Domestic Homicide Review
Overview Report

Report into the death of Adult A

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1. INTRODUCTION

1.1 This domestic homicide review follows the death of Adult A on 2 March 2012 at his home in Ash. South East Coast Ambulance Service attended the address on that date in response to a telephone call from his partner, Adult B. A paramedic pronounced Adult A dead at the scene at 03:44.

1.2 A post-mortem examination conducted by a Consultant Forensic Pathologist on 2 March 2012 concluded that Adult A had died of severe abdominal, head and chest injuries, including traumatic sheering damage to the brain, bowel haemorrhage bleeding, ruptured liver and abdominal tears. There were no defence injuries. The pathologist was of the view that Adult A would not have been able to move after sustaining the injuries, indicating that he was assaulted and subsequently died at his home.

1.3 Adult B was found guilty of the murder of Adult A at Guildford Crown Court on 30 October 2012 and sentenced to life imprisonment, with a minimum tariff of 17½ years. A history of domestic abuse and Adult A's disability and vulnerability were cited as aggravating factors in the sentencing.

Purpose of Review

1.4 Domestic homicide reviews were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Adults Act 2004 and came into force on 13 April 2011. The Act requires 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 person to whom he was related or with whom he was or had been in an intimate personal relationship or a member of the same household as himself".

1.5 The Home Office's multi-agency statutory guidance for the conduct of domestic homicide reviews states the purpose as being to:

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

Subjects of Review

1.6 The subjects of this review are as follows:

Adult A:	Date of Birth	-	3 December 1974
(Male)	Date of Death	-	2 March 2012
Adult B:	Date of Birth	-	12 October 1967
(Female)			

1.7 Adult A was and Adult B is White British. They had no children together, although research indicates that Adult A had children with previous partners. No children are directly involved in this case or review.

Conduct of Review

1.8 Following notification by Surrey Police of the death of Adult A and consultation with partners, the Chairman of the Safer Guildford Partnership confirmed that the circumstances met the criteria set out in the statutory guidance for a domestic homicide review on 1 May 2012. The Home Office was informed of the intention to conduct a review on the same day.

1.9 A Panel comprising senior representatives of relevant partner organisations was convened to oversee the review. Following consultation with partners, Mark Reed, a Strategic Director at Guildford Borough Council, was appointed by the Chairman of the Safer Guildford Partnership to chair the review. Mark's background as an environmental health officer has provided him with extensive experience in regulation, enforcement, investigative procedures and joint agency and partnership working. Full membership of the Panel is set out below:

Pauline Disley, Manager, South West Surrey Domestic Abuse Outreach Service
Caroline Jones, Senior Manager, Adult Social Care, Surrey County Council
Susan Lawes, Associate Director of Quality and Safeguarding Children, NHS Hampshire
DCI Colin Matthews, Head of Northern Area Public Protection Department, Hampshire Police
Lin Pedrick, Service Director, Surrey and Sussex Probation Trust
Mark Reed, Strategic Director, Guildford Borough Council
DS Jon Savell, Head of Public Protection, Surrey Police
Diane Woods, Associate Director Commissioning, Mental Health & Learning Disabilities, NHS Surrey

1.10 Stephen Benbough, Policy and Partnerships Officer at Guildford Borough Council, acted as assistant to the Chair of the Panel throughout the review and provided advice and support to the organisations involved.

1.11 The Panel agreed that an Individual Management Review (IMR) should be conducted by each agency in accordance with the statutory guidance. As the review progressed and further possible contacts with Adult A and Adult B by various agencies emerged, IMRs were also commissioned from the following additional organisations:

Frimley Park Hospital NHS Foundation Trust
Hampshire County Council
Hampshire Probation Trust
Rushmoor Borough Council
South Central Ambulance Service NHS Foundation Trust
South East Coast Ambulance Service NHS Foundation Trust
Southern Health NHS Foundation Trust
Surrey and Borders Partnership NHS Foundation Trust

1.12 The Panel has given detailed consideration to and challenged robustly the IMRs submitted by individual agencies and the final documents have contributed significantly to this report. This documentation has been supplemented by:

- information provided by the general practices attended by Adult A and Adult B;

- discussions with and information provided by Surrey Police's Senior Investigating Officer in relation to the murder of Adult A;

- discussions with members of Surrey Police's Ash Neighbourhood Team; and

- attendance at the trial of Adult B and review of the evidence given, including by neighbours and acquaintances.

1.13 The Panel recognised that the family might have detailed knowledge about the victim's experiences that could support the review process. The Chair wrote to Adult A's parents after the initial Panel meeting to inform them that a formal review had commenced and to seek their involvement following completion of the criminal proceedings against Adult B. The Chair met Adult A's parents at their home in Aldershot on 24 January 2013 and information provided by them has been incorporated within this report where appropriate.

1.14 As Adult A and Adult B's home was a privately rented property, the Chair also wrote to the landlord on 9 August 2012 to request any information that he might be able to provide to assist with the review. No response was received. However, in a previous conversation with Surrey Police, the landlord advised that he was aware that Adult B was living at the address and that Adult A had moved in, but that he had never had cause to visit. The property had been allowed to get into a state of disrepair and his only involvement had been to arrange repairs by various trades.

Timescale for Review

1.15 The decision to undertake a review was taken by the Chairman of the Safer Guildford Partnership on 1 May 2012. The statutory guidance states that the overview report should be completed within a further six months of this decision unless an alternative timescale is formally agreed with the relevant community safety partnership. As soon as it emerges that the review cannot be completed within the timescale of six months, the Panel should notify the community safety partnership to renegotiate the timescale for completion.

1.16 The guidance goes on to state that, in cases where the suspect is arrested and charged, the commissioning of the final overview report should be held temporarily until the conclusion of the criminal case, but agencies and interested parties should be notified of the requirement and be obliged to secure any records pertaining to the homicide against loss and interference. In these circumstances, the Panel should ensure records are reviewed and a chronology drawn up to identify any immediate lessons to be learned (an immediate IMR). These should be brought to the attention of the relevant agency or agencies for action, secured for the subsequent overview report and forwarded to the disclosure officer for the criminal case. Any identified recommendations should be taken forward without delay. Following the criminal proceedings, the review should be concluded without delay.

1.17 In this case, the criminal proceedings concluded on 30 October 2012, with Adult B being found guilty of the murder of Adult A. Therefore, whilst IMRs were drawn up by each agency without delay, the commissioning of this report could not take place before that date. The Senior Investigating Officer also strongly advised the Panel that any interviews with family members or others should not take place prior to the completion of the trial.

1.18 The Chair of the Panel attended the meeting of the Safer Guildford Partnership Executive on 17 October 2012 to explain the situation regarding the progression of the review and an extension of the timescale for its completion was agreed unanimously.

Terms of Reference of Review

1.19 The intention of the Panel was to reflect on significant and relevant events leading up to Adult A's death, analyse the actions of relevant agencies and make recommendations, where appropriate, to ensure that lessons are learnt. The Chair of the Panel sought to instil an open and honest approach with a willingness to challenge robustly the actions, or lack of them, of his own and partner organisations. This required a high level of organisational self-awareness and a critical, but supportive and respectful approach. The detailed terms of reference of the review, as agreed by the Panel following consultation with members of the Safer Guildford Partnership, are as follows:

1. To review significant and relevant events up to the date of the death of Adult A on 2 March 2012, unless it becomes apparent to the Chairman that the timescale in relation to some aspect of the review should be extended. Agencies should begin their Individual Management Reviews from the time of their first contact with the victim and alleged perpetrator.

2. To review the actions of the agencies defined in Section 9 of the Domestic Violence, Crime and Victims Act 2004 who were involved with Adult A and/or his partner Adult B and, at the initiative of the chairman and subject to their agreement, any other relevant agencies or individuals.

3. To seek to involve family and friends in contributing to the review where appropriate.

4. To produce a report which:

    - summarises concisely the relevant chronology of events, including the actions of all involved agencies;

    - analyses and comments on the appropriateness of actions taken; and

    - offers recommendations, where appropriate, that ensure lessons are learnt by relevant agencies.

5. To have regard to any specific equality and diversity issues.

6. To complete a final overview report in a suitable timeframe following the conclusion of the criminal investigation and court proceedings relating to the death of Adult A. The timeframe will be negotiated and agreed with the Safer Guildford Partnership as necessary.

1.20 As referred to previously, the Chair of the Panel met Adult A's parents on 24 January 2013. The review also considered evidence provided by Adult A's family, friends and acquaintances at Adult B's trial. Further interviews with friends were not considered necessary as part of the review.

1.21 Adult A and Adult B commenced their relationship in February 2008. The primary focus of the review is, therefore, from that date until 2 March 2012. However, where relevant information from before that period has been identified, this has been included to provide background and context to the relationship and the individuals concerned, particularly where it helps to understand how Adult A viewed the world around him and why he may have made the decisions he did in the months leading up to his death.

2. BACKGROUND AND CHRONOLOGY

2.1 This section of the report provides some background on the lives of Adult A and Adult B before they met in February 2008. It then provides an overview of their relationship and events prior to the death of Adult A on 2 March 2012.

Adult A (up to February 2008)

2.2 Adult A had an extensive criminal record. The majority of his offences were committed in Hampshire and Surrey and both police forces had frequent contact with him for over 20 years. Adult A's behaviour deteriorated whilst he was still at school. He was expelled from three secondary schools for fighting and truancy and left education at the age of 15 without any qualifications. He started mixing with older people and quickly got into drugs, alcohol and criminal activities.

2.3 Police involvement with Adult A dates back to 1991 when he was convicted of shoplifting. Since then, he was arrested and charged on numerous occasions in Hampshire and Surrey, mainly for theft, violence, criminal damage and public order offences. Most offences were committed whilst Adult A was drunk. In the period up to April 2008, Adult A had been convicted on more than 50 occasions of over 100 offences. There was a longstanding pattern of prison terms followed by Adult A being arrested again within days of release predominantly due to alcohol-related offences. He also had a tendency to behave violently towards the police when drunk and, over the years, often assaulted officers when being arrested for other offences.

2.4 Interspersed amongst the very high volume of minor offences were some more serious cases that are worth highlighting, as follows:

(a) In 1996, Adult A (aged 22 years) was convicted of attempted robbery at an off-licence and received a sentence of 42 months imprisonment. He received a consecutive six months sentence for shoplifting and drugs offences. This four year term was his first lengthy prison sentence.

(b) In 2000, Adult A was sentenced to nine months imprisonment after stabbing his neighbour in the chest with a knife.

(c) In 2003, Adult A was convicted of causing actual bodily harm against his then female partner. He had caused injuries to her face and arm during a drunken argument. This was his first recorded conviction for domestic violence.

(d) In 2003, Adult A was convicted of harassment after persistently visiting his parents' address in Aldershot whilst drunk and causing a nuisance. As well as receiving a term of imprisonment of 56 days, a restraining order was made preventing him from entering or going to his parent's road. The order was breached frequently, which resulted in further convictions for harassment. The most significant, in October 2004, resulted in a custodial sentence of 18 months. The restraining order was still in existence at the time of Adult A's death, although it was routinely breached with the consent of his parents making enforcement extremely difficult.

(e) During 2005 and 2006, eight domestic incidents were recorded by Hampshire and Surrey Police involving Adult A and his then partner [Partner 1]. The incidents involved verbal abuse, harassment and physical violence by Adult A. Alcohol or drugs were always a factor in his

behaviour. On 7 June 2006, Adult A was convicted of harassment and threatening behaviour towards Partner 1 and a second restraining order was made against him.

(f) In January 2007, Adult A was convicted of five separate violent offences and received a 12 months custodial sentence. Due to the nature of the offences, he was registered as a Multi-Agency Public Protection Arrangements[1] (MAPPA) case and recorded as a Category 2 (violent) offender to be managed by Hampshire Probation Service. Adult A was released from prison on licence on 14 June 2007, but appeared in court again on 22 June 2007 (charged with racially abusive threatening behaviour) and 4 July 2007, the latter resulting in a four month prison sentence for assaulting a police officer. His licence expired on 13 December 2007 and Hampshire Probation Service's involvement ceased. MAPPA management of Adult A also ended as he did not meet the criteria for ongoing supervision (i.e. he was not considered to pose a serious risk of harm to the public requiring multi-agency management).

2.5 Adult A is known to have had a child from his relationship with Partner 2 whom he met in 1990 when she was 16 years old. It is understood that he had no contact with the mother or child as Partner 2's parents forbade this when they found out she was pregnant. Adult A also appears to have had a child with Partner 3, a heroin addict. The child was taken into care, possibly due to her mother's heroin addiction. Adult A married Partner 4, who lives in Aldershot, in 2002. The marriage did not last, largely due to their alcohol and drug abuse.

2.6 Adult A was first prescribed with anti-depressants by his GP in 1995 (aged 21 years) and was seen twice by medical practitioners that same year following overdoses. He continued to receive various prescription drugs to treat depression over the following years. A third overdose in 2000, this time of a drug used to treat alcohol withdrawal symptoms, resulted in a serious life-threatening episode and treatment in intensive care at Frimley Park Hospital. He was treated for Tuberculosis in the same year.

2.7 In December 2006, Adult A was taken to Frimley Park Hospital having overdosed with Naxproxen and alcohol. He had also self-harmed by cutting his arm and was feeling suicidal. He was seen at Frimley Park Hospital on two further occasions in June 2007 with injuries to his arm caused by self-harm.

2.8 Adult A had various referrals to and contact with mental health and drug and alcohol services between 2000 and 2008. However, his engagement with such services and attendance at appointments was erratic at best.

2.9 As Adult A's dependency on drugs and alcohol increased, his lifestyle became more chaotic. It appears that he was never in any form of sustained employment and that he was financially dependent on benefit payments. He took little care of himself and lived most of his life in an alcohol and drug induced stupor. He associated with other adults with similar issues, which made him vulnerable to abuse, usually through drunken brawls. Adult A had attended the Emergency Department at Frimley Park Hospital on over 20 occasions by 2008, often presenting with head or facial injuries as a result of fights and assaults.

2.10 Following his release from prison for offences committed in 2007, Adult A had been required as part of his licence conditions to reside at specified approved premises. Although his licence conditions expired on 13 December 2007, he remained living at Elderfield House, a hostel near Winchester, after this date.

[1] MAPPA are statutory arrangements for managing sexual and violent offenders. They provide a mechanism through which agencies can better discharge their statutory responsibilities and protect the public in a coordinated manner. The purpose of MAPPA is to help reduce the re-offending behaviour of sexual and violent offenders in order to protect the public, including previous victims, from serious harm.

2.11 On 11 October 2007, Adult A was registered under the multi-agency Prolific and Other Priority Offenders (PPO) scheme in north Hampshire prior to his anticipated return to the Aldershot area due to his high risk of reoffending. The scheme aims to identify and stabilise the drivers of reoffending behaviour, in this case alcohol, to encourage engagement with other agencies and services. Adult A's support worker under the scheme met him at Elderfield House on 6 December 2007 and drew up an action plan with him, which included remaining at the premises until appropriate housing had been found, attending Alcoholics Anonymous (AA) meetings and continuing to receive support from the local drop-in centre. Despite considerable efforts, Adult A failed to attend AA meetings, did not attend a fork lift truck course arranged for him and generally disengaged from his support worker. He was charged with the theft of alcohol from a garage near Elderfield House on 5 January 2008 and was convicted later that month.

2.12 On 21 January 2008, Adult A and another resident were involved in a fight at Elderfield House and Adult A was evicted against the advice of his PPO support worker. Adult A then returned to the Aldershot area. He moved in with his parents for a couple of weeks, but this was difficult as he had to share a bedroom with his brother. Adult A then commenced his relationship with Adult B and moved in with her at her flat in Ash.

Adult B (up to February 2008)

2.13 Adult B also has an extensive criminal record and, again, the majority of offences were committed in Hampshire and Surrey. Both police forces have had frequent contact with her for the last 30 years or so.

2.14 During the period 1981 to 1984, from the age of 13, Adult B was subject to a court care order and referred to Fairfield Lodge Observation and Assessment Centre in Southampton. This was the result of persistent non-attendance at school and disruptive behaviour at home.

2.15 Police involvement with Adult B dates back to 1982 when she was convicted of shoplifting. Since then, she was arrested and charged on numerous occasions in Hampshire and Surrey, mainly for theft, drugs, fraud, violence and driving offences. In the period up to April 2008, Adult B had been convicted on 26 occasions for 46 offences.

2.16 Adult B's most serious offence was in 1999 when she was convicted of supplying a Class A drug (heroin) and various associated drugs offences. She was sentenced to 66 months imprisonment, which was reduced from seven years on appeal. She was convicted for three offences involving violence, including assaulting a police officer in 1995, assaulting a prisoner whilst serving a prison term at HM Prison Send in 1999 and assaulting her sister in 2005.

2.17 Adult B had alcohol and drug addiction problems. She was referred to the Acorn Drug and Alcohol Service operated by Surrey and Borders Partnership NHS Foundation Trust in November 2005. Following an assessment, a prescription for methadone commenced in April 2006. Except for a period in prison during November and December 2007 for breaching a community order, Adult B attended appointments at Acorn clinics at Frimley Park Hospital, albeit erratically, from this date until 28 March 2008. She continued to use heroin and crack cocaine on top of her methadone script during this period.

2.18 Research indicates that Adult B has never married and has no children. There are no records of her being involved in an abusive relationship with any previous partners.

Adult A and Adult B (from February 2008 to March 2012)

2.19 Adult A and Adult B met and commenced their relationship in February 2008. He soon moved in with her at her flat in Ash, a privately rented property. Both Adult A and Adult B were unemployed and living on benefits. Adult A was reported to be stable on methadone at this time and was receiving Paroxetine for depression.

2.20 As stated previously, Adult B had attended the Acorn Drug and Alcohol Service regularly since April 2006 to receive her methadone prescription. However, after attending an appointment on 28 March 2008, she was not seen for four months and was discharged as a client on 26 July 2008.

2.21 The first domestic incident at their flat in Ash was reported on 31 March 2008. Surrey Police attended in response to an abandoned 999 call from the address in which a great deal of shouting could be heard. Adult A stated that there had been an argument, but that the phone had dialled 999 by mistake whilst in his pocket. No allegations were made and no further action was taken by the police.

2.22 Adult A was deregistered as a PPO in April 2008 by the multi-agency North and East Hampshire PPO (Rhino) Committee. The reasons given were that Adult A's offending was more of a nuisance than criminal behaviour, that this predominantly affected his family rather than the wider community and that he had disengaged from his support worker.

2.23 A second attendance at their home address by Surrey Police on 1 May 2008 was more serious. Adult A and Adult B had both inflicted blows upon each other and Adult A had received a head wound after being hit with a plastic toilet seat. He was taken by ambulance to Frimley Park Hospital. Adult B was arrested but, following an investigation, Surrey Police concluded that there was no realistic prospect of a successful prosecution.

2.24 On 14 May 2008, Hampshire Police received a complaint from Person 1 and her boyfriend, Person 2, that Adult A and Adult B had threatened them at Aldershot Railway Station. Adult A was charged with threatening behaviour and convicted at North East Hampshire Magistrates' Court on 1 August 2008. He was fined £100 and ordered to pay costs of £50. No further action was taken against Adult B due to insufficient evidence.

2.25 Adult A called the police on 9 June 2008 to report having been assaulted by Adult B at their home. He was extremely drunk, but stated that there had been an argument between Adult B and himself. Adult A would not give further details, but asked the police to call him the next day. Surrey Police contacted Adult A on 10 June 2008 and met him at Aldershot Police Station later that day, where he was accompanied by Adult B. Both were drunk and stated that there had been an argument, but no assault.

2.26 Surrey Police responded to a call from Adult A at his home address at 23:05 on 14 July 2008. On arrival, officers found the front door to the property open and Adult A and Adult B both calm, but drunk inside. Adult A stated that an argument had taken place, but accepted that it had not been necessary to call the police on this occasion. At 23:59, Adult B's mother called the police to report that her daughter had locked herself in the toilet at home in Ash and was too frightened to come out due to the behaviour of Adult A. She was allegedly covered in blood. A second police unit was deployed to the address that evening. Officers had to wake Adult A and Adult B, who were both unaware of why the police had been called.

2.27 On 14 August 2008, Neighbour 1 reported to the police that an argument was taking place between Adult A and Adult B, which had continued into the communal stairwell at the address. Surrey Police attended and found that Adult A had broken a panel on the communal front door

and the lock on the door of his own flat and had then left the premises. He was found on his way to Aldershot, warned about returning home and taken to his parents' address in Aldershot.

2.28 On 19 August 2008, Hampshire Police attended an incident at a shop in Aldershot High Street. Adult A and Adult B were drunk and had abused the shop owner, damaged stock and pushed and spat at two young customers. Both Adult A and Adult B were arrested. Adult A was convicted of threatening behaviour at Winchester Crown Court on 17 February 2009 and received a sentence of four months imprisonment, together with an Anti-Social Behaviour Order (ASBO) until 16 June 2011. Adult B received a sentence of six months imprisonment for racially aggravated threatening behaviour.

2.29 Adult A attended Aldershot Police Station on 5 September 2008 in a drunken state and with a bleeding lip. He alleged that he had been beaten up by Adult B and a male associate in Princes Gardens, Aldershot. An ambulance was called and treated Adult A in situ as he refused to go to hospital. Later that evening, a patrol officer saw Adult A and Adult B drinking together in Princes Gardens, Aldershot. Adult B claimed that they had been arguing because Adult A had stolen money from her. No action was taken as both parties refused to make a formal complaint.

2.30 Adult A attended Aldershot Police Station on 18 September 2008 and reported being assaulted by Adult B during a drunken argument outside Iceland in Aldershot. No action was taken in response to this incident as Adult A failed to respond to requests to make a formal complaint.

2.31 On 19 September 2008, South East Coast Ambulance Service responded to a 999 call at Adult A and Adult B's home in Ash. Adult A had sustained a bump to the back of his head following a fall. He also complained of pain in his jaw and left eye area as a result of injuries sustained the previous day. Adult A was abusive to the ambulance crew and refused treatment or transport to hospital.

2.32 On 26 September 2008, Surrey Police were contacted by South East Coast Ambulance Service, who were attending an incident at Adult A and Adult B's home in Ash. Adult A had sustained a laceration to his head and alleged that Adult B had hit him with a glass ashtray. Adult B was arrested. She stated that Adult A had threatened her with a knife and that, as she pushed passed him to leave the flat, he had fallen and opened an old head injury. In view of a lack of cooperation and formal statement from Adult A, the explanation given by Adult B and there being no witnesses, no further action was taken by Surrey Police.

2.33 Hampshire Police attended an incident at 10:01 on 26 November 2008 where Adult A was drunk and laid on the ground in Aldershot High Street lashing out at passers by who were trying to help him. The police attended and, noting injuries to his leg and head, called an ambulance. He was left in the care of the ambulance crew who checked him at the scene.

2.34 Frimley Park Hospital records show that Adult A also arrived by ambulance at 12:50 on 26 November 2008 and had suffered a possible stroke. Therefore, it seems likely that there were two separate incidents involving Adult A that day, although this is not verified by South East Coast Ambulance Service NHS Trust records.

2.35 The following day, on 27 November 2008, Adult A was taken by ambulance to Frimley Park Hospital at 13:59 following a drink-related fall outside his home in Ash. Adult A reported that he kept falling over due to his right-sided weakness. The possibility that he had suffered a stroke was again noted, although a CT scan of his brain showed no acute injury to account for his symptoms.

2.36 Adult A was taken by ambulance to Frimley Park Hospital for a second time on 27 November 2008 at 23:56. He had continued drinking since leaving the hospital earlier that day and had been

found in a public place by a group of youths. He had no new injuries, but presented with numbness, slurred speech and a painful right knee and arm.

2.37 Following his conviction and custodial sentence on 17 February 2009, Adult A was released from prison on 30 March 2009. On 4 April 2009, he attended his parents' address in Aldershot whilst drunk and caused a disturbance. He was arrested for breaching his ASBO, but the Crown Prosecution Service decided that there was insufficient evidence to prove the breach and no further action was taken.

2.38 Adult B was released from HMP Bronzefield on 8 April 2009 with a home detention curfew from 3.45 p.m. to 6:45 a.m. until 18 May 2009. Intelligence was received by Hampshire Police on 16 April 2009 and summarised on its database as:

> *"Adult B has been released from prison. She and her partner, Adult A, continue to drink heavily and are also using Class A drugs again. They continue to assault each other when drinking resulting in serious injuries to both of them. Adult B could end up killing Adult A in one of these fights as he attacks her and she retaliates. She bottled Adult A in their most recent fight."*

2.39 Due to persistent breaches, Adult B's home curfew licence was revoked on 5 May 2009 and she was returned to custody. Adult B was subsequently released from prison on 22 May 2009.

2.40 Adult B was referred back to the Acorn Drug and Alcohol Service following her release from prison and prescribing of methadone and reducing Diazepam commenced on 28 May 2009. Adult B attended her Acorn Drug and Alcohol Service appointments on a frequent but inconsistent basis up to the date of her arrest for Adult A's murder.

2.41 On 3 June 2009, Adult B was detained by security staff in the Wellington Centre, Aldershot having stolen items valued at £14.37 from a shop. She admitted the offence and was given a Fixed Penalty Notice.

2.42 Adult A was seen in the Neurology Clinic at Frimley Park Hospital on 16 June 2009 regarding his right sided weakness following a referral by his GP. It was planned to perform a MRI scan. The subsequent scan on 29 October 2009 showed some scarring of the left side of his brain, which suggested there had been significant injuries. The brain was also noted to be slightly thinner than expected for his age, which was compatible with alcohol induced damage. Adult A was seen again in the Neurology Clinic on 17 November 2009, when he was noted to have an increasing tremor. A further MRI scan of his spine was planned to exclude damage there as well but, despite all efforts, Adult A failed to attend any subsequent appointments. His parents have since advised that the reason he failed to attend appointments was that he was "terrified" of the MRI scanner.

2.43 On 23 September 2009, Hampshire Police attended an incident where Adult A and another male were arguing over the ownership of a walking stick in Redan Hill, Aldershot whilst heavily drunk. Adult A had a cut to his face that he said occurred when he fell over whilst drunk. No action was taken other than to advise both parties regarding their behaviour.

2.44 At 19:20 on 28 September 2009, Neighbour 2 contacted Surrey Police to report that Adult A was very drunk and banging on her door. Officers were not able to attend immediately and called Neighbour 2 back at 20:36. They were advised that Adult A had been taken to hospital by ambulance with facial injuries. The ambulance service paperwork reported that Adult A had been assaulted by Adult B with a stick, but the patient reported at Frimley Park Hospital that he had been drinking and had fallen over. It had been difficult to ascertain the actual cause of his injuries

because he left after being seen in triage and was accompanied by Adult B, the potential perpetrator.

