domestic abuse services;
- Mental health;
- Community and social support services.

The Process

1) Vulnerable adults are considered for referral to the group by any agency. Referral criteria will not be tightly defined so as not to exclude, but will centre on the themes identified in 'The focus' section above.

2) Key professionals involved with the case will be invited to group meetings to present their case. They will be asked to consider what the root cause and strategies to success could be.

3) The group will identify potential strategies to success from their agency expertise. The strategic panel will offer direction encouraging a flexible cross agency, cross locality response. They will also encourage the involved agencies to take the strategy detailed above. This often may include an appropriate statutory or voluntary partner to take the role of single point of contact.

4) The involved agencies will report back to the group with progress against agreed indicators.

5) The involved agencies will then continue long term engagement with vulnerable person to continue to deliver the strategy.

The Need for Change

1) The needs of an individual vulnerable adult are often relevant to multiple service sectors and sometimes are across local authority boundaries. For example an individual may have needs in relation to alcohol abuse and poor mental health at their home address and be a victim of domestic violence in another locality.

   However specialist service provision is often allocated to address these needs in isolation e.g community mental health support, drug and alcohol support, specialist domestic abuse support OR it is focused on only one local authority geographical area.

2) The needs of a vulnerable adult are often long term in nature and originate from a significant historic life event and/or learned behaviour over a long time period.

   However specialist service provision is often delivered on a short term basis, when the vulnerable person is in crisis or at a level of high need. Once the level of crisis or need is reduced then the service offered is often reduced or removed.

3) The needs of any person receiving a service are often best met by delivering a consistent point of contact, allowing rapport and a positive working relationship to develop. This is often even more vital for a vulnerable adult who may have a history of negative social relations with others and particularly persons seen as authority figures. This relationship can be the basis for putting in place the long term social support that can give the individual independence in their life.

   However specialist service provision for a vulnerable adult with multiple needs are often delivered by a range of professionals from different agencies each working with the individual for a short time and typically only focusing on one need. There is a risk that services are being duplicated and the vulnerable person has multiple contacts offering a confusing picture.

This model unwittingly encourages a strategy which:

- Focuses on individual agency remits when delivering services;
- Addresses issues in the short term;
- Targets intervention on the symptom rather than the root cause of the need;
- Shares information only when cases are in crisis or of high need;
- Is reactive;
- Is un-coordinated and inefficient across agencies;
- Does not build engagement with the vulnerable adult often creating further barriers to successful delivery.

Instead it is hypothesised that a more successful and cost effective strategy would be:

- Taking a cross agency, cross locality approach with the needs of the individual being at the core as opposed to that of any individual agency or locality;

- Targeting a long term improvement in well-being and movement towards independence rather than short term one which often is not able to address any root cause of need;
- Targets intervention on the root cause of need(s). This is often dysfunctional relationships or social isolation which then influences mental health, substance misuse and causes further isolation/dysfunctional relationships.
- Shares information regularly to plan and prevent crisis's rather than to respond to them;
- Is proactive to address needs before they reach a high need or crisis point;
- Coordinates actions across service areas to deliver a more effective, efficient service;
- Engages with the vulnerable adult using a consistent, single point of contact wherever possible;

Through its work this group will influence multi-agency partners to adopt this strategy.

Safer Leicester CSP Logo

DOMESTIC HOMICIDE REVIEW:

EXECUTIVE SUMMARY REPORT

INDEPENDENT OVERVIEW REPORT

INTO THE DEATH OF

'Janice'

PREPARED BY RICHARD CORKHILL

20 July 2016

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PART 1: DOMESTIC HOMICIDE REVIEW, BACKGROUND AND PROCESS

1.1 Purpose of the review:

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

1.2 Who the report is about:

This DHR is about *'Janice'* [1], who was 57 when she died as a result of domestic violence perpetrated by her partner '*Ian*'. From her early 20's Janice had spent long periods living abroad, in the USA and Europe. At the time of her death she had 2 adult children who had remained resident in the USA. Other family members included 2 sisters living in the North West of England. Janice had a history of problems related to alcohol misuse and mental illness. She also had a reported history as a victim of domestic violence in previous relationships.

Janice moved to Leicester in November 2014. Initially she stayed with a friend who she had met abroad, before moving into the Dawn Centre (temporary homeless accommodation). Over the last 6 months of her life Janice had 2 brief periods of residence at the Dawn Centre:

- 24/11/4 – 21/12/14
- 14/1/15 – 15/1/15

[1] For reasons of confidentiality, pseudonyms of 'Janice' and 'Ian' (homicide victim and perpetrator, respectively) are used throughout the report. Other pseudonyms are used for family members, ex-partners, etc.

Janice left the Dawn Centre voluntarily on 21/12/14, when she went to stay with her sister in Blackburn for a short period, before being re-admitted to the Dawn Centre on 14/1/15. On 15/1/15 Janice was asked to leave as she was suspected of supplying illicit substances to another resident.

From 15/1/15 until the homicide (which was on or around 3/5/15) Janice had no secure or stable accommodation. On occasions she stayed at Ian's address, where there were a number of reported domestic violence incidents, including 6 occasions when the police were involved. There was also involvement by emergency medical services and other agencies. The full report includes a chronological summary and detailed analyses of these incidents.

1.3 Perpetrator background:

At the time of the homicide Ian was 44 years old. He was born in the Republic of Ireland and moved to Leicester around 1998. Police records show that he had a history as a perpetrator of domestic violence in previous relationships and had 8 previous criminal convictions for domestic violence related offences. Alcohol misuse was a common factor in these offences. On 2 occasions Ian had received 3-month prison sentences for assaulting previous partners. The last recorded offence had been in 2008.

1.4 Janice and Ian's relationship

Janice and Ian's relationship commenced at some time between late November 2014 and early January 2015. Agency IMRs indicate that none of the services involved with Janice or Ian had knowledge of the relationship until January 2015.

At this time, Ian was already well known to the services based in the Dawn Centre building, including the hostel itself and GP Practice 1 which provides primary health care services to hostel residents and other people in the locality affected by homelessness and complex needs. Ian had recently moved into his

privately rented flat, with support from homelessness services and the Anchor Centre (city centre day service for street drinkers).

The collective evidence from agency IMRs suggests that a significant feature of the relationship was mutual binge drinking followed by verbal conflict, escalating to physical violence. When violent incidents were reported (to the police or other services) it often proved difficult to reliably ascertain whether Ian or Janice had been the primary instigator.

Throughout the period of the relationship, Ian was resident as the sole tenant of his privately rented flat. Apart from her 2 brief periods of residence at the Dawn Centre, she had no secure accommodation. She may on occasions have slept rough or stayed with other people, but this detail is unknown.

For some periods Janice stayed overnight in Ian's flat, but she would then leave - or be ejected by Ian – often following an alcohol fuelled conflict. During daytime periods Ian and Janice sometimes attended the Anchor Centre, either together or separately.

In summary:

- When the homicide happened Janice and Ian had known each other for around 6 months.
- It had been a highly volatile relationship between 2 people who each had a long history of alcohol misuse, street drinking and periods of homelessness.
- Ian had a history in previous relationships as a perpetrator of domestic violence, including some serious assaults resulting in prison sentences. This pattern of behaviour continued in his relationship with Janice.
- Janice had a history in previous relationships as a victim of domestic violence.

1.5 Outline summary of the homicide incident:

At 7:28pm on Saturday 2nd May 2015 Leicestershire Police received an anonymous telephone call stating that a woman had been murdered at Ian's address, which was a flat (situated in a block of flats) in Leicester. The male caller rang off before any further detail could be obtained. Police officers attended at 7:50pm but were unable to gain entry to the block. The supervisory officer present concluded that the available information / intelligence did not justify the use of force to enter the flats and the incident was closed.

The following day, Sunday 3rd May 2015, the incident was reviewed and further intelligence checks were completed. That process identified previous incidents involving Ian and Janice at this address. Entry was forced into the flat at 12:23pm when Janice's body was discovered.

A forensic pathologist's report was unable to specify the cause of death, but Ian pleaded guilty to manslaughter and was subsequently sentenced to 3 years 8 months' imprisonment.

1.6 Involvement of family members and friends:

Janice's sister in Blackburn was invited to contribute to the DHR and it was hoped that she may also facilitate communication with Janice's (now adult) children who remain resident in the USA. This invitation was declined.

The female friend that Janice met in Spain and stayed with for a short period (in November 2014) in Leicester was also contacted, but she also chose not to take any part in the DHR.

1.7 Agency involvement:

The following agencies had significant involvement with Janice and Ian during the period under review and contributed Individual Management Reviews (IMRs):

Organisation	**Primary reason for contact With perpetrator (and/or) victim**
Leicestershire Police	Call outs to domestic incidents (P&V) & homicide response
Leicester City Council Homeless Prevention & Support Service	Periods of accommodation at Dawn Centre hostel (P&V separately)
Leicester City Council Housing Options Service	Housing applications (P&V separately)
SAFE Project	Domestic violence helpline contacts (V)
GP Practice 1	G.P. and other primary healthcare services (V & P)
University Hospitals of Leicester NHS Trust	Treatment at Emergency Department, Leicester Royal Infirmary (V)
George Eliot Hospitals NHS Trust[2]	Treatment at Urgent Care Centre, Leicester Royal Infirmary (V)
Anchor Centre	'Wet' day centre for street drinkers (V&P)
Nottingham University Hospitals NHS Trust	Treatment at Emergency Department, Queens Medical Centre (V)
Leicestershire Partnership NHS Trust	Community mental health services

[2] At the time these events occurred the Urgent Care Centre was managed by George Eliot Hospitals NHS Trust whilst the Emergency Department (on the same hospital site) was managed by UHL. The Urgent Care Centre has since been taken over by the UHL Trust. Separate IMRs were provided, in relation to events at Emergency Department and the Urgent Care Centre.

PART 2: SUMMARY OVERVIEW OF FINDINGS AND KEY LEARNING POINTS

This summary overview of findings is structured around the lines of enquiry which were set out in the DHR Terms of Reference. The detailed evidence bases for these findings are detailed in Part 2 of the full report.

1. To review whether practitioners involved with Ian and Janice were knowledgeable about potential indicators of domestic violence and aware of how to act on concerns about a victim or perpetrators

There is evidence that some practitioners were knowledgeable about indicators and how to act. For example, the responses by staff at Queens Medical Centre in assessing risks and then taking actions aimed reducing future risks have been identified as good practice. Similarly, the Outreach Alcohol Support Worker demonstrated a good understanding of the risks Janice was facing and acted appropriately. There are several other examples of good practice highlighted in Part 2 of the report.

There is also some evidence of lack of understanding of risk factors in some agencies, either at individual practice levels or at policy and procedure levels Examples include:

- Awareness of impact of homelessness as a DV risk factor.
- Closely associated with homelessness - isolation from informal social support apart from local street drinking networks.
- Awareness of significance of Ian's past history as a perpetrator in previous relationships as a risk factor in current relationship.
- Possible 'downgrading' of perceived risks and need for strategic multi-agency actions, where violence is believed to be mutual – failure to recognise that mutual violence may actually indicate *higher* risks.
- Insufficient recognition of power balance in the relationship.

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

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

ii) whether police DV risk assessments and management plans of Ian took account of his early forensic /criminal history, and assessments of risk made during this period.

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

iv Whether risk assessments considered risk to individuals when services were withdrawn

Warning signs:

- There were clear and repeated warning signs. This included 6 police incidents in the months leading up to the homicide and 2 CAADA-DASH risk assessments which found Janice to be at high risk.

Risk assessments:

- There is clear evidence that police DV risk assessments did not take sufficient (if any) account of Ian's early forensic and criminal history.
- Risk assessments also did not sufficiently take into account a number of other factors, including those associated with Janice being homeless.
- There was no assessment of the increased domestic violence risks to Janice, when a decision was taken to evict her from the Dawn Centre hostel accommodation.
- There were many missed opportunities by housing, homeless, primary healthcare and alcohol services, when incidents of domestic violence were

disclosed, but no formal risk assessment was carried out and no pro-active attempt made to engage Janice with specialist support. This appears to have been primarily due to a lack of staff training and awareness in relation to domestic violence risk assessment processes and local multi-agency policies and procedures, including the MARAC protocol.

Risk management plans:

- Although two different agencies completed MARAC referrals (only one of which has been confirmed as received by the MARAC office) Janice's situation was not discussed at MARAC, due to a breach MARAC policy / procedure. As a result of this there was never any clear multi-agency risk management plan. This has been identified as a very significant missed opportunity.

Mental capacity:

- It is very probable that when heavily under the influence of alcohol Janice's ability to recognise risks and make informed decisions about possible DV risks posed by Ian was temporarily impaired. However, there is no evidence to suggest Janice's mental capacity was impaired or that there would have been any grounds to formally assess her mental capacity to make decisions about her relationship or about whether or not to drink excessively.

Information sharing:

- There was some sharing of information by some of the agencies involved and there were significant (but unsuccessful) attempts to support and encourage Janice to effectively engage with specialist DV services.
- On one occasion staff at the Dawn Centre refused to share information with Nottingham Womens Aid, without Janice's written consent. The DHR has concluded that, given the urgency of the situation (i.e. potential placement

in a women's refuge) seeking verbal consent via a telephone call to the hospital where Janice was an in-patient would have sufficiently addressed concerns about confidentiality.

3. **To identify whether services that were involved with either Ian or Janice were aware of the circumstances of Janice's presence in the home and agencies involved with them. Whether connections were made and information shared between these services in order to establish a full picture of the vulnerability and risks arising from the relationship.**

Most services in regular contact with this couple were aware that Janice and Ian were in an intimate relationship; that this included occasions when Janice would stay at Ian's flat and that there were increasing concerns about violent incidents. Collectively, the agency IMRs also show that there was significant communication and information sharing between agencies. This included an intensive period of communication between GP Practice 1, CPN, Anchor, SAFE and Housing Options, in attempts to put an effective plan to reduce risk levels. Within these communications there are examples of good practice as well as some examples of communication breakdowns.

In summary, it appears that most services did recognise that there were significant domestic violence risks and attempts were made to share information, refer for specialist DV support from SAFE to establish a risk management plan. However, it is not clear that the *'full picture of vulnerability and risks arising from the relationship*' was established. A full picture would have included:

- Sharing of police records which would have highlighted Ian's past history as a serious DV perpetrator and recognition of the significance of that history in assessing current risk levels
- Wider recognition of Janice's homelessness as a major risk factor, because she stayed in Ian's flat when she had no other options.

Multi-agency weaknesses in respect of the above points was a major factor in the circumstances leading up to the homicide.

4. Did agencies involved make routine enquiry about domestic violence when working with these adults and if so were any opportunities missed.

There is evidence that some agencies frequently engaged with both Janice and Ian about domestic violence issues. A number of agencies took opportunities to advise both Ian and Janice to end the relationship as it was widely recognised that there were significant domestic violence risks when the Janice and Ian were drinking excessively. However, there were many missed opportunities when the level of risk that Janice was under could have been more effectively and accurately assessed, followed by more proactive signposting and referral for specialist support. Advising Janice to end the relationship was a simplistic response which failed to recognise that the process of separation from an abusive relationship can often lead to a period of significantly higher risk.

5. To establish whether agencies responded to alcohol and drug dependence and offer appropriate services and support to Ian and Janice.

As noted above, when the couple were together and drinking excessively, this was widely recognised as a major risk factor for potential domestic violence. The couple were offered support to bring their drinking under control. Both Ian and Janice had access to support and harm reduction approaches at the Anchor Centre. Janice also had contact with an alcohol outreach worker.

In summary the evidence is that alcohol was recognised as a highly significant issue and both Ian and Janice were actively encouraged to access relevant services. The Anchor Centre provided a ‘wet house’ which helped reduce immediate risks associated with street drinking. Unfortunately, it appears that

neither Janice or Ian were able to engage with longer term treatment for alcohol dependency / misuse issues. This has highlighted the need for substance misuse services to develop more flexible and opportunistic responses to people who are homeless and have a range of complex needs.

6. At each point of contact with emergency health services for assaults, self-harm and injuries –were enquiries made about domestic violence and procedures followed?

The level and quality of response from emergency health services was variable:

- Responses from the Urgent Care Centre tended to make assumptions that any active follow up to domestic violence concerns was the responsibility of other agencies.
- At Janice's first contact with Leicester Royal Infirmary following a reported domestic violence incident, no CAADA-DASH assessment was completed, which is breach of local policy and procedure. At her second contact an assessment was completed, resulting in a MARAC referral which according to hospital records was emailed to the MARAC office. However, there is no record of it being received by the MARAC office. Due to weaknesses (since resolved) in the hospital's email systems it is not possible to be certain whether or not the email was in fact sent to the correct email address.
- Queens Medical Centre (Nottingham) followed multi-agency policy and procedure, completed a CAADA-DASH assessment and made a MARAC referral. QMC's overall response has been identified as good practice.