2.45 A second call was received by Surrey Police that night at 00.14 from Neighbour 1 reporting that Adult A had had an altercation with Adult B, which had resulted in Adult B hitting him with his walking stick. Surrey Police attended the address and found both Adult A and Adult B highly drunk. Adult B claimed that Adult A's injuries had been caused when he fell over in Aldershot the previous week. Adult A stated that Adult B had beaten him with his walking stick. Adult B was arrested and Adult A was again taken by ambulance to Frimley Park Hospital. Following an investigation by Surrey Police, the case was closed.

2.46 On 29 September 2009, Hampshire Police were called to an incident where Adult A was slumped in a bus shelter in Aldershot High Street. Adult A had a cut to his face that he alleged had been caused by Adult B hitting him with a trainer. Adult A was taken by ambulance to Frimley Park Hospital. Adult B denied the offence and, following some enquiries, no further action was taken by Hampshire Police.

2.47 Surrey Police attended Adult A and Adult B's home address on 23 November 2009 in response to a call from Adult B. Adult A had knocked over a vase causing it to smash. Adult B stated that an argument had occurred because Adult A believed that she was sleeping around. He was drunk at the time.

2.48 On 30 November 2009, Neighbour 1 contacted Surrey Police and stated that Adult A was kicking the communal door down. The Police attended the incident and Adult B said that she had been involved in an argument with Adult A because he had accused her of having an affair with his friend, Person 3. Adult B had asked Adult A to leave, whereupon he left the flat but remained outside, kicking and punching the front door. Adult A, who was very drunk, was arrested for criminal damage. Following an investigation, the case was filed and closed by Surrey Police.

2.49 On 1 December 2009, Hampshire Police were called to Adult A's parents' address in Aldershot as he was drunk and banging on the door. He was arrested for breaching his ASBO and restraining order. However, he was not charged as the behaviour was not considered to be sufficiently disorderly to prove the breach of the ASBO and Adult A's parents had been complicit in the restraining order being breached on numerous occasions by inviting Adult A into their house.

2.50 On 23 December 2009, Adult B contacted Surrey Police to report an assault. The Police attended their home address and found Adult A in the living room with a cut to his neck, swelling and bruising to his right eye and a cut to his right hand. Adult B had minor reddening and scratches to her upper right arm. Both were extremely drunk. Adult B stated that Adult A had been assaulted by Person 3 using a wooden pole and scissors after he had accused him of sleeping with her. Adult B stated that she had also been attacked by Person 3. Person 3 had left the property before the police attended. Adult A was taken by ambulance to Frimley Park Hospital, where he required six stitches to his neck injury and surgical glue was applied to other lacerations. Neither Adult A nor Adult B wished to pursue allegations against Person 3 and the case was closed.

2.51 On 19 February 2010, Adult A submitted a housing application to Rushmoor Borough Council for a property in Aldershot. Two further applications were submitted on 18 March 2010. These were the first of a total of 40 unsuccessful housing applications submitted by Adult A between February 2010 and March 2011.

2.52 On 19 May 2010, Surrey Police received a call from Adult A stating that Adult B had hit him following an argument about the cat and the amount of alcohol they had consumed that day. The police attended their home address and found both Adult A and Adult B heavily drunk. Adult A

repeated that Adult B had hit him and showed the officers a small scratch under his chin. He did not wish to make a formal complaint. The incident was filed and the case closed.

2.53 Adult A submitted 23 unsuccessful housing applications to councils for properties in Aldershot (13), Guildford (4), Ash (2), Fleet (2), Farnborough (1) and Farnham (1) from 28 May 2010 to the end of September 2010.

2.54 On 25 September 2010, Adult A called 999 in an extremely drunken state and indicated that he had been fighting with Adult B. Surrey Police attended their home address in Ash and found Adult A drunk to the point of vomiting and incoherent. No further action was taken.

2.55 On 18 October 2010, Adult B called the police to report that she was involved in a domestic dispute with Adult A at their home. Surrey Police attended the incident. Adult A had become aggressive towards Adult B and she had pushed him off the bed. Adult B called the police when Adult A refused to leave the property and then left the flat herself. Both were drunk and possibly under the influence of drugs. Officers took Adult A to his parents' address in Aldershot. No formal allegations were made and no further action was taken.

2.56 On 23 October 2010, Neighbour 3 contacted Surrey Police to report that Adult A had knocked on her door with injuries to his head. The Police attended the address and an ambulance was called. Adult A was extremely drunk and became distressed when spoken to by officers. Adult A stated that Adult B had hit him over the head with a lump of wood and kicked him causing him to fall down the stairs. He said that she did it all the time. Adult A was taken to Frimley Park Hospital for treatment. Adult B was arrested. She denied hitting or kicking Adult A. Adult A did not wish to pursue the allegation against Adult B and the case was closed.

2.57 Adult A submitted a further 14 unsuccessful housing applications to councils for properties in Aldershot (8), Farnborough (5) and Guildford (1) between 28 October 2010 and 12 March 2011. On 22 February 2011, he advised Rushmoor Borough Council that he had found a one-bedroom property and needed rent in advance. Adult A was advised that the Council was not able to assist, but that he could apply to the Job Centre for an advance loan.

2.58 On 3 June 2011, Adult A saw his GP with a head injury following two falls the previous night. He reported that an ambulance crew had attended, but that he had refused to go to hospital.

2.59 On 13 September 2011, Adult A was confirmed as being Hepatitis C positive. He was also referred to the Gastroenterologist at Frimley Park Hospital as his liver blood tests were abnormal. Adult A was seen in the Gastroenterology Clinic on 16 November 2011 and at the Viral Hepatitis Clinic on 14 December 2011, but failed to attend subsequent appointments.

2.60 On 23 November 2011, Adult A was seen by his GP complaining of abdominal pain. The GP noted that he had fallen on many occasions recently and that he felt unsteady on his feet. He had facial bruises consistent with falls. Adult A was drunk and unable to stand and fell over a number of times on his way to the GP's room.

2.61 On 9 February 2012, Neighbour 4 contacted Surrey Police to report an argument between Adult A and Adult B. Officers attended the incident and Adult B, who was drunk, reported that Adult A had fallen over the cat. An argument had ensued which led her to telling him to pack a bag and get out. Adult A did leave but, according to Adult B, had fallen asleep in the garden. He then made his way to an unknown location in Aldershot. Adult B did not make any formal allegations and no further action was taken.

2.62 On 14 February 2012, Hampshire Police were called to Adult A's parents' address as he had turned up drunk. Prior to their arrival, Adult A's brother had taken him home to Ash.

2.63 On 17 February 2012, Surrey Police attended a road traffic incident in Ash where Adult B's mother's car had collided with the grass verge and flipped over causing significant damage. Adult A's documentation was found in the back of the vehicle. When contacted, Adult B's mother reported that the car was parked at her daughter's address.

2.64 On 23 February 2012, South East Coast Ambulance Service responded to a 999 call where Adult A had sustained a head injury following a fall in the Frimley area. He was taken to Frimley Park Hospital, but left before being seen.

2.65 Surrey Police encountered Adult A outside his home on 29 February 2012 whilst unsuccessfully trying to contact Adult B in connection with the accident involving her mother's car. Adult A stated that he was Adult B's partner and had slept in the car the night before the accident following an argument. He also said that there should be empty cans in the vehicle as he had been drinking. The police noted many cuts, bruises, bumps and swellings on Adult A's face, although none appeared to be new. Adult A said he had fallen over the night before and hit his face on the kerb. Adult A was reported to look very uncomfortable when standing and appeared unsteady on his feet. His upper torso was slouched forward making his stance even more unsteady.

2.66 In the morning of 1 March 2012, Adult A saw an old friend, Person 4, outside his parents' address in Aldershot. Adult A said that he left the flat early every day because, once Adult B started drinking, she would hit him. When asked why he put up with being hit by Adult B, Adult A responded that he had nowhere else to go and was looking for a one bedroom flat.

2.67 On 2 March 2012, South East Coast Ambulance Service responded to a 999 call at Adult A and Adult B's home address in Ash. CPR instructions were given to Adult B over the telephone as Adult A was reported to be not breathing. The attending ambulance crew declared Adult B to be dead at 03:44 due to rigor mortis being present and resuscitation efforts being futile. Surrey Police were contacted to report an incident involving the sudden death of Adult A.

2.68 Following the incident on 23 October 2010, the frequency of domestic incidents involving Adult A and Adult B reported to Surrey and Hampshire Police reduced significantly. In the 16 months leading up to his death, the only domestic incident involving the police was when Surrey Police responded to a call about a relatively minor argument at their home address on 9 February 2012. Rather than this being the result of the relationship between Adult A and Adult B becoming more harmonious, it seems more likely that this was due to episodes of violence no longer being reported.

2.69 At Adult B's trial, neighbours reported that they continued to hear arguments and shouting, predominantly by Adult B, emanating from their home several times a week. The arguments peaked about 18 months before Adult A's death and their nature led to some neighbours believing that their relationship had ended. Around this time, Adult A told his mother that he wished he was dead. From this point, the arguments mainly involved Adult B shouting and swearing about "how many times have I told you to get out", "leave me alone" and "why do I always let you back in". Arguments often ended with Adult A being thrown out of house late in the evening and him returning in the early hours.

2.70 To put this in context, it is worth noting the events of 1 March 2012 when Adult A was fatally attacked by Adult B. Neighbours overheard shouting for three or four hours, repeated threats by

Adult B to kill Adult A followed by loud bangs and then sudden silence, but did not consider this to be sufficiently out of the ordinary to warrant a call to the police.

2.71 Adult B admitted during her trial that she regularly hit Adult A with his walking stick. One such assault was witnessed by a neighbour some months before Adult A's death when Adult B also pushed him off a wall in front of their home. At least one walking stick had broken as a result of these assaults. Adult A also told Person 4 on the morning of the day of his death that Adult B hit him when she started drinking.

2.72 Adult A appears to have been sleeping on the sofa in the lounge of the flat for at least three months before his death. This would often involve him falling asleep in a drunken stupor. Adult B claimed that they were still in a relationship at the time of Adult A's death, but that she had wanted him to leave and get his own flat for some time. This is confirmed by conversations between Adult A and his parents, where he told them that it would be better for their relationship if he had a place of his own.

2.73 Adult A had submitted 40 unsuccessful applications for housing to councils between February 2010 and March 2011, but none since then. He had expressed frustration to his parents about his inability to secure a flat and his mother feels that he gave up because he thought he would never get one. However, he did say to Person 4 on 1 March 2012 that he was looking for a one bedroom flat, although there is no further evidence to substantiate this.

2.74 Adult A often visited his parents at their home in Aldershot after arguments with Adult B. He would always want to go back to his home in Ash and his mother would telephone Adult B, who would agree to Adult A returning. He told his mother on one occasion about two years before his death that Adult B had hit him. However, his mother believes that he did not do so again because she had confronted Adult B about this incident. She also felt that Adult A would have been embarrassed to say that he was regularly being hit by a woman.

2.75 As referred to previously, Adult A had suffered from stroke-like symptoms since November 2008 and experienced a weakness to the right side of his body. His health continued to deteriorate, particularly during the last two years of his life. His speech was slurred and he had restricted use of his right arm. His balance became much worse and he walked with a walking stick. He was unsteady on his feet, extremely so when drunk. He often fell over in public places and, when drunk, was not able to get up again without help. He also suffered liver problems associated with alcohol misuse. Neighbours would often hear Adult A falling over at home (causing the ceiling to shake). He always had facial injuries, including black eyes, cuts and bruises due to falls, fights and assaults by Adult B.

2.76 Adult A would drink around eight to ten cans of super-strength lager every day, starting early in the morning. He was rarely seen sober and would often be extremely drunk. He also took un-prescribed methadone and other illicit drugs when he could access them. Adult A and Adult B had both taken heroin a few days before the murder.

2.77 Fights between Adult A and Adult B had become increasingly one-sided, with Adult B becoming the main aggressor. In addition to the poor state of his health, Adult A was also a relatively slight man weighing 11½ stone (75kg), whereas Adult B was a large woman weighing 16½ stone (105kg). In these circumstances, if an assault ended with Adult A being drunk on the floor of the flat, which is highly likely, he would have had little opportunity to call the police. There was no landline telephone in the flat and Adult A did not own a mobile phone (he sometimes borrowed Adult B's). It would also have been difficult to alert any neighbour, which he had resorted to in the past, as he would not have been able to get up without assistance. This may partly explain the significant reduction in calls to the police in the last 18 months or so of his life.

2.78 In addition, following the assault on him by Adult B on 23 October 2010 where she hit him with a piece of wood and kicked him down the stairs, Adult A informed PC 1 of Surrey Police that Adult B hit him all the time, but always got away with it. No action was taken following this incident, partly because Adult A would not pursue a formal complaint. This was the last time that Adult A contacted the police to report an assault. It may be the case that Adult A stopped reporting incidents to the police as no positive action ever resulted. However, any lack of action was often due to Adult A's failure to support police investigations.

2.79 The same may be true of his neighbours, who had made previous calls to the police, but seen little change as a result. Added to this is their likely reluctance to become involved due to their fear of intimidation. This reason was given by neighbours for not wishing to become involved in the investigation of the incident on 30 November 2009 where Adult A had been arrested for criminal damage to the communal front door of his home address. They would also not engage with the investigation of the alleged assault on Adult A by Person 3 on 23 December 2009.

2.80 Whatever the case, the reduced reporting of alleged assaults and domestic incidents after October 2010 did not appear to reflect a cessation of violence or abuse in the relationship.

2.81 As referred to previously, relevant agencies have produced Individual Management Reviews (IMRs) in relation to this case and these form an important basis of this report. The objective of IMRs is to provide an accurate account of agencies' involvement with Adult A and Adult B, evaluate their actions and identify improvements for the future. In some cases, IMRs identify changes in practice implemented during the period under review to improve responses in cases of domestic abuse. All IMRs have been challenged robustly by the Panel and, where appropriate, subject to review and revision since their initial submission.

2.82 The following sections of this report analyse the responses of the agencies involved to significant and relevant events up to the date of Adult A's death on 2 March 2012. Where appropriate, this includes comments upon the appropriateness of actions taken (or not taken) and offers recommendations to ensure that lessons are learnt by relevant agencies. The Chair and Panel are keen to emphasise that these comments and recommendations are made with the benefit of hindsight and knowledge that the relationship between Adult A and Adult B would ultimately end in his murder.

3. SURREY POLICE

3.1 Adult A and Adult B both have extensive police records. Surrey Police's first contact with Adult A was in 1992, when he was arrested for the possession of an offensive weapon in a public place. Since then, he was arrested and charged on numerous occasions in Hampshire and Surrey for mainly theft, violence, criminal damage and public order offences. Adult A had a Police National Computer (PNC) record, with warnings for violence, ailment (alcoholic) and drugs. He had a local Surrey Police warning for domestic violence.

3.2 Adult B first came into contact with Surrey Police in 1986 for a shoplifting offence. Since then, the Police in Surrey and Hampshire have had extensive contact with Adult B for mainly, theft, drugs, fraud, violence and driving offences. She has a PNC record, with warnings for drugs and offending whilst on bail. She also has a local Surrey Police warning for domestic violence.

3.3 The focus of this analysis is on the involvement of Surrey Police with Adult A and Adult B after he moved in with her at her flat in Ash in February 2008.

Review of Involvement

Domestic Incident: 31 March 2008

3.4 An abandoned 999 call was initially made to the Hampshire Police Control Room from Adult A and Adult B's home address in Ash in which a great deal of shouting could be heard. The incident was transferred to the Surrey Police Contact Centre. The call handler made contact with Adult A, who stated that he was having an argument with Person 5 and Adult B. Officers attended the address, where Adult A informed them that he had dialled 999 by mistake. Adult A made no allegations and there were no injuries to any of those present. No further action was taken by Surrey Police.

Comment:

3.5 This was the first call made by Adult A to Surrey Police during his relationship with Adult B. The response was as would have been expected for this type of incident, with the call being immediately traced back to the caller. There was concern about the nature of the call due to the argument taking place in the background and, therefore, officers were deployed to the address.

Grievous Bodily Harm: 1 May 2008 (21:00)

3.6 A Surrey Police armed response vehicle was flagged down by an ambulance crew outside Adult A and Adult B's home address in Ash and informed that an assault had taken place inside. Officers had to force entry to the flat, where they found Adult A heavily drunk with a serious head injury. Adult A informed officers that he had been arguing with Adult B about her sleeping around. They had started fighting and ended up in the bathroom, where Adult B ripped the toilet seat from its brackets and hit Adult A across his head causing an injury. Adult A was treated by the attending paramedics and taken to Frimley Park Hospital. Adult B had left the property, but was located by targeted patrol officers and arrested on suspicion of inflicting grievous bodily harm on Adult A.

3.7 A Domestic Abuse Risk Indicator Questionnaire[2] was completed with Adult A by PC 2. Adult A provided six positive responses and was assessed as high risk in terms of the likelihood of further abuse.

3.8 The investigation was initially undertaken by DC 1, the duty detective for Guildford Criminal Investigation Department (CID) and then passed to the Public Protection Investigation Unit (West) during normal working hours. House-to-house enquiries were carried out at the other flats within the property. A scenes of crime officer and photographer attended and examined the scene of the alleged assault.

3.9 No independent witnesses were identified and Adult A declined to make a formal complaint. Adult B was interviewed and claimed that she had assaulted Adult A in self-defence after he had attacked her in their bedroom. It was recorded that Adult B had a black eye and grazing to her nose. She stated that she and Adult A were struggling to come off drugs (crack cocaine and heroin) and drank strong lager as a substitute. Adult B was bailed while further enquiries were carried out.

3.10 The incident was reviewed by DS 1 of the Public Protection Investigation Unit (West), who felt that without Adult A's support and the existence of a counter-complaint from Adult B, which the investigation could not disprove, there was no realistic prospect of a successful prosecution. Therefore, it was concluded that it was not in the public interest to pursue a conviction.

3.11 DS 1 recorded her concerns about the volatility of the relationship between Adult A and Adult B and directed that a 39/24 (Vulnerable Adult Coming to the Notice of Police)[3] form should be completed for Adult A due to his alcohol and drug dependencies. DS 1 also directed that the local police neighbourhood team should be made aware of the incident to enable any future tensions at the address to be monitored.

3.12 Adult A and Adult B were provided with contact numbers for domestic abuse outreach and victim support services. A Location of Interest (LOI) marker[4] was requested for the address and a Domestic Violence (DV) marker[5] was entered on the records of Adult A and Adult B on the Surrey Police Crime Information System. These markers would alert the police of the need to respond to subsequent incidents at their home address.

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[2]The Domestic Abuse Risk Indicator Questionnaire, introduced in October 2007, was a pro-forma comprising 17 questions designed to assist police staff in determining the level of risk to a victim of domestic abuse. Three positive responses to the questions should result in a high or very high risk grading. Two or more high risk incidents in a rolling 12 month period should be considered for referral to a MARAC (Multi Agency Risk Assessment Conference). A very high risk grading should result in an immediate referral to a MARAC. In October 2010, the Domestic Abuse Risk Indicator Questionnaire was replaced by the Domestic Abuse, Stalking and Honour Based Violence (DASH) form designed by CAADA (Coordinated Action against Domestic Abuse) and adopted nationally across the police service.

[3]A 39/24 form is used by Surrey Police to report contact with a child or vulnerable adult. This form has recently become known as an Adult at Risk form. The form is completed by an attending officer and forwarded to the relevant PPIU for review as to whether any further action is required and then shared with the Surrey County Council Contact Centre. Since April 2011, all completed 39/24s are forwarded to the Surrey Police Central Referral Unit (CRU) for review and sharing with partner agencies.

[4]A Location of Interest (LOI) marker is part of the internal flagging system used by Surrey Police. It is instigated by the investigating police officer if there is concern about an address (i.e. risk of future crime). The officer completes a LOI request form outlining their concerns, which is forwarded to the Surrey Police Contact Centre and entered on the Computer Aided Dispatch (CAD) system. The CAD records all emergency and non-urgent calls into the Contact Centre. A LOI Marker will automatically flag up on the CAD should there be any further calls from the address and should influence future call grading and the level of response. A LOI marker is in place for six months and is then reviewed by the officer who originally requested it to see whether the marker is still required.

[5] A Domestic Violence (DV) marker is similar to a LOI marker, except that this is put in place against named individuals (victim and perpetrator) on the Surrey Police Crime Information System (CIS).

Comment:

3.13 This was the first recorded incident of domestic abuse between Adult A and Adult B. As required in response to all domestic abuse incidents, a risk assessment questionnaire was completed with Adult A. This produced six positive responses and assessed Adult A as being at high risk of further domestic abuse.

3.14 National Policing Improvement Agency Guidance on Investigating Domestic Abuse (2008) states that all victims should be provided with contact numbers for outreach and victim support services as a minimum. Both Adult A and Adult B were given relevant contact details in response to this incident.

3.15 The high risk rating in response to this incident was appropriate in the circumstances given the seriousness of the event and the fact that it was the first recorded domestic incident between Adult A and Adult B. However, it is worth noting that, having mistakenly believed that Adult B lived in Aldershot, the Hampshire Police Domestic Abuse Coordinator concluded that Adult B should be referred to the Aldershot MARAC following this initial incident as it involved serious injuries. There was no such referral to the West Surrey MARAC[6].

3.16 Despite the direction by DS 1, it appears that a 39/24 (Vulnerable Adult Coming to the Notice of Police) form was not completed for Adult A. Surrey Police were not able to locate a copy of the form and Surrey County Council has no record of it being received. The completion of a 39/24 form would have alerted Surrey County Council and, subsequently, other relevant partners to pertinent safeguarding issues and enabled appropriate procedures to have been implemented.

3.17 In terms of the overall investigation, the police are able to undertake a third party prosecution in circumstances where the victim declines to cooperate with an investigation and the injuries sustained are sufficiently serious (amounting to actual bodily harm or more). This would normally be pursued in circumstances, for example, where the victim does not want to support an investigation through fear of repercussions by their partner. This did not appear to be the case in this incident, where both parties were claiming that they had been assaulted by each other, but neither would support an investigation. On this basis, the investigation by Surrey Police of the incident was appropriate and the decision not to pursue a prosecution was reasonable on the grounds that there was not a realistic prospect of securing a successful prosecution.

Domestic Incident: 9 June 2008 (19:30)

3.18 The Hampshire Police Control Room received a call from Adult A reporting that he had been assaulted by Adult B at their home in Ash. The incident was transferred to the Surrey Police Contact Centre. Adult A would not state why he was calling and put the phone down. The call handler immediately called Adult A back. He sounded extremely drunk, but stated that he had been involved in an argument with Adult B, but would not give any more details. Adult A requested that the police contact him the next day.

[6] A Multi Agency Risk Assessment Conference (MARAC) is a meeting where information about high risk domestic abuse victims (those at risk of murder or serious harm) is shared between local agencies. By bringing all agencies together at a MARAC, a risk focussed, coordinated safety plan can be drawn up to support the victim. In Surrey, there are currently four area based MARACs. The West Surrey MARAC covers the Guildford and Waverley borough areas. MARACs were established in Surrey in 2008. Each MARAC was chaired by the area Public Protection Investigation Unit (PPIU) Detective Inspector and had a coordinator, usually a PPIU Officer. From April 2011, responsibility for making MARAC referrals transferred from the area PPIU to the Central Referral Unit, which reviews all domestic incidents recorded on the Surrey Police Crime Information System (CIS), including those referred by PPIU supervisors. This centralisation of MARAC referrals provides greater consistency and continuity to the process. The chairing of Surrey MARACs also transferred from the area PPIU Detective Inspectors to the Central Referral Unit Detective Inspector.

3.19 An officer called Adult A on 10 June 2008 as requested and was informed that everything was now fine and that he did not need police assistance. The officer was concerned about Adult A's welfare in light of the previous incident on 1 May 2008 and wanted to check that all was in order. Adult A agreed to see Surrey Police officers at Aldershot Police Station later that day. Adult A attended the police station accompanied by Adult B and was seen by PC 3. Both Adult A and Adult B were drunk. They stated that they had had an argument, but that there had been no assault. They did not want to cooperate further and walked out of the police station. PC 3 noted that neither had any obvious recent injuries.

3.20 PC 3 completed a Domestic Abuse Risk Indicator Questionnaire based on his observations of Adult A. This was forwarded to PS 1 of the Public Protection Investigation Unit (West) for review. PS 1 assessed Adult A as being at medium risk of domestic abuse from Adult B based on there being no other incidents in the last 12 months.

3.21 The Public Protection Investigation Unit (West) sent a standard domestic violence letter to Adult A providing a crime reference number for the case, details of the officer dealing with the case and information about the support available to him, such as domestic abuse outreach and victim support services. This is standard practice by Public Protection Investigation Units.

3.22 As no formal allegation had been made by Adult A, the investigation was closed.

Comment:

3.23 As Location of Interest and Domestic Violence markers were in place, Surrey Police should have attended the address in response to Adult A's call, rather than acquiescing to his request to contact him the following day. In this case, the call handler was influenced by the fact that Adult A was extremely drunk and felt that it would be more appropriate for officers to speak to him the next day. However, Adult A was evidently sober enough to call 999 and report that he had been assaulted, so a police unit should have been deployed immediately.

3.24 Surrey Police did call Adult A back on 10 June 2008. Whilst the response could have been restricted to this telephone call, it is positive that, due to concerns about his welfare, PC 3 insisted that Adult A should meet him at Aldershot Police Station. However, it would have been more appropriate to have seen him at his home address to enable a better risk assessment to be undertaken.

3.25 It is good practice to complete a domestic abuse risk assessment at the time of initial contact with a victim. If this is not possible, officers should make a further early approach to the victim at a more suitable time. In cases where the victim is incapacitated through drink or drugs or refuses to participate, officers are trained to complete a risk assessment using their own observations and professional judgement, as demonstrated by PC 3 in this instance.

3.26 PS 1 of Public Protection Investigation Unit (West) made an error when reviewing the risk assessment on this occasion. PS 1 assessed Adult A as being at medium risk of domestic abuse on the basis that there had been no other incidents in the previous 12 months. Clearly, there had been an allegation of a serious assault on Adult A by Adult B on 1 May 2008. Had this incident been factored into the risk assessment, it would have been graded as high risk and would have met the criteria for referral to the West Surrey MARAC.

Domestic Incident: 14 July 2008 (23:05)

3.27 Adult A called the Surrey Police Contact Centre and requested that officers attend his home address. On arrival, officers found the front door to the flat open and Adult A and Adult B drunk inside. Adult A stated that an argument had taken place between them, but accepted that there had been no need to call the police on this occasion. A Domestic Abuse Risk Indicator Questionnaire was completed with Adult A. The attending officers warned Adult A and Adult B about calling the police unnecessarily.