7. To establish whether mental health needs of the adults subject to this review were supported and managed appropriately by local agencies

Although Janice spoke of having a bi-polar disorder which she said was diagnosed when she lived in the USA, the IMR from GP Practice 1 indicates no known history or medical record of such a diagnosis. It also indicates that, during the period under review, Janice's mental health was assessed by the GP service, but she was found to show no symptoms of psychosis or of risk of suicide.

However, Janice was referred to the Homeless Mental Health Service, which provided her with support from a Mental Health Nurse. Janice also had an appointment with a CPN, who made a verbal referral to the SAFE project.

In summary, it appears that Janice's mental health needs were adequately supported.

There is no evidence to indicate that Ian had significant mental health needs.

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

The alcohol outreach worker raised concerns in an email on 27/2/15 with Housing Options about the DV risks resulting from Janice being homeless and reliant on an abusive boyfriend for overnight accommodation. It is unclear what Housing Options did with this information.

9. To establish if there were any barriers experienced by Ian, Janice or family / friends that prevented them from accessing help to manage domestic violence; including how their wishes and feelings were ascertained and considered.

Ian has stated that he felt he had been a DV victim as well as a perpetrator, but that as a man he experienced a barrier, because services assumed that the male partner could not be a victim. However, the DHR has not found evidence that would indicate Ian was at any significant risk of serious injury or homicide.

As a homeless person with alcohol problems, Janice experienced many barriers related to her lifestyle and flexibility of service provision. Many professionals genuinely listened to her wishes and feelings and she was offered support by specialist domestic violence services. However, as her basic need for safe and sustainable housing was not met, this undermined attempts to achieve consistent engagement with domestic violence services. Her homelessness created additional barriers for services trying to make and maintain contact. Even contact by mobile phone was unreliable, as Janice would not always be able to keep the battery charged. As a general rule domestic violence services are reluctant to leave voice mail messages, due to fears that a perpetrator may pick up message resulting in higher risks to the victim.

In summary, this DHR has highlighted the need for agencies to develop more flexible, creative and responsive services, in order to reduce or remove some of the barriers which impacted negatively on Janice.

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

There is evidence that there was a lack of awareness within local services of the voluntary pepetrator programme, which could potentially have worked with Ian to

address what was a clearly established pattern of abusive and violent behavior in this and in previous relationships.

11. To establish whether agency DV risk assessments and response to risk followed agreed local multi-agency procedures.

See responses above and to question 12. There were procedural breaches.

12. To establish how referrals into MARAC were responded to, whether these responses were in line with local multi-agency procedures and whether they were appropriate, in the light of information about risk which was available at the time of referral.

The first recorded MARAC referral was generated by QMC on 20/3/15, after they had scored Janice as being at high risk on the CAADA Dash risk assessment. This was following the incident on 19 March when Janice attended the QMC Emergency Department after the incident when she stated Ian had poured boiling water on her head and stabbed her in the thigh. The evidence reviewed by the Police (including the apparently minor nature of Janice's injuries and a third party witness statement which contradicted Janice's account) indicated no realistic prospect of successfully prosecuting Ian with any criminal offence.

A decision was taken by the MARAC office that this would not be discussed at MARAC. The primary basis for this decision appears to be that the allegations made by Janice that she had been violently attacked by Ian were, in the judgement of police officers, not supported by the presenting evidence.

However, the decision in this instance was contrary to local MARAC protocol and procedures and represented a very significant **missed opportunity** to establish a coordinated multi-agency approach, which could have better recognised and more effectively managed ongoing domestic violence risks. It is fundamentally important

to recognise that the lack of evidence to support a criminal prosecution was *not* an indicator for low risk of further domestic violence.

The second MARAC referral was recorded as having been made by UHL's Emergency Department on 30/3/15. This was after Janice attended ED with bruising to her face and back, and a bump to her head. Whilst the MARAC referral is recorded by UHL as having been sent by email, UHL have been unable to locate any email history to confirm that is was sent to the correct MARAC email address. It is understood that this is due to weaknesses in UHL's electronic communications systems, which have since been addressed.

Due to the absence of reliable records, the DHR has not been able to ascertain precisely what happened, but the outcome was that no MARAC process followed.

13. To establish whether vulnerable adult / adult safeguarding concerns were recognised by agencies and were appropriate multi-agency procedures followed.

The DHR has not found significant learning in relation to this question

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

Janice's gender, mental health problems, alcohol misuse and homelessness were all highly significant factors in relation to Janice's needs as a person who was at risk from domestic violence. Learning in relation to these factors is disseminated throughout the report.

15. How effective were local assessments on Ian & Janice's housing needs? Was appropriate housing support offered? How well did Leicester and Nottingham Housing agencies work together in safeguarding Janice?

Janice's homelessness status (after losing her space at the Dawn centre on 15/1/15) was a critical risk factor for domestic violence, but this appears not to have been sufficiently recognised or acted on.

Janice was evicted from the Dawn Centre in January 2015 for an alleged incident of supplying an illicit substance to another resident. An internal review of this decision by Leicester's Homeless Service has since concluded that a final warning would have been a more appropriate response. On eviction, there was no assessment of the likely impact of this decision, even though it was known that she was at risk of domestic violence and had been assaulted on the day preceding her eviction.

When she was admitted to QMC in Nottingham (20/3/15) there were attempts to negotiate some form of suitable housing, including a refuge placement (for which there were no vacancies in the local area) homeless provision in Nottingham and a return to the Dawn centre. However, none of these were offered.

Another factor in Janice being refused services in Nottingham was her previous eviction from the Dawn Centre, so it can be seen that the earlier decision by the Dawn Centre then had significant 'knock-on' effects in further reducing the chances of her finding suitable and safe accommodation. This seems to have been compounded by the Dawn Centre then refusing to share further information with WAIS unless Janice completed a written consent form. Given the urgency of the situation when Janice was a patient at QMC, verbal consent over the telephone could have been sought.

In summary, housing and homeless services in Leicester and Nottingham did not work effectively together to safeguard Janice from further domestic violence.

16. To establish how effectively Leicester / Nottingham agencies and professionals worked together to safeguard Janice.

There was very good communication from staff at QMC hospital and agencies in Leicester, but unfortunately this did not lead to any positive outcomes in relation to Janice's immediate need for safe and secure accommodation. See also response to question 15.

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

See responses above.

18. Identify any areas of good practice

This DHR has established a pattern dominated by missed opportunities, poor inter-agency communications and breaches of procedure in relation to risk assessments and the MARAC process. However, there were isolated examples of good practice, including:

- Responses by staff at Queens Medical Centre in allowing Janice to remain in hospital when medically fit for discharge, having assessed her as being at high risk from domestic violence, then attempting (unfortunately without success) to work with outside agencies in Nottingham and Leicester to establish a safe discharge arrangement.
- The Outreach Alcohol Support Worker demonstrated a good understanding

of the risks Janice was facing and acted appropriately to meet her immediate needs and to try (unfortunately without success) to ensure her engagement with Housing Options services.

- There are several examples of good practice by GP Practice 1, when concerns about domestic violence were proactively explored by practitioners and referral for specialist support was offered.
- Following the first 3 police incidents, Leicestershire Police carried out a review and increased assessed risk levels from standard to medium, due to cumulative evidence of risk.
- UHL's completion of the CAADA DASH risk assessment and the application of professional judgement in deciding to generate a MARAC referral was also good practice, but it is unfortunate that did not result in implementation of the MARAC process. (See question 12)

Key learning points:

The following is a summary of all key learning points from the full report:

Key learning point 1: There were breaches of operational procedure at the LRI Emergency Department and Housing Options which resulted in missed opportunities to assess potential domestic violence risks. There had also been a missed opportunity to carry out a risk assessment (or refer to a specialist domestic violence service for assessment) at the GP practice. This highlights the importance of ensuring that staff awareness and understanding of domestic violence policy, procedure and good practice is promoted through training, supervision and management processes.

Key learning point 2: There is a potential misconception – possibly shared by some professionals as well as members of the public – that 'domestic abuse' can

only take place within the confines of a domestic dwelling. This may result in homeless victims of abuse being effectively excluded from multi-agency domestic abuse procedures.

There is evidence that homeless people are likely to be at higher risk from domestic violence compared to the general population, as is illustrated by this case and other recent DHRs[3]. It is therefore essential that all services which work with homeless people should ensure that staff understand that any abuse within the context of an intimate relationship – *regardless of the physical location of incidents* – should be recognised as domestic abuse and responded to accordingly, within local multi-agency policy, procedure and good practice guidance.

Key learning point 3: When conducting domestic violence risk assessments, police officers should review local and national police records relating to the perpetrator. Where these records confirm a history in previous relationships of serious domestic violence (including in this case criminal convictions resulting in custodial sentences) this is a strong indicator of higher risks in the current relationship. The time period which may have elapsed since the last recorded police incident should not unduly influence officers towards a lower risk score, as it is entirely possible that the abusive behaviour has continued but has not been reported to the police.

Key learning point 4: There was a pattern of assumption on the part of UCC staff that responsibility for addressing concerns about domestic violence risks to Janice lay with the police and other services she was in contact with.

[3] For example: DHR SW01 published June 16 by Safer South Warwickshire CSP: apps.warwickshire.gov.uk/api/documents/WCCC-671-101

As a minimum, UCC staff should have discussed ongoing domestic violence risks with Janice, with a view to referring her for specialist support. Additionally, concerns about domestic violence should have been flagged on UCC records and discussed with her GP and other relevant services. (The UCC DHR Action Plan addresses these issues in more detail.)

In fairness, it must be acknowledged that a number of other services (such as housing, homelessness and primary healthcare services) appear to have followed a similar pattern of assuming that 'somebody else' would be leading in relation to domestic violence concerns, so this learning point is relevant not just to UCC.

Key learning point 5: There is a need to ensure consistency of practice in the use of CAADA-DASH assessments where people present as homeless and there is evidence that that domestic violence is a factor in this presentation. The risk assessment should be conducted at the time of the homelessness presentation and not delayed until a decision is made regarding the person's statutory homeless status, which may be up to 33 working days later. As is clearly shown by Janice's experiences, if the individual is fleeing a violent relationship this period of 33 working days may well be a particularly high risk period.

Key learning point 6: Even if Janice's eviction from the Dawn Centre had been unavoidable due to concerns about other vulnerable service users, there should have been careful consideration of her ongoing vulnerability as a domestic violence victim. Attempts should have been made at finding more suitable alternative accommodation or at the very least signposting to specialist support services.

Key learning point 7: When carrying out DASH risk assessments officers should consider cumulative risk, especially when there has been a succession of similar

incidents within a short space of time. A risk assessment which fails to consider such recent events and evidence of escalation is likely to be unreliable. (See also key learning point 3.)

Key learning point 8: It should be recognised that people with multiple and complex needs such homelessness, alcohol problems and domestic violence (i.e. those in the most critical and urgent need of help) are very frequently the most difficult people for services to meaningfully engage with and effect positive change. However, there could have been more concerted and proactive attempts at getting Janice to attend Housing Options with a view to finding her somewhere safe to stay. This did not happen and the outcome was that Janice remained dependent on her violent partner for accommodation, which was apparently her only option other than rough sleeping.

Key learning point 9: **Clarifying victim / perpetrator roles and identifying risks**	
Ian	**Janice**
Confirmed history / criminal convictions as perpetrator of domestic abuse and serious physical assaults in previous relationships.	Self-reported history as victim of domestic abuse and physical assault in previous relationships
Recent and repeated history of assaulting Janice, causing significant injuries requiring hospital treatment	Observed on occasions to be physically aggressive and towards Ian, not known to have caused him serious injuries
Securely housed	Homeless, largely dependent on staying at Ian's as alternative to rough sleeping
Serious problems with binge drinking	Serious problems with binge drinking, history of mental health problems.

Key learning point 10: In an urgent situation where a person is fleeing domestic abuse and potentially seeking a refuge placement, the requirement for written consent before sharing information with the refuge service may create an unnecessary barrier to them being able to access the service. Where the person is willing and able to confirm verbal consent over the telephone (provided their identity can be verified with reasonable certainty) this should be a sufficient basis for sharing information.

Key learning point 11: The MARAC referral should not have been screened out of the MARAC process, regardless of any doubts that police officers or others may have regarding the reliability of an alleged victim's statement. That there was insufficient evidence to bring criminal charges should not have resulted in any assumptions about levels of domestic violence risks.

To screen and reject MARAC referrals on such a basis completely undermines a key principle: MARACs should consider risk assessments and risk management strategies from a *shared and multi-agency* perspective.

There is a need to ensure that the above points are made completely clear in the local MARAC Protocol.

Key learning point 12: When agencies refer to MARAC they must ensure that they retain a clear record of the risk assessment and the MARAC referral and request and receive a confirmation that the referral has been received. They should also be notified when the case will be discussed at MARAC and invited to attend the MARAC meeting.

Key learning point 13: It is important that GPs and other primary healthcare professionals have a good knowledge and awareness of domestic violence issues in general and of the MARAC process in particular. If there is any doubt about whether there is a current MARAC referral or MARAC coordinated risk management plan, this should be checked with the MARAC Coordinator.

Key learning point 14: This report has appropriately focussed very much on the availability and effectiveness of services to support and protect Janice. However, it is equally important to acknowledge the potential benefits of targeted interventions with repeat domestic violence perpetrators, which may ultimately change this behaviour pattern and protect other women from future abusive relationships. This also highlights the need to increase knowledge and awarness of local services which can offer such interventions.

PART 3: RECOMMENDATIONS

3.1 Recommendations reproduced from the Single Agency Action Plans attached to Individual Management Reviews:

Leicestershire Police recommendations:

1) It is recommended that supervisory officers are reminded of their responsibility to supervise domestic abuse investigations and the importance of fully recording the rationale for their decision making**.**

2) It is recommended that officers are reminded of the various support agencies that are available to persons who are alcohol dependent in order that they are signposted to the most appropriate agency to receive the required support.

3) It is recommended that officers are reminded of the need to adopt a more lateral problem solving approach to domestic abuse when faced with a victim who is reluctant / reticent to engage beyond the initial report of the abuse.

4) It is recommended that the police DASH risk assessment be amended with notes of guidance in the ‘professional judgement’ field, to guide decision makers regarding factors, outside of the main DASH questions,

which should lead an assessor to increase the risk level. These are to include:

- History of DV offending against other separate victims (serial perpetrator)
- Significant increase in frequency of Standard and Medium risk incidents

This change will be marketed to all officers involved in completing DASH risk assessment and otherwise reviewing DV (DAST team)

Leicester City Council Homeless Prevention & Support Service recommendations:

1) Consider how services are withdrawn for victims of Domestic Abuse
2) Service Users presenting with Alcohol Issues should receive additional support to encourage access to treatment.
3) Ensure that Homelessness Services staff are fully aware of ASC responsibilities for vulnerable adults.
4) Assist One Roof to compile a referral form to highlight indicators of DV.
5) Ensure the learning from this IMR is shared amongst Homelessness Services Management Team.

Leicester City Council Housing Options Service recommendations

1) Provide further guidance to Officers as feedback from completing this process of lessons learnt and examples of good practice.

2) Case Management procedures reviewed.

Safe project:

No recommendations

GP Practice 1 recommendations:

1) A DVA lead be designated to lead on this area of work and ensure the practice remains up to date in its protocols and activity.
    a. Improve awareness of the agencies (such as UAVA) and processes (such as MARAC) involved with supporting people experiencing Domestic Abuse within the team.
    b. Improve understanding of CAADA-DASH risk assessment process
    c. Ensure appropriate training for clinical and non-clinical staff
    d. Guard against desensitisation to risks and optimise understanding of HIGHER risks in mutually violent relationships
    e. Engage with local safeguarding and DVA organisations and systems to improve primary care involvement more generally.

2) Systems to flag both victims and perpetrators of DVA within the clinical system (IT) are sought and that routine queries and offers of support and referral take place when flags are present.

Anchor Centre recommendations

No recommendations

Nottingham University Hospitals NHS Trust recommendations

No recommendations

Leicestershire Partnership NHS Trust recommendations

No recommendations

University Hospitals of Leicester NHS Trust Recommendations

1) Improve staff knowledge and awareness of domestic abuse and where to seek specialist advice by incorporating domestic abuse information / training into the mandatory adult safeguarding e-learning module.

2) Revise the face to face training on domestic abuse for ED / UCC staff to incorporate the learning from this review.

3) Review and revise the Emergency Department Standard Operating Procedure for Domestic Abuse, in line with the Trust's overarching DA Policy and best practice. This should include routine enquiry where domestic abuse is disclosed or suspected.
4) Review and revise the Emergency Department Standard Operating Procedure for Safeguarding Adults, in line with the Trust's overarching SA Policy and the Care Act.

5) Increase ED / UCC staff knowledge, awareness and confidence when

dealing with domestic abuse, in light of this review (by implementing the above).

6) Explore the possibility of securing additional funding to recruit a permanent IDVA to work across UHL, alongside the UHL safeguarding teams

7) Ensure that the organisation maintains a secure record of all MARAC referrals made by ED / UCC staff.