3.28 At 23:59, the Surrey Police Contact Centre was contacted by the Hampshire Police Control Room advising that it had received a call from Adult B's mother to the effect that Adult B had locked herself in the toilet at her home in Ash and was covered in blood. Surrey Police called an ambulance to the address and a second police unit was deployed, which arrived at 00:15. Officers had to wake the occupants of the property. Neither Adult A nor Adult B was aware of why the police had been called. There was no evidence of a disturbance, neither had sustained any obvious injuries and no allegations were made. Surrey Police contacted Adult B's mother and provided reassurance that all appeared to be in order at the address. It seems probable that Adult B called her mother during the earlier argument with Adult A and that her mother then delayed her call to the police.

3.29 In the circumstances, the officers did not consider that it was necessary to remove either Adult A or Adult B from the property as there were insufficient grounds to justify an arrest.

3.30 The domestic abuse risk assessment and incident report were reviewed by PS 1 of Public Protection Investigation Unit (West). PS 1 assessed Adult A as being at high risk on the basis of two positive responses to the questionnaire and there being three domestic abuse incidents, including one of alleged grievous bodily harm, in the last three months.

3.31 DC 2 of Public Protection Investigation Unit (West) made contact with Adult A, who maintained that he did not want to make a formal complaint. He was offered referrals to domestic abuse outreach and victim support services, but declined. As there was no formal complaint from Adult A, the case was closed.

Comment:

3.32 Although the incident on 1 May 2008 that PS 1 had previously overlooked was considered in this latest assessment, the case was still not referred to the West Surrey MARAC despite the relevant criteria being met.

Domestic Incident: 14 August 2008 (23:05)

3.33 Neighbour 1 called Surrey Police to report that an argument was taking place between Adult A and Adult B at the address. It had started outside and continued into the communal stairwell. Neighbour 1 reported that Adult A had broken a panel on the communal front door to the flats.

3.34 Officers attended the incident and located Adult B inside the flat. She informed them that she was going to stay with her mother in Aldershot. Adult A was found in the street outside the property and he explained that he was on his way to Aldershot. The police took Adult A to his parents' address in Aldershot and warned him to keep away from Adult B.

3.35 No injuries were seen on either Adult A or Adult B. PC 4 completed a Domestic Abuse Risk Indicator Questionnaire with Adult B and she provided four positive responses. Adult B stated that she was not frightened of Adult A and that she did the same back to him. Adult B was

assessed as being at very high risk. Adult B informed PC 4 that she did not want the police to make any further contact with her.

3.36 The risk assessment and incident report were reviewed by PS 1 of Public Protection Investigation Unit (West). PS 1 agreed with the very high risk rating and detailed PC 5 to continue the investigation. Despite Adult B not wanting any further contact with the police, PS 1 directed that she should be visited and offered support services. PC 5 visited Adult B on 15 August 2008. She declined all support services and informed the officer that she was still with Adult A and, if he hit her, she would give as good as she gets. As there was no formal complaint from Adult B, the investigation was closed.

Comment:

3.37 The very high rating on the domestic abuse risk assessment should have triggered a referral to the West Surrey MARAC for Adult B. However, no referral was made.

3.38 Taking Adult A to his parents' address placed him in breach of his restraining order, which prohibited him from entering the road in Aldershot. However, the attending officers would have been unaware of the existence of this order as it was not recorded appropriately by Hampshire Police on his Police National Computer (PNC) record. Recommendations are included in this review to address weaknesses in the recording of restraining orders by Hampshire Police.

Actual Bodily Harm: 26 September 2008 (17:05)

3.39 The Surrey Police Contact Centre was called by the South East Coast Ambulance Service Control Room to report that an ambulance was at Adult A and Adult B's home in Ash attending to a head injury sustained by Adult A. Adult A had stated that Adult B had hit him with an ashtray. Officers attended the address.

3.40 Adult A was heavily drunk and paramedics felt that he had also been taking drugs. Adult A was refusing medical assistance and stated that he was going to stay with his parents in Aldershot. PC 6 completed a Domestic Abuse Risk Indicator Questionnaire with Adult A. Being drunk, Adult A gave yes or no answers to the questions. He provided six positive responses, including that the abuse was becoming worse and happening more often, and he was assessed as being at very high risk. Officers seized a knife, a glass ashtray and clothing at the address. Adult B was not at the flat, but was quickly located and arrested for assault.

3.41 The investigation was taken over by DS 2, who interviewed Adult B. She stated that they had been drinking and Adult A had threatened her with a knife. She had pushed him out of the way and he had lost his balance and fallen into a door. She claimed that Adult A already had an injury to his head and that the impact of the fall had knocked the scab off. She acknowledged that she had a drink problem and indicated that this was being addressed by 'DV officers' (police officers specialising in domestic violence). Adult B was bailed pending further enquiries.

3.42 DS 2 tried on a number of occasions to contact Adult A to see if he wanted to make a formal complaint. Due to his lack of engagement, DS 2 decided to close the investigation. This decision was supported by DI 1 of Public Protection Investigation Unit (West). Adult B's bail was cancelled and the investigation was closed. Adult A could not be contacted to offer support services, but a standard domestic violence letter was sent to him.

Comment:

3.43 The response by the targeted patrol officers was as would have been expected for this type of domestic incident. PC 6 did record on the crime report that, due to there being no other targeted patrol officers available to assist them, they had to deal with both the victim and suspect. PC 6 acknowledged that this was not good practice due to the possible contamination of evidence, but was unavoidable in the circumstances. The priority had been to arrest Adult B to preserve evidence and ascertain whether she too had sustained any injuries and required medical attention.

3.44 DS 2 could have had the ashtray examined forensically to see if it had been used by Adult B to cause the injury to Adult A's head. However, without the cooperation of Adult A, it would have been difficult to obtain medical evidence to prove the cause and degree of injury. DS 2 closed the case when he was unable to contact Adult A to confirm whether he wished to make a formal complaint. On the basis of previous experience, it is considered unlikely that Adult A would have cooperated if contact had been made.

3.45 This incident occurred at the weekend. At that time, Public Protection Investigation Units did not operate at weekends and, therefore, incidents were usually investigated by CID or the Prisoner Investigation Unit. Since April 2010, weekend cover has been provided by the Public Protection Investigation Units. Records indicate that an initial risk assessment was undertaken by PC 7, who decided that, in view of the number of positive responses given by Adult A to the questionnaire and there being three other recorded incidents in the last 12 months, the case should be classified as very high risk. This risk assessment does not appear to have been reviewed by a Public Protection Investigation Unit Supervisor and, as such, no consideration was given to referring Adult A to the West Surrey MARAC. It has not been possible to establish why this review was overlooked, but it was another missed opportunity to make a referral in response to a very high risk rating.

Actual Bodily Harm: 28/29 September 2009

3.46 At 19.20 on 28 September 2009, Neighbour 2 contacted Surrey Police to report that a male neighbour (Adult A) was banging on her door and was very drunk. She was concerned that Adult A would damage her property. Neighbour 2 also stated that she thought that the male had been arguing with his partner at their flat. It was not possible to deploy a police unit to attend immediately as all targeted patrol team officers were otherwise engaged on priority incidents.

3.47 At 20:36, an officer telephoned Neighbour 2 and was informed that Adult A had been taken to hospital by ambulance with a facial injury. An officer contacted Frimley Park Hospital and was informed that Adult A was in attendance. There was no indication that Adult A had been assaulted and, as no criminal offences were apparent, no further action was taken by Surrey Police at this stage.

3.48 At 00.14 on 29 September 2009, Neighbour 1 contacted Surrey Police to report that her neighbours [Adult A and Adult B] had been having an argument for the last hour, with lots of shouting and banging. Officers attended the address. Both Adult A and Adult B were extremely drunk. Adult A had facial injuries (possible broken nose, laceration under the left eye and bruising and swelling around the right eye) and stated that Adult B had beaten him with his walking stick. Adult B stated that Adult A had sustained his injuries when he fell over in Aldershot several days earlier. Adult B was arrested at 01:00 and taken to Woking Custody Centre. An ambulance was called by the police and Adult A was taken to Frimley Park Hospital for treatment for a second

time that night. A Domestic Abuse Risk Indicator Questionnaire was not completed due to Adult A's intoxication.

3.49 The incident was reviewed by DS 3 of Public Protection Investigation Unit (West). Based on this incident and the previous domestic abuse history, Adult A was assessed as high risk. The investigation was allocated to PC 8 of Public Protection Investigation Unit (West) to continue.

3.50 PC 8 interviewed Adult B, who denied the assault stating that Adult A had sustained his head injury during a fight with another male in a local park over a week ago. She claimed that Adult A would pick at his wounds causing them to re-open. Adult B was bailed pending further enquiries.

3.51 Adult A was located by PC 8 in a park at St Michael's Road, Aldershot. He was very drunk and barely able to speak, so it was not possible to complete a Domestic Abuse Risk Indicator Questionnaire. Adult A stated that he was a heroin user and had not collected his methadone prescription. He was adamant that Adult B had caused his injuries and signed PC 8's notebook to this effect. Whilst speaking to PC 8, Adult A became quite animated and upset over the situation.

3.52 PC 8 left Adult A in the park and made enquiries at Aldershot Police Station to see if Adult A had been involved in an assault in a park as alleged by Adult B. Hampshire Police confirmed that officers had attended an incident on 23 September 2009 after a member of the public reported that two males were fighting over a walking stick. The Hampshire Police report recorded that Adult A had a cut to his face, which he said he had sustained from a fall. PC 8 also made enquiries at a shop near to where the incident took place and a member of staff who knew Adult A confirmed that he had seen him with facial injuries during the previous week.

3.53 PS 1 of Public Protection Investigation Unit (West) reviewed the investigation and, as it could not be discounted that Adult A had sustained his injuries in an earlier incident and there were no independent witnesses to the alleged assault, the investigation was filed as a 'no crime'. A standard domestic violence letter was sent to Adult A at his parents' address. Adult B's bail was cancelled.

Comment:

3.54 The initial call from Neighbour 2 did not indicate that Adult A had sustained any injuries as a result of an assault. The officer who contacted Neighbour 2 recorded that Adult A's injuries were the result of him falling whilst drunk. However, South East Coast Ambulance Service records state that his injuries were caused by his girlfriend assaulting him with a stick and this information was conveyed to Frimley Park Hospital on handing over Adult A. This information was not passed to Surrey Police by either agency.

3.55 In relation to the investigation of the second incident, the case was filed as a 'no crime' as Surrey Police could not discount the fact that Adult A had sustained his injuries in an incident on 23 September 2009 in Aldershot. However, a number of elements in this particular incident suggest that the investigation could have been pursued more robustly:

(a) the domestic incident was reported by a neighbour, who had heard shouting and banging emanating from Adult A and Adult B's flat for an hour;

(b) the injuries incurred by Adult A on 28 September 2009 were considered to be sufficiently serious for him to be taken by ambulance to Frimley Park Hospital on two separate occasions that evening; and

(c) Adult A remained adamant that he had been assaulted by Adult B and had signed PC 8's police notebook to that effect.

3.56 PC 8 never went back to Adult A to see if he would make a formal statement and to discuss the potentially controvertible evidence that he had sustained his injuries in a previous fight in Aldershot. PC 8 should have arranged to meet Adult A either at his home or a police station to determine whether he would make a statement and to challenge the evidence about how he had sustained his injuries.

3.57 No domestic abuse risk assessment was completed in relation to this incident due to Adult A's intoxication. However, in cases where the victim is incapacitated through drink or drugs, officers are trained to complete a risk assessment using their own observations and professional judgement. This should have happened.

3.58 Adult A should already have been referred to the West Surrey MARAC by this time. Although the previous domestic incident had taken place on 26 September 2008 (just over 12 months previously), this was another opportunity for a MARAC referral to be considered and, in view of the violent nature of the alleged assault and history of abuse, this course of action should have been pursued.

Domestic Incident: 23 November 2009 (20:15)

3.59 Adult B contacted Surrey Police to report an argument with Adult A. He had apparently knocked over a vase causing it to smash after he had accused Adult B of sleeping around. Adult B indicated that Adult A was drunk.

3.60 Officers attended the incident. Adult A had left the property. Adult B did not want to make a formal allegation as she had not been assaulted. She was drunk and drinking a can of lager when the police arrived. A Domestic Abuse Risk Indicator Questionnaire was completed with Adult B. She provided five positive responses, including that she was scared of Adult A when he drinks as they argue and she thinks he might assault her.

3.61 The risk assessment and incident report were reviewed by DS 3 of Public Protection Investigation Unit (West), who assessed Adult B to be at high risk due to the number of positive responses and there being one repeat incident in the last 12 months. DS 3 directed that early contact was to be made with Adult B and that she should be offered support services.

3.62 IO 1 contacted Adult B by telephone. She stated that she had not seen Adult A since the incident, but she thought that their relationship would continue. She was only annoyed about his drinking. She accepted the offer of support from the domestic abuse outreach service. IO 1 sent the referral to the outreach service on 24 November 2009. There being no formal allegation, the investigation was closed.

Comment:

3.63 On the basis of DS 3's review, which assessed Adult B as being at high risk due to the number of positive responses and there being one repeat incident in the last 12 months, this incident met the criteria for a referral to the West Surrey MARAC.

Criminal Damage: 30 November 2009 (21:30)

3.64 Neighbour 1 contacted Surrey Police to report that Adult A was kicking the communal door down. Officers attended the address and spoke to Adult B. She stated that she had been involved in an

argument with Adult A after he had accused her of sleeping with their friend, Person 3. Adult B stated that Adult A had then started kicking and punching the front door to the flats. She stated that she had ended her relationship with Adult A and did not want him back. The incident had apparently been witnessed by Person 3. PC 9 completed a Domestic Abuse Risk Indicator Questionnaire with Adult B. She provided seven positive responses to the questions.

3.65 Adult A was located and arrested for criminal damage. He was very drunk. Once sober, he was interviewed and gave no comment responses to the questions put to him. He was bailed until 5 January 2010.

3.66 The risk assessment and incident report were reviewed by DS 3 of Public Protection Investigation Unit (West), who assessed Adult B as being at very high risk due to the number of positive responses given and as this was the fourth incident within the last 12 months. The investigation was continued by PC 10 of Public Protection Investigation Unit (West).

3.67 Neighbour 1 did not want to provide a witness statement and none of the other residents contacted in the neighbouring flats would get involved due to fear of intimidation. Person 3 could not be contacted and the landlord of the property was not identified. Adult B informed PC 10 that she was back with Adult A and had not seen him cause the damage to the door, signing a statement to this effect.

3.68 The investigation was reviewed by DS 4 of Public Protection Investigation Unit (West), who decided that the case should be closed as there was no formal complaint and there were no witnesses as to how the damage was caused.

Comment:

3.69 This incident was classified by Surrey Police as "criminal damage". This resulted in the investigation focusing on the minor damage to the door caused by Adult A. However, the incident had been triggered by an argument between Adult A and Adult B and, therefore, a more appropriate classification might have been "non-crime domestic incident", as used in the similar previous incident on 14 August 2008. The damage to the door could then have been one aspect of a domestic incident investigation, rather than the main focus. This should have been identified by one of the Public Protection Investigation Unit (West) supervisors.

3.70 There was no referral to the West Surrey MARAC for Adult B despite the very high risk rating and there is no record of any support services being offered. DS 3 also appears to have been confused as to the method for identifying the number of repeat incidents within the previous 12 months. In this case, three previous incidents were taken into account. However, when reviewing the incident on 23 November 2009, only one week earlier, DS 3 had identified only one previous case. Perhaps due to the classification of this incident, the minimum requirement of providing Adult B with details of support services was not fulfilled on this occasion.

Grievous Bodily Harm: 23 December 2009 (23:19)

3.71 The Hampshire Police Control Room contacted the Surrey Police Contact Centre to report that it had received a call from Adult B's mother to the effect that a male had forced his way into Adult A and Adult B's flat, ripped Adult B's clothes off and there was blood all over the place. Officers were deployed to the address where Adult B informed them that Adult A had been assaulted by Person 3 at the flat. Adult A was found in the living room of the property with a laceration to his neck, swelling to his right eye and a laceration to his right hand. Adult B had minor reddening and scratches to her upper right arm. Both were extremely drunk.

3.72 Adult B stated that Person 3 had attacked Adult A using a wooden pole and scissors after Adult A had accused him of sleeping with her. She made no allegations about having her clothes ripped off and was fully clothed when officers arrived. Person 3 had left the flat prior to the police arriving. The police called an ambulance and both Adult A and Adult B were taken to Frimley Park Hospital. Adult A received six stitches to his neck injury and surgical glue was applied to his other lacerations. Adult B did not require any medical treatment.

3.73 Person 3 was located at his home in Ash. There was initially no answer when the police arrived, but blood on the door lock prompted concern for Person 3's welfare and officers forced entry to the flat. Person 3 was lying on a sofa in an unconscious state with his head and hair covered in blood. Officers administered first aid to cuts on Person 3's head. An ambulance was called, but Person 3 became obstructive and refused to go to hospital. Person 3 was arrested on suspicion of causing grievous bodily harm and taken to the Royal Surrey County Hospital.

3.74 More police officers were deployed to Adult A and Adult B's home address to cordon and preserve the scene of the assault and seize any relevant exhibits, including the wooden pole and scissors used to attack Adult A. House-to-house enquiries were carried out at the neighbouring flats, but there were no independent witnesses as none of the neighbours wanted to get involved. A police photographer attended and photographed the scene. Photographs were also taken of the injuries sustained by Adult A and Adult B and the blood smears around the lock on Person 3's front door. Officers seized Person 3's clothing at the hospital and also took hand swabs from him for comparison with the recovered wooden pole and scissors.

3.75 The investigation was taken over by Guildford CID. However, despite the considerable injuries he had sustained, Adult A did not want to make a formal complaint against Person 3. He would also not provide medical consent to enable officers to obtain formal evidence of his injuries from a doctor, which would have enabled a third party prosecution to be considered. During interview, Person 3 refused to answer questions and did not make a counter-complaint.

3.76 The investigation was reviewed by DC 3 of Guildford CID, who decided that, as there were no formal allegations and no independent witnesses, the investigation should be filed. The case was reviewed by DI 2, who approved the decision, and the case was filed as undetected.

Actual Bodily Harm: 19 May 2010 (23:10)

3.77 Adult A called Surrey Police to report that Adult B had hit him following an argument about a cat and the amount of alcohol that they had consumed that day. Officers attended the incident at Adult A and Adult B's home address and found them both heavily drunk. Adult A stated that Adult B had hit him and showed the officers a small scratch under his chin. However, he stated that he did not want to make a formal complaint and wanted to be left alone with Adult B. He signed PC 11's notebook to this effect. When the officers explained to Adult A that, in the light of what he had told them, he would not be able to stay with Adult B, he became angry.

3.78 It was difficult for PC 11 to go through the Domestic Abuse Risk Indicator Questionnaire with Adult A as he restricted his answers to yes or no. Adult B informed the officers that she and Adult A had been arguing, but did not mention any physical contact between them. Adult B informed the officers that she would go and stay with her mother as Adult A had nowhere else to go. Adult B was taken to her mother's address in Aldershot.

3.79 The incident report and risk assessment were reviewed by DS 3 of Public Protection Investigation Unit (West). Adult A was assessed as being at very high risk based on four positive responses and three repeat incidents in the previous 12 months. DS 3 directed that Adult A should be advised about the support services available and asked whether he wished to make a formal complaint.

3.80 Adult A was visited by PC 12 on 20 May 2010 and declined to make a formal complaint. PC 12 submitted a referral to the domestic abuse outreach service for Adult A on 20 May 2010, despite the fact that Adult A had declined the offer of support. As there was no formal allegation to investigate, the case was closed.

Comment:

3.81 Again, despite Adult A being rated as being at very high risk, the case was not referred to the West Surrey MARAC. PC 12 was proactive in referring Adult A to outreach services without his consent. However, no subsequent attempt was made to establish whether Adult A had engaged with the support available. In this instance, the domestic abuse outreach service was unable to make contact with Adult A.

Concern for Safety: 25 September 2010

3.82 Adult A called Surrey Police in an extremely drunken state. The call handler recorded that it was not clear whether he was reporting that he had been fighting with his girlfriend or whether someone was unwell. As there was a Location of Interest marker in place for the address, Surrey Police deployed a police unit to attend. Officers found Adult A at home and recorded that he was drunk to the point of vomiting. No further action was taken

Comment:

3.83 No further information about this incident was recorded by Surrey Police. Adult A would appear to have been left in the company of Adult B, although there is no direct reference to her being present in the record of this incident. However, there was no evidence that any offence had been committed and no allegations were made.

Common Assault: 18 October 2010 (20:51)

3.84 Adult B called 999 and was put through to the Hampshire Police Control Room. She reported that she had had an argument with Adult A over methadone. Adult B stated that Adult A had become aggressive towards her and that she had pushed him off the bed. Adult B wanted Adult A to leave the flat. The Hampshire Police Control Room immediately transferred the incident to the Surrey Police Contact Centre. Officers attended Adult A and Adult B's flat and found them both to be heavily drunk. The officers took Adult A to his mother's address in Aldershot.

3.85 PC 13 completed a DASH (Domestic Abuse, Stalking and Honour Based Violence) checklist with Adult B. (As referred to previously, the DASH form replaced the Domestic Abuse Risk Indicator Questionnaire in October 2010.) Adult B indicated that Adult A had threatened to kill her, but that she did not know whether to believe him. She stated that Adult A had drug and alcohol dependencies and had problems with leading a normal life. Adult B also stated that she put Adult A in his place and was not afraid of him. Based on the number of positive responses to the DASH form, PC 13 rated Adult B as being at standard risk of further domestic abuse. However, PC 13 also felt that Adult B should be referred to the West Surrey MARAC and indicated this on the checklist.

3.86 The incident report and DASH checklist were reviewed by DS 4 of Public Protection Investigation Unit (West). DS 4 agreed the standard risk grading but, despite PC 13's recommendation, the case was not referred to the West Surrey MARAC as the incident was not deemed to be high risk under the new DASH assessment process.

3.87 As no injuries had been sustained by Adult A or Adult B, there were no independent witnesses and Adult B did not want to make a formal complaint, the investigation was filed.

Comment:

3.88 The officers attending the incident took positive action by removing Adult A from the flat. However, as mentioned previously, taking Adult A to his parents' address placed him in breach of his restraining order.

3.89 Given the previous history of domestic incidents and Adult B's references to threats to kill, alcohol and drugs, the standard risk assessment rating comes as a surprise and was not borne out by the more serious incident only five days later. The definitions used under the new procedure are as follows:

- Standard Risk – Current evidence does not indicate likelihood of causing serious harm.

- Medium Risk – There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm, but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse.

- High Risk – There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact could be serious.

3.90 PC 13 appeared to recognise this, as despite the standard rating, he still concluded that the case should be referred to the West Surrey MARAC. This course of action was not pursued by DS 4 and no further advice or support appears to have been offered to Adult B.

Actual Bodily Harm: 23 October 2010 (22:00)

3.91 Neighbour 3 contacted Surrey Police to report that Adult A had knocked on her door with injuries to his head. He informed her that Adult B had hit him over the head with a piece of wood. Officers attended the incident and located Adult A. He was very drunk and became distressed when spoken to. He stated that Adult B had hit him over the head with a lump of wood and had kicked him, which caused him to fall down the stairs. He had a number of injuries to his head and the police called an ambulance. Adult A was taken to Frimley Park Hospital for treatment. Adult B was arrested for assault. She stated that she had been drinking since 10:00 that morning.

3.92 Due to the circumstances, a DASH form was not completed with Adult A. PC 1 completed the DASH checklist based on the little information she had and the previous history between Adult A and Adult B. Adult A informed PC 1 that Adult B hit him all the time and he kept bursting into tears. Adult A stated that he was going to see his GP on 27 October 2010 and was hoping to be referred to the Acorn Drug and Alcohol Service, which Adult B already attended. He stated that he was going to go to the Phoenix Drop-In Centre (a centre for drug and alcohol support) in Aldershot.

3.93 PC 1 graded Adult A as being at medium risk. The officer also completed a Vulnerable Adult (39/24) form for Adult A, which was forwarded to the Public Protection Investigation Unit (West) for review and sharing with partner agencies. The DASH checklist recorded that PC 1 discussed MARAC with Adult A, but he declined to consent to sharing information with partner agencies.

3.94 The incident report, DASH checklist and 39/24 form were reviewed by DS 1 of Public Protection Investigation Unit (West). DS 1 directed that Adult A should be offered advice and support. PC 12

of Public Protection Investigation Unit (West) subsequently visited Adult A and discussed the specialist support available. Adult A declined referrals to domestic abuse outreach or victim support services.

3.95 Adult B was interviewed and denied hitting or kicking Adult A. Adult A would not make a formal complaint against Adult B. As there were no independent witnesses or medical evidence with which to consider a third party prosecution, the investigation was closed.

Comment:

3.96 In view of the degree of violence used and as the DASH risk assessment had been completed using an officer's own professional judgement, this incident should have been graded as high risk. In fact, having further researched the background of Adult A and Adult B, PC 1 recorded on the crime report and 39/24 form completed for Adult A that, despite the medium risk rating, she now felt that Adult A was at high risk. The change of grading was not added to the DASH form.

3.97 The crime report was subjected to a final review by DS 1 of Public Protection Investigation Unit (West). However, the change in the risk assessment rating did not lead to any further action. Bearing in mind the previous incidents, including one only five days earlier, this case clearly met the criteria for referral to a MARAC.

3.98 PC 1 completed an informative 39/24 form for Adult A as she rightly felt that he was vulnerable due to his drug and alcohol abuse. The 39/24 form was shared with Surrey County Council on 25 October 2010, whose response in discussed later in this report.

Domestic Incident: 9 February 2012 (00.01 a.m.)

3.99 Neighbour 4 contacted Surrey Police to report an argument between Adult A and Adult B. Officers were deployed to the incident and established that Adult A and Adult B had got into an argument over a cat. Adult B had told Adult A to leave the flat. Adult B stated that she thought he was making his way to Aldershot. A DASH checklist, which due to Adult B's intoxication contained only basic information, was completed by PC 14, who graded Adult B as being at standard risk.

3.100 The DASH form and incident report were reviewed by PS 1 of Public Protection Investigation Unit (West), who agreed the standard risk rating and directed that the investigation could be filed as no allegations had been made by Adult B.

Comment:

3.101 This was the first reported domestic incident between Adult A and Adult B in over 15 months and the last before Adult A's murder by Adult B on 2 March 2012.

Analysis of Involvement

3.102 There were no prosecutions in response to any of the 15 incidents recorded between Adult A and Adult B. In 13 cases, the relevant party would not make a formal complaint or support an investigation. In the other two cases, it was not properly established whether the alleged victim would be prepared to pursue a formal complaint. In the majority of cases, there were no witnesses for the police to consider a third party prosecution. Where witnesses were identified, they did not want to get involved through fear of intimidation from either Adult A or Adult B or both.

3.103 The review has revealed a number of areas where the actions of Surrey Police did not meet required standards. In particular, there were repeated failures to follow approved procedures for dealing with cases of domestic abuse. The vulnerability of Adult A also appears to have gone largely unnoticed or ignored and certainly was not acted upon. The response of Surrey Police is analysed in more detail in the following paragraphs.

Initial Response by Surrey Police

3.104 Following the incident on 1 May 2008, a Location of Interest marker was placed against Adult A and Adult B's home address in Ash and a Domestic Violence marker was entered on the records of Adult A and Adult B. In 11 of the subsequent 13 incidents, police officers were deployed to the address in response to calls. The exceptions were the incidents on 9 June 2008 and 28 September 2009.

3.105 In the first, on 9 June 2008, Adult A had called the Hampshire Police Control Room and reported being assaulted by Adult B at their home. This was transferred to the Surrey Police Contact Centre and the call handler agreed that Surrey Police would contact Adult A the next day. As Location of Interest and Domestic Violence markers were in place, officers should have been deployed immediately in response to this incident.

3.106 In the second, on 28 September 2008, Neighbour 2 contacted Surrey Police to report that a male neighbour (Adult A) was banging on her door and was very drunk. The initial call from Neighbour 2 did not indicate that Adult A had sustained any injuries as a result of an assault. It was not possible to deploy a police unit to attend immediately as all targeted patrol team officers were otherwise engaged on priority incidents. The officer who subsequently contacted Neighbour 2 recorded that Adult A's injuries were the result of him falling whilst drunk.

3.107 Of the incidents to which Surrey Police officers were deployed, positive initial action was taken, where required, in the form of arranging medical treatment if necessary, arresting or removing either Adult A or Adult B from the address and commencing an investigation. However, it should be noted that, following the incidents on 14 August 2008 and 18 October 2010, this involved taking Adult A to his parents' address in Aldershot, which placed him in breach of his restraining order. Officers would have been unaware of the existence of this order due to deficiencies in the way it was recorded on Adult A's Police National Computer (PNC) record by Hampshire Police. This is discussed later in this report and recommendations have been included to address this concern.

3.108 Adult A and Adult B appear to have been left together at their home following relatively minor incidents on 14 July 2008 and 25 September 2010. In these cases, the officers justifiably took this course of action as there were no signs of injury, no allegations were made and there were no reasonable grounds to make an arrest.

3.109 In response to all but two of the incidents, a Domestic Abuse Risk Indicator Questionnaire or later DASH checklist was completed with the victim or on their behalf if they were incapacitated through drink or drugs or refused to cooperate. The exceptions were the second incident on 28 September 2009 and the incident on 25 September 2010. In the first case, an assessment should have been completed by officers themselves using their professional judgement due to Adult A's intoxication. In the second, there was no evidence or allegations of any domestic abuse and a risk assessment was not required.

Public Protection Investigation Unit Review, Risk Assessments and Investigation

3.110 With the exception of the incident on 26 September 2008, all cases that were deemed to be domestic incidents or assaults between Adult A and Adult B were reviewed by the duty Detective Sergeant (DS) of Public Protection Investigation Unit (West). Any lines of enquiry were identified, annotated on the corresponding crime report and allocated to a Public Protection Unit Investigator (Detective Constable, Police Constable or Investigating Officer) to complete. It has not been possible to establish why no review took place in relation to the incident on 26 September 2008.

3.111 In most incidents, neither Adult A nor Adult B would make a formal complaint. Investigators considered third party prosecutions, particularly where the degree of injury sustained amounted to serious harm and actively sought independent witnesses to support this process. However, any potential witnesses that were identified declined to make statements through fear of intimidation from Adult A or Adult B. Medical evidence relating to the injury sustained is also key to any criminal prosecution for an assault charge and neither Adult A nor Adult B would provide written consent for the police to obtain such evidence. In most cases, this left the Public Protection Investigation Unit (West) Supervisors with little option other than to close investigations.

3.112 The exceptions to the above circumstances were the responses to the incidents on 26 September 2008 and 28 September 2009. In the former case, Adult A could not be contacted to determine whether he wished to pursue a formal complaint that Adult B had assaulted him with an ashtray. In the latter case, Adult A remained adamant that Adult B had assaulted him with his walking stick and signed PC 8's notebook to that effect, but no attempt was made to contact him as part of the investigation to determine whether he would be prepared to make a formal statement. These incidents suggest a certain lack of vigour in pursuing prosecutions but, on the basis of previous experience, it seems unlikely that Adult A would have cooperated fully with any investigation and successful prosecutions would have been difficult to secure.

3.113 Other than for the incident on 26 September 2008, all completed Domestic Abuse Risk Indicator Questionnaires and DASH checklists were examined by the duty Public Protection Investigation Unit Supervisor and graded in terms of the level of risk in accordance with the relevant criteria.

3.114 Eight out the nine incidents for which Domestic Abuse Risk Indicator Questionnaires were completed rated the risk as being high (4) or very high (4) and recorded that there had been two or more incidents within the previous 12 months. However, none of the four Public Protection Investigation Unit (West) Supervisors who reviewed the incidents directed that a referral should be made to the West Surrey MARAC. This undermines the value of completing risk assessments because high and very high risk cases were not subjected to any proper risk management processes. It also raises the question as to whether Public Protection Investigation Unit Supervisors understood the MARAC referral procedure.

3.115 From memory, DS 3 suggested that that there had been confusion about the previous Domestic Abuse Risk Indicator Questionnaire system and that it was very subjective. In DS 3's view only recordable offences were included when determining how many previous incidents were factored into the MARAC referral criteria. This means that non-crime domestic incidents would be subject to the risk assessment process, but would not be counted as qualifying incidents for possible MARAC referrals. This is an peculiar interpretation as, by their very nature, non-crime domestic reports contain valuable information and intelligence about a relationship and have always been included in any risk assessment process.

3.116 Having revisited the four incidents that he reviewed, PS 1 advised that he was satisfied with the risk assessment ratings he made at the time. However, PS 1 accepts that his assessment of Adult

B as being at very high risk following the incident on 14 August 2008 should have resulted in a referral to MARAC. PS 1 could not recall why he did not follow this course of action in connection with this incident or others meeting the MARAC criteria and accepted that these were errors on his part. PS 1 was a Police Sergeant undertaking a detective learner programme (to become a Detective Sergeant) at the Public Protection Investigation Unit when he reviewed these incidents and it is possible that he was being guided by other supervisors who did not fully understand the Domestic Abuse Risk Indicator Questionnaire process.

3.117 The Domestic Abuse Risk Indicator Questionnaire method of assessment was based on the number of positive responses given to questions and the number of domestic incidents in the previous 12 months. The threshold for meeting the MARAC qualification criteria was relatively low and had the potential for a large number of cases to be referred. This may have contributed to what appears to be a rather ad hoc system of risk assessments by Public Protection Investigation Unit (West) Supervisors. However, this does not explain the apparent lack of knowledge and awareness of risk assessment procedures, both under the previous Domestic Abuse Risk Indicator Questionnaire system and current DASH checklists, unveiled by this review.

3.118 Surrey Police adopted the Association of Chief Police Officers (ACPO) approved DASH risk assessment system in October 2010. The new system was designed to remove some of the subjectivity around risk assessments using a clearer and more realistic scoring system to identify high risk and repeat victims.

3.119 Surrey Police responded to three incidents involving Adult A and Adult B after the implementation of the DASH risk assessment process. The following summarises the position in relation to the DASH checklists:

(a) On 18 October 2010, PC 13 rated Adult B as being at standard risk, but also indicated on the checklist that he felt that the case should be referred to the West Surrey MARAC.

(b) On 23 October 2010, PC 1 completed a checklist on behalf of Adult A, who was intoxicated, and rated him as being at medium risk. In view of the level of violence used and the fact that the checklist had been completed by a police officer, this incident should have resulted in a high risk rating. PC 1 subsequently recorded this on the crime report, but no further action was taken by DS 1 of Public Protection Investigation Unit (West) when reviewing the case.

(c) On 9 February 2012, PC 14 completed a checklist on behalf of Adult B, who was intoxicated, and rated her as being at standard risk. There had been an interval of over 15 months since the previous reported incident and the rating of this incident as standard risk was reasonable.

3.120 None of the above incidents resulted in a referral to MARAC. However, DS 1 should have noted that Adult A and Adult B were in a relationship, identified that the incident on 23 October 2010 was, therefore, a repeat incident and notified the Central Referral Unit to enable consideration of a MARAC referral.

3.121 This failure to identify a repeat incident under the current system of risk assessment is concerning and raises questions as to whether current Public Protection Investigation Unit Supervisors are fully conversant with risk assessment procedures and the criteria for MARAC referrals. All frontline officers and staff of all ranks and grades were required to undertake DASH risk assessment training before the new system was implemented. However, Surrey Police have been unable to establish how many members of staff have or have not completed the training.

Multi-Agency Risk Assessment Conference (MARAC)

3.122 The MARAC model of intervention involves risk assessments in all reported cases of domestic abuse so that a multi-agency approach can be pursued to address the highest risk cases. By bringing relevant agencies together through a MARAC, a coordinated safety plan can be prepared to support the victim.

3.123 In this case, no MARAC referrals were made by Surrey Police. There were many points between March 2008 and October 2010 when, as victims, Adult A or Adult B met the MARAC referral criteria. However, as no referrals were made, opportunities were missed to intervene in this relationship.

3.124 It is not possible to say whether Adult A or Adult B would have actively engaged with the MARAC process and, on past experience, it might be considered that this would have been unlikely. However, a referral would, at least, have provided relevant agencies with opportunities to share information and consider what action could be taken to reduce the risks. In this case, there is an indication that Adult B wanted Adult A to leave their home about 18 months to two years before his death. This is also borne out by the 40 unsuccessful bids for social housing submitted by Adult A between February 2010 and March 2011. Adult A also told a friend on the morning of the day of his death that he was looking for his own place and only stayed with Adult B because he had nowhere else to go. A referral of the case by Surrey Police to the West Surrey MARAC would have enabled housing issues to have been explored.

Information Sharing and Working Together

3.125 The only multi-agency interaction to reduce the risks that Adult A and Adult B posed to each other were the domestic abuse outreach service referrals made (one for Adult A and one for Adult B) and one completed 39/24 (Vulnerable Adult Coming to the Notice of Police) form.

3.126 Following most, but not all, incidents examined in this review, Surrey Police offered Adult A or Adult B support services either orally or in the form of a standard domestic violence letter. In the majority of these cases, the offer was declined. Referrals can be made to outreach services without the consent of the victim, but it would be difficult for a single agency to provide effective support without the engagement of the victim.

3.127 Surrey Police did refer Adult B, with her consent, to domestic abuse outreach services following the incident on 23 November 2009. Adult A was also referred following the incident on 19 May 2010, despite him declining any support. In both these cases, the outreach service was unable to contact Adult A or Adult B. However, such support services do not provide feedback to agencies on the outcome of a referral. In this particular case, Surrey Police was not advised by the South West Surrey Domestic Abuse Outreach Service that no contact had been made with Adult A or Adult B following their respective referrals and did not take any action to identify the outcome of the referrals itself. This reduces the likelihood of alternative approaches or strategies being considered where support services have not been able to implement effective interventions.

3.128 Adult A's vulnerability has been referred to previously. He was nearly always drunk, took illicit drugs and had significant health problems. He was very unsteady on his feet, particularly when drunk, and used a walking stick. He always had facial injuries as a result of frequent falls, drunken brawls and repeated assaults by Adult B. There appears to have been little formal recognition by Surrey Police that Adult A was vulnerable to abuse and in need of support from Adult Social Care. In addition to the case not being referred to MARAC, only one 39/24 (Vulnerable Adult Coming to the Notice of Police) form was completed and shared with Surrey County Council. This followed the penultimate domestic incident involving Adult A and Adult B on 23 October 2010. On that

occasion, PC 1 felt that, during moments of heavy intoxication, Adult A lacked capacity and was, therefore, vulnerable.

3.129 The assessment made by PC 1 accords with the Surrey Safeguarding Adults Multi-Agency Procedures, Information and Guidance 2011 definition of an adult at risk, as follows:

"An adult at risk may, therefore, be a person who:

- *Is elderly and frail due to ill health, physical disability or cognitive impairment*
- *Has a learning disability*
- *Has a physical disability and/or a sensory impairment*
- *Has mental health needs including dementia or a personality disorder*
- *Has a long-term illness/condition*
- *Misuses substances or alcohol*
- *Is a carer where the person meets the definition*
- *Is unable to demonstrate the capacity to make a decision and is need of care and support."*

3.130 The Surrey Police policy in relation to vulnerable adults states that "Surrey Police works in accordance with the Surrey Safeguarding Adults procedure". However, the current Surrey Police definition of a vulnerable adult (adult at risk) is different:

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

3.131 Operationally, it would be sensible for Surrey Police to adopt the same definition as contained in the Surrey Safeguarding Adults Multi-Agency Procedures, Information and Guidance 2011 to ensure consistency with partner agencies when identifying adults at risk.

3.132 The completion of a 39/24 form by PC 1 following the incident on 23 October 2010 was the correct course of action. There are other instances when this course of action would have been appropriate. In fact, after the incident on 1 May 2008, DS 1 directed that a 39/24 form should be completed for Adult A due to her concerns about the volatility of the relationship and his drug and alcohol dependencies. However, this did not happen and, despite alcohol, drugs and violence remaining a constant theme and Adult's A's health deteriorating over time, his vulnerability was not formally recognised again by Surrey Police until PC 1's intervention in October 2010.

3.133 As with the domestic abuse outreach referrals mentioned previously, Surrey Police had no knowledge of whether Surrey County Council's Adult Social Care service had acted upon the 39/24 form submitted by PC 1 (which would not have been the case had either Adult A or Adult B been referred to MARAC). In fact, in this case, errors in Surrey County Council's handling of this information resulted in no safeguarding or other action been taken. This is discussed later in this report.

3.134 Since April 2011, the procedure for reviewing and sharing 39/24 forms has changed. They are now centrally managed by the Surrey Police Central Referral Unit (CRU). The CRU is notified through the Surrey Police Crime Information System (CIS) of all public protection incidents where 39/24 forms (for both children and adults at risk) have or should have been completed. The CRU reviews each 39/24 form, determines any further action to be taken and ensures that the forms are shared with partner agencies. The CRU also follows up cases with officers where the submission of 39/24 forms has been delayed or forgotten.

3.135 A particular issue arising from this review has been the mechanism for sharing information and intelligence relating to domestic incidents between police forces. An example would be where partners who live in a neighbouring county are involved in a domestic incident in Surrey. Surrey Police has no formal mechanism for notifying neighbouring forces of such incidents. This review has revealed that the same is true of Hampshire Police and that this may be a national issue. Clearly, an incident in Surrey could impact on, for example, a MARAC case or referral in another police force area and, without this information, agencies are not being presented with a full picture of the domestic situation. Therefore, Surrey Police will introduce an appropriate information sharing procedure using the intelligence reporting system to notify other police forces where the parties reside of any domestic incidents that occur in Surrey.

3.136 Overall, information sharing with partner agencies in this case was limited. This would have been greatly improved had Adult A and Adult B been subject to the MARAC process and there had been a multi-agency approach to managing the risks associated with this relationship.

Effective Practice/Lessons Learnt

3.137 Surrey Police relies on policies and procedures to ensure a consistency of approach and adherence to national police guidelines. These are reviewed and updated regularly and are subject to inspection by Her Majesty's Inspectorate of Constabulary (HMIC). This review has identified an issue to be addressed in terms of the definition of vulnerable adults used by Surrey Police.

3.138 The review demonstrates that each incident involving Adult A was managed by a supervisor within Public Protection Investigation Unit (West), which is in accordance with standard procedure. However, the review has also highlighted the failure of successive supervisors to identify when a referral should have been made to MARAC. This has been commented upon at length. Current supervisors must understand the DASH risk assessment process and be able to identify high risk and repeat victims. Recommendations have been made to this effect.

3.139 The review also highlighted the need for a mechanism for sharing information and intelligence relating to domestic incidents between police forces. This is particularly relevant where incidents occur outside the police force area where the people involved live. Surrey Police will introduce an appropriate information sharing procedure to notify other police forces of such incidents. Such an approach is required at a national level to ensure that the relevant force has full knowledge of a case when determining the most appropriate course of action.

Recommendations

3.140 That Surrey Police ensure that:

(a) training on the DASH risk assessment process is undertaken by all Surrey Police staff new to frontline duties or to the Public Protection Investigation Unit Supervisor role;

(b) all Public Protection Investigation Unit Supervisors have received the requisite DASH risk assessment process training and are able carry out effective risk assessments, including the identification of cases that should be referred to a MARAC;

(c) all officers employed in the role of Public Protection Investigation Unit or Central Referral Unit Supervisor carrying out DASH risk assessments recognise that domestic incidents involving either partner as a victim within the previous 12 months would meet the repeat incident criteria for a MARAC referral;

(d) Police Public Protection Investigation Units report all incidents of domestic abuse that take place in Surrey involving persons who do not normally reside in the county to their home area police force using the intelligence reporting system; and

(e) the definition of vulnerable adults (adults at risk) used by Surrey Police in its policies and procedures is amended to use the definition set out in the Surrey Safeguarding Adults Multi-Agency Procedures, Information and Guidance 2011 and that appropriate guidance and training be provided to all relevant staff.

3.141 That the Home Office be made aware of issues raised by this review in relation to the lack of sharing of information between relevant forces on incidents of domestic abuse and be requested to ensure that a system is established at a national level to address this matter.

4. HAMPSHIRE POLICE

4.1 The extensive police records of Adult A and Adult B have been documented previously. Hampshire Police, in common with Surrey Police, has arrested and charged both Adult A and Adult B on numerous occasions for many offences. The more serious offences and convictions prior to March 2008 are detailed in Section 2 of this report.

4.2 The focus of this analysis is on the involvement of Hampshire Police with Adult A and Adult B after February 2008, when their relationship commenced.

Review of Involvement

Domestic Incident: 1 May 2008 (21:45)

4.3 Hampshire Police Control Room received a telephone call to attend Adult B's mother's address in Aldershot as Adult B had reported that she had been assaulted by Adult A during a domestic dispute that had occurred at their home.

4.4 Hampshire Police attended Adult B's mother's address and were joined by officers from Surrey Police. It was noted that Adult A had allegedly also been assaulted during the incident and was at Frimley Park Hospital with a head wound. In line with national protocol, Surrey Police took responsibility for investigating the incident. Adult B was arrested by Surrey Police officers, who progressed the investigation.

4.5 As noted previously, the Hampshire Police Domestic Abuse Coordinator mistakenly thought that Adult B lived in Aldershot and assumed responsibility for providing domestic abuse advice. The Domestic Abuse Coordinator was unsuccessful with attempts to contact Adult B, but sent a safety planning advice letter to her in which Adult B was also asked to make contact.

4.6 There is no record that Adult B made contact with the Domestic Abuse Coordinator. As the incident involved serious injuries, it was rated as high risk and it was stated that Adult B should be referred to the Aldershot MARAC. As Adult A and Adult B both lived in Surrey, the Domestic Abuse Unit Sergeant identified that this was not a case for the Aldershot MARAC and the Surrey Public Protection Unit was advised that Hampshire Police would not be providing further support to either party.

Comment

4.7 The incorrect recommendation for a referral to the Aldershot MARAC was recognised and rectified. What is of more interest is the proactive response of Hampshire Police to this incident. The Domestic Abuse Coordinator sent advice to Adult B and requested that she make contact. Despite this being the first domestic incident between Adult A and Adult B that Hampshire Police was aware of, the recommended referral to a MARAC contrasts with the repeated failure of Surrey Police to pursue this course of action.

Public Order Incident: 14 May 2008 (17:14)

4.8 Person 1 and her boyfriend, Person 2, contacted Hampshire Police to complain that Adult A and a female matching the description of Adult B had made threatening remarks to them at Aldershot Railway Station. Statements were taken from Person 1 and Person 2 that suggested that this was a public order incident and not a threat to kill as originally reported. Adult A was charged with threatening behaviour and convicted at North East Hampshire Magistrates' Court on 1 August

2008. He was fined £100, with £50 costs. Adult B was interviewed under caution but, due to insufficient evidence, no further action was taken against her.

Domestic Incident: 9 June 2008 (19:08)

4.9 Adult A contacted the Hampshire Police Control Room to report having been assaulted by Adult B at their home in Ash. As any offence would have been committed in Surrey, this was immediately passed to Surrey Police to deal with and cross-referred within Hampshire Police records.

Domestic Incident: 15 July 2008 (00.06)

4.10 Adult A contacted the Hampshire Police Control Room to report having been assaulted by Adult B at their home in Ash. Again, this was immediately passed to Surrey Police and cross-referred within Hampshire Police records.

4.11 Adult B's mother subsequently contacted the Hampshire Police Control Room to report that Adult B had telephoned her from her home in Ash, where she had locked herself in the toilet and was covered in blood. It was reported that Adult A had assaulted her on previous occasions and that he was present at the address. As the incident was taking place in Surrey, this was also immediately referred to the Surrey Police Contact Centre to deal with and cross-referred within Hampshire Police records.

Public Order Incident: 19 August 2008 (17:21)

4.12 The owner of a shop in Aldershot High Street contacted the Hampshire Police Control Room to report that Adult A and Adult B were drunk, fighting with people in his shop and damaging stock. The incident resulted in Adult A and Adult B being arrested and charged with affray.

4.13 The affray charge against Adult A was subsequently replaced by a charge of threatening behaviour. Adult A pleaded guilty and was sentenced to a term of four months imprisonment at Winchester Crown Court on 17 February 2009. He was also issued with an Anti-Social Behaviour Order for the period up to 16 June 2011 prohibiting him from:

(a) being disorderly under the influence of drink in any public place in the Borough of Rushmoor;

(b) using words or actions that would cause any person to fear for the safety of any person or property;

(c) using foul, offensive or racist language likely to be abusive, threatening or insulting; and

(d) entering the shop in Aldershot where the offence had been committed.

4.14 The affray charge against Adult B was replaced by a charge of racially aggravated threatening behaviour. Adult B pleaded guilty and was sentenced to a term of 6 months imprisonment at Winchester Crown Court.

Domestic Incident: 5 September 2008 (17:12)

4.15 Adult A attended Aldershot Police Station in a drunken state with a fat and bleeding lip. He stated that he had been beaten up by Adult B and a male associate in Princes Gardens, Aldershot. An ambulance was called and the staff treated him at the Police Station as he refused to go to

hospital. Adult A would not make a complaint at the time and said that he would return the next day to make a statement.

4.16 Later that evening, a patrol officer came across Adult A and Adult B drinking together in Princes Gardens, Aldershot. Adult B stated that they had had an argument as Adult A had stolen some money from her. Adult B declined to make any complaint and Adult A stated that he did not wish to make a statement about the assault.

4.17 On 7 September 2008, both Adult A and Adult B were seen again by a police officer to ask formally whether either wished to make a complaint and both declined. Adult A could not even remember the incident due to being so drunk at the time. As a result, no further action was taken.

Comment

4.18 A domestic abuse risk assessment was not completed in relation to this incident and it was not reported to Surrey Police.

Domestic Incident: 18 September 2008

4.19 Adult A attended Aldershot Police Station and reported a small cut to his lip allegedly caused by Adult B during a drunken argument in Aldershot High Street earlier that day. Adult A was too drunk to make a statement and arrangements were made to see him at a later date. Over the next two weeks, the investigating officer visited several addresses and left messages on telephones for Adult A to contact him.

4.20 By 1 October 2008, no contact had been made by Adult A and no further action was taken. However, the investigating officer had received information from Surrey Police that Adult A had made a complaint to them about a separate assault four days earlier (26 September 2008). Adult B had been arrested by Surrey Police, but no action had been taken because Adult A had refused to substantiate his complaint.

Comment

4.21 A domestic abuse risk assessment was not completed in relation to this incident and it was not reported to Surrey Police.

Public Order Incident: 26 November 2008 (10.01 a.m.)

4.22 Hampshire Police were called to Aldershot High Street where Adult A was reported to be drunk and laying on the ground lashing out at passers-by who were trying to help him. Police attended and noted injuries to Adult A's leg and head. An ambulance was called and paramedics treated him at the scene. Adult A told officers that the injuries had been caused when he had been attacked earlier in the day, although he provided no further details and did not make a formal complaint of assault.

Breach of Restraining Order/Anti-Social Behaviour Order: 4 April 2009

4.23 Adult A caused a disturbance at his parents' address in Aldershot whilst drunk. He was arrested by Hampshire Police for breaching his Anti-Social Behaviour Order. The Crown Prosecution Service decided that the breach had not been proven as his conduct was not disorderly and no further action was taken. A domestic abuse risk assessment form was completed showing a standard risk.

Comment

4.24 Officers dealing with this incident took no action regarding Adult A's evident breach of the restraining order which prohibited him from entering the road in which his parents lived. However, this review has identified an unsatisfactory process by which restraining orders are recorded on Hampshire Police's record management system and officers attending Adult A's parents' address were unlikely to have been aware of its existence. This is discussed later in this report.

Intelligence Report: 16 April 2009

4.25 Intelligence was received by Hampshire Police and summarised on its database as:

> *"Adult B has been released from prison. She and her partner, Adult A, continue to drink heavily and are also using class A drugs again. They continue to assault each other when drinking resulting in serious injuries to both of them. Adult B could end up killing Adult A in one of these fights as he attacks her and she retaliates. She bottled Adult A in their most recent fight."*

Comment

4.26 Intelligence from sources provided to Hampshire Police is received in an "unsanitised" format. This contains the raw information received and may identify the source. Unsanitised intelligence is amended to remove the risk of the source being identified and is recorded on the Hampshire Police database in a "sanitised" version, as was the case with the above.

4.27 During the domestic homicide review, it was established that the wording of the unsanitised intelligence included the following wording in one section of the form:

> *"… that during one of these fights one of the parties is going to kill the other."*

In another section of the form, the following words were used:

> *"… Adult B could end up killing Adult A in one of these fights…"*

4.28 In this case, the sanitisation process altered the tone of the intelligence received.

4.29 Regardless, it was intended that the intelligence should be sent to Surrey Police and it was marked to this effect. However, the review has demonstrated that it was not passed to Surrey Police at that time and was only received by them after the death of Adult A in March 2012 as part of the murder investigation.