3.2 Overview Recommendations agreed by DHR Panel

1) Leicestershire Police should review operating procedure, guidance and training for domestic violence risk assessments using DASH, to include a requirement that checks must be made on police records (Police National Computer and Police National Database) to ascertain whether the alleged domestic violence perpetrator has a history of reported domestic violence incidents and / or criminal convictions. Where such a history exists, but the current risk score has not reached the threshold for automatic referral to MARAC, officers should consider a MARAC referral based on professional judgement. (*Key learning point 3*)

2) There should be a multi-agency review of the MARAC procedure and domestic violence training needs, in the light of learning from this case, to include

    - Systems for sending, receiving and recording MARAC referrals
    - Potential need for clarification of guidance for specialist domestic violence staff, particularly around the requirement that any domestic violence victim identified as high risk in CAADA-DASH must be considered at a multi-agency MARAC meeting. *(Key learning points 11 & 12)*

- Need for wider agency training and awareness raising about domestic violence and the role of MARAC, with a specific focus on training needs in primary healthcare and housing and homelessness services, to include appropriate use of the DASH risk assessment tool in cases where there are presenting concerns relating to domestic abuse.
- Supporting and training staff responsible for assessing domestic violence risks where there are multiple and complex needs, including evidence of mutually violent behaviours. (*Key learning point 9*)
- Ensuring that service users' wishes and intentions are clearly accounted for in safety planning and that follow actions are in place; particularly when the service user is identified as being high risk.

3) There should be work to increase awareness about local services which carry out specialist and targeted work with serial domestic abuse perpetrators. Perpetrators who have a history of criminal domestic abuse offences should be prioritised for such targeted interventions, which may be on a voluntary basis or as an element of criminal court imposed sanctions. If this recommendation highlights issues of insufficient capacity to meet demand, this should be considered by commissioners as a potential area for increased resource allocation. (*Key learning point 14*)

4) All of key learning points from this DHR should be disseminated as widely as possible to local health, social care, housing, homelessness and criminal justice agencies likely to be working with people affected by domestic violence. (*All Key learning points)*

FINAL REPORT
DOMESTIC HOMICIDE REVIEW: INDEPENDENT OVERVIEW REPORT INTO THE DEATH OF
'Janice'

PREPARED BY RICHARD CORKHILL

20 July 2016

INDEX

PART 1: DOMESTIC HOMICIDE REVIEW, BACKGROUND AND PROCESS

1.1 Purpose of the review

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

1.2 Who the report is about

1.2.1 This DHR is about 'Janice'[1], who was 46 when she died as a result of domestic violence perpetrated by her partner 'Ian'. The following description of Janice's background is based mainly on information provided by her family members in the course of police enquiries following the homicide. The family were unable to provide precise dates for some periods of Janice's life, much of which was spent abroad in the USA and in parts of Europe.

1.2.2 Janice was born in Blackburn and had 2 sisters. Both of her parents were alcohol dependent and died a number of years ago. Having spent her formative years in Blackburn, in her late teens Janice travelled through Europe working as a Nanny.

1.2.3 Whilst in her 20's Janice moved to the USA, where she met her first husband, with whom she had a son (born 1994) and a daughter (born 1997) This is reported to have been a happy marriage whilst the children were young. However, Janice's family report that she drank excessively and that this became more problematic after she started working in a local bar. Ultimately the marriage broke down and Janice's son and daughter remained in the care of their father.

1.2.4 Following the breakdown of her first marriage, Janice married another USA citizen. Janice's family described her second husband as having had alcohol and drug problems, leading to a further increase in Janice's excessive use of alcohol. Janice was arrested for being drunk and disorderly, at which point it was discovered by USA authorities that she did not have citizenship to stay in

[1] For reasons of confidentiality, pseudonyms of 'Janice' and 'Ian' (homicide victim and perpetrator, respectively) are used throughout the report. Other pseudonyms are used for family members, ex-partners, etc.

the country. She remained in prison in the USA for 18 months before being deported back to the UK. Whilst she was in prison, her second husband died.

1.2.5 On her return to the UK in 2008, Janice lived with her sister in Blackburn and commenced work at a local hotel where she organised events. Janice's sister described her as being very good company when she had her drinking under control, but also recalled that Janice could be short tempered and volatile for no apparent reason.

1.2.6 After a period of time Janice moved out of her sister's house to live with a friend in the Blackburn area. At some point after that she was prosecuted for drink driving, following which she moved to Spain.

1.2.7 Whilst in Spain Janice formed a new relationship with a man whose details are not known. Neither had jobs and they lived a nomadic lifestyle, moving from hostel to hostel. The family describe the relationship as a volatile one during which Janice suffered domestic abuse. She would often ask her sisters for money and on 2 occasions they funded flights back to the UK as they were concerned about this abuse.

1.2.8 In Autumn 2014 Janice flew back from Spain to the UK, on a flight paid for by one of her sisters. It appears that she spent some weeks with a male friend in London before travelling to Leicester to stay with a female friend whom she had previously met in Spain. This friend has since advised that Janice's behaviour became aggressive as a result of excessive alcohol consumption and after a period of about 2 weeks she wanted Janice to leave. Janice presented to

1.2.9 Leicester's Homelessness Prevention and Support Service, and was accommodated at the Dawn Centre (temporary homeless accommodation) in November 2014. At this stage, Janice disclosed that she had recently been violently assaulted by a male friend in London, resulting in an injury to her finger.

1.2.10 Janice informed clinicians at GP Practice 1[2] that she had a history of mental health problems, including a bi-polar disorder. As this reported history was when she was living abroad, it is uncertain whether or not there had been a confirmed or reliable medical diagnosis of a bi-polar condition. GP Practice 1 clinicians did not identify symptoms of a bi-polar disorder or any other type of psychosis, but Janice was prescribed medication for anxiety.

[2] This GP Practice is a Community Interest Company. It specialises in working with people who are homeless or in temporary accommodation.

1.2.11 Janice had serious problems of alcohol misuse, including particularly episodes of excessive consumption (binge drinking), when it seems that her behaviour could become out of control. She appeared not to have had a serious physical addiction to alcohol, or any other substances. When sober, she presented as having a socially confident and bright personality, with no reason to question her mental capacity to make decisions about her life and life-style.

November 14 – May 2015:

1.2.12 Part 2 of the report provides more detailed description and analyses of events during this last period of Janice's life. The following is a brief outline:

1.2.13 Janice had 2 stays at the Dawn Centre:

- Around 4 weeks in November / December 2014
- One night in January 2015

1.2.14 Janice left the Dawn Centre voluntarily in December 2014, when she went to stay with her sister in Blackburn for a short period, before being re-admitted to the Dawn Centre around 3 weeks later. After one night Janice was asked to leave as she was suspected of supplying illicit substances to another resident.

1.2.15 After leaving the Dawn Centre until the homicide (around 15 weeks later) Janice had no secure or stable accommodation. On occasions, she stayed at Ian's address, where there were a number of reported domestic violence incidents. Some of these incidents resulted in the involvement of the police, emergency medical services and other agencies, as detailed in part 2 of this report.

1.3 Perpetrator background:

1.3.1 At the time of the homicide Ian was 44 years old. He was born in the Republic of Ireland and moved to Leicester around 1998, following an incident in Ireland that resulted in one of his family members being stabbed. In 1998 (aged 27 years) he formed a relationship with 'Karen'[3] who was then 16 years old. The following year the couple moved from Leicester to Dublin, where their first child was born. Ian and Karen went on to have 2 more children born in 2002 and 2004. The family unit returned to live in Leicester in 2004. It was reported that Ian had decided to leave Ireland after a violent incident with a man who Ian believed had assaulted his brother[4]. The relationship between Ian and Karen was volatile with reported incidents of violence, threats and abuse resulting in the involvement of Leicestershire Police (see table below for

[3] Karen is a pseudonym used for reasons of confidentiality

[4] This reported incident was outside UK police jurisdiction and the full details of what took place remain unclear.

further detail). Excessive use of alcohol by Ian was a common factor in all of the reported incidents. It is understood that the couple separated at some point during 2005.

1.3.2 Following this, it appears that Ian had a number of short-term relationships with women. Some of these relationships also featured police involvement following reports of violent or aggressive behaviour by Ian when under the influence of alcohol. During this period, he was well known to Leicester's Homeless Outreach Team as a person with a history of rough sleeping and street drinking behaviours.

1.3.3 Ian's last relationship (prior to meeting Janice) was with 'Linda'[5]. The couple had lived together, but the relationship ended as a result of Ian's excessive and problematic use of alcohol. There is no reported history of violence in this relationship. In November 2014 Ian referred himself again to homelessness services in Leicester. With support, he secured a privately rented flat in Leicester. This flat was the location of the homicide.

1.3.4 Ian has 8 previous convictions which involve the commission of 12 offences. The majority of these convictions involve alcohol abuse and violent behaviour. The following is a summary of the history of police involvement with Ian, prior to the start of his relationship with Janice:

Date	Summary of incident	Outcome
April 2005 (Following Ian's separation from Karen)	Karen reported a burglary. The offender had broken in through a glass panel in a back door, consumed a large quantity of alcohol and food, then boarded the door back up. Ian was arrested and charged with an offence of criminal damage.	Charge withdrawn: Insufficient evidence.
May 2005	Ian attempted to force entry to Karen's house and threatened to throw a wheelie bin through the window.	Ian was arrested and charged with using violence to secure entry to premises. Released on bail with conditions.

[5] Linda is a pseudonym used for reasons of confidentiality

June 2005	Ian gained entry to Karen's house around 6am, when Karen was in bed. She heard loud music downstairs and found Ian, who initially refused and shouted at her, before eventually leaving. As a consequence of this incident Karen and her children moved to a women's refuge for a period, as she feared for her safety.	Criminal conviction: Ian was being sought by the police for this and the previous offence. He was arrested about a week a later and after period remanded in custody, he was fined for these offences.
Nov 2005	Police records show that Ian had been in a new relationship with 'Jane'[6] since July 2005. In Nov 2005 it was reported that Jane was approached by Ian in Leicester city centre (around 11am), when he verbally abused her and made threats to injure her. She walked to the police station with Ian following her. After she left the police station it was reported that: • Ian grabbed her and dragged her across the road, causing injuries to her knee. • Took a carrier bag from her, which contained 4 cans of lager. Later on the same day it was reported that Ian again approached Jane in the street, when it was alleged that: • He was verbally abusive • He grabbed Jane from behind • He subjected Jane to a sustained assault, head-butting her several times and	Police investigation failed to identify any independent witnesses. In early December Jane was seen by officers but she refused to give any further statement or to assist with the investigation, describing the incidents as 'inconsequential'. It appeared she was still in a relationship with Ian at this time. No further police action was taken against Ian in relation to these alleged incidents.

[6]Jane is a pseudonym used for reasons of confidentiality

	striking her head against a wall. At this stage police officers attended the scene and arrested Ian. In addition to Jane's injuries it was noted that Ian had grazing to his hands and a bruised cheekbone.	
October 2006:	Jane (now resident at Dawn Centre) reported that Ian had assaulted her. Dawn Centre staff confirmed that Jane had facial injuries	Ian was interviewed by the police on the same day and denied the allegation of assault. As there was no independent witness, no further action was taken in respect of this allegation
December 2006:	Police were called to hostel in Leicester after a report that Jane had been assaulted. She was seen to have severe bruising and swelling to her face.	Criminal conviction / 3-month prison sentence: A number of witnesses at the hostel were identified. Ian was interviewed and claimed that Jane had instigated the violent incident and he had retaliated with a 'slap'. He said he then blacked out and had no recollection of what followed. He was remanded in custody before pleading guilty to assault occasioning actual bodily harm (ABH) and received a 3-month prison sentence.

April 2008:	Metropolitan Police officers attended a flat in Stoke Newington (London). At this time Ian was in a relationship with a different partner, 'Beryl'. Beryl stated that Ian had placed his hands round her throat and tried to strangle her. She was recorded as being in a very distressed state and told officers that there had been a gradual escalation of violence towards her by Ian, in the preceding few months.	Criminal conviction / 3-month prison sentence: Ian was arrested and admitted the assault. He was convicted for common assault and received a 3-month prison sentence.
June 2011:	Karen reported to the police that Ian had gone to her home address and banged on the door. Demanding to see one her children.	No police action followed as no offences were reported.

1.3.5 From 2008 until the commencement of his relationship with Janice, there is no further record of police involvement with Ian. There were several more police incidents involving Ian and Janice in the period from Jan 2015 until the homicide in May 2015. These incidents are described in Part 2 of this report.

1.4 Janice and Ian's relationship

1.4.1 Janice and Ian's relationship commenced at some time between late November 2014 and early January 2015. Agency IMRs indicate that none of the services involved with Janice or Ian had knowledge of the relationship until January 2015.

1.4.2 At this time, Ian was already well known to the services based in the Dawn Centre building, including the hostel itself and GP Practice 1 which provides primary health care services to hostel residents and other people in the locality

1.4.3 affected by homelessness and complex needs. Ian had recently moved into his privately rented flat, with support from homelessness services and the Anchor Centre (city centre day service for street drinkers).

1.4.4 The collective evidence from agency IMRs suggests that a significant feature of the relationship was mutual binge drinking followed by verbal conflict,

escalating to physical violence. When violent incidents were reported (to the police or other services) it often proved difficult to reliably ascertain whether Ian or Janice had been the primary instigator.

1.4.5 Throughout the period of the relationship, Ian was resident as the sole tenant of his privately rented flat. Janice's first presentation as being homeless in Leicester was in November 2014. She was resident at the Dawn Centre for 2 relatively short periods (as detailed at 1.2 above) but apart from this she had no secure accommodation. She may on occasions have slept rough or stayed with other people, but this detail is unknown.

1.4.6 For some periods Janice stayed overnight in Ian's flat, but she would then leave - or be ejected by Ian – often following an alcohol fuelled conflict. During daytime periods Ian and Janice sometimes attended the Anchor Centre, either together or separately.

1.4.7 In summary:

- When the homicide happened Janice and Ian had known each other for around 6 months.
- It had been a highly volatile relationship between 2 people who each had a long history of alcohol misuse, street drinking and periods of homelessness.
- Ian had a history in previous relationships as a perpetrator of domestic violence, including some serious assaults resulting in prison sentences. This pattern of behaviour continued in his relationship with Janice.
- Janice had a history in previous relationships as a victim of domestic violence.

1.5 Outline summary of the homicide incident:

1.5.1 At around 7.30 am on a Saturday morning, Leicestershire Police received an anonymous telephone call stating that a woman had been murdered at Ian's address, which was a flat (situated in a block of flats) in Leicester. The male caller rang off before any further detail could be obtained. Police officers attended at 7:50pm but were unable to gain entry to the block. The supervisory officer present concluded that the available information / intelligence did not justify the use of force to enter the flats and the incident was closed.

1.5.2 The following day (Sunday), the incident was reviewed and further intelligence checks were completed. That process identified previous incidents involving Ian and Janice at this address. Entry was forced into the flat at 12:23pm when Janice's body was discovered.

1.5.3 A forensic pathologist's report was unable to specify the cause of death, but a guilty plea to manslaughter was accepted by the prosecution. Ian had admitted placing Janet in a choke hold, during an alcohol fuelled row. The Court were informed that he did not intend to kill his victim.

1.6 Police Professional Standards investigation

1.6.1 The initial police response to the anonymous phone call was referred to the Independent Police Complaints Commission (IPCC) who decided the matter could be investigated locally by the Leicestershire Police Professional Standards Department (PSD).

1.6.2 The PSD investigation concluded that the failure to force entry to the flat on the Saturday would not have saved Janice's life as it is believed she had been dead for approximately 12 hours prior to the telephone call. However, in light of the available intelligence and information regarding domestic incidents at the address, the investigation found that the supervisory officer should have taken greater steps to identify the actual premises. It was recommended that management advice should be given to that officer.

1.7 Decision to carry out a DHR

1.7.1 The statutory Home Office Guidance[7] on the conduct of DHRs states:

> "*Domestic Homicide Review means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—*
>
> *(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or*
>
> *(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.*
>
> *Where the definition set out in this paragraph has been met, then a Domestic Homicide Review must be undertaken*."

1.7.2 In this case, the presenting evidence was that the couple had been in an intimate relationship (but not formally co-habiting) for a period of several months leading up to the homicide incident. On this basis, Leicester CSP

[7]Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised version, August 2013. Home Office

confirmed that a DHR would be undertaken, in line with their statutory responsibilities.

1.8 Review timescales

1.8.1 Home Office guidance suggests a target period of 6 months for the completion of DHRs. This DHR has taken nearly 12 months from outset to completion. This has been due to a number of factors, including the need to wait for completion of the criminal process so that DHR enquiries would not unduly interfere with the criminal case which concluded in autumn 2015.

1.9 Confidentiality

1.9.1 Pending Home Office approval for publication of the report, the DHR panel and Leicester CSP have managed all information about this case as highly confidential. Information sharing has been restricted to members of the DHR Panel, their line managers and senior managers of services which provided Individual Management Reviews.

1.10 DHR Panel

1.10.1 There was no Adult Services involvement in this case, allowing Adult Services Directorate senior managers to chair meetings with professional independence.

1.10.2 The Panel Chairs were:

- Mr. Paul Kitney, Head of Service Adult Safeguarding, Leicester City Council (first 2 meetings)[8]
- Ms. Ruth Lake, Director Adult Social Care & Safeguarding Leicester City Council (subsequent meetings).

1.10.3 Independent Consultant Richard Corkhill[9] was appointed as Overview Report Author. Mr. Corkhill has been a self-employed consultant since 2004. His professional background includes practitioner and senior manager roles in the social care and supported housing sectors. In the last 4 years, he has worked as a DHR Chair / Author for a number of different Community Safety Partnerships. He has never been employed by any of the organisations which had involvement in this case.

[8] Mr. Kitney left his employment with Leicester City Council during the course of the DHR and was replaced as DHR Panel Chair by Ms. Lake.
[9] Further information about the report author can be found at: www.richardcorkhill.org.uk

1.10.4 In addition to the Chair and Report Author, the Panel included representation from the following organisations:

- Action Homeless
- Anchor Centre
- GP Practice 1
- Leicester City Clinical Commissioning Group
- Leicester City Council Domestic Violence Coordinator
- Leicester City Council Housing Options & Homelessness Services
- Leicestershire Partnership NHS Trust
- Leicestershire Police
- Living Without Abuse
- Nottingham City Council Domestic Violence service
- Nottingham University Hospitals NHS Trust
- SAFE (Non-statutory domestic violence service)
- University Hospitals of Leicester NHS Trust

1.10.5 Administrative support was provided by Leicester City Council.

1.11 Terms of reference

1.11.1 Each of the agencies which had been identified as having significant and relevant involvement with Janice and / or Ian carried out an Individual Management Review (IMR) of that agency's involvement. The terms of reference required IMRs and this overview report to address the following questions, covering the period from September 2014 until Janice's death.

DHR TERMS OF REFERENCE AS AGREED BY SAFER LEICESTER

1. To review whether practitioners involved with Ian and Janice were knowledgeable about potential indicators of domestic violence and aware of how to act on concerns about a victim or perpetrators

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

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

ii) whether police DV risk assessments and management plans of Ian took account of his early forensic /criminal history, and assessments of risk made during this period.

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

iv) whether risk assessments considered risk to individuals when services were withdrawn

3. To identify whether services involved with Janice and/or Ian were aware of the circumstances of Janice presence in the home and agencies involved with them. Whether connections were made and information shared between these services in order to establish a full picture of the vulnerability and risks arising from the relationship.

4. Did agencies involved make routine enquiry about domestic violence when working with these adults and if so were any opportunities missed.

5. To establish whether agencies responded to alcohol and drug dependence and offered appropriate services and support to Ian and Janice.

6. At each point of contact with services for assaults, self-harm and injuries – were enquiries made about Domestic Violence and procedures followed?

7. To establish whether mental health needs of the adults subject to this review were supported and managed appropriately by local agencies.

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

9. To establish if there were any barriers experienced by Ian, Janice or family / friends that prevented them from accessing help to manage domestic violence; including how their wishes and feelings were ascertained and considered.

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

11. To establish whether agency DV risk assessments and response to risk followed agreed local multi-agency procedures.

12. To establish how referrals into MARAC were responded to, whether these responses were in line with local multi-agency procedures and whether they were appropriate, in the light of information about risk which was available at the time of referral.

13. To establish whether vulnerable adult / adult safeguarding concerns were recognised by agencies and were appropriate multi-agency procedures followed.

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

15. How effective were local assessments on Ian & Janice's housing needs? Was appropriate housing support offered? How well did Leicester and Nottingham Housing agencies work together in safeguarding Janice?

16. To establish how effectively Leicester / Nottingham agencies and professionals worked together to safeguard Janice.

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

1.12 Chronologies and Individual Management Reviews

1.12.1 Chronologies and IMRs were provided by the following organisations:

Organisation	Primary reason for contact	With perpetrator (and/or) victim
Leicestershire Police	Call outs to domestic incidents & homicide response	(P&V)
Leicester City Council Homeless Prevention & Support Service	Periods of accommodation at Dawn Centre hostel	(P&V separately)
Leicester City Council Housing Options Service	Housing applications	(P&V separately)
SAFE Project	Domestic violence helpline contacts	(V)
GP Practice 1	G.P. and other primary healthcare services	(V & P)

University Hospitals of Leicester NHS Trust	Treatment at Emergency Department, Leicester Royal Infirmary	(V)
George Eliot Hospitals NHS Trust[10]	Treatment at Urgent Care Centre, Leicester Royal Infirmary	(V)
Anchor Centre	'Wet' day centre for street drinkers	(V&P)
Nottingham University Hospitals NHS Trust	Treatment at Emergency Department, Queens Medical Centre	(V)
Leicestershire Partnership NHS Trust	Community mental health services	

1.13 Involvement of family members and friends

1.13.1 Janice's sister in Blackburn was invited to contribute to the DHR and it was hoped that she may also facilitate communication with Janice's (now adult) children who remain resident in the USA. This invitation was declined.

1.13.2 The female friend that Janice met in Spain and stayed with for a short period in Leicester was also contacted, but she also chose not to take any part in the DHR.

1.14 Meeting with perpetrator

1.14.1 The perpetrator accepted an invitation to contribute to the DHR and was visited in prison by the report author and Leicester City Council's Domestic Violence Coordinator. His prison-based Offender Supervisor was also in attendance.

1.14.2 Contents and learning points from this meeting are summarised in part 3 of this report.

[10] At the time these events occurred the Urgent Care Centre was managed by George Eliot Hospitals NHS Trust whilst the Emergency Department (on the same hospital site) was managed by UHL. The Urgent Care Centre has since been taken over by the UHL Trust. Separate IMRs were provided, in relation to events at Emergency Department and the Urgent Care Centre.

PART 2: CHRONOLOGY OF AGENCY INVOLVEMENT: ANALYSIS AND KEY LEARNING

2.1 Introduction

2.1.1 This section of the report provides a chronological overview of the most significant incidents and agency contacts with Janice and Ian during the critical period from Janice's first arrival at the Dawn Centre, until the homicide around 5 months later.

2.1.2 It also includes sections of analysis and key learning, set out as follows:

> **Analysis & key learning**
>
> Where events and agency responses have resulted in important points of key learning, this is highlighted and placed within boxes.
>
> The purpose of this format is to ensure separation between factual accounts of what took place and analytical content.

2.1.3 **November 14:** Janice made a homeless declaration to Leicester City Council's Housing Options service, as the friend she had been staying with was no longer willing to allow this arrangement to continue. From the information, available it appears that Janice and Ian's relationship had not commenced at this point in time. In her homelessness assessment Janice stated that she was fleeing from a domestic violence incident which had occurred in London. (The precise date of this incident is not known, but it appears to have been 2-3 weeks earlier). Janice was offered and accepted temporary accommodation at the Dawn Centre. The Housing options IMR notes that the Janice was assessed as vulnerable (i.e. the legal definition of vulnerable under homeless legislation) due to her reported bi-polar disorder and being at risk of rough sleeping.

2.1.4 Following advice from a Leicester GP practice[11], Janice presented at the Leicester Royal Infirmary (LRI) Emergency Department, (part of UHL NHS Trust) with an injury to her finger, which she said had been inflicted in the domestic violence incident in London, some 3 weeks earlier. She had already given the GP practice the same information about the cause of this injury.

[11] Care Centre has since been taken over by the UHL Trust. Separate IMRs were provided, in relation to events at Emergency Department and the Urgent Care Centre.

2.1.5 The UHL IMR clarifies that this was a 'mallet injury', which is common minor injury to the finger usually associated with accidental trauma and not commonly seen as a result of violent assault.

2.1.6 Janice was provided with appropriate treatment for her injury. A nurse arranged a follow up appointment for 1 week later and recorded: "discuss DV in view of 3 week delayed presentation".

2.1.7 **December 2014:** Janice attended the follow up appointment at LRI and was seen by a doctor at the fracture clinic who took the opportunity to discuss the incident which caused the injury. It was recorded by the doctor that 'call was not counted as domestic violence, according to her, as it happened on the street.'

2.1.8 No formalised or recorded domestic violence risk assessment was undertaken by any of the services (i.e. homeless service, GP practice, Emergency Department or the fracture clinic) in relation to this disclosure of domestic abuse.

2.1.9 **December 2014:** Janice registered with the Anchor Centre. (At this time, Ian had been a long-standing client of the Anchor Centre.) At her initial registration with the Anchor Centre she disclosed that she had a history of depression in the past, when she had been victim of domestic violence.

2.1.10 **December 2014:** Janice registered with GP Practice 1. (Specialist primary healthcare service for people who are homeless or vulnerably housed). On the following day Janice attended an initial GP appointment and advised she was waiting for emergency dental treatment for a cracked molar, after being beaten up by an ex-partner. This appears to have been related to the same incident in London when she sustained the injury to her finger, although records are not entirely clear on this point. There was no suggestion that she had any ongoing contact from the person who had beaten her up or that this person presented an ongoing threat. Janice was referred to the Homeless Mental Health Service. There is no record of any further discussion at this appointment in relation to domestic violence. On the next day, Janice was seen again at GP Practice 1 for a physical health check, when it was noted that her alcohol consumption was very high. Referral to a specialist alcohol service was discussed, but Janice felt she would get support with this at the Dawn Centre and declined a referral. Domestic violence issues were not discussed.

2.1.11 2 days later Janice was seen again at GP Practice 1, for a New Patient Check with the Practice Nurse. This included use of 'Alcohol Use Disorders

Identification Test (AUDIT) for which she scored 19[12]. Domestic violence was discussed at this appointment and Janice disclosed that she had a history as a victim of domestic violence in previous relationships over a period of 15 years. Janice was offered a referral to SAFE (voluntary sector domestic violence service) but she declined, stating that she was no longer in an abusive relationship. A week later she had another appointment at GP Practice 1 for routine medical tests. Domestic violence issues not discussed. 2 days after this GP appointment, Janice vacated the Dawn Centre hostel and advised that she was going to stay with her sister in Blackburn.

2.1.12 For the following 2 – 3 weeks, there is no record of Janice having contact with Leicester based services.

Analysis / key learning

All of the evidence from this period shows that Janice was willing to openly share information (i.e. with homelessness services, primary and secondary healthcare services and the Anchor Centre) about her recent and longer term history as a domestic abuse victim. Notwithstanding her history as a victim of domestic violence, she was generally perceived by these services as having a socially confident personality, rather than as someone with obvious vulnerabilities.

The IMR produced by UHL NHS Trust confirms that Emergency Department procedures for domestic abuse were not followed at the initial contact. Under these procedures staff should complete a CAADA-DASH RIC whenever a patient discloses that they have suffered domestic abuse. Depending on the level of risk identified, specific pathways should then be followed. That this did not happen in this case was a missed opportunity, not only to assess levels of risk, but also to open a dialogue with Janice about the issue of domestic abuse and possible strategies to reduce risk.

Risk assessments could also have been (but were not) completed when Janice made her homeless declaration and when she attended her GP practice, both of which were prior to going to the Emergency Department. In the case of her homeless declaration, the absence of a domestic violence risk assessment was contrary to Housing Option's procedures.

It is acknowledged that, had there been a risk assessment (by any of the services involved at this stage), it is probable that risks would have been assessed as being at a standard level (and thus would not have resulted in a MARAC referral) given that the alleged perpetrator was in London, there was

[12] Score of 19 in this standardised test indicates 'higher risk and nearing possible dependence'

no suggestion that he posed an ongoing risk to Janice and no evidence that Janice had entered another abusive relationship.

Key learning point 1:

There were breaches of operational procedure at the LRI Emergency Department and Housing Options which resulted in missed opportunities to assess potential domestic violence risks. There had also been a missed opportunity to carry out a risk assessment (or refer to a specialist domestic violence service for assessment) at the GP practice. This highlights the importance of ensuring that staff awareness and understanding of domestic violence policy, procedure and good practice is promoted through training, supervision and management processes.

At the follow-up appointment a week later, the doctor did ask Janice about the circumstances of her injury and this was good practice. The IMR author for the Trust advises that it is not possible to determine how (or whether) Janice's view that the incident 'did not count as domestic violence as it happened on the street' influenced the doctor's actions.

Key learning point 2:

There is a potential misconception – possibly shared by some professionals as well as members of the public – that 'domestic abuse' can only take place within the confines of a domestic dwelling. This may result in homeless victims of abuse being effectively excluded from multi-agency domestic abuse procedures.

There is evidence that homeless people are likely to be at higher risk from domestic violence compared to the general population, as is illustrated by this case and other recent DHRs[13]. It is therefore essential that all services which work with homeless people should ensure that staff understand that any abuse within the context of an intimate relationship – regardless of the physical location of incidents – should be recognised as domestic abuse and responded to accordingly, within local multi-agency policy, procedure and good practice guidance.

Although the above learning points follow events at LRI, it should be recognised that Janice had already disclosed the recent domestic violence incident (and her longer-term history of abusive relationships) to other professionals, including the homelessness service and a GP practice, and they

[13] For example: DHR SW01 published June 16 by Safer South Warwickshire CSP: apps.warwickshire.gov.uk/api/documents/WCCC-671-101

also did not pro-actively explore this issue with Janice. It would therefore be unfair to single out LRI for criticism, when responsibility was shared between a number of services.

At subsequent appointments GP Practice, there were more missed opportunities to open dialogue with Janice about her experience as a victim of domestic violence.

At the following GP Practice Nurse appointment, there was discussion about domestic violence, when Janice talked about her longstanding pattern of entering relationships with domestic abuse perpetrators. At this appointment, Janice was offered referral to a specialist domestic violence service (SAFE). This was good practice, as SAFE may have been able to help Janice to develop strategies to try and break the pattern of entering relationships with abusive men. Unfortunately, Janice declined a referral to SAFE.

There appears to have been a common judgement (by each of the services Janice had contact with in November / December 2014) that current domestic violence risks were low, not least because she had removed herself from the perpetrator who was understood to still be in London. Other factors appear to have been the delay in Janice seeking medical attention, the minor nature of her physical injuries and her general presentation as a bright and socially confident individual.

On the basis of the evidence available at the time, it seems probable that a CAADA-DASH assessment at any point during this period would have supported a view that Janice was currently at standard risk (i.e. the lowest level of risk category in the CAADA-DASH assessment model) as she appeared not to be in a current relationship and the last reported incident was in London. However, it would at least have been an opportunity to open a dialogue with her about her history as a domestic violence victim and potential strategies for reducing risks in the future.

As none of the agencies involved at this stage had any knowledge of a relationship with Ian (either because the relationship had not commenced or Janice chose not to disclose it – it is not entirely clear which of these was the actual position) it seems unlikely that a risk assessment during November and December 2014 would have led to specific actions which could have directly prevented the homicide some months later.

2.1.13 **January 2015 (Late morning / lunch time):** Street incident witnessed by Anchor Centre staff[14]. Janice had been asked to leave the Anchor Centre after a dispute with another female service user. A staff member subsequently saw Janice in the street (near the Anchor Centre) when she was congregated in a group of around 8 other people. There was then a confrontation between Janice and the same female service user, who had also been required to leave the centre around 10-15 minutes after Janice. The staff member phoned the police (non-emergency line) and was told the situation was being monitored on CCTV. Following this Janice was seen by another Anchor Centre staff member in a physical confrontation with Ian, on the same street. In this confrontation, Janice was observed by the Anchor staff member to be the primary aggressor, with Ian repeatedly trying to push her away. The police were phoned again by an Anchor Centre member of staff, this time using the 999 system. It was confirmed again that the situation was being monitored on CCTV.[15]

2.1.14 **January 2015:** Janice failed to attend an appointment with the Mental Health Nurse from the Homeless Mental Health Service. She had been referred to this service by GP Practice 1. This was the third appointment she had missed with this service.

2.1.15 **January 2015**, Police incident 1: At 7.47pm Janice called the police to report she had been assaulted by Ian at his flat in Leicester. The call taker noted that Janice sounded intoxicated.

2.1.16 At the time of her call Janice was on her way to the Dawn Centre (and arrived there before the call ended) and was no longer with Ian. As she was not in immediate danger it was agreed she would attend the police station the following day, to formally report the incident.

2.1.17 Janice attended the police station on the following day as agreed and reported the following:

- She visited Ian at his flat after he had texted her, inviting her for a drink.
- 3 other people were present when she arrived.
- Ian was heavily intoxicated and asked Janice to remove a hat she was wearing, which she declined to do.

[14] This incident was not referred to directly in the Anchor Centre IMR, but has been described by the Anchor Centre manager (who was one of the witnesses to the incident) in the course of DHR enquiries.

[15] DHR enquiries have confirmed that Leicestershire Police did receive these calls and there was a police presence after the second call, but no offences recorded. However, there was no record of either Janice or Ian being identified by name. Consequently, these incidents would not be included in either party's police record and are not referenced in the police chronology or IMR.