4.30 The significance of this omission should not be over-stated. By April 2009, Surrey Police would already have been aware of the volatile and violent nature of the relationship between Adult A and Adult B. The intelligence report provided further background information to support and strengthen this view. However, it did not include specific actionable intelligence.

Public Order Incident: 23 September 2009

4.31 Adult A and another male were involved in a drunken argument at Redan Hill, Aldershot over the ownership of a walking stick. Police attended and warned them about their behaviour, including advising Adult A that, if he was abusive or disorderly, he would be in breach of his Anti-Social

Behaviour Order. Adult A had a cut to his face that he said had been caused by him falling over whilst drunk.

Domestic Incident: 29 September 2009 (20:56)

4.32 Hampshire Police were called to attend Adult A, who had been seen slumped in a bus shelter in Aldershot High Street shouting and screaming and bleeding from a cut above his left eye and mouth. When police arrived, he was too drunk to stand and could barely provide details of what had happened. He managed to say that he had been assaulted by Adult B with a trainer. As well as the two bleeding cuts to his face, he also had another cut under his right eye and a bandaged cut to his nose that he stated had been caused by an assault by Adult B the previous day. Adult A was too drunk to make a statement and was taken to Frimley Park Hospital.

4.33 Officers attended Adult B's mother's address with the intention of arresting Adult B. Her mother said that Adult B had not been there since 15:00. She also stated that she had seen Adult A with these injuries to his face earlier in the afternoon and that he had told her that they had been caused by another man during an argument over a walking stick the previous day. Officers undertook house-to-house enquiries at the scene of the alleged assault, but found no witnesses. There was also no CCTV at the scene.

4.34 Adult A was spoken to by the investigating officer at Frimley Park Hospital the following morning and arrangements were made to obtain a statement later that day. When Adult A made his statement, he alleged that Adult B had kicked him three times in the head, which differed from his previous account.

4.35 The investigating officer was approached later by another officer who had stop-checked Adult A at 14:00 on 29 September 2009 and noted the facial injuries several hours before the alleged assault by Adult B. The investigating officer was also contacted by an officer from Surrey Police who had dealt with another assault on Adult A by Adult B on 28 September 2009, which appeared to relate to these same injuries.

4.36 Adult B was seen by Hampshire Police on 30 September 2009. She denied the assault allegations and, due to the discrepancies in Adult A's account, no further action was taken.

4.37 On 30 September 2009, the Domestic Abuse Team Sergeant requested the investigating officer to complete a domestic abuse risk assessment once he had clarified the account from the Adult A.

Comment

4.38 Despite the specific request, a domestic abuse risk assessment was not completed and no reason was recorded for not doing so. The details of the incident were not reported to Surrey Police.

Breach of Restraining Order/Anti-Social Behaviour Order: 1 December 2009 (18:50)

4.39 Hampshire Police were called to Adult A's parents' address in Aldershot as he was drunk and banging on the door. He was arrested for breaching his Anti-Social Behaviour Order and restraining order. The Duty Inspector reviewed the investigation and decided not to charge Adult A for a breach of the Anti-Social Behaviour Order as his behaviour was not sufficiently disorderly to prove the offence.

4.40 A breach of the restraining order was also not pursued as Adult A's parents had been complicit in breaches on numerous occasions by inviting him into their home. Breaches were only reported by Adult A's parents when he became abusive. Officers explained to the parents that they

needed to either support the enforcement of the restraining order consistently in its entirety or apply for its discharge. The parents responded that they wished the order to remain in force and understood the obligations that this placed upon them in future. Adult A was released without charge.

4.41 A domestic abuse risk assessment was completed and forwarded to the specialist domestic abuse team who graded the risk as being medium. Adult A's mother was contacted by telephone by the domestic abuse team and safety planning was discussed, including the future enforcement of the restraining order.

Domestic Incident: 18 October 2010 (20:35)

4.42 Adult B contacted the Hampshire Police Control Room to report that she was being subjected to verbal domestic abuse by Adult A at their home in Ash. As this incident was taking place in Surrey, the details were immediately passed to Surrey Police to deal with and cross-referred within Hampshire Police records.

Breach of Restraining Order/Anti-Social Behaviour Order: 14 February 2012 (22:46)

4.43 Hampshire Police were called to Adult A's parents' address in Aldershot as he had turned up drunk. Prior to the police arriving, Adult A's brother had taken him home to Ash. A domestic abuse risk assessment form was completed. The risk level was determined as being standard. Details of victim support services were provided to Adult A's parents, but any such support was declined.

Comment:

4.44 Again, officers dealing with this incident took no action regarding Adult A's apparent breach of the restraining order prohibiting him from entering the road.

Analysis of Involvement

4.45 The main focus of this analysis is on events from February 2008, when Adult A and Adult B were in a relationship. For analytical purposes, the involvement of Hampshire Police has been categorised, as follows:

- incidents occurring in Surrey reported to Hampshire Police;
- public order incidents in Aldershot;
- incidents involving Adult A at his parents' address in Aldershot; and
- domestic incidents involving Adult A and Adult B in Aldershot.

4.46 Further comment is also included on the intelligence report received by Hampshire Police on 16 April 2009 regarding the continuing violence between Adult A and Adult B.

Incidents occurring in Surrey reported to Hampshire Police

4.47 Four domestic incidents involving Adult A and Adult B were reported to the Hampshire Police Control Room where the incident was taking place, or had taken place, at their home address in Ash. In three cases (9 June 2008, 15 July 2008 and 18 October 2010), telephone calls made from their home defaulted to the Hampshire Police Control Room due to the geographical location of the caller. In the other (1 May 2008), Adult B's mother, who lived in Aldershot, reported an incident where Adult B had complained of an assault by Adult A at their home address in Ash. In

each case, the incident was quite properly passed to Surrey Police for attendance and investigation and correct procedures were followed.

Public order incidents in Aldershot

4.48 There were three public order incidents involving Adult A and/or Adult B in Aldershot town centre. The incident on 14 May 2008 resulted in the conviction of Adult A for using threatening behaviour against Person 1 and Person 2 at Aldershot Railway Station. The second incident at a shop in Aldershot on 19 August 2008 resulted in both Adult A and Adult B being convicted of public order offences. An Anti-Social Behaviour Order was also secured against Adult A, which would allow for a more proactive future police response for its duration. Breaches could also attract more substantial sentences than further prosecution of minor public order offences. The third incident on 23 September 2009 involved a minor dispute between Adult A and another male over the ownership of a walking stick and resulted in advice being given to both parties. Each incident was dealt with effectively and properly by Hampshire Police and, where appropriate, investigations led to successful prosecutions.

Incidents involving Adult A at his parents' address in Aldershot

4.49 Between 2001 and November 2003, Adult A was arrested and charged on six occasions with various public order and drink related offences following disturbances at his parents' address in Aldershot. Following the last incident, he was charged and convicted of harassment. Adult A was imprisoned for six months and also made the subject of a restraining order. The order, which remained in existence until his death, prohibited Adult A from entering the road in which his parents lived.

4.50 Adult A breached the restraining order in May 2004. The resulting sentence of six months' imprisonment demonstrates the robust criminal justice outcomes that a restraining order can provide. This was illustrated again by a sentence of 18 months imprisonment imposed on Adult A following a further breach of the order in October 2004.

4.51 In 2005, Hampshire Police established Public Protection Units, which incorporated specialist domestic violence officers. Significant training and development of procedures took place surrounding domestic incidents and a requirement to undertake risk assessments was established.

4.52 After the instigation of these new domestic abuse procedures, Hampshire Police responded to a further seven incidents involving disturbances caused by Adult A at his parents' address dating from 10 November 2006 to 14 February 2012. In each case, attending officers recognised these as being domestic incidents, completed risk assessments and offered specialist safety planning advice where required by the level of risk.

4.53 However, this review has identified an unsatisfactory process by which restraining orders are recorded on Hampshire Police's records management system. Officers attending Adult A's parents' address following domestic incidents on 10 November 2006, 1 February 2008, 20 February 2008 and 4 April 2009 appear to have been unaware of the existence of the restraining order and, therefore, took no action regarding breaches by Adult A.

4.54 In November 2009, the Hampshire Police Intelligence Unit added the restraining order to the records management system to remind officers that it was still active. However, the order was not appropriately flagged or described in the correct way and would have been all but invisible to police officers and staff, other than when undertaking the most detailed of research on the database. This was demonstrated by the incident attended by Hampshire Police on 14 February

2012, where again officers were not aware of the restraining order. It also explains why Surrey Police responded to two domestic incidents at Adult A and Adult B's home in Ash by taking Adult A to his parents' home despite the existence of the order.

4.55 In a similar way, the restraining order against Adult A issued in June 2006 to protect his previous partner, Partner 1, would have been largely unidentifiable to officers. The potential consequences of this weakness in the recording of restraining orders are serious and this issue needs to be rectified as a matter of urgency. Recommendations for such recording on the records management system to ensure that the details are clearly accessible to officers and staff have been included in this report.

4.56 In this particular case, it should be noted that the restraining order had become all but unenforceable. Adult A often visited his parents' home, but breaches were only reported to Hampshire Police when he became aggressive or abusive. Following an incident on 1 December 2009, officers explained to Adult A's parents that, if they were not prepared to support the consistent enforcement of the order, they should apply for it to be discharged. Despite the parents wishing the order to remain in force and accepting the obligations that this placed upon them, it is clear that Adult A continued to visit their home frequently right up until the day of his death.

Domestic incidents involving Adult A and Adult B in Aldershot

4.57 Adult A made allegations to Hampshire Police on three occasions that he had been assaulted by Adult B in Aldershot town centre. Each time , both Adult A and Adult B were very drunk.

4.58 On 5 September 2008, Adult A decided not to make a complaint. Following the incident on 18 September 2008, he failed to return to Aldershot Police Station to make a complaint as arranged and, despite several attempts, he could not be located or contacted. An investigation into the third alleged assault on 29 September 2009 found discrepancies in Adult A's account and no further action was taken.

4.59 Domestic abuse risk assessments were not completed in relation to any of these incidents, despite records showing that officers recognised that Adult A and Adult B were in a relationship and comments being included regarding domestic abuse. On two occasions, work sheets were added to the records requesting that risk assessment forms be completed, but this did not happen.

4.60 It would have been difficult to complete the risk assessment with Adult A at the time he made the allegations as he was always drunk, sometimes to the extent of being incoherent. However, policy and training is explicit that risk assessments must be completed for all cases of domestic violence and that they must be undertaken at the time of taking the initial report to enable an immediate assessment of risk so that appropriate safeguarding of the victim takes place. This requirement extends to cases where the victim is unable or unwilling to answer the risk assessment questionnaire. In such cases, the officer or staff member should make the assessment using professional judgement taking into account the circumstances of the incident and by using historical information from police records.

4.61 A factor in the two assaults reported in September 2008 was that Adult A walked into Aldershot Police Station and made his initial complaints to civilian staff who, at that time, were not trained on the completion of risk assessments. The complaints were taken and injuries assessed (an ambulance was called on 5 September 2008) and then, on both occasions, Adult A left the police station of his own accord whilst still drunk, agreeing to be seen by officers at a later time or date.

However, even when the cases were allocated to investigating officers, retrospective risk assessments were not undertaken.

4.62 Civilian staff have now been trained to undertake domestic abuse risk assessments. It is expected that they will now complete an immediate risk assessment when taking an initial report from a victim unless a police officer is immediately available to do so and take responsibility for the investigation.

4.63 Had risk assessments been completed in relation to these three incidents, they would have been submitted to the Hampshire Police Public Protection Unit's Domestic Abuse Coordinators. At the time of each of these alleged assaults, it was clear in Hampshire Police records that Adult A and Adult B lived together in Surrey. Therefore, the details of each incident and the completed risk assessments should have been sent to Surrey Police to enable them to build a full picture of the type and number of domestic incidents taking place between Adult A and Adult B and re-assess the risk level.

4.64 The need to share information between police forces in domestic abuse cases would be just as important had only one partner lived in another force area, be it the victim or the offender. In the case of the victim, the risk assessment should be sent to the police force where he or she lives to enable proper safety planning to be managed. If the perpetrator lives in another force area, that force would benefit from being made aware of the offending behaviour so as to manage any associated risks in their area and to identify repeat offending.

4.65 Hampshire Police domestic abuse procedures and training make it explicit that officers should take positive action to deal with incidents, including arresting suspects in appropriate circumstances. The more serious the allegation or the more frequently that repeat incidents occur, then the more important it becomes that positive action is taken.

4.66 Following the alleged assault on 5 September 2008, there is no evidence that Adult A was questioned sufficiently to establish whether there were viable lines of enquiry that needed to be followed up and his injuries were not photographed. Opportunities to pursue evidence, such as the possible availability of CCTV footage, potential witnesses and house-to-house enquiries were not explored. The response to the incident on 18 September 2008 was similar.

4.67 The absence of risk assessments and lack of positive action on both occasions suggests that these were not dealt with as domestic incidents. Had risk assessments been undertaken and records searched, the officers involved would have recognised that these were the fourth and fifth domestic incidents (including those in Surrey) involving Adult A and Adult B in five months.

4.68 The incident on 29 September 2009 was responded to promptly by Hampshire Police. Adult A was taken to Frimley Park Hospital by ambulance, interviewed at the hospital and a statement was taken in which he stated that Adult B had inflicted the injuries to his face. House-to-house enquiries and a CCTV check were undertaken, without positive results. Clearly, more positive action was taken in relation to this investigation than in previous cases, but still no risk assessment was completed.

4.69 Adult B could not be located immediately so that she could be arrested. However, when she contacted Hampshire Police the following day, she was not arrested and the opportunity to obtain a formal account of events from Adult B under caution was missed. Subsequent information, including from Surrey Police, shed doubt on the cause of Adult A's injuries. This appears to have influenced the decision to speak to Adult B informally at which time she denied assaulting Adult A and formed the basis for the decision to take no action.

4.70 Although there was more evidence of positive action in response to the incident on 29 September 2009, the absence of a risk assessment and the missed opportunity to arrest Adult B suggests that, again, it was not responded to explicitly as a domestic assault. All three domestic incidents seem to have been dealt with as one-off events with minor consequences and regarded as further episodes of their drunken presence around Aldershot town centre, rather than by application of the domestic abuse policy.

4.71 Officers need to be able to distinguish between the two types of incident and to identify assaults by partners in public places as domestic incidents and respond to them by taking positive action in keeping with the domestic abuse policy. Three recommendations have been included in this report to that effect.

4.72 In addition to the seven domestic assaults recorded, Hampshire Police was also aware of Adult A's alcoholism through his general presence in Aldershot town centre and in connection with specific responses to incidents there and at his parents' address. His poor physical condition would also have been apparent. However, at no stage did Hampshire Police appear to recognise his vulnerability and take action to implement appropriate safeguarding procedures.

Intelligence Report

4.73 Previous reference has been made to the intelligence report received by Hampshire Police on 16 April 2009 describing escalating domestic violence between Adult A and Adult B since the latter's release from prison on 8 April 2009 and including the statement that "… *Adult B could end up killing Adult A in one of these fights as he attacks her and she retaliates …".*

4.74 The intelligence was correctly submitted to the Aldershot Intelligence Unit and, ultimately, tasked to the Force Intelligence Bureau for dissemination to Surrey Police. However, the intelligence was not provided to Surrey Police until after Adult A's death on 2 March 2012. The dissemination of relevant intelligence reports to outside police forces has not been identified as an issue by Hampshire Police in any other cases and the evidence of this review suggests that this was an isolated error.

4.75 Improvements have been made to processes for sharing intelligence between neighbouring police forces since 2009. For example, a Surrey Police Intelligence Officer is now embedded within Hampshire Police's Aldershot Intelligence Office and relevant intelligence can now be shared within this single team. In addition, the Surrey Police Intelligence Officer has direct access to the Hampshire Police database. However, the embedding of officers into neighbouring intelligence teams is costly and wider shared access to intelligence databases is being explored. Given the changes to operational processes and the isolated nature of the failure in this case, no recommendations are included in this report regarding intelligence sharing.

4.76 In terms of the failure to share the specific intelligence received in April 2009, it should be noted that Surrey Police was clearly already aware at this time of the frequent domestic incidents involving Adult A and Adult B. The intelligence would have confirmed the position, but did not contain specific information that could have been acted upon. Given the response by Surrey Police to previous domestic incidents, it is considered unlikely that the intelligence would have prompted any further proactive measures, such as a referral to the West Surrey MARAC.

Effective Practice/Lessons Learnt

4.77 Improvements need to be made to the way that restraining orders are recorded on the Hampshire Police database so that their existence is clearly apparent to frontline officers to enable positive action to be taken in connection with breaches.

4.78 Risk assessments must be completed in all reported cases of domestic abuse even if the victim is unwilling or unable to complete the DASH questionnaire. This will support the safeguarding of victims, act as a notification to specialist domestic abuse coordinators and other specialist services and, in high risk cases, support a referral to a MARAC. Officers and staff must also recognise other factors, such as alcohol and drug abuse, that contribute towards a victim's vulnerability.

4.79 Assaults between partners in a public place must be recognised, not as a public nuisance or brawls, but as domestic violence triggering positive action and the application of the domestic abuse policy. The message that domestic abuse is not restricted to the home needs to be clear.

4.80 There needs to be better communication between police forces in situations where domestic incidents occur in a location other than the police force area in which the parties live. This includes not only situations where both parties live elsewhere, but also those where either the victim or the alleged perpetrator live in another police force area. The force in which the parties live needs to have a complete picture of all domestic incidents so that they can make fully informed decisions regarding the seriousness and frequency of domestic incidents and, therefore, undertake effective and well informed assessments of the level of risk to the victim and also track repeat offenders.

Recommendations

4.81 That Hampshire Police ensure that:

(a) restraining orders are recorded and flagged on its database to highlight the existence of all live court orders to officers and staff, including those from other police forces;

(b) it is made explicit to all frontline officers and staff that the requirement to complete DASH risk assessments includes domestic incidents where the victim is unable or unwilling to respond to the risk assessment questionnaire, in which case the officer or staff member should make the assessment using professional judgement taking into account the circumstances of the incident and by using historical information from recording systems;

(c) when police officers deal with incidents between partners that take place in a public place, these are recognised and treated as domestic incidents and the relevant domestic abuse policy is applied, including the completion of risk assessments and the taking of positive action; and

(d) when domestic incidents occur in the Hampshire Police area involving one or more parties who live in another police force area, the details of the incident, including any risk assessments, should be reported to that other force to enable them to understand the full extent of the risk, provide appropriate support to the victim and recognise repeat offending by the perpetrator.

5. FRIMLEY PARK HOSPITAL NHS FOUNDATION TRUST

5.1 Frimley Park Hospital NHS Foundation Trust reviewed its contact with Adult A and Adult B over the period 19 December 2006 until the date of Adult A's death on 2 March 2012. Initially, the main hospital records were unavailable for review as these had been sent to the Coroner's Office, although copies were eventually secured. At the request of the Panel, the Trust has accepted that, in future, a copy of any records and medical notes sent to the Coroner's Office should be retained.

5.2 This report focuses on the more frequent contacts by Frimley Park Hospital with Adult A. However, a review of Adult B's hospital medical records was also undertaken. No Emergency Department attendances were recorded for Adult B. Attendances by Adult B between 26 April 2010 and 13 June 2012 related to ongoing medical treatment with the Gastroenterologist for Hepatitis C.

5.3 Of the 15 expected attendances, Adult B failed to attend appointments on seven occasions. Each time, a reminder letter was sent to Adult B with a new appointment date and this was copied to her GP in accordance with hospital protocol. After each attendance, a letter was sent by the consultant or specialist nurse to Adult B's GP, with a copy to her, outlining her ongoing clinical care and requirements.

5.4 Adult B's records did not identify any occasions when consideration of adult safeguarding issues was required and there was no indication of any domestic abuse.

Review of Involvement

20 December 2006

5.5 Adult A arrived at Frimley Park Hospital by ambulance at 00:01 with a laceration to to his left arm caused by self-harm. He left the Emergency Department at 00:30 before being seen by a medical practitioner.

22 June 2007

5.6 Adult A arrived at Frimley Park Hospital by ambulance at 00:05. He had been drinking and had self-inflicted cuts to his lower arm. The injuries were superficial. Adult A was under arrest at the time of this incident and was escorted from the hospital by police at 01:45. It would have been custom and practice at this time for a letter to be sent to inform his GP of this attendance and associated self-harm. However, there is no evidence to substantiate that this happened.

30 June 2007

5.7 Adult A arrived at Frimley Park Hospital by ambulance at 07:23. He was under the influence of alcohol, having been drinking since the night before, and had self-inflicted lacerations to his left arm. His injuries were minor. The Emergency Department liaised with the Psychiatric Team and there was a discussion with Adult A about his suicidal feelings. He denied that he wanted to commit suicide. A letter was sent to Adult A's GP asking that this be followed up.

1 May 2008

5.8 Adult A arrived at Frimley Park Hospital by ambulance at 22:59. He had been attacked by his girlfriend (Adult B) and hit over the head with a toilet seat suffering a four inch laceration. He had

taken non-prescribed drugs (Temazepam and Diazepam) and was under the influence of alcohol. He reported that he had been a heroin user, but had now stopped, and that he lived with an un-named girlfriend. He refused to allow his next of kin to be notified. His wound was sutured and an X-ray revealed no fracture to his head. Adult A stayed in the Emergency Department overnight and then self-discharged at 07:00 against medical advice.

Comment

5.9 The Safeguarding Adults: Surrey Multi-Agency Policy 2008 was not followed in response to this incident, which should have resulted in a referral to the Surrey County Council Contact Centre. This was a missed opportunity to instigate appropriate safeguarding procedures. It would also appear that no letter was sent to Adult A's GP about this incident.

26 and 27 November 2008

5.10 Adult A arrived at Frimley Park Hospital by ambulance at 12:50 on 26 November 2008. Hampshire Police had attended an incident where Adult A was found drunk and laid on the ground in Aldershot High Street with injuries to his leg and head. Adult A was seen in the Emergency Department and presented as having a weak right arm and leg and slurred speech. Adult A was informed that he may have suffered a stroke. Adult A was transferred to a the Clinical Decisions Unit and a CT scan was performed. He then left the hospital at 17:30 against medical advice.

5.11 Adult A arrived by ambulance at Frimley Park Hospital at 13:59 the following day (27 November) after a fall outside his home in Ash. On this occasion, he had drunk four cans of lager and suffered grazing to his face and forehead. It was noted that he kept falling over due to his right-sided weakness. No abnormalities were revealed by the CT scan performed the previous day, but the possibility of a stroke was again noted.

5.12 A full medical review was undertaken and Adult A was transferred to the Emergency Department at 18:00 for neurological observations. He was reviewed at 19:40 and discharged. Adult A was collected by his mother. The notification to Adult A's GP asked that his right-sided weakness be reviewed and that he be referred to Frimley Park Hospital's Neurology Clinic if necessary.

5.13 Adult A was taken by ambulance to Frimley Park Hospital for a third time in two days on 27 November at 23:56. He had continued drinking since leaving the hospital earlier that day and had been found in a public place by a group of youths. He had no new injuries, but presented with numbness, slurred speech and a painful right knee and arm. He was identified as an alcoholic and a frequent attendee. Adult A was advised to stop drinking alcohol and to drink lots of water.

Comment

5.14 Adult A received appropriate care during these attendances and an informative letter was sent to his GP after his attendances on 27 November 2008.

5.15 However, Adult A had attended the Emergency Department by ambulance on three occasions in two days in connection with alcohol-related incidents. He was informed that he may have suffered a stroke. Despite this and his previous attendance following an alleged domestic assault, no consideration appears to have been given to initiating the Trust's safeguarding procedures.

5.16 Adult A's alcoholism was recognised at the Emergency Department and he was advised to stop drinking during his third attendance. However, there is no documented evidence to demonstrate that advice was given on available support services, such as the Acorn Drug and Alcohol Service or Drug and Alcohol Action Team.

16 June 2009

5.17 Adult A was seen in the Neurology Clinic at Frimley Park Hospital on 16 June 2009 regarding his right sided weakness. This followed a referral by his GP. It was planned to perform a MRI scan of his brain and, if this was normal, to proceed to a scan of his spine. A letter to Adult A's GP from the Neurologist suggested possible reasons for his condition, including cerebral demyelination[7] or that he had damaged his spine following a reported fall around Christmas 2008.

28 and 29 September 2009

5.18 At 20:06 on 28 September 2009, Adult A arrived at Frimley Park Hospital by ambulance. The ambulance service's paperwork reported that Adult A had been assaulted by his girlfriend with a stick. Adult A, who was accompanied by his un-named girlfriend, was assessed in triage and noted to have cuts to his nose and around his left eye. His explanation for his injuries was that he had been drinking and his leg had given way causing him to fall. Adult A left the hospital at 21:45, 30 minutes after being assessed in triage, but before any treatment. A letter was sent to notify his GP of this attendance.

5.19 Adult A was taken by ambulance to Frimley Park Hospital for a second time that night arriving at 01:27. He reported that he had been hit by his girlfriend with his walking stick. A possible broken nose, bruising to his left eyebrow and slurred speech due to alcohol were noted. Adult A was noted as a frequent attendee at the Emergency Department, with five visits in the past year. It was planned to admit him to the Clinical Decisions Unit for neurological observations, but he self-discharged at 05:00.

5.20 Adult A arrived by ambulance at Frimley Park Hospital at 21:46 on 29 September 2009, a third attendance at the Emergency Department in two days. He was drunk and had sustained facial injuries following an alleged assault by his girlfriend. He received an X-ray to assess whether he had sustained any facial fractures and this confirmed that there were none. Adult A stayed in the Clinical Decisions Unit overnight and was discharged after a review by the Registrar at 08:45 the following morning.

Comment

5.21 It would have been difficult to ascertain the actual cause of Adult A's injuries during his first attendance on 28 September 2009 because he left after he had been seen in triage and was accompanied by the potential perpetrator. However, there were clear opportunities to talk to Adult A during his subsequent attendances as he was unaccompanied.

5.22 There is no documented evidence that he was offered any advice relating to domestic abuse or drug and alcohol support services. There is also no information to suggest that the matter was referred to the Safeguarding Lead for Vulnerable Adults in accordance with the agreed policy, which should have led to the implementation of appropriate safeguarding procedures. In addition, no letter appears to have been sent to Adult A's GP about the latter two of the three incidents.

5.23 The doctor who reviewed Adult A during his second attendance did identify his high number of previous attendances over the last year. In addition to these latest attendances following alleged domestic assaults, these included three attendances in November 2008 due to alcohol-related

[7] A disease of the nervous system impairing the conduction of signals in affected nerves and causing deficiency in sensation, movement, cognition or other functions.

falls and other incidents. However, records were paper-based and held off-site and, therefore, the reasons for those previous attendances would have been unknown.