- When Janice went to the toilet Ian followed and started shouting at her about the hat, before removing it and punching her several times on the top of the head.
- He then pulled her away from the toilet and pinned her down on the floor with her legs over her head.
- Janice managed to break free and ran away from the flat, she then made the telephone call to the police

2.1.18 Janice was unable to complete a statement whilst at the police station due to a pre-arranged appointment with the local housing department, however the officer completed a Domestic Abuse, Stalking and Honour Based Violence (DASH) risk assessment and the risk was graded as 'standard'.

2.1.19 Subsequently, this incident was followed up by a local beat officer, who met with Janice. Police records show that her recall was confused. Following this, further efforts by the police to engage Janice in the matter were unsuccessful. When she was contacted by the police in telephone calls she was recorded to have been verbally abusive, refusing to answer questions or to have another meeting with the officer.

2.1.20 Although efforts were made to arrest Ian, these were not successful. Ultimately, a decision was taken for no further police action, primarily due to Janice's non-cooperation.

Analysis / key learning

The Police IMR and follow up enquiries from the DHR Panel have not been able to establish whether or not Leicestershire Police domestic violence risk assessments (following this and all subsequent police incidents) were informed by reference to Ian's history as a domestic violence perpetrator in previous relationships. As detailed in Part 1 of this report, this history included a significant number of reported incidents and 2 convictions for acts of domestic violence, each resulting in custodial sentences. The last recorded police incident had been in 2008, but officers should have considered the fact that most domestic violence incidents are not reported to the police. Another factor in this case was that for some of this period Ian was believed to have been resident in the Republic of Ireland and any records of police incidents or convictions whilst outside of UK police jurisdiction would not be recorded on UK police systems.

Key learning point 3

When conducting domestic violence risk assessments, police officers should review local and national police records relating to the perpetrator.

Where these records confirm a history in previous relationships of serious domestic violence (including in this case criminal convictions resulting in custodial sentences) this is a strong indicator of higher risks in the current relationship. The time period which may have elapsed since the last recorded police incident should not unduly influence officers towards a lower risk score, as it is entirely possible that the abusive behaviour has continued but has not been reported to the police.

The police decision for no further action against Ian was due primarily to Janice being apparently unwilling to engage with police enquiries following the incident. It is acknowledged that the chances of a successful prosecution would have been greatly undermined by Janice's non-cooperation. However, it is also noted that there were (according to Janice) 3 other potential witnesses present, who were not interviewed by the police. It is arguable that these witnesses should have been followed up, but as they were reported to have been in a different room from the alleged assault and may well have been intoxicated it is unclear whether they could have been useful witnesses.

2.1.21 **January 2015:** Janice accommodated at Dawn Centre. Immediately following Police incident 1, Janice attended the Dawn Centre and self-referred, stating that she was fleeing domestic violence. The Dawn Centre record of her self-referral includes the observation that she was 'in a bad way'. She was allocated a place at the Dawn Centre for one night pending interview with the Housing Options Service the following morning. That evening (around 10.50 pm) Janice presented at Urgent Care Centre, where she described the assault she had already reported to the Police and to staff at the Dawn Centre. She initially said that her assailant had tried to strangle her, had punched her twice in mouth. She was subsequently seen by a locum GP at the UCC when she said she had been on the floor, stamped on around the chest, strangled and repeatedly punched in the face and chest. Her injuries were recorded, including:

- Faint bruising around her neck
- Large bruise to right chest just above breast
- Bruise to right forehead
- Mild soft tissue swelling

2.1.22 There was no indication of bone fractures, lacerations or other serious injuries. Janice was prescribed pain killers and discharged.

Analysis / key learning

There appears to have been a degree of inconsistency in Janice's description of the incident, but the nature of the injuries observed at the

UCC indicates that she did suffer a significantly violent assault and that Dawn Centre's record of her being 'in a bad way' was accurate, if not very descriptive.

The UCC IMR has identified a pattern (relating to each of her 4 attendances over the period under review) whereby Janice's injuries have been medically treated appropriately, but there has not been proactive enquiry into the background to the assault, or consideration of the need to refer for specialist domestic violence support, or to flag her on UCC systems as being at risk from domestic violence. A key factor in this has been the understanding of UCC staff that the matter had already been reported to the police and that there was therefore no requirement for further action. The IMR for the UCC notes that:

"UCC does triage for ED (Emergency Department) so if a patient is being transferred to ED then treatment/referral is done in ED usually. However, this could be better communicated. In none of the consultations there is any documented evidence of offering any help/referral for domestic violence. Again, this could be due to the fact that it was assumed that if the police were aware then a referral was not warranted. On 2 occasions when she was discharged home there was no documentation of mental health assessment or offer of referral to Mental Health. It seems there is also a pattern of assumption that if police are aware then a safeguarding referral is not warranted."

Key learning point 4

There was a pattern of assumption on the part of UCC staff that responsibility for addressing concerns about domestic violence risks to Janice lay with the police and other services she was in contact with.

As a minimum, UCC staff should have discussed ongoing domestic violence risks with Janice, with a view to referring her for specialist support. Additionally, concerns about domestic violence should have been flagged on UCC records and discussed with her GP and other relevant services. (The UCC DHR Action Plan addresses these issues in more detail.)

In fairness, it must be acknowledged that a number of other services (such as housing, homelessness and primary healthcare services) appear to have followed a similar pattern of assuming that 'somebody else' would be leading in relation to domestic violence concerns, so this learning point is relevant not just to UCC.

2.1.23 **Housing Options** - Having been accommodated overnight at the Dawn Centre, Janice presented at Housing Options the following morning, as had been agreed. Housing Options did not find proof of homelessness, but Janice was offered another night at the Dawn Centre, in dormitory accommodation.

2.1.24 At her Housing Options appointment, Janice divulged the violent incident on the previous evening, but asserted that she was not at risk of domestic violence because Ian had no reason to look for her. The record does not clarify whether or not Janice was in a relationship with Ian at this point. No risk assessment for domestic violence was conducted by Housing Options.

2.1.25 **Janice evicted from Dawn Centre** - On the same day, Janice was required to leave the Dawn Centre. The reasons for this decision were that she was suspected of supplying an unknown substance to another Dawn Centre service user and her behaviour towards staff when challenged about this.

Analysis / key learning

Janice informed Housing Options of the violent incident on preceding evening, but no CAADA-DASH assessment was carried out. This was a missed opportunity to more closely examine the background to the violent assault on the previous evening and to assess the risks of further such incidents occurring. Even though the decision of whether or not Janice was in fact a homeless person (i.e. in line with homelessness legislation) was pending, it was very clear that domestic violence was a primary factor in her presentation to the Housing Options service.

Key learning point 5

There is a need to ensure consistency of practice in the use of CAADA-DASH assessments where people present as homeless and there is evidence that that domestic violence is a factor in this presentation. The risk assessment should be conducted at the time of the homelessness presentation and not delayed until a decision is made regarding the person's statutory homeless status, which may be up to 33 working days later. As is clearly shown by Janice's experiences, if the individual is fleeing a violent relationship this period of 33 working days may well be a particularly high risk period.

Following her eviction from Dawn Centre Janice was homeless. Janice's homelessness would have added significantly to her vulnerability to domestic abuse, because she appears to have had very limited (if any) choice but to spend periods staying in Ian's flat, even when the relationship subsequently became increasingly volatile and violent.

The circumstances leading to Janice's eviction have been more closely reviewed by the IMR author for Homeless Service. The local policy on suspected supply of illicit substances on or near to the Dawn Centre premises states that:

"As a minimum a written warning to be issued, this can vary up to immediate eviction depending on specific circumstances".

It is understood that immediate eviction was judged appropriate in this case, as a result of behaviour Janice displayed when approached about the alleged supply of substances and behaviour she had presented at her previous stay at the Dawn Centre.

In reaching this decision Dawn Centre staff would have faced the difficult challenge of balancing concerns about potential risks to Janice (if evicted) with the wider needs of a population of more than 40 other vulnerable residents.

Following closer review of all of the circumstances, the IMR author has concluded that, even taking account of the needs of the wider resident population, a written warning would have been a more appropriate response to this particular allegation regarding supply of substances. The DHR panel supports this conclusion, whilst acknowledging that the decision to evict did not have the benefit of hindsight concerning the events which followed.

Having reached the decision to evict Janice from the Dawn Centre, there was no further assessment of needs or risks (see previous learning point) and no strategies put in place to meet her accommodation needs or manage ongoing risks. This was despite the fact that it was known that her admission on the previous evening had followed a domestic violence incident resulting in significant physical injuries. In these circumstances, it should have been apparent that the decision to evict would significantly increase the possibility of her returning to stay with the perpetrator, as possibly her only option other than rough sleeping.

Key learning point 6

Even if Janice's eviction from the Dawn Centre had been unavoidable due to concerns about other vulnerable service users, there should have been careful consideration of her ongoing vulnerability as a domestic violence victim. Attempts should have been made at finding more suitable alternative accommodation or at the very least signposting to specialist support services.

2.1.26 **January 2015**, Police Incident 2: Janice telephoned the police (10.47 am) advising that she was on her way to the police station to report an assault by Ian. Officers then met her, when she reported that she had gone to Ian's flat to collect belongings, when an argument ensued and Ian had pushed her and had hurt her arm. The officers observed that Janice appeared to be heavily intoxicated and confused about the exact details of the incident. They also recorded that there was no visible sign of injury. Janice stated an intention to return to stay with her family in Blackburn and was given a lift to Leicester Railway station. It subsequently transpired that she did not leave Leicester.

2.1.27 A DASH risk assessment was completed and found the risk level to be standard. There were subsequent attempts by officers to follow up and take a formal statement, which had not been possible at the time, due to Janice's apparent intoxication and confusion. However, these attempts were unsuccessful and a decision was then taken that there would be no further police action in relation to this reported incident.

2.1.28 **January 2015** Police incident 3: Janice telephoned the police (at 23.02) stating that Ian had attacked her. Officers attended and found Janice in the street with a member of the public. Janice appeared to be extremely intoxicated and was very difficult to communicate with. She was taken to the police station where she reported the following:

- She had called at Ian's flat during the evening but he was not there so decided to wait for him to return and went to a friend's flat.
- When Ian arrived at that flat he appeared drunk. An argument began regarding the purchase of more alcohol so Janice left and went to Ian's flat alone before returning to her friend's flat around 15 minutes later.
- The argument with Ian continued and resulted in him pushing Janice against a wall whereupon he grabbed her around her neck.
- Janice managed to escape from the flat but she asked for her belongings to be returned to her and, in frustration, kicked the flat door. She then left the flat complex and contacted the police.

2.1.29 A DASH risk assessment was completed by officers and the risk level at this stage was assessed as medium. Due to Janice's responses to the standard DASH assessment, a DASH stalking form was also completed, and also resulted in a risk level of medium. As in her previous contact with the police Janice was still stating that she planned to return to Blackburn, but she did not do so.

2.1.30 **January 2015**, Police Domestic Abuse Review: As a result of the three previous incidents a review was completed by Leicestershire Police's Domestic

Abuse Investigation Unit (DAIU) to establish if there were any clear and obvious underlying problems that were identifiable.

2.1.31 The review highlighted the abuse of alcohol, the frequenting of similar locations to consume alcohol and the lack of a fixed address for Janice as key factors for the continuing incidents. In line with that assessment a number of actions were drawn up and included referrals to support agencies with Janice and Ian's consent. The actions were allocated to a local officer to complete.

Analysis / key learning

A pattern was emerging of Janice and Ian drinking excessively in his flat then having arguments which developed into physical fights. The increase in assessed risks to medium is an indication that officers were considering cumulative evidence across the 3 incidents which had so far taken place and this can be identified as good practice. It was also good practice to carry out a separate assessment for risk of stalking behaviours when the standard assessment indicated that this may be an issue of concern.

The DAIU review on shows that the police were attempting to proactively identify and manage risks and the planned referrals to support agencies (subject to consent on the part of Janice and Ian) is further evidence that the police were trying to find solutions and reduce risks.

However, even at the DAIU review, it is still not clear whether officers had accessed police records, or had any knowledge of Ian's history as a domestic violence perpetrator. (See key learning point 3).

If the DAIU review taken account of Ian's history of domestic violence related incidents and convictions, this could have resulted in an application of professional judgement, leading to an increase of assessed risks from medium to high and escalation into the MARAC process. **That this did not happen at this stage was a missed opportunity.**

2.1.32 **February 2015**, Police incident 4: At 11.35pm Janice contacted police to report she had been assaulted by Ian at his flat. Police attended and found Janice sitting in the doorway of a wine shop. Police records show she was intoxicated. Janice stated that Ian had held a knife to her throat and assaulted her. She did not explain the circumstances as to how the incident had developed and ultimately refused to engage with the officers. It was noted that there was no apparent injury to her neck but there was a small amount of bruising and a lump on her head.

2.1.33 The attending officer erroneously believed no domestic incident had taken place and did not complete a DASH risk assessment. The oversight was quickly identified and a DASH was completed with the risk graded as 'standard'.

2.1.34 Despite the investigating officer's continued efforts, it took nearly three weeks to contact Janice by which time she had changed her stance and stated she did not require any further police involvement, she had sorted things out with Ian and had left him. Janice stated that she was in the process of arranging permanent accommodation of her own and was unwilling to assist the police any further. A supervisory officer reviewed the incident marking it 'no further action'.

Analysis / key learning

The previous DASH assessment in January reached a conclusion of medium risk. However, 10 days later (after another reported incident which for the first time included an allegation of a threat of violence using a lethal weapon) the DASH outcome was standard risk. In the interim the DAIU had identified actions needed to reduce risks from an assessed medium level, but (due to extreme difficulty in contacting or establishing effective engagement with either Janice or Ian) none of the actions had been completed.

This indicates that the officer(s) who carried out the latest risk assessment were doing so purely on the basis of the current incident, with no reference to the recent history of reported domestic violence incidents or risk assessments. If these recent police records were not consulted, it is very unlikely that there was any reference to Ian's longer term police record as a domestic violence perpetrator.

Key learning point 7

When carrying out DASH risk assessments officers should consider cumulative risk, especially when there has been a succession of similar incidents within a short space of time. A risk assessment which fails to consider such recent events and evidence of escalation is likely to be unreliable. (See also key learning point 3.)

2.1.35 **February 2015**, Consultation with Consultant Nurse at GP Practice 1: This was one of number of contacts which Janice had with GP Practice 1 outreach services, during the period following her eviction from the Dawn Centre. The following points of significance were recorded at this appointment:

- Janice said she was currently 'sofa surfing' and still in a relationship with her abusive partner, but she was planning to end the relationship.
- She said that, because she is from a different area, the council cannot house her and she cannot get a place in a refuge, but can seek private rented housing, using a rent deposit scheme.
- She disclosed that (4 days previously) Ian had punched her hard on the chest, causing her to fall back against a wall.
- Examination confirmed that Janice had extensive bruising to her left shoulder and bruising to her thigh. Bruising was also noted under her right eye, which she said was an older injury.

2.1.36 **February 2015**, Consultation with GP Practice 1 Homeless Mental Health Service CPN: Following on from the above consultation Janice was referred directly for further support from the CPN who was present in same building. (Homeless Mental Health Service, Leicestershire Partnership NHS Trust).

2.1.37 Janice explained to the CPN that she was currently staying with her abusive partner (as a sofa surfer). As she has nowhere else to go she planned to go back to stay at his flat, even though she really wanted to end the relationship. She confirmed that she had been offered assistance through the LCC rent deposit scheme and would like to gain stable housing so she could 'sort herself out' and then have regular contact with her children in the USA.

2.1.38 Following discussion between CPN, the Consultant Nurse and an Outreach Worker, CPN records state that a verbal referral was made to the SAFE domestic violence service who agreed to contact with Janice and offer her support to find alternative accommodation.

2.1.39 **Alcohol Outreach Worker arranges 3 nights B&B accommodation for Janice:** Immediately following the CPN appointment (on a Friday), the Alcohol Outreach Worker approached One Roof Leicester who arranged for Janice to stay in B&B accommodation for 3 nights (Friday – Sunday). On the same day, the Outreach Worker emailed Housing Options and advised that on Monday Janice would have no accommodation and would therefore be either rough sleeping or (more probably) return to the abusive relationship, which was known to be her usual pattern. He further asked if they could assist her with something, even a refuge and asked them to re look at her case given the change in her situation and ongoing domestic violence incidents.

2.1.40 On the following day (Saturday) the Alcohol Outreach Worker saw Janice and advised her to attend Housing Options on the Monday morning as early as possible and to consider a refuge place if one was available, regardless of where it might be. He advised her that he had written to the Housing Options Service and they would be expecting her.

2.1.41 **Monday:** Janice did not attend Housing Options

Analysis / key learning

The intervention of the Alcohol Outreach Worker in securing 3 nights B&B accommodation provided Janice with a short period of relative safety and security. The outreach worker's email to Housing Options shows that they recognised (and most importantly communicated clearly) that Janice would be at a serious ongoing risk of domestic violence, unless suitable accommodation could be secured immediately. These practical interventions from the Outreach Worker are recognised as examples of good practice.