29 October 2009

5.24 Adult A's scan at the Neurology Clinic at Frimley Park Hospital showed some scarring of the left side of his brain, which suggested that the injury had been more significant than previously thought. Although it was not in an area that would account for his weakness, the injury was considered significant enough to cause other problems. The brain was also noted to be slightly thinner than expected for his age, which was compatible with alcohol induced damage.

5.25 Adult A was seen again in the Neurology Clinic on 17 November 2009, when he was noted to have an increasing ("very impressive and progressive") tremor. The abnormal findings of his brain scan were explained as was the need for a MRI scan of his spine to exclude damage there as well. If the MRI scan proved negative, the Neurologist suggested that the investigation should be pursued as far as a lumbar puncture to determine the cause of Adult A's condition. On 24 February 2010, the Neurologist wrote to Adult A as he had not attended the appointment for the scan of his neck and this was followed up with a letter from his GP.

24 December 2009

5.26 Adult A arrived by ambulance at Frimley Park Hospital at 00:39 following a reported assault by a friend (Person 3) with a walking stick, glass ashtray and pair of scissors. He had cuts to his neck, head and hand. His girlfriend, who was not in attendance, had reported a loss of consciousness. He received six stitches to his neck injury and surgical glue was applied to the cuts on his head and hand. Adult A's GP was notified by letter about this assault and the associated injuries and treatment and asked to remove the stitches in 7 to 10 days.

Comment

5.27 By this stage, Adult A had attended the Emergency Department as a result of various alcohol-related falls and domestic assaults. He was also being treated by the hospital for a neurological condition which caused a right-sided weakness and balance problems. However, despite receiving serious injuries as a result of this assault by Person 3, Adult A's vulnerability does not appear to have been recognised and no consideration appears to have been given to safeguarding issues.

5.28 In this case, Adult A's GP was advised of the assault and resulting injuries. This contrasts with the five attendances following alleged assaults by Adult B, none of which was notified to his GP.

23 October 2010

5.29 Adult A arrived by ambulance at Frimley Park Hospital at 23:26. He had sustained a head injury after allegedly being assaulted with a walking stick and kicked downstairs by his girlfriend. He was given head injury advice and discharged home to the care of his parents at 01:15.

Comment

5.30 The new safeguarding policy implemented in October 2010 was not followed in response to this incident. This may partly be explained by the Emergency Department's algorithm to provide guidance for staff on the management of patients considered to be at risk of domestic abuse omitting the step requiring referral to the Adult Safeguarding Lead. However, given that there is no evidence that Adult A received any advice or support relating to domestic abuse and the

response to previous incidents, it would seem that Adult A's vulnerability was simply not recognised. Adult A's GP was not informed about this incident.

16 November 2010

5.31 Adult A's GP wrote to the Neurologist at Frimley Park Hospital advising that Adult A had now decided that he wanted to have the planned MRI scan of his spine. The Neurologist wrote to Adult A on 19 November 2010 asking him to reschedule the scan and urging him to attend. However, Adult A failed to attend his subsequent appointment. On 9 February 2011, the Neurologist wrote to Adult A reminding him that, despite promises, he had failed to attend his scan appointment and had not made contact to cancel it. Adult A advised that the appointment had been scheduled at Clare Park Hospital in Farnham, which he was unable to get to and that he had contacted them. He wanted an appointment at Frimley Park Hospital.

13 September 2011

5.32 A second test confirmed that Adult A was Hepatitis C positive and he was referred by his GP to the Gastroenterologist at Frimley Park Hospital. Adult A was seen in the General Medical Clinic at Frimley Park Hospital on 16 November 2011 and further blood tests were arranged. He was advised to reduce his alcohol intake with a view to stopping drinking. Adult A attended his appointment at the Viral Hepatitis Clinic on 14 December 2011 in the company of Adult B, but failed to attend subsequent appointments on 23 January and 13 February 2012.

23 February 2012

5.33 Adult A arrived by ambulance at Frimley Park Hospital at 23:55. He had been found drunk by a passer-by on the pavement having fallen and sustained facial bruising. He was booked into the Emergency Department by a receptionist, but left before being seen.

Analysis of Involvement

5.34 During the period from 20 December 2006 to the date of his death on 2 March 2012, Adult A attended Frimley Park Hospital on 24 occasions. Eleven of these were for outpatient consultations following communications between Adult A's GP and specialist consultants. All episodes were managed correctly from a medical perspective and appropriate clinical care was given where possible.

5.35 Thirteen attendances at the Emergency Department over this period were unplanned and, in each case, he arrived by ambulance either from his home or a public place. Alcohol was generally involved. The three earliest incidents involved self-harm. Four attendances were the result of falls and associated neurological symptoms. Six episodes were due to injuries sustained following alleged assaults, five of these reportedly by his girlfriend.

5.36 There is no evidence that domestic abuse was discussed with Adult A during the five attendances following alleged assaults by his girlfriend or that he was offered any advice on the support available. This would have been difficult on his visit to the Emergency Department on 28 September 2009 as he attended with his girlfriend, who was the alleged perpetrator, and left the hospital soon after being assessed in triage. However, he did attend the Emergency Department again later that night at 01:27 reporting a domestic assault and stayed until 05:00 before self-discharging. He also attended at 21:49 on 29 September 2009 reporting a third assault by his girlfriend in two days and remained in the Clinical Decisions Unit overnight before being formally discharged by the Registrar. On none of these occasions was domestic violence discussed or advice and support given. Similarly, advice should have been given on alcohol support services at

these and other attendances and this should have been raised in communications with Adult A's GP to enable a possible referral to be pursued.

5.37 Trust policies on safeguarding vulnerable adults were not followed and there was inconsistent knowledge amongst staff on correct procedures relating to domestic abuse. This resulted in a failure to instigate required safeguarding measures on each occasion following domestic assaults, including the referral of the case to the Lead for Vulnerable Adults.

5.38 Adult A was known to be an alcoholic and frequent attendee following falls, fights and domestic assaults. He also had significant health problems, including a right-sided weakness and used a walking stick. These risk factors and indicators of his vulnerability further emphasise that a safeguarding referral should have been made following domestic assaults and, possibly, other attendances.

5.39 There was also a lack of evidence to indicate that the Emergency Department had notified Adult A's GP of his attendances. Where evidence was found, these letters did not address Adult A's vulnerability and the fact that he had been the victim of domestic assaults, but detailed only his physical injuries.

5.40 Whilst acknowledging that opportunities to provide advice and support were missed, the Trust points out that, given his intoxicated state, it may not always have been appropriate to raise an emotional issue such as domestic abuse with Adult A until he was sober. Nevertheless, in these circumstances, the importance of raising the issue in communications with his GP is only amplified.

Effective Practice/lessons learnt

5.41 Until April 2012, documentation of actual care delivered by the Emergency Department was recorded on paper records, which were transferred off-site after three months. As a result, after three months, previous records were not readily available to consult during subsequent attendances by patients. Since April 2012, with the introduction of the new Symphony IT system, all records are stored electronically and are accessible at all times. This provides a clear picture of previous attendances and allows specific details and patterns of attendance to be investigated. This support for clinicians was not available during Adult A's attendances at Frimley Park Hospital.

5.42 During the period of Adult A's attendances, details of handovers from the ambulance service to the hospital were not always captured satisfactorily. This issue was addressed alongside the opening of the new Emergency Department at Frimley Park Hospital in September 2012. A new system has been introduced requiring both hospital and ambulance staff to acknowledge the handover electronically.

5.43 The lack of evidence to indicate that Adult A's GP had been notified of attendances at the Emergency Department was also addressed with the introduction of the Symphony system in April 2012. This automatically generates a letter to the GP when a patient is discharged populated with relevant clinical information. However, it is important that the GP is notified of all relevant information following attendances at the Emergency Department. As well as clinical information, this should provide details of relevant safeguarding considerations, including instances of alleged domestic abuse, and a copy must be retained by the hospital.

5.44 There was very little documentation or evidence to suggest that any advice or support relating to domestic abuse or drug and alcohol support services had been given to Adult A. The only exception was on 27 September 2008, where he may have been signposted to the Acorn Drug and Alcohol Service. Proper records of advice and support offered should be retained.

5.45 The review has revealed failures within the Emergency Department to follow the Trust's safeguarding policy for vulnerable adults. The guidance provided to staff in the Emergency Department did not comply fully with the Trust's policy and is likely to have contributed to the non-referral of the case to the Lead for Vulnerable Adults. This resulted in a number of missed opportunities to instigate appropriate safeguarding procedures for Adult A. There was also a lack of awareness of policy regarding domestic abuse cases. A review of the guidance and training of Emergency Department staff is required. This should cover not only domestic abuse, but also the identification and safeguarding of vulnerable adults more generally.

5.46 This case highlights that patients who become frequent attendees can often become treated in routine or standard ways, without consideration being given to the wider circumstances or procedures required in response to each specific incident. Frequent attendees at the Emergency Department are often more vulnerable and, where appropriate, should be identified as being at high risk. In response to this review, Frimley Park Hospital will use its High Intensity Users' Review Group as a further mechanism to identify patients at risk.

Recommendations

5.47 That Frimley Park Hospital NHS Foundation Trust:

(a) ensure that notifications to patients' GPs following attendances at the Emergency Department detail all relevant information, including safeguarding considerations and instances of alleged domestic abuse;

(b) ensure that staff within the Emergency Department record details of advice given to patients on available services, such as drug and alcohol and domestic abuse support;

(c) review the Emergency Department's guidance to staff on safeguarding vulnerable adults to ensure that it is consistent with Trust-wide policies and procedures;

(d) ensure that nursing and medical staff in the Emergency Department receive training on the safeguarding procedure for vulnerable adults, including the requirement to refer domestic abuse cases to the Trust's Lead for Vulnerable Adults; and

(e) ensure that frequent attendees at the Emergency Department are identified as being at high risk to enable appropriate safeguarding procedures to be considered and implemented.

6. SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

6.1 The South East Coast Ambulance Service NHS Foundation Trust had several contacts with Adult A over the period reviewed (March 2006 to March 2012). However, South East Coast Ambulance Service records are stored by home address, so it was not possible to identify incidents where Adult A was treated by ambulance crews in the community or taken to hospital from a public place through its own internal records. Where possible, these contacts were identified through police and hospital records provided as part of this review.

6.2 Patient Clinical Records (PCRs) were unavailable for five incidents recorded in 2008 and 2009. Of these, some cannot be definitively identified as being for Adult A, although there is corroborating evidence from other agencies that suggests this is the case.

6.3 There were also issues in securing some of the older paperwork due to the way records were retained in the former ambulance trust covering Surrey. Records have been held and stored centrally since 2010 and older records are slowly being collated and scanned. This created a challenge regarding the older cases identified within this review process.

Review of Involvement

19 December 2006 (00:06)

6.4 South East Coast Ambulance Service attended a 999 call at Aldershot Police Station. Adult A had self-harmed by cutting his arms and was taken to Frimley Park Hospital.

21 June 2007 (23:17)

6.5 South East Coast Ambulance Service responded to a 999 call at Aldershot Railway Station. Adult A was reported to be feeling suicidal and was taken to Frimley Park Hospital. He was noted as being a drug and alcohol user.

30 June 2007 (06:33)

6.6 South East Coast Ambulance Service responded to a similar 999 call at Aldershot Railway Station where Adult A had cuts to his left arm. Adult A stated that he wanted to kill himself and refused to allow observations to be taken. Despite an initial refusal, he was eventually taken by ambulance to Frimley Park Hospital.

1 May 2008 (21:52)

6.7 South East Coast Ambulance Service responded to a 999 call at Adult A and Adult B's home address in Ash. Records indicate that Adult A had been hit repeatedly over the head with a toilet seat by his girlfriend, sustained a cut to his head and suffered some blood loss. Adult A reported feeling light-headed and a bit sick and stated that he had been drinking and taken some prescription drugs. He was taken to Frimley Park Hospital.

5 September 2008 (16:50)

6.8 South East Coast Ambulance Service responded to a 999 call at Aldershot Police Station where Adult A had facial injuries. He refused to be taken to hospital. The Trust's PCR for this incident is unavailable, but Hampshire Police records indicate that Adult A's injuries were caused by an

alleged assault by Adult B and a male associate in Princes Gardens, Aldershot. He was drunk and had a fat and bleeding lip.

19 September 2008 (14:45)

6.9 South East Coast Ambulance Service responded to a 999 call at Adult A and Adult B's home address in Ash. Adult A had sustained a bump to the back of his head as a result of a fall. He was abusive to the crew and refused treatment or transportation to hospital. He also complained of pain in his jaw and left eye area from injuries sustained the previous day. He was left in the care of an unnamed female friend (presumably Adult B). The record of this incident also notes that Adult A had a history of alcohol abuse.

26 September 2008 (22:24)

6.10 South East Coast Ambulance Service responded to a 999 call at Adult A and Adult B's home address in Ash. The record, part of which is missing, indicates that Adult A reported being hit with a hammer and that he was not taken to hospital. There is no record of the possible assailant. Surrey Police records indicate that the South East Coast Ambulance Service contacted the Surrey Police Contact Centre to report this incident, although he reported to attending police officers that his head injury had been caused by Adult B hitting him with an ashtray. Adult A had refused medical assistance.

26 November 2008

6.11 South East Coast Ambulance Service attended an incident where a male had been assaulted in Aldershot High Street. The record indicates that he was not taken to hospital. South East Coast Ambulance Service was unable to confirm the male as being Adult A from its records. However, Hampshire Police indicate that they attended an incident involving Adult A in Aldershot High Street at 10:01 and contacted South East Coast Ambulance Service. Adult A had sustained injuries following an unspecified attack earlier in the day. He was left in the care of the ambulance crew who checked him at the scene.

6.12 Frimley Park Hospital records show that Adult A also arrived by ambulance at 12:50 that day and had suffered a possible stroke. Therefore, it seems likely that there were two separate incidents involving Adult A, although this has not been verified by ambulance service records.

27 November 2008

6.13 South East Coast Ambulance Service responded to a 999 call at 13:03 after Adult A had fallen in a public place. Someone at the scene was noted to be trying to give him more alcohol. Adult A was taken to Frimley Park Hospital. Frimley Park Hospital records indicate that he had been drinking and fallen outside his home in Ash and the possibility of a stroke was again noted.

6.14 South East Coast Ambulance Service responded to a second 999 call that day from Hampshire Police at 23:15. Records indicate that there was a possibility that Adult A had discharged himself from hospital that morning following a possible stroke 48 hours earlier. He was noted to have been drinking all day and his speech was slurred. No other stroke symptoms were evident. Adult A was taken back to hospital where it became apparent that he had been discharged formally and had not self-discharged.

28 and 29 September 2009

6.15 South East Coast Ambulance Service responded to a 999 call at a park near Adult A and Adult B's home in Ash. The record indicates that Adult A had sustained facial lacerations and notes that these injuries may have been sustained the previous week following a fall. The record does not indicate that the injuries were the result of an assault. However, Frimley Park Hospital records show Adult A arriving by ambulance at 20:06 and the paperwork provided to the hospital by the ambulance crew stated that Adult A had been assaulted with a stick by his girlfriend.

6.16 South East Coast Ambulance Service responded to a second 999 call at Adult A and Adult B's home in Ash later that night at 00:46. Adult A was taken to Frimley Park Hospital having reportedly been assaulted with a stick by his girlfriend. Injuries were noted as a possible fractured nose and a swollen and cut left eye. Old injuries from a previous assault were also noted as was the fact he had been drinking.

6.17 South East Coast Ambulance Service attended a third incident involving Adult A in two days at 20:58 on 29 September 2009. Records indicate that a male had been badly beaten in Aldershot High Street and was taken to Frimley Park Hospital. Although, South East Coast Ambulance Service was unable to confirm the male as Adult A from its own records, this is corroborated by Hampshire Police and Frimley Park Hospital. Frimley Park Hospital records show that Adult A arrived at 21:46 and that the ambulance crew reported that he had suffered facial injuries following an assault by his girlfriend.

23 December 2009 (23:36)

6.18 South East Coast Ambulance Service responded to a 999 call at Adult A and Adult B's home in Ash. The record of this incident states that Adult A had been assaulted, including being hit below his right eye (unable to open fully) and sustaining a laceration to the left side of his neck. It also states that he was an alcoholic. Adult A was taken by ambulance to Frimley Park Hospital.

23 October 2010 (22:31)

6.19 The ambulance service responded to a 999 call from a neighbour's address in Ash following an alleged assault on Adult A by Adult B with a walking stick. Adult A complained of pain in his ribs, but no swelling or bruising was noted. Adult A's history of having a right-sided weakness following a fall downstairs and associated head and neck injuries was noted. Adult A was taken by ambulance to Frimley Park Hospital.

3 June 2011

6.20 Adult A was seen by his GP on 3 June 2011 complaining of a head injury following two alcohol related falls the previous night at around midnight. He reported that an ambulance crew had attended and assessed him, but that he had refused to go to hospital. As this incident would have been in a public place, it has not been confirmed separately by South East Coast Ambulance Service.

23 February 2012 (21:22)

6.21 South East Coast Ambulance Service responded to a 999 call after a male had sustained a head injury following a fall in the Frimley area. South East Coast Ambulance Service was unable to confirm the male as being Adult A from its own records and the first name on the PCR is different. However, the presentation of the patient as having been drinking and being aggressive indicate

that this may be the case. Frimley Park Hospital has a record of Adult A attending by ambulance that evening under similar circumstances, although at the later time of 23:55.

2 March 2012

6.22 South East Coast Ambulance Service responded to a 999 call at Adult A and Adult B's home in Ash. CPR instructions were given to Adult B over the telephone as Adult A was reported to be not breathing. The attending ambulance crew declared life extinct at 03:44 due to rigor mortis being present and resuscitation efforts being futile.

Analysis of Involvement

6.23 Internal South East Coast Ambulance Service records, together with information provided by other agencies, suggest that the ambulance service had between 17 and 19 contacts with Adult A between March 2006 and March 2012. There were no separate contacts with Adult B.

6.24 The first three contacts with Adult A during this period involved incidents of deliberate self-harm in December 2006 and two in June 2007, prior to his relationship with Adult B. On each occasion, Adult A was taken by ambulance to Frimley Park Hospital.

6.25 Subsequent contacts were intermittent with some calls to Adult A's home address and others to public places. There were two particular concentrations of contact, with South East Coast Ambulance Service responding to seven or eight incidents between 1 May 2008 and 27 November 2008 and four between 28 September 2009 and 23 December 2009. Sometimes, this involved multiple contacts within one or two days. After 2009, incidents became less frequent.

6.26 Most of the incidents attended by South East Coast Ambulance Service involved Adult A sustaining injuries either as a result of assaults or alcohol-related falls. Alcohol and violence were a common theme. Adult A had been assaulted on nine occasions prior to his murder. On seven occasions, Adult B was allegedly responsible.

6.27 The previously noted difficulties with accessing Trust records and the lack of detail available on specific incidents mean that only three of the alleged assaults are explicitly noted as being perpetrated by Adult B. However, information provided by Surrey Police, Hampshire Police and Frimley Park Hospital suggest that ambulance staff attending incidents would have been aware of alleged domestic assaults by Adult B in at least six instances. For example, on occasions, ambulance staff reported the alleged domestic assault on the handover of Adult A to Frimley Park Hospital, but did not then record the alleged cause of the injuries in the record of the incident.

6.28 South East Coast Ambulance Service appears to have dealt with each incident as a stand-alone case, with police and hospital interventions being sought as necessary. Local knowledge or recognition of an address by crews are key elements in identifying frequent callers and patterns of calls within the service. The sporadic nature of the calls in this case, sometimes from public places and sometimes from Adult A's home address and with relatively long intervals between pockets of more concentrated activity, may have led to Adult A not becoming well known to local crews. The Trust is currently undertaking work to define a frequent caller profile and subsequent expectations for the management of these cases will need to be agreed.

6.29 The Trust's safeguarding procedures state that ambulance crews should refer cases where they have concerns regardless of other agency interventions or other referrals being made. However, the Trust IMR states that the procedure does not make specific reference to making referrals in relation to cases of domestic abuse without there being additional parental or caring

responsibilities involved as, historically, these have not met local authority thresholds for intervention and generally are seen to be managed by the police.

6.30 This is an unusual interpretation of the Trust's own safeguarding policy and procedures and is not borne out by a review of the content. South East Coast Ambulance Service records indicate that it was aware of Adult A's alcoholism and his right-sided weakness. The service also attended numerous incidents where Adult A had been subject to domestic abuse, other assaults and alcohol-related falls. However, there is no evidence that any consideration was given to his vulnerability. Physical abuse, domestic violence and drug and alcohol abuse combined with Adult A's poor physical health and disabilities should clearly have triggered the completion of a vulnerable person report in accordance with the Trust's safeguarding procedures.

6.31 The Trust suggests that the failure to identify Adult A's vulnerability may have been due to his lack of caring responsibilities and his "choosing" to stay within his relationship with Adult B. Alternatively, it may have been due to his chaotic, heavy drinking lifestyle where violence and injury through falls are common. The Trust also states that Adult A's often aggressive and obstructive manner raises the possibility that ambulance staff felt that he was as much a perpetrator as a victim of violence.

6.32 On the basis of the Trust IMR, the Panel would draw the conclusion that Adult A's chaotic and alcohol dependent lifestyle obscured ambulance staff to his other health needs and vulnerabilities, including the risks posed by his violent relationship with Adult B. This led to a failure to instigate the Trust's safeguarding referral procedures.

6.33 The Trust also points out that the police and Frimley Park Hospital were frequently involved in incidents attended by South East Coast Ambulance Service and that crews may have assumed that these agencies would instigate appropriate procedures and support. However, this would also represent a breach of the Trust's safeguarding procedure, which requires the identification and referral of vulnerable adults regardless of the actions of other agencies.

Effective Practice/lessons Learnt

6.34 Emergency responses made by South East Coast Ambulance Service appear to have been managed appropriately and in line with Trust practices. Adult A was conveyed to hospital where appropriate and it was clearly documented when Adult A refused care. The Police were contacted in relevant cases.

6.35 There were some difficulties in accessing archived paper records as part of this review. In addition, the system was not able to identify incidents involving Adult A that took place in a public place due to its address-based nature without the use of corroborating information from other agencies.

6.36 This issue has been addressed by South East Coast Ambulance Service with a new records management system being in place since 2010. All patient records are now scanned and held centrally. This will not change the fact that the primary records system will be address driven. However, the Trust is currently undertaking a project using its Intelligence Based Information System (IBIS) which will improve the capture of information about patients.

6.37 Once fully evaluated and commissioned, this new system will enable the Trust to review all records from both address and individual patient levels and will facilitate much clearer identification of callers. This will be used to profile frequent callers and the Trust's response to these patients. However, it should be noted that there will still be occasions where it is not possible to identify patients, such as when they refuse or are unable to provide details.

6.38 No safeguarding referrals were made by the Trust in response to any of the incidents involving Adult A. Despite comments, feedback and encouragement from the Panel, South East Coast Ambulance Service did not identify any improvements or learning points arising from this review in relation to the application of its safeguarding procedures. The Trust states that there would not have been added value in ambulance staff completing a referral to the local adult social care team when the police were already involved. It also states that, given Adult A's chaotic lifestyle and alcohol dependence, understanding the risk of escalating domestic abuse would have been almost impossible for ambulance crews to identify.

6.39 It has already been noted that the Trust's records specifically detail three incidents of domestic assaults on Adult A, but that attending ambulance staff were aware of further occasions when his injuries had been caused by assaults by his partner. Given Adult A's known alcoholism and health condition, the Panel is of the view that these repeated domestic assaults should have resulted in his vulnerability being recognised and the completion of a vulnerable person report in accordance with the Trust's safeguarding procedures. Adult A's alcohol-dependency and lifestyle appears to have masked his vulnerability rather than being considered as a contributory factor.

6.40 The Trust's response that the lack of a referral may have been due to Adult A not having any caring responsibilities demonstrates a lack of clarity or understanding of its own current safeguarding policy. It is recommended that the policy should be reviewed to emphasise that domestic abuse is a standalone factor in assessing the vulnerability of adults.

6.41 It is also worth repeating that the co-attendance of the police at incidents following alleged domestic assaults is not a satisfactory reason for not making safeguarding referrals and is contrary to the Trust's own policy. This matter should also be clarified in the policy and associated guidance and training for staff.

6.42 On a more positive note, South East Coast Ambulance Service NHS Foundation Trust is currently scoping a partnership with a local domestic abuse charity to pilot a screening toolkit for domestic abuse risk and onward referral to an independent domestic violence advocate service. This service would refer cases to the relevant MARAC or offer other support as required.

Recommendations

6.43 That South East Coast Ambulance Service NHS Foundation Trust be strongly urged to:

(a) review its safeguarding policy and procedure to ensure that domestic abuse is identified as a standalone factor in assessing the vulnerability of adults;

(b) ensure ambulance staff receive guidance and training on the application of its safeguarding procedures in relation to incidents of domestic abuse, including:

(i) the requirement to make safeguarding referrals in appropriate cases regardless of the actions or interventions of other agencies; and

(ii) the identification of vulnerable adults, including victims of domestic abuse, in the context of alcohol and substance misuse regardless of gender.

7. GENERAL PRACTICE (GP)

7.1 Brief overviews have been provided by both Adult A and Adult B's GPs in connection with this review. These, together with an analysis of their medical records undertaken by NHS Hampshire and information provided by Frimley Park Hospital NHS Foundation Trust, have been used to provide the following summary of the involvement of general practice in this case.

Review of Involvement (Adult A)

7.2 Adult A had been registered at a surgery in Aldershot since 11 March 2008, just after he commenced his relationship with Adult B. He had been registered at the surgery for two previous periods from 1989 to 1996 and 1998 to October 2007.

7.3 Adult A was seen by the registrar on 11 March 2008 to obtain a Med 3 Certificate indicating that he was not fit for work. This was granted for a period of one month with a diagnosis of depression and alcoholism. At his appointment, Adult A commented that he was much happier, in a new relationship and trying to cut down on his drinking. He was stable on a methadone prescription of 20 mls and was receiving Paroxetine for depression. He also advised that he was waiting to be seen by the Acorn Drug and Alcohol Service. Acorn Drug and Alcohol Service records indicate that no approach had been made by or on behalf of Adult A at this time. Adult A was seen again and reviewed by the registrar a month later. He reported that he was not sleeping well and it was suggested that he use relaxation tapes.