Janice did not follow the Outreach Worker's advice to attend Housing Options on the Monday , which was obviously very unhelpful to her prospects of being assisted in accessing any type of accommodation. This was part of a continuing pattern of agencies finding that Janice was a difficult person to help.

However, there is no record to show that Housing Options workers made pro-active attempts to follow up Janice's non-attendance, for example by contacting the Alcohol Outreach Worker and asking them try and locate Janice and get her to an urgent appointment. **This was a missed opportunity.**

Key learning point 8

It should be recognised that people with multiple and complex needs such homelessness, alcohol problems and domestic violence (i.e. those in the most critical and urgent need of help) are very frequently the most difficult people for services to meaningfully engage with and effect positive change. However, there could have been more concerted and proactive attempts at getting Janice to attend Housing Options with a view to finding her somewhere safe to stay. This did not happen and the outcome was that Janice remained dependent on her violent partner for accommodation, which was apparently her only option other than rough sleeping.

2.1.42 **March 2015**, Anchor Centre: An incident was observed at the Anchor Centre when Janice kicked Ian. He did not react. Janice was asked to leave the centre.

2.1.43 **March 2015**, Police incident 5: The police were called to Ian's flat by a third party. Both Ian and Janice had minor facial injuries, but both claimed these had been caused in a separate assault earlier in the day. They were making no

complaints against each other. Although their explanation was not believed by officers, Ian and Janice refused to answer questions and the matter was recorded as a verbal argument only.

2.1.44 **March 2015**, SAFE response to referral: Following some inter-agency confusion in the interim period, it was confirmed on that SAFE had received the referral made by the CPN around 1 week earlier and had made several calls to Janice's mobile number, but had received no response. SAFE policy was not to leave voice mail messages due to the risk that an abusive partner may pick them up. Janice was given SAFE's number by the Homeless Outreach Service and by the Anchor Centre, with advice to contact them if she wanted support or access to the women's refuge.

2.1.45 **March 2015**, Anchor Centre: The manager at the Anchor Centre spoke to Ian and raised concerns about his visible injuries and those of Janice. Ian stated that it was Janice who started fights and when they are drunk it escalates. He said he was concerned he may lose his tenancy.

Analysis / key learning

Whilst it was good practice on the part of the Anchor Centre manager to engage with Ian about his injuries, there appears not to have been any discussion with either Ian or Janice about possible sources of support to help to reduce domestic violence risks. This was a missed opportunity.

2.1.46 **March 2015**, Police incident 6: The Police were contacted by East Midlands Ambulance Service, reporting that they were en-route to Queens Medical Centre Nottingham with Janice who had a puncture wound to her thigh and a burn mark on her left hand. Officers attended QMC and Janice described the incident as follows:

- Ian had been increasingly angry due to problems with his welfare benefits
- That evening she had been at his flat with another female friend trying to calm him down.
- Without warning Ian picked up a kettle and poured the contents over her head
- Janice ran to the bathroom and Ian followed and held a knife to her throat, before slamming the bathroom door onto her hand.
- Janice stayed in the bathroom for 15 minutes until Ian assured her that he had calmed down.
- She then came out of the bathroom and switched on the kettle to make a drink. When the kettle switched itself off Ian grabbed it and poured boiling water over her head. He then hit on the back of the head 2 or 3 times and stabbed her once in thigh with the knife he had had earlier.

- Janice then managed to escape the flat and went to a local hostel, who called the ambulance.

2.1.47 On the following morning, Ian was arrested. He confirmed that they had been drinking in his flat together with the other female friend, but his account of the incident was very different:

- At some stage in the evening Janice had picked up a kitchen knife and lunged towards him. He managed to take the knife from her, but she continued to be aggressive towards him.
- Later he boiled the kettle for a drink. About 10 minutes after it had boiled they had an argument about the water and were both pulling at the kettle, resulting in hot water spilling over both of them. At this point, Ian asked Janice to leave.

2.1.48 The female friend was also interviewed by the police. According to her account:

- All three of them had been drinking very heavily.
- Janice had picked up the knife, had held it to her own throat, before stabbing herself in the thigh.
- As this was happening the female friend and Janice were shouting at each other and Ian was sitting on the bed.
- The friend took the knife from Janice and Ian took it from her.

2.1.49 The outcome of the police investigation was that no further action would be taken against Ian.

2.1.50 A domestic violence risk assessment was completed by police officers and the risk was graded as medium.

Decision not to charge Ian with any offences:

Janice's description events, if accurate, would represent an extremely violent and dangerous domestic violence incident. However, the police's decision not to charge Ian with any offence appears to have been reasonable, given the lack of evidence to corroborate Janice's allegations. Specifically:

The IMR in respect of QMC describes redness to the skin on the back of Janice's neck and that she was medically fit for discharge on the morning after her admission. On this basis, it was reasonable for officers to conclude that Janice's injuries were not consistent with having had a kettle of boiling water poured over her head.

The stab wound to her thigh was relatively minor (QMC described a 1-inch stab wound) and appeared to officers to be more likely to have been self-inflicted, as described by the other witness present in the flat.

The other witness's statement generally supported Ian's account of what took place and in no way supported Janice's.

Police risk assessment

The police risk assessment judged ongoing domestic violence risks to be medium, which may well have been influenced in part by the fact that Janice's account of the incident was judged to be unreliable, as outlined above.

However, it is important to make a distinction between evidence to support a criminal charge against Ian (which was not a realistic prospect) and evidence of risk of repeat incidents of serious domestic violence. In assessing these risks the following factors should have been considered:

- **This was the 6th reported domestic violence incident in just over 2 months.**
- **A weapon (a knife) had been used, even if the stab wound was believed to have been self-inflicted.**
- **All parties to this incident were reported to have been very heavily under the influence of alcohol.**
- **The reported fight involving a kettle of hot (probably not boiling) water between people heavily under the influence of alcohol was an additional risk factor**
- **Janice's homeless status meant that she was likely to return to stay at Ian's flat because she had little other option, apart from sleeping rough.**

As with all of the previous risk assessments, it is not clear whether Ian's police records were accessed. However, if his history as a domestic abuse perpetrator had been considered, along with the other risk factors outlined above, this should have resulted in a risk assessment finding of high risk, resulting in a MARAC referral. That this did not happen was a significant missed opportunity.

Clarifying victim / perpetrator roles and risk profiles

It is evident that Janice was not always an entirely a passive victim of abuse, as her behaviour towards Ian and others had been observed (for example at the Anchor Centre) as having been aggressive at times, even though the outcomes were usually that she sustained significant injuries and Ian was relatively unharmed. The reality was that the risks to Janice

were probably increased significantly because she tended not to accept a passive role in the relationship. It should be acknowledged that in relationships of this nature victim / perpetrator roles may become very difficult to define and this creates real challenges for the police and other services in trying to accurately assess and effectively manage risks. Clearly, risk assessments should not make automatic assumptions based on gender (i.e. 'male = perpetrator / female = victim') even though it is clearly true that male violence on female partners is much more common than the reverse.

Having said this, there were known factors in this case, which could and should have helped agencies more clearly assess the relative **power and risk** factors in the relationship between Ian and Janice. If these factors (as summarised in learning point 9, below) had been taken into account, this would have helped to ensure an appropriate challenge to any 'victim blaming' responses from the agencies involved.

Key learning point 9:

Clarifying victim / perpetrator roles and identifying risks

Ian	Janice
Confirmed history / criminal convictions as perpetrator of domestic abuse and serious physical assaults in previous relationships.	**Risk factor:** Self-reported history as victim of domestic abuse and physical assault in previous relationships
Recent and repeated history of assaulting Janice, causing significant injuries requiring hospital treatment	**Risk factor:** Observed on occasions to be physically aggressive and towards Ian, not known to have caused him serious injuries, but has received serious injuries in these conflicts.
Securely housed	**Disempowered:** Homeless, largely dependent on staying at Ian's as alternative to rough sleeping
Serious problems with binge drinking	**Risk factor:** Serious problems with binge drinking. **Risk factor:** History of mental health problems.

2.1.51 **Queens Medical Centre following police incident 6**: Janice was taken to QMC (Nottingham) by ambulance as this was the closest treatment centre with access to specialist treatments for burns. She arrived at 23.24. On examination she was found to have:

- Redness to skin on the back of her head
- 1-inch stab wound to thigh
- Injury to right index finger

2.1.52 Janice was then transferred to a short stay unit attached to the Emergency Department (ED) for further review and due to concerns about potential domestic abuse. By the following morning, she was deemed medically fit for discharge, but she was not discharged due to continuing concerns about domestic violence risks. A domestic violence risk assessment (DASH RIC) was completed and resulted in a finding of high risk. A MARAC referral was generated and sent to the MARAC office which is managed by Leicestershire Police. This MARAC referral was subsequently rejected, on the basis that Janice's statement to the police about the incident on had been judged by officers as being inconsistent with the presenting evidence.

2.1.53 Janice remained an in-patient at QMC for 5 nights.. During this period QMC records show that staff attempted to secure suitable accommodation and support for her, contacting a number of services including Nottingham Women's Aid, Nottingham Street Outreach service, Leicester EDT[16] and SAFE.

2.1.54 (Sunday) **Telephone call from SAFE helpline to Janice**: 3 days after her admission SAFE telephoned Janice (still in-patient at QMC), in response to a police referral received following the incident. (Previous attempts made by QMC ward staff to contact the SAFE helpline had been unsuccessful) A risk assessment was conducted over the telephone, which resulted in a score of 12 (medium risk). However, the assessing worker also noted additional risk factors concerning Janice's mental health and recorded that there was a need for assessment by a senior IDVA, in relation to a MARAC referral.

2.1.55 Over the following 2 days there were a series of telephone contacts and conversations between SAFE and QMC and various other services, including:

- Refuge and domestic violence services in Nottingham and Leicester
- Dawn Centre
- Homelessness and Housing services in Nottingham and Leicester

[16] The EDT service in Leicester does not have any record of this contact.

2.1.56 The inter-agency communications at this stage were protracted and complex, but the outcomes can be summarised as follows:

- The clear advice from the SAFE project was that Janice should not return to Leicester as she would continue to be at risk from Ian. On this basis, a referral was made to Shine, a Nottingham based domestic violence support service.

- The Dawn Centre told QMC that they had no vacancies, but that she would not be allowed to return anyway, due to the events leading to her eviction in January. The information regarding Janice's eviction from the Dawn Centre was reportedly passed on from a member of QMC's nursing staff to Women's Aid Integrated Services (WAIS) in Nottingham. On this basis, WAIS advised that the background to her eviction from the Dawn Centre may present a barrier to her being accepted at the Nottingham refuge, due to potential concerns about the safety and wellbeing of other women and children resident there. WAIS attempted to make further enquiries directly with the Dawn Centre about this, but were advised that the Dawn Centre could not disclose any information, without written consent from Janice.

- QMC staff recorded that, following a number of phone calls (including to Leicester Emergency Duty Team and the Dawn Centre) no vacancies could be found in hostels in Leicester.

- Janice was discharged from QMC and went to Nottingham Housing Aid. During the course of an interview lasting about 15 minutes, Janice gave some information about her background and the incident leading to her admission to QMC. The Housing Officer enquired into her safety and she stated that she was safe. She also made it clear that she wished to return to Leicester. With public transport fares paid by Nottingham Housing Aid, Janice returned to Leicester.

Analysis / key learning

Although Janice's injuries were not serious, QMC staff recognised that there were significant ongoing risks and did not immediately discharge Janice back into a dangerous situation. This decision to allow her to remain in hospital whilst attempts were made to secure appropriate support and safe accommodation was an example of very good practice.

Similarly, the decision to carry out a domestic violence risk assessment and the resulting MARAC referral due to the finding of high risk was also a good practice example.

It was very unfortunate that the multi-agency attempts over the following days to find Janice suitable accommodation and support proved unsuccessful, despite very considerable efforts made by QMC staff.

Janice's discharge from hospital back into precisely the same set of circumstances and risks has to be recognised as a missed opportunity. Although Nottingham Housing Aid records show that Janice made it clear that she wanted to return to Leicester, the reality was that she had not been offered any viable alternative. This resulted partly from weaknesses in communications between different agencies in Leicester and Nottingham.

It is concerning that staff at the Dawn Centre reportedly refused to share information with WAIS, without written consent. In a situation of urgent need, information should have been shared, subject to verbal consent which Janice could have provided over the telephone. In any event, there appears to have been an element of inconsistency, as information about the circumstances of Dawn's eviction had apparently already been shared with a member of the QMC nursing staff.

Key learning point 10

In an urgent situation where a person is fleeing domestic abuse and potentially seeking a refuge placement, the requirement for written consent before sharing information with the refuge service may create an unnecessary barrier to them being able to access the service. Where the person is willing and able to confirm verbal consent over the telephone (provided their identity can be verified with reasonable certainty) this should be a sufficient basis for sharing information.

MARAC referral

DHR enquiries have established that a decision was taken by a non-supervisory officer within the MARAC process that the referral generated by QMC would not be discussed at MARAC. The primary basis for this decision appears to be that the allegations made by Janice that she had been violently attacked by Ian were believed by the police to be seriously undermined by the presenting evidence.

However, Leicestershire MARAC protocol and procedures do not give any authority for such screening and rejection of referrals received into the MARAC process. Once QMC had assessed Janice as being at high risk from domestic violence and referred to MARAC, this should have resulted in this case going to MARAC for multi-agency discussion and planning. **That this did not happen was a very significant missed opportunity.**

Key learning point 11

The MARAC referral should not have been screened out of the MARAC process, regardless of any doubts that police officers or others may have regarding the reliability of an alleged victim's statement. That there was insufficient evidence to bring criminal charges should not have resulted in any assumptions about levels of domestic violence risks.

To screen and reject MARAC referrals on such a basis completely undermines a key principle: MARACs should consider risk assessments and risk management strategies from a shared and multi-agency perspective.

There is a need to ensure that the above points are made completely clear in the local MARAC Protocol.

2.1.57 **March 2015**, Urgent Care Centre & Leicester Royal Infirmary: Janice presented herself to UCC (approx. 8pm) with head and facial injuries. She said she had been drinking all day and that she had been assaulted by her boyfriend – 'punched to floor and possibly kicked to the left side of face'. She informed the Triage Nurse she had reported this to the police. (The police have no record of an incident being reported) Janice also referred to the previous incident. The Nurse noted that Janice had small grazes and swelling to the top of her head and under her left eye. The Nurse cleaned Janice's face and sent her to the Emergency Department at LRI.

2.1.58 Further examination at ED noted that Janice had superficial facial bruising, a bump to her head and bruising to her shoulder blade, the middle of her back and her buttock. Janice told ED staff that she had been subjected to a 30-minute assault by Ian and that the police were aware of this allegation. Although Janice was judged not to require any further medical care or treatment she remained in the ED overnight as a place of safety before being discharged the following morning, to attend GP Practice 1.

2.1.59 The IMR prepared by UHL in respect of the Emergency Department states that, as a result of this attendance:

"there is evidence that staff appropriately completed a CAADA-DASH Risk Identification Checklist (RIC) and this prompted a referral to MARAC. The RIC score was recorded as 12, which is below the standard score for referral to MARAC, however the nurse indicated additional risk factors to justify the referral in this case (it was recorded that there had been 3 or more incidents reported to Police between Jan-Feb 2015 and that the nurse was using her professional judgement".

2.1.60 DHR enquiries have established that the MARAC office can find no record to show that this referral was received. Consequently, no MARAC process followed.

Analysis / key learning

The decision by ED staff to keep Janice in hospital overnight as a place of safety before discharging to an appointment with Inclusion Health Care is an example of good practice.

Missing MARAC referral

The completion of a risk assessment and the application of professional judgement to make a MARAC referral (as reported in UHL's IMR) were good practice.

Follow up DHR enquires with UHL confirm they retained a copy of the referral documentation in Janice's records. Whilst the MARAC referral is recorded by UHL as having been sent by email, UHL have been unable to locate any email history to confirm that is was sent to the correct MARAC email address. It is understood that this is due to weaknesses in UHL's electronic communications systems, which have since been addressed.

Due to the absence of reliable records, the DHR Panel has not been able to ascertain precisely what happened, but the outcome was that no MARAC process followed.

Key learning point 12

When agencies refer to MARAC they must ensure that they retain a clear record of the risk assessment and the MARAC referral and request and receive a confirmation that the referral has been received. They should also be notified when the case will be discussed at MARAC and invited to attend the MARAC meeting.

If this second MARAC referral was not received by the MARAC office this would have significantly compounded the issue of the first MARAC referral having been screened out. Had the second referral been received, this might have further highlighted cause for concern, as 2 different agencies had each assessed Janice as being at sufficiently high risk to warrant a MARAC referral. **This represents another significant missed opportunity.**

2.1.61 **March 2015**, GP Practice 1: Following her discharge from ED, Janice attended the appointment with at GP Practice 1, as arranged. At this consultation, recent domestic violence incidents and hospital admissions were discussed. It

was recorded that the police were aware of the recent incidents and 'has been in touch with MARAC'. Janice said she was planning to go back and stay with Ian, as she would otherwise be homeless. Janice also reported that SAFE had contacted refuge services but there were no vacancies.

Analysis / key learning

The record of this consultation shows that the GP was making real efforts to engage with Janice about increasing domestic violence concerns, whilst recognising and recording the fact that she seemed to have no immediate choice but to stay with her violent partner. This GP's obvious concern and level of individual engagement with Janice on domestic violence issues at this consultation was good practice.

Janice's recorded reference to MARAC in this consultation appears to confirm that a MARAC referral had been discussed with her at ED on the previous evening. The GP's note 'has been in touch with MARAC' does not provide any clear record of what (if anything) was expected to happen next in terms of a MARAC process. It also suggests a possible misunderstanding of what MARAC is (i.e. a multi-agency process rather than a service which Janice could have been in contact with). There was also a risk that the reference to MARAC may have resulted in an assumption (which with the benefit of hindsight was incorrect) that the matter was now being dealt with through this multi-disciplinary process.

Ideally the GP would have followed up the reference to MARAC and asked a practice administrator to contact the MARAC Coordinator to clarify whether or not there had been a MARAC referral. In fairness, such proactive engagement with MARAC from primary healthcare services is (unfortunately) very unusual. This is probably due to issues of time and resources as well as gaps in knowledge and awareness of the MARAC process.

Key learning point 13

It is important that GPs and other primary healthcare professionals have a good knowledge and awareness of domestic violence issues in general and of the MARAC process in particular. If there is any doubt about whether there is a current MARAC referral or MARAC coordinated risk management plan, this should be checked with the MARAC Coordinator.

Had the GP been able to ascertain that there was no current MARAC involvement an option would have been for the GP practice to carry out a CAADA-DASH assessment, with a view to generating a new MARAC referral. An alternative course would have been referral to the specialist domestic

violence service for assessment. **That neither of these courses of action were followed represents a missed opportunity.**

2.1.62 **April 2015**: Janice had a further appointment at GP Practice 1, where she was seen by a Consultant Nurse. At this appointment she said she was no longer living with Ian, though it is not clear where she was living at this stage, or if she was sleeping rough.

2.1.63 **April 2015**: 12 later, Janice was seen by a GP at GP Practice 1. This consultation was for medical issues not directly related to domestic violence. There was no discussion in this consultation about domestic violence concerns, or about where Janice was staying or whether she was sleeping rough. On the same day, Janice was seen at the Anchor Centre, where staff were assisting her with an appeal letter in relation to her exclusion from the Dawn Centre, although there is no record of such a letter having been received by Housing Options.

Analysis and key learning

It is notable that during April there were no further recorded incidents of domestic violence, the last one having been police incident 6 in March. It is unknown whether this was because no incidents occurred or because incidents were not reported by Janice.

During this period there is little evidence of ongoing actions to try and resolve Janice's ongoing homeless status, apart from the Anchor Centre assisting her to challenge the Dawn Centre exclusion. The Anchor Centre deserve some credit for trying to assist in this way, though some more proactive advocacy directly with Housing Options might have been of more immediate assistance.

The apparent lack of action from housing and homelessness services may well have been due largely to Janice being in less frequent contact with services and the absence of new reports of domestic violence.

2.1.64 March 2015: Following an anonymous phone call, police forced entry to Ian's flat, where they discovered Janice, deceased.

2.1.65 **Perpetrator perspective**: Ian accepted an invitation to meet with the overview review author and another DHR Panel member. The following is a summary of key points from this meeting which are of particular relevance to DHR learning:

- Ian felt that his and Janice's excessive and uncontrolled alcohol use was a major cause of violence in the relationship and ultimately to the homicide itself.

- Ian stated that at times he had felt used and jealous on occasions when Janice would come to stay with him, before 'disappearing' for a number of days.

- He felt that Janice's homelessness was a major issue, which meant she was often reliant on him for somewhere to stay. He did not feel that local services had offered Janice adequate help with her housing needs.

- Ian acknowledged that the police and Anchor Centre staff had spoken to him about the relationship and warned him that it was very high risk. He observed that both he and Janice had ignored these warnings, thinking that they 'knew better'.

- Ian recalled that that he had previously attended intervention programmes to address alcohol issues, but could not recall being offered any interventions which specially addressed issues of domestic violence.

- Ian felt that he was a victim of violence in the relationship as much as Janice was, but that local services did not recognise this. He believes local services viewed him as 'alpha male' and therefore assumed that he could not be a victim of violence from a female partner.

Analysis key learning

Ian's observations about the very significant impacts of his and Janice's alcohol misuse and of Janice's unmet housing needs are valid and have already been discussed in some detail.

There is evidence which supports Ian's assertion that Janice was at times violent towards him and she may well have been the instigator of some conflicts. However, it is also clear that Ian had a previous history as a domestic abuse perpetrator and was the person with most of the power and control in this relationship. (See learning point 9) The outcomes were that Janice sustained some very significant injuries in a series of incidents, before ultimately losing her life. The DHR has not seen evidence to indicate that Ian was at high risk, or needed specialist support as a male victim of domestic violence.

Probably the most significant learning arising from Ian's contribution to the DHR is that he cannot recall ever being offered attendance (or required to attend as part of a criminal order) any interventions to specifically target

what was clearly a pattern of abusive and violent behaviour towards female partners.

Key learning point 14

This report has appropriately focussed very much on the availability and effectiveness of services to support and protect Janice. However, it is equally important to acknowledge the potential benefits of targeted interventions with repeat domestic violence perpetrators, which may ultimately change this behaviour pattern and protect other women from future abusive relationships. This also highlights the need to increase knowledge and awareness of local services which can offer such interventions.

PART 3: SUMMARY OVERVIEW OF FINDINGS AND KEY LEARNING POINTS

3.1 This section of the overview report returns to the topics set out in the DHR terms of reference to summarise findings and learning points. Evidence bases for these are detailed in Part 2 of the full report.

To review whether practitioners involved with Ian and Janice were knowledgeable about potential indicators of domestic violence and aware of how to act on concerns about a victim or perpetrators

3.2 There is evidence that some practitioners were knowledgeable about indicators and how to act. For example, the responses by staff at Queens Medical Centre in assessing risks and then taking actions aimed reducing future risks have been identified as good practice. Similarly, the Outreach Alcohol Support Worker demonstrated a good understanding of the risks Janice was facing and acted appropriately. There are several other examples of good practice highlighted in Part 2 of the report.

3.3 There is also some evidence of lack of understanding of risk factors in some agencies, either at individual practice levels or at policy and procedure levels Examples include:

- Awareness of impact of homelessness as a DV risk factor.
- Closely associated with homelessness - isolation from informal social support apart from local street drinking networks.
- Awareness of significance of Ian's past history as a perpetrator in previous relationships as a risk factor in current relationship.
- Possible 'downgrading' of perceived risks and need for strategic multi-agency actions, where violence is believed to be mutual – failure to recognise that mutual violence may actually indicate higher risks.
- Insufficient recognition of power balance in the relationship.

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

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

ii) whether police DV risk assessments and management plans of Ian took account of his early forensic /criminal history, and assessments of risk made during this period.

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

iv Whether risk assessments considered risk to individuals when services were withdrawn

3.3 Warning signs: There were clear and repeated warning signs. This included 6 police incidents in the months leading up to the homicide and 2 CAADA-DASH risk assessments which found Janice to be at high risk.

3.4 Risk assessments:

- There is clear evidence that police DV risk assessments did not take sufficient (if any) account of Ian's early forensic and criminal history.
- Risk assessments also did not sufficiently take into account a number of other factors, including those associated with Janice being homeless.
- There was no assessment of the increased domestic violence risks to Janice, when a decision was taken to evict her from the Dawn Centre hostel accommodation.
- There were many missed opportunities by housing, homeless, primary healthcare and alcohol services, when incidents of domestic violence were disclosed, but no formal risk assessment was carried out and no pro-active attempt made to engage Janice with specialist support. This appears to have been primarily due to a lack of staff training and awareness in relation to domestic violence risk assessment processes and local multi-agency policies and procedures, including the MARAC protocol.

3.5 Risk management plans:

- Although two different agencies completed MARAC referrals (only one of which has been confirmed as received by the MARAC office) Janice's situation was not discussed at MARAC, due to a breach MARAC policy / procedure. As a result of this there was never any clear multi-agency risk management plan. **This has been identified as a very significant missed opportunity.**

3.6 Mental capacity:

- It is very probable that when heavily under the influence of alcohol Janice's ability to recognise risks and make informed decisions about possible DV risks posed by Ian was temporarily impaired. However, there is no evidence to suggest Janice's mental capacity was impaired or that there would have been any grounds to formally assess her mental capacity to make

decisions about her relationship or about whether or not to drink excessively.

3.7 Information sharing:

- There was some sharing of information by some of the agencies involved and there were significant (but unsuccessful) attempts to support and encourage Janice to effectively engage with specialist DV services.
- On one occasion staff at the Dawn Centre refused to share information with Nottingham Womens Aid, without Janice's written consent. The DHR has concluded that, given the urgency of the situation (i.e. potential placement in a women's refuge) seeking verbal consent via a telephone call to the hospital where Janice was an in-patient would have sufficiently addressed concerns about confidentiality.

To identify whether services that were involved with either Ian or Janice were aware of the circumstances of Janice's presence in the home and agencies involved with them. Whether connections were made and information shared between these services in order to establish a full picture of the vulnerability and risks arising from the relationship.

3.8 Most services in regular contact with this couple were aware that Janice and Ian were in an intimate relationship; that this included occasions when Janice would stay at Ian's flat and that there were increasing concerns about violent incidents. Collectively, the agency IMRs also show that there was significant communication and information sharing between agencies. This included an intensive period of communication between GP Practice 1, CPN, Anchor, SAFE and Housing Options, in attempts to put an effective plan to reduce risk levels. Within these communications there are examples of good practice as well as some examples of communication breakdowns.

3.9 In summary, it appears that most services did recognise that there were significant domestic violence risks and attempts were made to share information, refer for specialist DV support from SAFE to establish a risk management plan. However, it is not clear that the 'full picture of vulnerability and risks arising from the relationship' was established. A full picture would have included:

- Sharing of police records which would have highlighted Ian's past history as a serious DV perpetrator and recognition of the significance of that history in assessing current risk levels
- Wider recognition of Janice's homelessness as a major risk factor, because she stayed in Ian's flat when she had no other options.

3.10 Multi-agency weaknesses in respect of the above points was a major factor in the circumstances leading up to the homicide.

Did agencies involved make routine enquiry about domestic violence when working with these adults and if so were any opportunities missed.

3.11 There is evidence that some agencies frequently engaged with both Janice and Ian about domestic violence issues. A number of agencies took opportunities to advise both Ian and Janice to end the relationship as it was widely recognised that there were significant domestic violence risks when the Janice and Ian were drinking excessively. However, there were many missed opportunities when the level of risk that Janice was under could have been more effectively and accurately assessed, followed by more proactive signposting and referral for specialist support. Advising Janice to end the relationship was a simplistic response which failed to recognise that the process of separation from an abusive relationship can often lead to a period of significantly higher risk.

To establish whether agencies responded to alcohol and drug dependence and offer appropriate services and support to Ian and Janice.

3.12 As noted above, when the couple were together and drinking excessively, this was widely recognised as a major risk factor for potential domestic violence. The couple were offered support to bring their drinking under control. Both Ian and Janice had access to support and harm reduction approaches at the Anchor Centre. Janice also had contact with an alcohol outreach worker.

3.13 In summary, the evidence is that alcohol was recognised as a highly significant issue and both Ian and Janice were actively encouraged to access relevant services. The Anchor Centre provided a 'wet house' which helped reduce immediate risks associated with street drinking. Unfortunately, it appears that neither Janice or Ian were able to engage with longer term treatment for alcohol dependency / misuse issues. This has highlighted the need for substance misuse services to develop more flexible and opportunistic responses to people who are homeless and have a range of complex needs.

At each point of contact with emergency health services for assaults, self-harm and injuries –were enquiries made about domestic violence and procedures followed?

3.14 The level and quality of response from emergency health services was variable:

- Responses from the Urgent Care Centre tended to make assumptions that any active follow up to domestic violence concerns was the responsibility of other agencies.
- At Janice's first contact with Leicester Royal Infirmary following a reported domestic violence incident, no CAADA-DASH assessment was completed, which is breach of local policy and procedure. At her second contact an assessment was completed, resulting in a MARAC referral which according to hospital records was emailed to the MARAC office. However, there is no record of it being received by the MARAC office. Due to weaknesses (since resolved) in the hospital's email systems it is not possible to be certain whether or not the email was in fact sent to the correct email address.
- Queens Medical Centre (Nottingham) followed multi-agency policy and procedure, completed a CAADA-DASH assessment and made a MARAC referral. QMC's overall response has been identified as good practice.

To establish whether mental health needs of the adults subject to this review were supported and managed appropriately by local agencies

3.15 Although Janice spoke of having a bi-polar disorder which she said was diagnosed when she lived in the USA, the IMR from GP Practice 1 indicates no known history or medical record of such a diagnosis. It also indicates that, during the period under review, Janice's mental health was assessed by the GP service, but she was found to show no symptoms of psychosis or of risk of suicide.

3.16 However, Janice was referred to the Homeless Mental Health Service, which provided her with support from a Mental Health Nurse. Janice also had an appointment with a CPN, who made a verbal referral to the SAFE project.

3.17 In summary, it appears that Janice's mental health needs were adequately supported.

3.18 There is no evidence to indicate that Ian had significant mental health needs.

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

3.19 The alcohol outreach worker raised concerns in an email in February 2015 with Housing Options about the DV risks resulting from Janice being homeless and reliant on an abusive boyfriend for overnight accommodation. It is unclear what Housing Options did with this information.

To establish if there were any barriers experienced by Ian, Janice or family / friends that prevented them from accessing help to manage domestic violence; including how their wishes and feelings were ascertained and considered.

3.20 Ian has stated that he felt he had been a DV victim as well as a perpetrator, but that as a man he experienced a barrier, because services assumed that the male partner could not be a victim. However, the DHR has not found evidence that would indicate Ian was at any significant risk of serious injury or homicide.

3.21 As a homeless person with alcohol problems, Janice experienced many barriers related to her lifestyle and flexibility of service provision. Many professionals genuinely listened to her wishes and feelings and she was offered support by specialist domestic violence services. However, as her basic need for safe and sustainable housing was not met, this undermined attempts to achieve consistent engagement with domestic violence services. Her homelessness created additional barriers for services trying to make and maintain contact. Even contact by mobile phone was unreliable, as Janice would not always be able to keep the battery charged. As a general rule, domestic violence services are reluctant to leave voice mail messages, due to fears that a perpetrator may pick up messages resulting in higher risks to the victim.

3.22 In summary, this DHR has highlighted the need for agencies to develop more flexible, creative and responsive services, in order to reduce or remove some of the barriers which impacted negatively on Janice.

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

3.23 There is evidence that there was a lack of awareness within local services of the voluntary perpetrator programme, which could potentially have worked with Ian to address what was a clearly established pattern of abusive and violent behaviour in this and in previous relationships.

To establish whether agency DV risk assessments and response to risk followed agreed local multi-agency procedures.

3.24 See responses above and to question 12. There were procedural breaches.

To establish how referrals into MARAC were responded to, whether these responses were in line with local multi-agency procedures and whether they were appropriate, in the light of information about risk which was available at the time of referral.

3.25 The first recorded MARAC referral was generated by QMC in March 2015, after they had scored Janice as being at high risk on the CAADA Dash risk assessment. This was following the incident when Janice attended the QMC Emergency Department after the incident when she stated Ian had poured boiling water on her head and stabbed her in the thigh. The evidence

reviewed by the Police (including the apparently minor nature of Janice's injuries and a third-party witness statement which contradicted Janice's account) indicated no realistic prospect of successfully prosecuting Ian with any criminal offence.

3.26 A decision was taken by the MARAC office that this would not be discussed at MARAC. The primary basis for this decision appears to be that the allegations made by Janice that she had been violently attacked by Ian were, in the judgement of police officers, not supported by the presenting evidence.

3.27 However, the decision in this instance was contrary to local MARAC protocol and procedures and represented a very significant missed opportunity to establish a coordinated multi-agency approach, which could have better recognised and more effectively managed ongoing domestic violence risks. It is fundamentally important to recognise that the lack of evidence to support a criminal prosecution was not an indicator for low risk of further domestic violence.

3.28 The second MARAC referral, also in March 2015, was recorded as having been made by UHL's Emergency Department. This was after Janice attended ED with bruising to her face and back, and a bump to her head. Whilst the MARAC referral is recorded by UHL as having been sent by email, UHL have been unable to locate any email history to confirm that is was sent to the correct MARAC email address. It is understood that this is due to weaknesses in UHL's electronic communications systems, which have since been addressed.