7.4 Adult A attended the surgery on various subsequent occasions in 2008 in connection with his prescription drugs, depression, alcohol use, medical certificates and lower back pain. Frimley Park Hospital did not notify the practice of his Emergency Department attendance on 1 May 2008 following an alleged assault by Adult B.

7.5 Adult A was seen by a GP at the surgery on 8 August 2008. He admitted to drinking heavily again and stated that he was staying at his parents' home. By the time Adult A was seen by the practice on 22 October 2008, he reported that he was living with his girlfriend again, who was also known to be an alcoholic, and he admitted to drinking four cans of strong lager a day.

7.6 The practice was informed that Adult A had attended the Emergency Department at Frimley Park Hospital once on 26 November 2008 and on two separate occasions on 27 November 2008 following falls linked to alcohol and a weakness to the right side of his body. He was seen by his GP on 28 November 2008 in relation to these incidents. He was covered in bruises, smelled strongly of alcohol and admitted to falling regularly. He denied that his balance problems could be due to alcohol.

7.7 Adult A was seen again at the practice on 23 December 2008. He was very drunk and covered in facial bruises. Adult A was admitted to Frimley Park Hospital overnight and given a CT scan, which was found to be normal. He reported no weakness to his right side, although his speech was affected. He was seen again on 5 January 2009 at the practice and was advised that he would need to be referred to the Neurology Clinic at Frimley Park Hospital.

7.8 Following his conviction and custodial sentence on 17 February 2009, Adult A was released from HM Prison Winchester on 30 March 2009. He had completed a methadone detoxification regime and had been prescribed Citalopram for depression and Promethazine to reduce agitation.

7.9 On 26 June 2009, the practice received notification of an examination of Adult A at the Neurology Clinic at Frimley Park Hospital regarding his right-sided weakness. This suggested cerebral

demyelination or spinal damage following a fall as potential causes. MRI scans of his brain and spine were planned to explore this further.

7.10 Adult A attended the surgery on 3 July 2009 about his insomnia. His alcoholism and possible engagement with the Acorn Drug and Alcohol Service were discussed, but Adult A was not interested in cutting down his drinking. A number of further routine appointments were attended by Adult A in the following months concerning prescription drugs and medical certificates.

7.11 It appears that the practice was informed that Adult A had been seen in triage at the Emergency Department of Frimley Park Hospital on 28 September 2009 with a laceration to his face. However, no such notification seems to have been received about his two attendances at the Emergency Department on 29 September 2009 following alleged assaults by Adult B.

7.12 The practice was notified of the results of a scan on Adult A undertaken at the Neurology Clinic at Frimley Park Hospital on 29 October 2009. This showed scarring of his brain and that it was thinner than expected for a man of his age, which would be compatible with alcohol-induced damage. Adult A was seen at the practice on 30 October 2009 and was very pleased to report that he had not had a drink for five weeks. The GP highlighted the need for care at Christmas and to avoid alcohol, which had been a time of increased incidents in previous years.

7.13 Adult A was seen again in the Neurology Clinic at Frimley Park Hospital on 17 November 2009 and was noted to have an increasing tremor. The abnormal findings of the brain scan were explained and the GP was notified of a planned MRI scan of his spine. The Neurologist wrote to Adult A on 24 February 2010 as he had failed to attend the MRI scan and this was followed up by a letter from his GP.

7.14 Adult A was seen at the surgery on 20 November 2009 regarding his medication and a medical certificate was given to him. He reported drinking about 30 units of alcohol per week.

7.15 The practice was informed of Adult A's admission to the Emergency Department at Frimley Park Hospital on 24 December 2009 following the alleged assault by Person 3. He had received multiple injuries and required six stitches in his neck having been stabbed with a pair of scissors.

7.16 Adult A was seen by the practice on 5 August 2010. He stated that he had fallen down the stairs as it was dark and that he had a pain in his neck.

7.17 The practice does not appear to have been notified of Adult A's attendance at the Emergency Department of Frimley Park Hospital on 23 October 2010 following an alleged assault by Adult B.

7.18 Following an appointment on 15 November 2010, the practice wrote to the Neurologist to confirm that Adult A had now decided that he did want to have the MRI scan. He also advised that his new address was at his parents' home in Aldershot, although he would still be accessible through his girlfriend's address in Ash. The GP received a copy of a letter sent by the Neurologist to Adult A on 19 November 2010 asking him to confirm that he would attend if the scan was rescheduled.

7.19 Adult A attended the surgery on 21 January 2011. He was drinking heavily again and was tearful and depressed. The GP advised Adult A to re-engage with the Phoenix alcohol misuse counselling service in Aldershot. He attended again on 28 January 2011 feeling ill. He reported cutting down on alcohol and stated that he would attend Phoenix.

7.20 The Neurologist at Frimley Park Hospital copied a letter sent to Adult A on 9 February 2011 to the practice. This asked him to confirm that he would attend the proposed MRI scan if it was rescheduled as he had failed to attend the previous appointment.

7.21 Adult A was seen at the practice on 3 June 2011 where he complained of a head injury following two alcohol-related falls the previous night. An ambulance crew had attended and assessed him at the time, but he had refused to go to hospital. He advised that he was aiming to cut down his alcohol usage and was waiting for a response from the Acorn Drug and Alcohol Service. There is no evidence that Adult A had made any approach to Acorn at this time.

7.22 On 13 September 2011, a second test confirmed that Adult A was Hepatitis C positive. He was referred to the Gastroenterologist at Frimley Park Hospital as liver blood tests were also abnormal. The Gastroenterologist copied a letter sent to Adult A on 27 October 2011 to the practice asking that he have blood tests before his clinic appointment. The Gastroenterologist wrote to the practice on 16 November 2011 about the plan of care for Adult A having seen him in the clinic that day.

7.23 Adult A was seen at the practice on 23 November 2011 complaining of abdominal pain. He was drunk and unable to stand and fell over a number of times on his way to the room. The GP noted that Adult A had fallen on many occasions recently and that he felt unsteady on his feet. He had facial bruises consistent with falls.

7.24 Adult A was seen by a nurse at the practice on 30 November 2011 and was asked to make an appointment for his blood tests. Adult A reported that he was finding sleeping difficult after reducing his alcohol consumption as advised by the consultant due to his liver problems (although this was not evidenced by his previous attendance on 23 November 2011). The GP was reluctant to prescribe sleeping tablets and advised him to discuss this at his clinic appointment.

7.25 Adult A attended his appointment at the clinic at Frimley Park Hospital to review his viral hepatitis on 14 December 2011 in the company of Adult B, but failed to attend two subsequent appointments on 23 January and 13 February 2012. The practice was notified on each occasion.

Review of Involvement (Adult B)

7.26 Adult B has been registered at a different surgery in Aldershot since August 2001. Initially, the practice would not release details of Adult B's medical records without her informed consent. However, following her conviction, the practice reviewed Adult B's records to determine whether any opportunities had been missed to predict or prevent the death of Adult A and agreed to release her records if required.

7.27 Adult B was known by the practice to have substance misuse problems and to be under the care of the Acorn Drug and Alcohol Service. She was an irregular attendee at the surgery and there were gaps in her records presumed to be due to terms in prison. The exact nature of her convictions were unknown, but they were assumed to be related to drugs misuse. No prison health records had been received by the practice and no concerns had been raised.

7.28 The practice had not received communications from any other service or agency to make it aware of any previous domestic abuse or any increased risk and nothing had been disclosed by Adult B in consultations. The practice was aware that her partner was registered elsewhere, but had no information of concern about him.

7.29 Given this response, the Panel concluded that there were no opportunities for the practice to predict or prevent the murder of Adult A or to mitigate risks of further domestic abuse.

Analysis of Involvement

7.30 Adult A's practice was aware of his substance and alcohol abuse problems, neurological symptoms and associated poor physical condition and history of self-harm and depression. He often presented with facial injuries and bruises caused by falls and reported being unsteady on his feet. In November 2011, Adult A even fell over several times at the surgery when attending an appointment. His girlfriend was also known to be an alcoholic. These were clear risk factors and indicators of Adult A's vulnerability.

7.31 However, no concerns or disclosures about domestic abuse were made by Adult A to GPs or staff at the surgery. In addition, Frimley Park Hospital failed to notify the practice about Adult A's Emergency Department attendances following alleged assaults by Adult B. As a result, no consideration was given by the practice to the instigation of its safeguarding procedures.

7.32 Despite the risk factors, there is no record that Adult A was ever asked about domestic abuse. The practice's policy is that, as in all primary care consultations, a general enquiry would routinely be made about the effect of a patient's problems on their home, work and social life.

Effective Practice/lessons Learnt

7.33 The practice concerned recognises Adult A's death as being a significant event and will be reviewing its policies to determine whether changes could improve outcomes in similar cases in future. Its lead for safeguarding vulnerable adults will also be attending training on domestic abuse, particularly in the context of vulnerable adults, to raise awareness and disseminate relevant information within the practice. In this particular case though, it should be noted that the practice was unaware of any domestic abuse in Adult A's relationship.

7.34 However, general practice may be the first formal agency where the victim presents in many cases of domestic abuse. GPs may have an opportunity to help victims through early identification and sign-posting to specialist support services. Current best practice guidance to GPs covers issues such as:

- awareness of and engagement with local domestic abuse services;
- recognising the signs of domestic abuse;
- enquiring sensitively about domestic abuse;
- training for practice staff;
- procedures following the disclosure of domestic abuse by patients; and
- information sharing and multi-agency working.

7.35 The Panel considers that the opportunity should be taken to remind general practice of the need to have effective procedures and arrangements in place for dealing with domestic abuse. Given the presence of significant risk factors, it is also considered that GPs should be encouraged to be pro-active in enquiring sensitively about possible domestic abuse. Such interventions would be more likely if this was backed by sound knowledge of local domestic abuse support services.

Recommendations

7.36 That the strategic lead for domestic abuse of the Guildford and Waverley Clinical Commissioning Group ensures that general practices maintain effective procedures and arrangements for dealing with cases of domestic abuse, including to encourage GPs to be pro-active in enquiring about possible domestic abuse in appropriate cases.

8. SURREY COUNTY COUNCIL

8.1 Surrey County Council's only record of involvement with Adult A concerned the receipt by Adult Social Care of the 39/24 (Vulnerable Adult Coming to the Notice of Police) form completed by PC 1 following the domestic incident responded to by Surrey Police on 23 October 2010. This is discussed further below. Surrey County Council has no record of any contact with Adult B.

Review of Involvement

8.2 The Adult Social Care Contact Centre, which is responsible for first telephone contacts and referrals from professionals, individuals and other organisations, received a 39/24 (Vulnerable Adult Coming to the Notice of Police) form from Surrey Police on 25 October 2010. The form detailed domestic violence inflicted on Adult A by Adult B, as follows:

> "He [Adult A] said Adult B kicked him and then pushed him down the stairs although he was confused about the order of events. He just kept stating that his ribs really hurt and he wanted to leave the [Frimley Park] hospital. He said he would go and stay with his mother [in Aldershot].
>
> Adult A was still very intoxicated and his words were slurred. He was not capable of providing a statement or providing answers to the DASH risk assessment. The most information he provided was that she hits him all the time and he kept bursting into tears when asked any further details.
>
> The hospital stated that they would not release him to his mother's address unless they knew that there would be someone there to observe him throughout the night. They stated that there was a possibility that Adult A could have fractured ribs although this did not show up on X-ray they could not discount it either.
>
> According to the original informant Adult B and Adult A both have serious drink problems which has frequently resulted in violent incidents between them.
>
> Pending the DASH assessment being completed once Adult A is capable of answering the questions and based on the history known so far between these two and the fact there have been several repeat incidents I would deem this as high risk.
>
> Photos have been taken of his injuries and these are exhibited as PAB/2 Photos. These will be placed with the handover."

8.3 The police report was considered in accordance with the protocol for staff at the Adult Social Care Contact Centre, as follows:

- Is there a vulnerable adult/adult at risk involved?
- Is there evidence or an allegation of abuse?
- If the above are confirmed, a profile note is made.

8.4 In this case, a profile note recording the contacting agency, type of contact and reason for contact was created and the police report was logged on the Adult Information System by a support worker at the contact centre. It was agreed that this was a safeguarding situation and recorded as such. The details and assessment were checked and confirmed by the Team Manager and faxed to the Guildford Community Mental Health Team (CMHT) on 26 October 2010. There was

no further contact with the Guildford CMHT as there is an expectation by contact centre staff that action will be taken in response to a safeguarding alert.

Analysis of Involvement

8.5 Surrey Adult Social Care works to the Surrey Safeguarding Adults Multi-Agency Procedures, Information and Guidance 2011. This requires Adult Social Care to assess reported information and decide whether this relates to a vulnerable adult. If it does, a decision is made about the type of abuse that may have occurred.

8.6 The report on Adult A was assessed by a social worker at the contact centre, who agreed that this was to be recorded as a safeguarding contact. The safeguarding procedures had been applied appropriately up to this point.

8.7 The safeguarding adults protocol then requires the details to be sent to the relevant service team to initiate further investigation. In the case of Adult A, the information was sent to a community mental health team. It is not clear why this decision was taken as alcohol abuse, rather than mental health issues, was identified as the primary concern in the police report. In addition, community mental health teams only accept referrals from an individual's GP and would not have accepted a direct referral from Adult Social Care.

8.8 The report on Adult A was also sent to the Guildford Community Mental Health Team. However, the relevant area community mental health team depends upon the location of an individual's GP. No details of Adult A's GP were recorded and this information was not included in the police report. As Adult A's GP was based in Aldershot, the correct geographical referral would, in fact, have been to a Hampshire community mental health team.

8.9 There is no indication that the Guildford Community Mental Health Team forwarded the relevant information to the correct service team or informed the Adult Social Care Contact Centre that an incorrect referral had been made.

8.10 The referral should, in fact, have been made to the Guildford Locality Team, the local adult social care team. This would have instigated an initial safeguarding meeting with relevant partners, including Adult Social Care, Surrey Police and South West Surrey Domestic Abuse Outreach Service, and efforts would have been made to engage Adult A.

8.11 The effectiveness of the safeguarding adults procedures was not tested in relation to the domestic abuse experienced by Adult A as the case was not referred or forwarded on to the correct team. In addition, the Adult Social Care Contact Centre was not informed that the report had been sent to the wrong team. Therefore, no safeguarding action was taken in response to the police report.

8.12 The police report had originated from a domestic incident on 23 October 2010, which had resulted in Adult A attending Frimley Park Hospital. There was an opportunity for hospital staff to raise a safeguarding alert for Adult A at this time, but there is no record that the Adult Social Care Team at Frimley Park Hospital was alerted to any concerns. Therefore, no assessment was carried out and another opportunity to offer support to Adult A through the safeguarding process was missed.

Effective Practice/Lessons Learnt

8.13 The Surrey Adult Social Care Team had no contact with Adult B and was involved in only one incident concerning Adult A. Department-wide safeguarding adults procedures are in place and

staff are required to have attended relevant training so that they are aware of what constitutes a safeguarding alert and the appropriate action to be taken.

8.14 In this case, Adult A's vulnerability was correctly identified in the context of domestic abuse and safeguarding. However, despite this, an incorrect referral meant that appropriate safeguarding procedures were not implemented. A recommendation is included to address this issue.

Recommendations

8.15 That Surrey County Council introduces a process to ensure that Adult Social Care receives confirmation of the correct receipt of a safeguarding referral from relevant service teams.

9. SOUTH WEST SURREY DOMESTIC ABUSE OUTREACH SERVICE

9.1 The South West Surrey Domestic Abuse Outreach Service received one referral from Surrey Police for Adult B and one for Adult A. The action taken by the service in response to those referrals is discussed below.

Review of Involvement

9.2 Following a domestic incident on 23 November 2009, Adult B accepted an offer from IO 1 of Surrey Police of support from the South West Surrey Domestic Abuse Outreach Service. IO 1 referred the case to the outreach service on 24 November 2009.

9.3 In response to the referral, the outreach service made three telephone calls to Adult B on separate days and at different times, but no answer was received. No message was left with any of these calls and no letter was sent as the alleged perpetrator lived at the same address and it was not considered safe to do so.

9.4 PC 12 of Surrey Police referred Adult A to the outreach service following a domestic incident on 19 May 2010, despite him declining the offer of such support. The outreach service again made three telephone calls to Adult A on separate days and at different times and again no answer was received. Messages were not left and no letter was sent as this was not considered to be safe.

Analysis of Involvement

9.5 The Surrey Domestic Violence Outreach Core Standard Service Criteria states that contact should be attempted three times by telephone and, if this is without success, a letter should then be sent (if safe to do so). Should no contact then be received, the referral is entered on a database and the paperwork is filed.

9.6 For each of the referrals made to the South West Surrey Domestic Abuse Outreach Service in this case, the relevant minimum requirements were met and appropriate protocols were followed. However, no contact was made with either Adult A or Adult B and no further communication took place with other agencies, including the referrer, Surrey Police.

Effective Practice/Lessons Learnt

9.7 The South West Surrey Domestic Abuse Outreach Service met its core requirements in dealing with the referrals of Adult A and Adult B. In this case, it is difficult to envisage that Adult A or Adult B would have engaged with support services even if contact had been made.

9.8 Consideration has been given to the possibility of reporting back to the referring agency when no contact has been possible. However, there is no clearly identifiable point in time following a referral when the service would be able to conclude categorically whether individuals had engaged or not. Individuals may self refer at any time or be referred by a variety of other sources. Such notifications would also create a significant administrative burden on the service. However, agencies need to be aware that a referral to the outreach service does not mean that a victim of domestic abuse has been successfully contacted and engaged.

9.9 In this and other repeat cases of domestic abuse, the most appropriate forum for sharing information about interventions and outcomes would be the relevant MARAC. Adult A and Adult B should clearly have been referred to the West Surrey MARAC and, if this had been the case, agencies would have been aware that South West Surrey Domestic Abuse Outreach Service had been unable to contact them after their respective referrals.

10. RUSHMOOR BOROUGH COUNCIL

10.1 Rushmoor Borough Council records indicate that Adult A submitted a significant number of bids for properties within its area. However, paper records relating to Adult A, including his original application for housing and any associated contemporaneous notes, have been destroyed in accordance with the Council's data retention practices. Therefore, this review of the involvement of Rushmoor Borough Council with Adult A is based on its electronic files and an interview with his housing case manager.

Review of Involvement

10.2 Adult A was accepted on Rushmoor Borough Council's housing register on 9 June 2005 and awarded the following points to determine his priority for accommodation:

Time On List	40
No Separate Private Access To Home	5
Non Household Member Shared Facility	10
Bedroom Deficiency	10
Total Points	65

10.3 On 9 July 2007, a request to renew his application was sent to Adult A at his mother's address. Adult A remained on the housing register after this time and, therefore, it is assumed that a positive response was sent to the Council.

10.4 On 12 November 2008, a process note was entered in Adult A's records that he was no longer in prison. A housing update form was sent to Adult A and his application was suspended pending receipt. Again, Adult A remained on the register after this time, so it would appear that the form was returned.

10.5 On 6 February 2010, the Council agreed to award Adult A ten additional points due to his homelessness. This would have followed contact by Adult A to advise of a change in his circumstances (e.g. that he could no longer stay at his current address). It also appears that Adult A notified the Council at this time about his medical condition.

10.6 On 16 February 2010, the Council sent a letter to Adult A confirming his acceptance on the housing register and detailing a change to his circumstances and the points awarded, as follows:

Time On List	40
No Separate Private Access To Home	5
Non Household Member Shared Facility	10
Bedroom Deficiency	10
Homeless	10
Total Points	75

10.7 The letter requested that Adult A submit a medical questionnaire and proof of current medication in support of his claim that his health was being adversely affected by his living accommodation. Adult A was also asked to provide proof of local residence, in the form of a utility bill, bank statement or official letter, in support of his application.

10.8 From February 2010 to January 2011, Adult A made 29 unsuccessful bids for properties in Aldershot, Farnborough, Ash, Farnham, Fleet and Guildford.

10.9 On 26 January 2011, a process note was entered in Adult A's record that he had not made contact for a period of one year since the award of homelessness points in February 2010. A decision was taken to remove the homelessness points until Adult A could show what he had been doing for that 12 month period. This suggests that Adult A had not responded to the request to complete a medical questionnaire and provide proof of his current medication and local residence.

10.10 In January and February 2011, Adult A made a further seven unsuccessful bids for properties in Aldershot, Farnborough and Guildford.

10.11 On 22 February 2011, a process note was entered in Adult A's record that he had been in prison for nine months and had been sofa surfing since his release in March 2010. (Adult A had actually been released from prison in March 2009). It was also recorded that Adult A had found a one-bedroom property and wanted rent in advance. Adult A was informed that the Council could not assist and he was advised to apply to the Job Centre for a rent in advance loan.

10.12 Adult A made four further unsuccessful bids in March 2011 for properties in Aldershot and Farnborough. These were the last bids submitted by Adult A.

10.13 In April and May 2011, letters were sent to all housing register customers explaining that a failure to respond confirming their continued need to be on the housing register would result in the revocation of their eligibility.

10.14 On 25 August 2011, a medical questionnaire was sent to Adult A. This would have followed notification by Adult A of details of his medical condition. It would appear that no response was received from Adult A to the questionnaire.

10.15 Adult A failed to respond to the generic letter after one year resulting in the revocation of his eligibility for inclusion on the housing register and the destruction of his file in July/August 2012.

Analysis of Involvement

10.16 Over the past 18 months, Rushmoor Borough Council's Housing Service has been through a development process, including migrating from paper-based files to an electronic system. As part of this, a decision was made to review the status of all customers on the housing register. This involved sending a generic letter to all housing applicants requesting a positive response if they wished to remain on the register. Where individuals failed to respond within a 12 month period from the date of the letter, the case was closed and the file destroyed in accordance with data protection principles. Adult A failed to respond to the generic letter and, in line with agreed practice, his case was closed and his file destroyed. As a result, it has not been possible to conduct a thorough investigation into the information provided in Adult A's original or subsequent applications for housing or any notes made as a part of the application process.

10.17 It is clear that Adult A made his original application for inclusion on the Council's housing register on 9 June 2005. As priority points are specifically awarded to applicants experiencing domestic abuse, no reference to this issue could have been made by Adult A at this point. Subsequent changes recorded to Adult A's circumstances also indicate that no reference was made to domestic abuse in relation his housing applications.

10.18 It has not been possible to ascertain the level of one-to-one contact that Adult A had with staff in connection with his housing needs. The cited contact is based on computer generated records of bids made by Adult A for available properties and individual case administration.

10.19 Adult A made his last bid for a property approximately 12 months before his death. After this, he failed to respond to a request from the Council to confirm his housing needs and, therefore, retain his place on the housing register.

10.20 Whilst the number of bids made by Adult A suggests significant engagement with housing staff, in reality, contact was minimal. Adult A had not bid on any properties for some time prior to his death and had failed to respond to correspondence from the Council. Therefore, it was reasonable to assume that he no longer wished to remain on the housing register. Staff are required to destroy case files that are no longer active on the understanding that an individual is at liberty to make an application for housing at any time and that this would be processed without prejudice in line with normal working practices.

Effective Practice/Lessons Learnt

10.21 As part of the significant changes made to the Council's housing service, a review of all clients on the housing register was undertaken to ensure that it is current and relevant. Electronic data management processes have now been established and this will ensure that all records are comprehensive and auditable in future. Data retention practices in relation to existing paper files are sound and the service adopts a positive attitude to processing applications.

10.22 Although not directly related to this case, discussions resulting from the review have revealed that staff would benefit from refresher training around safeguarding, substance misuse and understanding the nature of addiction. These requirements will be identified as part of a service training needs analysis process.

11. GUILDFORD BOROUGH COUNCIL

11.1 Guildford Borough Council records indicate only limited involvement and contact with Adult A and Adult B, as described in the following paragraphs.

Review of Involvement

11.2 The Council had a series of routine correspondence and communications with Adult B regarding benefits claims in relation her home in Ash in the period 11 February 2008 to 8 May 2012. This was a private rented property and, apart from spells in prison, had been her sole known address in that period. The four benefits application forms on file all showed Adult B claiming to live alone at the property.

11.3 The Council did respond to a complaint made by Adult B in January 2011 about the condition of the property. A visit was made to the property on 25 January 2011 and an officer met Adult B and her partner to discuss the required repairs. Liaison with the landlord resulted in the issue being resolved to the tenants' satisfaction.

11.4 The only contact with Adult A was by the Council's re-housing team. Adult A had bid, as a Rushmoor Borough Council housing applicant, for a number of properties in Guildford Borough through the Homeselecta[8] system. His application form showed contact address details as being c/o Adult A and Adult B's home in Ash. However, it stated that he was of no fixed abode and sleeping in parks and car parks or sofa-surfing with friends. He also stated that he was on medication for depression and had a medical condition that made walking difficult.

11.5 The bids for housing in the Guildford Borough area submitted by Adult A are detailed below:

(a) Adult A submitted a bid for a one-bedroom, first floor flat in Ash on 28 May 2010. The bid was refused by First Wessex Housing Association on the grounds of Adult A's previous anti-social behaviour. Adult A was notified of this decision by the Council.

(b) Adult A submitted a bid for a ground floor flat in Guildford on 1 July 2010. The property had been advertised as not being suitable for applicants with support needs and, therefore, he was not considered for or contacted about this property.

(c) Adult A submitted a bid for a ground floor flat in Guildford on 5 August 2010. Again, the property had been advertised as not being suitable for applicants with support needs. Adult A did not meet the criteria and was not contacted about the property.

(d) Adult A submitted a bid for a one bedroom ground floor flat in Guildford on 12 August 2010. The property was not suitable for applicants with support needs and, therefore, Adult A did not meet the relevant criteria. The Council attempted to contact Adult A to discuss the bids that he had been making and the fact that they were not meeting the required criteria due to his personal circumstances. However, records indicate that it was not possible to contact him.

(e) Adult A submitted a bid for a one bedroom ground floor flat in Guildford on 9 September 2010. However, ultimately, this property did not become available and Adult A was not contacted about it.

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[8] Homeselecta is a partnership arrangement between Guildford, Hart, Rushmoor and Waverley Councils under which each partner places a number of their own social housing properties into a pool . Housing applicants from the other partner areas can bid and will considered for these pooled properties.

(f) Adult A submitted a bid for a one bedroom first floor flat in Ash on 16 September 2010. The Council attempted to contact Adult A to confirm his interest in this property, but was unable to do so.

(g) Adult A submitted a bid for a one bedroom flat in Guildford on 20 February 2011. The marketing information stated that preference would be given to Waverley applicants, then Hart, then Rushmoor. It also stated that the property was not suitable for applicants who have or have had support in the past. An applicant from Waverley accepted the tenancy and Adult A was not contacted about it.