3.29 Due to the absence of reliable records, the DHR has not been able to ascertain precisely what happened, but the outcome was that no MARAC process followed.

To establish whether vulnerable adult / adult safeguarding concerns were recognised by agencies and were appropriate multi-agency procedures followed.

3.30 The DHR has not found significant learning in relation to this question

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

3.31 Janice's gender, mental health problems, alcohol misuse and homelessness were all highly significant factors in relation to Janice's needs as a person who

was at risk from domestic violence. Learning in relation to these factors is disseminated throughout the report.

How effective were local assessments on Ian & Janice's housing needs? Was appropriate housing support offered? How well did Leicester and Nottingham Housing agencies work together in safeguarding Janice?

3.32 Janice's homelessness status (after losing her space at the Dawn centre) was a critical risk factor for domestic violence, but this appears not to have been sufficiently recognised or acted on.

3.33 Janice was evicted from the Dawn Centre in January 2015 for an alleged incident of supplying an illicit substance to another resident. An internal review of this decision by Leicester's Homeless Service has since concluded that a final warning would have been a more appropriate response. On eviction, there was no assessment of the likely impact of this decision, even though it was known that she was at risk of domestic violence and had been assaulted on the day preceding her eviction.

3.34 When she was admitted to QMC in Nottingham there were attempts to negotiate some form of suitable housing, including a refuge placement (for which there were no vacancies in the local area) homeless provision in Nottingham and a return to the Dawn centre. However, none of these were offered.

3.35 Another factor in Janice being refused services in Nottingham was her previous eviction from the Dawn Centre, so it can be seen that the earlier decision by the Dawn Centre then had significant 'knock-on' effects in further reducing the chances of her finding suitable and safe accommodation. This seems to have been compounded by the Dawn Centre then refusing to share further information with WAIS unless Janice completed a written consent form. Given the urgency of the situation when Janice was a patient at QMC, verbal consent over the telephone could have been sought.

3.36 In summary, housing and homeless services in Leicester and Nottingham did not work effectively together to safeguard Janice from further domestic violence.

To establish how effectively Leicester / Nottingham agencies and professionals worked together to safeguard Janice.

3.37 There was very good communication from staff at QMC hospital and agencies in Leicester, but unfortunately this did not lead to any positive outcomes in relation to Janice's immediate need for safe and secure accommodation. See also response to question 15.

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

3.38 See responses above.

Identify any areas of good practice

3.39 This DHR has established a pattern dominated by missed opportunities, poor inter-agency communications and breaches of procedure in relation to risk assessments and the MARAC process. However, there were isolated examples of good practice, including:

- Responses by staff at Queens Medical Centre in allowing Janice to remain in hospital when medically fit for discharge, having assessed her as being at high risk from domestic violence, then attempting (unfortunately without success) to work with outside agencies in Nottingham and Leicester to establish a safe discharge arrangement.

- The Outreach Alcohol Support Worker demonstrated a good understanding of the risks Janice was facing and acted appropriately to meet her immediate needs and to try (unfortunately without success) to ensure her engagement with Housing Options services.

- There are several examples of good practice by GP Practice 1, when concerns about domestic violence were proactively explored by practitioners and referral for specialist support was offered.

- Following the first 3 police incidents, Leicestershire Police carried out a review and increased assessed risk levels from standard to medium, due to cumulative evidence of risk.

- UHL's completion of the CAADA DASH risk assessment and the application of professional judgement in deciding to generate a MARAC referral was also good practice, but it is unfortunate that did not result in implementation of the MARAC process. (See question 12)

Key learning points:

3.40 For ease of reference, the following is a summary of all key learning points from part 2 of the report:

Key learning point 1:

There were breaches of operational procedure at the LRI Emergency Department and Housing Options which resulted in missed opportunities to assess potential domestic violence risks. There had also been a missed opportunity to carry out a risk assessment (or refer to a specialist domestic violence service for assessment) at the GP practice. This highlights the importance of ensuring that staff awareness and understanding of domestic violence policy, procedure and good practice is promoted through training, supervision and management processes.

Key learning point 2:

There is a potential misconception – possibly shared by some professionals as well as members of the public – that 'domestic abuse' can only take place within the confines of a domestic dwelling. This may result in homeless victims of abuse being effectively excluded from multi-agency domestic abuse procedures.

There is evidence that homeless people are likely to be at higher risk from domestic violence compared to the general population, as is illustrated by this case and other recent DHRs. It is therefore essential that all services which work with homeless people should ensure that staff understand that any abuse within the context of an intimate relationship – regardless of the physical location of incidents – should be recognised as domestic abuse and responded to accordingly, within local multi-agency policy, procedure and good practice guidance.

Key learning point 3:

When conducting domestic violence risk assessments, police officers should review local and national police records relating to the perpetrator. Where these records confirm a history in previous relationships of serious domestic violence (including in this case criminal convictions resulting in custodial sentences) this is a strong indicator of higher risks in the current relationship. The time period which may have elapsed since the last recorded police incident should not unduly influence officers towards a lower risk score, as it is entirely possible that the abusive behaviour has continued but has not been reported to the police.

Key learning point 4:

There was a pattern of assumption on the part of UCC staff that responsibility for addressing concerns about domestic violence risks to Janice lay with the police and other services she was in contact with.

As a minimum, UCC staff should have discussed ongoing domestic violence risks with Janice, with a view to referring her for specialist support. Additionally, concerns about domestic violence should have been flagged on UCC records and discussed with her GP and other relevant services. (The UCC DHR Action Plan addresses these issues in more detail.)

In fairness, it must be acknowledged that a number of other services (such as housing, homelessness and primary healthcare services) appear to have followed a similar pattern of assuming that 'somebody else' would be leading in relation to domestic violence concerns, so this learning point is relevant not just to UCC.

Key learning point 5:

There is a need to ensure consistency of practice in the use of CAADA-DASH assessments where people present as homeless and there is evidence that that domestic violence is a factor in this presentation. The risk assessment should be conducted at the time of the homelessness presentation and not delayed until a decision is made regarding the person's statutory homeless status, which may be up to 33 working days later. As is clearly shown by Janice's experiences, if the individual is fleeing a violent relationship this period of 33 working days may well be a particularly high risk period.

Key learning point 6:

Even if Janice's eviction from the Dawn Centre had been unavoidable due to concerns about other vulnerable service users, there should have been careful consideration of her ongoing vulnerability as a domestic violence victim. Attempts should have been made at finding more suitable alternative accommodation or at the very least signposting to specialist support services.

Key learning point 7:

When carrying out DASH risk assessments officers should consider cumulative risk, especially when there has been a succession of similar incidents within a short space of time. A risk assessment which fails to consider such recent events and evidence of escalation is likely to be unreliable. (See also key learning point 3.)

Key learning point 8:

It should be recognised that people with multiple and complex needs such homelessness, alcohol problems and domestic violence (i.e. those in the most critical and urgent need of help) are very frequently the most difficult people for services to meaningfully engage with and effect positive change. However, there could have been more concerted and proactive attempts at getting Janice to attend Housing Options with a view to finding her somewhere safe to stay. This did not happen and the outcome was that Janice remained dependent on her violent partner for accommodation, which was apparently her only option other than rough sleeping.

Key learning point 9:

Clarifying victim / perpetrator roles and identifying risks

Ian	Janice
Confirmed history / criminal convictions as perpetrator of domestic abuse and serious physical assaults in previous relationships.	**Risk factor:** Self-reported history as victim of domestic abuse and physical assault in previous relationships
Recent and repeated history of assaulting Janice, causing significant injuries requiring hospital treatment	**Risk factor:** Observed on occasions to be physically aggressive and towards Ian, not known to have caused him serious injuries, but has received serious injuries in these conflicts.
Securely housed	**Disempowered:** Homeless, largely dependent on staying at Ian's as alternative to rough sleeping
Serious problems with binge drinking	**Risk factor:** Serious problems with binge drinking. **Risk factor:** History of mental health problems.

Key learning point 10:

In an urgent situation where a person is fleeing domestic abuse and potentially seeking a refuge placement, the requirement for written consent before sharing information with the refuge service may create an

unnecessary barrier to them being able to access the service. Where the person is willing and able to confirm verbal consent over the telephone (provided their identity can be verified with reasonable certainty) this should be a sufficient basis for sharing information.

Key learning point 11:

The MARAC referral should not have been screened out of the MARAC process, regardless of any doubts that police officers or others may have regarding the reliability of an alleged victim's statement. That there was insufficient evidence to bring criminal charges should not have resulted in any assumptions about levels of domestic violence risks.

To screen and reject MARAC referrals on such a basis completely undermines a key principle: MARACs should consider risk assessments and risk management strategies from a shared and multi-agency perspective.

There is a need to ensure that the above points are made completely clear in the local MARAC Protocol.

Key learning point 12:

When agencies refer to MARAC they must ensure that they retain a clear record of the risk assessment and the MARAC referral and request and receive a confirmation that the referral has been received. They should also be notified when the case will be discussed at MARAC and invited to attend the MARAC meeting.

Key learning point 13:

It is important that GPs and other primary healthcare professionals have a good knowledge and awareness of domestic violence issues in general and of the MARAC process in particular. If there is any doubt about whether there is a current MARAC referral or MARAC coordinated risk management plan, this should be checked with the MARAC Coordinator.

Key learning point 14:

This report has appropriately focussed very much on the availability and effectiveness of services to support and protect Janice. However, it is equally important to acknowledge the potential benefits of targeted interventions with repeat domestic violence perpetrators, which may ultimately change this behaviour pattern and protect other women from future abusive relationships. This also highlights the need to increase knowledge and awareness of local services which can offer such interventions.

PART 4: RECOMMENDATIONS

4.1 Recommendations reproduced from the Single Agency Action Plans attached to Individual Management Reviews:

4.1.1 **Leicestershire Police recommendations:**

4.1.2 It is recommended that supervisory officers are reminded of their responsibility to supervise domestic abuse investigations and the importance of fully recording the rationale for their decision making.

4.1.3 It is recommended that officers are reminded of the various support agencies that are available to persons who are alcohol dependent in order that they are signposted to the most appropriate agency to receive the required support.

4.1.4 It is recommended that officers are reminded of the need to adopt a more lateral problem solving approach to domestic abuse when faced with a victim who is reluctant / reticent to engage beyond the initial report of the abuse.

4.1.5 It is recommended that the police DASH risk assessment be amended with notes of guidance in the 'professional judgement' field, to guide decision makers regarding factors, outside of the main DASH questions, which should lead an assessor to increase the risk level. These are to include:

- History of DV offending against other separate victims (serial perpetrator)
- Significant increase in frequency of Standard and Medium risk incidents

This change will be marketed to all officers involved in completing DASH risk assessment and otherwise reviewing DV (DAST team)

4.1.6 **Leicester City Council Homeless Prevention & Support Service recommendations:**

4.1.7 Consider how services are withdrawn for victims of Domestic Abuse

4.1.8 Service Users presenting with Alcohol Issues should receive additional support to encourage access to treatment.

4.1.9 Ensure that Homelessness Services staff are fully aware of ASC responsibilities for vulnerable adults.

4.1.10 Assist One Roof to compile a referral form to highlight indicators of DV.

4.1.11 Ensure the learning from this IMR is shared amongst Homelessness Services Management Team.

4.1.12 **Leicester City Council Housing Options Service recommendations:**

4.1.13 Provide further guidance to Officers as feedback from completing this process of lessons learnt and examples of good practice.

4.1.14 Case Management procedures reviewed.

4.1.15 **SAFE Project:** No recommendations

4.1.16 **GP Practice 1 recommendations:**

4.1.17 A DVA lead be designated to lead on this area of work and ensure the practice remains up to date in its protocols and activity.

4.1.18 Improve awareness of the agencies (such as UAVA) and processes (such as MARAC) involved with supporting people experiencing Domestic Abuse within the team.

4.1.19 Improve understanding of CAADA-DASH risk assessment process

4.1.20 Ensure appropriate training for clinical and non-clinical staff

4.1.21 Guard against desensitisation to risks and optimise understanding of HIGHER risks in mutually violent relationships

4.1.22 Engage with local safeguarding and DVA organisations and systems to improve primary care involvement more generally.

4.1.23 Systems to flag both victims and perpetrators of DVA within the clinical system (IT) are sought and that routine queries and offers of support and referral take place when flags are present.

4.1.24 **Anchor Centre recommendations:** No recommendations

4.1.25 **Nottingham University Hospitals NHS Trust recommendations:** No recommendations

4.1.26 **Leicestershire Partnership NHS Trust recommendations:** No recommendations

4.1.27 **University Hospitals of Leicester NHS Trust Recommendations:**

4.1.28 Improve staff knowledge and awareness of domestic abuse and where to seek specialist advice by incorporating domestic abuse information / training into the mandatory adult safeguarding e-learning module.

4.1.29 Revise the face to face training on domestic abuse for ED / UCC staff to incorporate the learning from this review.

4.1.30 Review and revise the Emergency Department Standard Operating Procedure for Domestic Abuse, in line with the Trust's overarching DA Policy and best practice. This should include routine enquiry where domestic abuse is disclosed or suspected.

4.1.31 Review and revise the Emergency Department Standard Operating Procedure for Safeguarding Adults, in line with the Trust's overarching SA Policy and the Care Act.

4.1.32 Increase ED / UCC staff knowledge, awareness and confidence when dealing with domestic abuse, in light of this review (by implementing the above).

4.1.33 Explore the possibility of securing additional funding to recruit a permanent IDVA to work across UHL, alongside the UHL safeguarding teams

4.1.34 Ensure that the organisation maintains a secure record of all MARAC referrals made by ED / UCC staff.

4.2 Overview Recommendations agreed by DHR Panel

4.2.1 Leicestershire Police should review operating procedure, guidance and training for domestic violence risk assessments using DASH, to include a requirement that checks must be made on police records (Police National Computer and Police National Database) to ascertain whether the alleged domestic violence perpetrator has a history of reported domestic violence incidents and / or criminal convictions. Where such a history exists, but the current risk score has not reached the threshold for automatic referral to MARAC, officers should consider a MARAC referral based on professional judgement. (Key learning point 3)

4.2.2 There should be a multi-agency review of the MARAC procedure and domestic violence training needs, in the light of learning from this case, to include:

- Systems for sending, receiving and recording MARAC referrals
- Potential need for clarification of guidance for specialist domestic violence staff, particularly around the requirement that any domestic violence victim

identified as high risk in CAADA-DASH must be considered at a multi-agency MARAC meeting. (Key learning points 11 & 12)

- Need for wider agency training and awareness raising about domestic violence and the role of MARAC, with a specific focus on training needs in primary healthcare and housing and homelessness services, to include appropriate use of the DASH risk assessment tool in cases where there are presenting concerns relating to domestic abuse.

- Supporting and training staff responsible for assessing domestic violence risks where there are multiple and complex needs, including evidence of mutually violent behaviours. (Key learning point 9)

- Ensuring that service users' wishes and intentions are clearly accounted for in safety planning and that follow actions are in place; particularly when the service user is identified as being high risk.

4.2.3 There should be work to increase awareness about local services which carry out specialist and targeted work with serial domestic abuse perpetrators. Perpetrators who have a history of criminal domestic abuse offences should be prioritised for such targeted interventions, which may be on a voluntary basis or as an element of criminal court-imposed sanctions. If this recommendation highlights issues of insufficient capacity to meet demand, this should be considered by commissioners as a potential area for increased resource allocation. (Key learning point 14)

4.2.4 All key learning points from this DHR should be disseminated as widely as possible to local health, social care, housing, homelessness and criminal justice agencies likely to be working with people affected by domestic violence. (All Key learning points)

APPENDIX 1: GLOSSARY

Anchor Centre	'Wet' day centre service for street drinkers
AUDIT	Alcohol Use Disorders Identification Test
CAADA-DASH RIC	Coordinated Action Against Domestic Abuse Domestic Abuse, Stalking and 'Honour'-Based Violence Risk Assessment Checklist
CCG	Clinical Commissioning Group
CPN	Community Psychiatric Nurse
CSP	Community Safety Partnership
DAIU	Domestic Abuse Investigation Unit (Police)
Dawn Centre	Temporary homeless accommodation service in Leicester
DHR	Domestic Homicide Review
ED	Emergency Department (Part of UHL)
EMAS	East Midlands Ambulance Service
IMR	Individual Management Review
GP Practice 1	Specialist primary healthcare service for homeless & vulnerably housed people
IPCC	Independent Police Complaints Commission
LPT	Leicester Partnership NHS Trust
LRI	Leicester Royal Infirmary
MARAC	Multi Agency Risk Assessment Conference
PSD	(Police) Professional Standards Department
QMC	Queens Medical Centre (Nottingham)
SAFE	Voluntary sector domestic violence service
UCC	Urgent Care Centre (Part of UHL)
UHL	University Hospitals Leicester NHS Trust
WAIS	Women's Aid Integrated Services (Nottingham)