11.6 The Council's records show no further contact with Adult A or knowledge of his whereabouts.

Analysis of Involvement

11.7 The Council's IMR provides additional evidence that Adult A was making some attempts to secure his own housing accommodation during his relationship with Adult B. He submitted seven unsuccessful bids for housing in Guildford Borough between 28 May 2010 and 20 February 2011. This supplements the larger number of bids for housing submitted to Rushmoor Borough Council, but also demonstrates that Adult A was prepared to consider living in the Guildford area as well as in Aldershot or Ash.

11.8 The Council applied its housing allocation procedures and criteria in the appropriate way in connection with the bids submitted by Adult A. At one point, unsuccessful attempts were made to contact Adult A to discuss the type of bids he was submitting and the reasons that they did not meet the relevant criteria. It was also not possible to contact him to progress his bid for a property in Guildford on 16 September 2010.

11.9 None of these housing bids, nor any other contacts with Adult A or Adult B, raised any issues relating to domestic abuse. Indeed, the Council had no information or reason to believe that Adult A and Adult B were in a relationship.

Effective Practice/Lessons Learnt

11.10 The Council had no involvement in any relevant incidents prior to the death of Adult A. However, as a result of this review, the Council has produced new guidance for all staff on domestic abuse. The primary purpose is to ensure that staff respond appropriately to potential cases of domestic abuse involving residents or colleagues. Awareness raising sessions are also being arranged for managers and frontline workers.

12. SURREY AND BORDERS PARTNERSHIP NHS FOUNDATION TRUST

12.1 Surrey and Borders Partnership NHS Trust had limited contact with Adult A. This all pre-dated his relationship with Adult B and involved a previous manifestation of its Acorn Drug and Alcohol Service. The main period of contact was between 2000 and 2003 when Adult A received some support from outreach workers, whose role was to assist those who found it difficult to engage with support services. However, these interventions did not result in Adult A becoming a client.

12.2 The Trust had more extensive involvement with Adult B through the Acorn Drug and Alcohol Service and this is reviewed further in this section of the report.

Review of Involvement (Adult B)

12.3 As has been noted previously, Adult B had alcohol and drug addiction problems. She was referred to the Acorn Drug and Alcohol Service in November 2005. Following an assessment, a prescription for methadone commenced in April 2006. Except for a period in prison during November and December 2007, Adult B attended appointments at Acorn clinics at Frimley Park Hospital, albeit erratically, from this date until 28 March 2008. Adult B was formally discharged from the service on 26 July 2008, when she had not been seen for four months.

12.4 Adult B was referred back to Acorn following her release from HM Prison Bronzefield and prescribing of methadone and reducing diazepam commenced on 28 May 2009. Adult B attended her Acorn Drug and Alcohol Service appointments on a regular basis up to Adult A's death. Records show the following incidents of note:

(a) Adult B disclosed use of heroin by herself and her partner (17 September 2009).

(b) Adult B said that she was struggling to avoid using illicit drugs and a potential increase in her methadone prescription was discussed (15 October 2009). Her prescription was increased to 50mg per day on 28 October 2009 and to 60mg on 26 November 2009.

(c) Adult B reported that she had not used heroin, but that her partner continued to use heroin and street methadone (12 November 2009).

(d) Adult B reported using heroin once in the week prior to her appointment (10 December 2009).

(e) Adult B discussed her increasing alcohol consumption and expressed frustration that she was not eligible for incapacity benefits as her methadone script prevented some forms of employment (21 January 2010).

(f) Adult B reported illicit drug use and increased drinking (4 and 18 February 2010).

(g) Adult B disclosed use of crack cocaine and heroin and reported that her Hepatitis C screen had tested positive for antibodies (1 April 2010).

(h) Adult B complained of financial hardship and requested to plan for a reduction in her methadone prescription (15 April 2010).

(i) Adult B reported a cessation of alcohol to prepare for her Hepatitis C treatment (29 April 2010).

(j) Adult B reported drinking again and heroin use (27 May 2010).

(k) Adult B reported being currently abstinent from alcohol (30 September 2010).

(l) Adult B claimed to be using one £10 bag of heroin per week (25 November 2010).

(m) Adult B reported being abstinent from heroin for the previous two weeks (20 January 2011).

(n) Adult B advised that she had used heroin with her brother in the previous week (17 February 2011).

(o) Adult B continued to use illicit drugs on top of her prescription (17 March 2011).

(p) Adult B stated that she had used street diazepam to compensate for the lack of a methadone prescription since missing her appointment on 20 April 2011 (28 April 2011).

(q) Adult B reported detoxing herself from alcohol (24 June 2011).

(r) Adult B stated that she had not used heroin despite her partner's continuing use (29 July 2011).

(s) Adult B reported continuing abstinence from both drugs and alcohol. (12 August 2011).

(t) Adult B reported feeling well and refraining from alcohol and heroin use. She agreed to try a reduction in prescribed methadone (9 September 2011).

(u) Adult B reported that an argument with her partner had led to a lapse with her alcohol use (28 October 2011).

(v) Adult B expressed determination to pursue treatment for her Hepatitis C and to continue a reduction in prescribed methadone (11 November 2011).

(w) Adult B discussed treatment options for her partner and was advised that his best pathway would be through HOMER (Hampshire Operational Model For Effective Recovery), which provided a treatment and support service for those over the age of 18 years with a focus on recovery and community reintegration.

(x) Adult B's prescribed methadone dose continued to reduce as agreed with her (6 January 2012).

(y) Adult B discussed stress relating to benefits problems (3 February 2012). This was the last time that Adult B attended an appointment with the Acorn Drug and Alcohol Service.

12.5 Up to 24 June 2011, Adult B periodically disclosed illicit drug use on top of her methadone script and varying levels of alcohol consumption. From this point until her last appointment, Adult B generally reported abstinence from both drugs and alcohol. From September 2011, she persisted with a programme to reduce her methadone prescription. These reports coincide with her stated desire to pursue treatment for Hepatitis C.

12.6 These self-reported efforts to bring more order to her life must be considered with some caution as they are not entirely reflective of the views of other agencies or evidence given by neighbours and others at Adult B's trial regarding her alcohol and drug use. However, Neighbour 5 did

express the view that Adult B's drinking had reduced over the 18 months leading up to the Adult A's death.

Analysis of Involvement

12.7 During most of the period of her engagement with the Acorn Drug and Alcohol Service, Adult B was required to travel from her home in Ash to Frimley Park Hospital (6 miles) on a fortnightly basis. Eventually, she was offered appointments in a satellite clinic in Ash Vale, less than two miles away. On occasion, staff would assist in the effective maintenance of her prescribed needs by delivering prescriptions to her local chemist. This constituted a reliably accessible treatment program and was an example of good practice. The Acorn Service was generally effective at retaining its engagement with Adult B by continuing planned care, despite routine non-attendance at appointments at some points.

12.8 An assessment of clients' needs is central to the Acorn and other Surrey and Borders Partnership NHS Trust services. A comprehensive tool is used to assess risks, including the potential of violence either as a victim or perpetrator. Relevant assessments were performed in relation to Adult B and no risks of domestic violence were identified.

12.9 Practitioners were aware that Adult B was periodically upset about arguments that she may have had with her partner, but had no sense that such events were potentially violent altercations. They were never described as such by Adult B and there were no visible signs of violence during her appointments.

Effective Practice/Lessons Learnt

12.10 The Trust's policy on domestic abuse aims to ensure that all staff are aware of its commitment to raising awareness of the issue and guidance is provided to staff about its occurrence and effects. The policy also includes good practice guidelines and screening advice.

12.11 Trust clinicians are offered Surrey County Council provided training on issues relating to domestic abuse as routine. Although this is not mandatory for staff, there is a clear expectation that all practitioners will attend on at least a three yearly basis. It is recommend that such attendance should become mandatory.

12.12 Records held by the Acorn Drug and Alcohol Service confirm that relevant risk assessments were performed in relation to Adult B. However, these were not always well documented in her care records as they evolved. For example, it is not clear that risks were re-assessed after Adult B reported arguments with her partner.

Recommendations

12.13 That Surrey and Borders Partnership NHS Foundation Trust:

(a) require all relevant practitioners to attend mandatory domestic abuse training on a three yearly basis; and

(b) review existing risk assessment processes to ensure that care records and risks are updated to reflect clients' evolving and changing circumstances.

13. HAMPSHIRE PROBATION TRUST

13.1 Hampshire Probation Trust has had involvement with Adult A since 1994. This followed community orders made by the courts and periods where Adult A was on licence following custodial sentences. As described previously, Adult A had an extensive history of offending, including public order offences, violence, robbery, theft, drugs and criminal damage. He had also been managed under MAPPA and PPO arrangements due to his high risk of re-offending. Adult A was last supervised by Hampshire Probation Trust in October 2007.

13.2 Hampshire Probation Trust also had extensive contact with Adult B. This started in 1991 and, as with Adult A, the Trust's involvement had been regular, with the last period of formal supervision ending in 2007. Adult B's extensive history of offending includes public order, violence, theft, fraud and drugs offences. Most notably, she received a seven year custodial sentence in 1999 for supplying Class A drugs.

13.3 Hampshire Probation Trust's final contact with Adult A and Adult B was in early 2009, which involved the completion of a pre-sentence report for a court hearing on 17 February 2009. This resulted in Adult A being sentenced to four months imprisonment for using threatening words and behaviour. Adult B was sentenced on the same day to six months imprisonment for an offence of causing racially aggravated intentional harassment, alarm or distress in relation to the same incident. As a result of these sentences, neither Adult A nor Adult B was subject to further involvement by the Probation Service as statutory licences are only part of the requirements for adult offenders sentenced to 12 months or more in custody.

Review of Involvement

13.4 Hampshire Probation Trust does not have records in relation to Adult A and Adult B dating back beyond 2005. Therefore, the focus of this review is on the Trust's period of contact with Adult A and Adult B in 2007 and the assessments completed for both of them in connection with the preparation of pre-sentence reports in 2009, as referred to above.

Involvement with Adult A in 2007

13.5 Adult A was convicted of five separate violence offences and received a 12 months custodial sentence on 12 January 2007. Due to the nature of the offences, he was registered as a Multi-Agency Public Protection Arrangements (MAPPA) case on 14 February 2007.

13.6 Adult A was released from prison on 14 June 2007 on licence under the statutory supervision of Hampshire Probation Trust. He attended the probation office on the same day smelling of alcohol and also admitted using heroin four weeks ago in prison. He reported that he was not in a relationship at this time.

13.7 Adult A failed to attend the following three mandatory appointments at the probation office on 19 June, 26 June and 3 July 2007. A warning letter and final warning letter were sent to Adult A after the first two missed appointments and, following the third failure to attend, recall proceedings were instigated. Adult A's licence was revoked by the Ministry of Justice on 4 July 2007 and he was returned to custody until the end of his initial licence date on 13 September 2012. After this date, he would then be released on licence until his sentence end date on 13 December 2007.

13.8 Adult A was re-released on licence on 13 September 2007 and was referred to and accepted at The Grange Approved Premises as part of the requirements of the licence. He was also required

to abstain from alcohol use and undergo regular drug and alcohol tests whilst at The Grange. Regular tests undertaken in the period up to 17 November 2007 produced mainly negative results demonstrating good progress by Adult A in relation to substance misuse.

13.9 A MAPPA meeting was held on 27 September 2007 and a decision was taken to register Adult A at Level 2 due to the need for active inter-agency involvement to manage the risk of harm presented by him. No domestic abuse issues were identified and, at the time, it appeared that Adult A was not in a relationship. However, it was recorded that, if Adult A was in a relationship, his partner could be at risk of abuse or violence.

13.10 In November 2007, plans were agreed to transfer Adult A to Elderfield, a Langley House Trust property in Otterbourne near Winchester working with ex-offenders. During a trial period at Elderfield, he received a warning from the hostel and a formal warning letter from his offender manager for being heavily drunk on 21 November 2007.

13.11 Adult A was visited at Elderfield by his offender manager on 13 December 2007, which was the end date of his licence and sentence. During the visit, Adult A was abusive to another resident and smelt of alcohol. However, this marked the end of Hampshire Probation Trust's statutory involvement with Adult A.

13.12 On 22 January 2008, Adult A attended the probation office in Winchester stating that he had been evicted from Elderfield following a fight and requested a travel warrant to return to Aldershot.

Involvement with Adult B in 2007

13.13 On 1 June 2007, Adult B received a 12 month community order for driving whilst disqualified from holding or obtaining a licence and driving without insurance. Both offences were committed on 7 March 2007. The order included the following requirements:

- supervision
- offender substance abuse programme
- curfew
- drug rehabilitation (including drug tests)

13.14 At her first appointment with her offender manager on 4 June 2007, Adult B reported using crack cocaine most days and heroin occasionally, with the latter being controlled by prescribed methadone. She attended her next six appointments and key worker sessions up to 21 June 2007 and, on each of the four occasions she was tested, the results were positive for drugs use.

13.15 On 26 June 2007, Hampshire Probation Trust was notified by G4S that Adult B had breached her curfew requirement on 13 occasions to date. As a result, court proceedings were instigated for a breach of the community order. The breach was discussed with Adult B at her appointment on 2 July 2007 and she was informed that a continuation of the community order would be recommended. However, she then failed to attend her appointment the following day.

13.16 Adult B attended a meeting to review her community order and drug rehabilitation requirement, including her breaches of the curfew, on 4 July 2007. The order was allowed to continue, subject to the extension of the drug rehabilitation requirement and curfew by one month. However, a final written warning was issued to Adult B in relation to her failure to report on 3 July 2007.

13.17 Adult B again failed to attend her appointment on 5 July 2007. A letter regarding the breach was sent to Adult B and the matter was listed in court for 18 July 2007. On 11 July 2007, Adult B

provided medical evidence from her GP for missed appointments and the breach proceedings were subsequently withdrawn.

13.18 Adult B then failed to attend her next appointment on 12 July 2007 and a final warning letter was sent to her the next day. She attended her next four key worker and drug test appointments between 17 July and 31 July 2007. At the first appointment, Adult B tested positive for drugs and, in the following three, there were some positive and some negative results.

13.19 Adult B attended a court review on 1 August 2007 and received some positive feedback on the reduction in her use of some illicit drugs. However, she failed to attend her appointment and drug test the next day and a final written warning was sent to her on 3 August 2007. The missed appointment on 2 August 2007 should, in fact, have resulted in breach proceedings being instigated as she had already received a final warning as a result of her failure to report on 12 July 2007. A second unacceptable absence should result in automatic breach proceedings to enable the courts to determine further actions.

13.20 Adult B did attend her next appointment on 7 August 2007. The drug tests revealed some positive and mainly negative results demonstrating progress being maintained. However, Adult B failed to attend her next appointment on 9 August 2007 and a further final written warning was sent. This was a third unacceptable absence by Adult B and, again, should have resulted in breach proceedings being instigated. She had also already received two previous final written warnings.

13.21 Adult B attended appointments as required between 16 August and 23 August 2007. Drug tests continued to show some positive and some negative results. She then failed to attend on 30 August 2007 and breach proceedings were instigated. She again missed appointments on 3 September and 4 September 2007, although no further action was required as proceedings had already been instigated.

13.22 The breach hearing on 5 September 2007 was adjourned to enable Adult B to provide medical evidence. She claimed that she had been unable to attend her appointments as she had been looking after her young nephew and had also been unwell.

13.23 Adult B failed to attend her subsequent appointment on 6 September 2007. She did attend on 11 September 2007 with some positive and some negative results to her drug tests.

13.24 At the breach hearing on 12 September 2007, Adult B pleaded guilty to one unacceptable absence on 30 August 2007. The court allowed the community order to continue and extended the drug rehabilitation requirement by two months.

13.25 Adult B attended for her key worker session and drug test on 13 September 2007. However, she was asked to leave as she was too drunk to engage in any meaningful session. Adult B attended her next three appointments. The results of drug tests were positive at the first and third appointments, whilst some positive and some negative results were recorded at the second. Adult B then failed to attend her appointments on 27 September and 1 October 2007. A final warning letter was sent after the first missed appointment, but no action appears to have been taken in relation to the second. Adult B's failure to attend on 1 October 2007 should have resulted in proceedings being instigated for a breach of her community order.

13.26 Adult B attended her appointments on 2 October and 4 October 2007, with some positive and some negative results from the drug tests. She failed to attend on 15 October and 18 October 2007. The latter resulted in breach proceedings being instigated and a court hearing was listed for 31 October 2007, although enforcement action should have been taken after Adult B's failure to attend on 15 October 2007.

13.27 The breach hearing was adjourned until 7 November 2007 to enable Adult B to apply for legal aid. In the interim, Adult B attended four appointments, missed one and turned up at the last on 1 November 2007 very drunk and was refused entry.

13.28 At the breach hearing, the court decided that there was no option other than to return Adult B to custody due to her "wilful and persistent breach" of the community order. The court also felt that a suspended sentence order would set Adult B up to fail and, therefore, sentenced her to four months imprisonment. The community order was revoked and, as the sentence was for less than 12 months, the involvement of Hampshire Probation Trust with Adult B ceased.

Involvement with Adult A and Adult B in 2009

13.29 As referred to previously, Hampshire Probation Trust's contact with Adult A and Adult B in 2009 was restricted to the preparation of pre-sentence reports to assist Winchester Crown Court in sentencing at a hearing on 17 February 2009. Adult A had been charged with using threatening words and behaviour and Adult B with causing racially aggravated intentional harassment, alarm or distress following an incident at a shop in Aldershot High Street on 19 August 2008.

13.30 The initial report on Adult A was completed on 29 January 2009 and an addendum report on 13 February 2009. Its purpose was to enable an assessment to be made of Adult A's suitability for a community order with an alcohol treatment requirement.

13.31 In the assessment completed as part of the report and the report itself, the probation officer identified risks relating to domestic abuse. Adult A informed the report author that, at the time, he had been in a relationship with Adult B for approximately one year. Furthermore, he disclosed that there had been violence in this relationship and that he had been both victim and perpetrator. He also stated that, as with his other offending, the violence between the two had always been related to alcohol.

13.32 The report author identified the risk of domestic abuse and violence within the relationship in the risk assessment part of the offender assessment system (OASys). This triggered a requirement to complete a further risk assessment in relation to domestic abuse and the national assessment tool used by the Probation Service (Spousal Assault Risk Assessment). However, this was commenced, but never completed by the report author.

13.33 Neither the conclusion to the pre-sentence report nor the summary risk assessment included actions to address domestic abuse or reduce the risk of domestic violence by or against Adult A and domestic abuse did not feature as a part of the overall risk management plan. However, the sentence plan did include a proposal to address violent behaviour relating to alcohol use.

13.34 A second probation officer completed the pre-sentence report on Adult B and it is evident that there was no consultation with the author of the report on Adult A. The author of Adult B's report did not at any stage identify any domestic abuse or violence issues between Adult A and Adult B. The only reference to the relationship within this report was the statement from the author that *"I understand that the relationship has been stable since they both started to reduce their alcohol consumption".* The accompanying OASys risk assessment is equally void of relevant information stating only that there is "*no identified risk at this time".* Consequently, no risk management plan was put in place to address domestic abuse issues.

13.35 The proposal put before the court for Adult B was a community order with an alcohol treatment requirement and unpaid work. The proposal for Adult A was also for a community order with an alcohol treatment requirement, including to address his violent behaviour. In the event, on 17

February 2009, Winchester Crown Court sentenced Adult A to four months and Adult B to six months imprisonment, which did not include any licence requirements. As the probation proposals were not accepted by the court and short custodial sentences were imposed, neither probation plan was put in place and Hampshire Probation Trust had no further contact with either Adult A or B.

Analysis of Involvement

13.36 During 2007, Hampshire Probation Trust understood that neither Adult A nor Adult B was in any relationship with a partner and they were managed separately. The review of the Trust's involvement at this time demonstrates a failure to instigate proceedings against Adult B for a breach of her community order on a number occasions, but there were no indications of any issues relating to domestic abuse. However, Adult A and Adult B also appear to have been dealt with as separate individuals in 2009, with a lack of communication between the two authors of the pre-sentence reports.

13.37 The pre-sentence report assessments of Adult A identified domestic abuse concerns, but these were not acted upon in a sufficiently robust manner. In particular, the author should have taken forward the comments made by Adult A on domestic abuse, including by liaising with the author of the report on Adult B, in order to substantiate them. This would have enabled appropriate actions to be put in place to reduce the risk of domestic violence.

13.38 The assessments undertaken by the author of the report on Adult B were not of a satisfactory quality, particularly in terms of the failure to identify and address risks of domestic abuse. Further investigation should have taken place into the state of the relationship between Adult A and Adult B. Despite being aware that Adult A was a co-defendant and that a report on him had been prepared by a colleague in the same office, no liaison took place between the two authors to share information and ensure that relevant issues were addressed adequately within the pre-sentence reports and assessments.

13.39 In the case of Adult B, the author failed to identify any issues within the relationship, such as her partner's offending and violent behaviour. This resulted in a poor overall assessment, poor risk assessment and failure to identify domestic abuse issues. Consequently, no risk management plan was put in place to address domestic abuse.

Effective Practice/Lessons Learnt

13.40 This report raises issues about the quality of assessments in connection with pre-sentence reports and liaison between probation staff when completing reports and assessments in relation to co-defendants. There were also weaknesses in relation to the assessment of domestic abuse issues and a failure to address issues that were identified. However, these deficiencies did not have an impact in this particular case as the proposals for community orders were not accepted by the court and custodial sentences were imposed.

13.41 Hampshire Probation Trust does not consider that the shortcomings are an indication of wide-spread practice within the organisation, but reflect the quality of work carried out by individual staff members involved in this case. In addition, since 2009, the Trust has made significant changes and improvements to the way in which cases where domestic abuse is identified as an issue are assessed and addressed.

13.42 One of the main changes has been the introduction of the Integrated Domestic Abuse Module (IDAM), which is a 1:1 programme developed to address domestic abuse issues with perpetrators not deemed suitable for the accredited Integrated Domestic Abuse [Group] Programme (IDAP).

The introduction of IDAM has provided probation staff with a tool to use with domestic abuse perpetrators and there is now a more focused approach to this issue across all levels of Hampshire Probation Trust. In addition, the Trust now has sound processes for staff to access call-out information from the police in connection with the preparation of pre-sentence reports when issues around domestic abuse have been identified.

13.43 Given these improvements to procedures, no formal recommendations have been made in relation to the shortcomings identified by this review.

14. INVOLVEMENT OF OTHER AGENCIES

Hampshire County Council

14.1 Hampshire County Council had no direct involvement in any significant events involving Adult A and he did not receive any services from the authority. The only information on Adult A was held by the Children and Families Department and covered the period from 27 January 2000 to 22 February 2006. This included details of addresses recorded for Adult A and three notifications from the Prison Service about where he was serving prison terms. There was an exchange of e-mails in February 2006 regarding Adult A's MAPPA status and Hampshire County Council was invited to attend a multi-agency meeting to discuss this. However, records do not provide any information on the outcome or whether the Council attended.

14.2 The Children and Families Department had some involvement with Adult B as a child. During the period 1981 to 1984, from the age of 13, Adult B was subject to a court care order and referred to Fairfield Lodge Observation and Assessment Centre in Southampton. This was the result of persistent non-attendance at school and disruptive behaviour at home. There are no records on Adult B after 1988, by which time she had reached the age of 21.

14.3 Hampshire County Council has no information on domestic abuse involving Adult A or Adult B, either as victims or perpetrators, with any other partner. The Council had no involvement at all or any records on either Adult A or Adult B after they commenced their relationship in March 2008.

Surrey and Sussex Probation Trust

14.4 Surrey and Sussex Probation Trust's only involvement with Adult A was a request for a probation report from North East Hampshire Magistrates' Court on 10 July 2008 for a hearing on 1 August 2008. A letter was sent to Adult A on 18 July 2008 requesting that he attend an interview at the Guildford Probation Office on 23 July 2008. Adult A failed to attend this appointment and, therefore, a non-report was completed and submitted to the court. Adult A was convicted of threatening behaviour and fined £100.

14.5 The Trust has had no previous involvement with Adult B.

Southern Health NHS Foundation Trust

14.6 Southern Health NHS Foundation Trust (formerly Hampshire Partnership NHS Foundation Trust) records show only limited contact with Adult A in January 2008, about which no detailed information is available, and no contact with Adult B.

South Central Ambulance Service NHS Foundation Trust

14.7 South Central Ambulance Service NHS Foundation Trust has not identified any involvement or contact with either Adult A or Adult B.

15. CONCLUSIONS

15.1 Clearly, responsibility for Adult A's death rests with Adult B. Both Adult A and Adult B also made their own lifestyle choices and failed to engage with the support they were offered or received, whether in connection with alcohol, drugs, domestic violence or medical treatment. In fact, Adult A's unwillingness to address his 20 year alcohol dependency was perhaps the principal cause of his failure to engage with society and live a more normal life.

15.2 Adult A's parents confirmed the adverse and striking impact that alcohol would have on Adult A's personality and behaviour. This is borne out by the fact that, whilst Adult A often visited and was invited into his parents' home, they still felt that a restraining order was required to control his behaviour when drunk. His mother described him as a "Jekyll and Hyde" character. Due to his lifestyle, his premature death did not come as a surprise to his parents. Whilst they certainly did not anticipate his murder by Adult B, they were acutely aware of the risks of Adult A experiencing a traumatic event or his alcoholism causing irreparable damage to his body.

15.3 To a large extent, Adult A chose to remain in a relationship with Adult B despite being the victim of frequent domestic violence. Unless a victim wishes to leave a violent relationship, the opportunities for agencies to intervene successfully are restricted significantly. Ultimately, unless they lack competence, the acceptance of care and support rests with the individual. Adults are in charge of the decisions that affect their lives, even when those decisions might not be thought by others to be in their best interests.

15.4 Having said that, the assault that led to Adult A's death was not a one-off. There were clear warning signs. The purpose of this review has, therefore, been to learn lessons and assess what actions could be taken to prevent or, at least, reduce the risks of such incidents in future.

15.5 The Home Office's multi-agency statutory guidance for the conduct of domestic homicide reviews includes the following statement:

> "*Domestic violence is frequently repeated by the perpetrator and the violence can escalate over time. A domestic violence incident which results in the death of the victim is often not the first attack and is likely to have been preceded by psychological and emotional abuse. Many people and agencies may have known of these attacks – neighbours, for example, may have heard violence, a GP may have examined injuries, housing organisations may have been called repeatedly for repairs to homes, the police may have been called, there may have been previous prosecutions, or injunctions, and so on. This can sometimes make serious injury and homicide in domestic violence cases preventable with early intervention. Therefore, it follows that local agencies should have adequate policies and procedures in place to instruct agency staff on how to intervene in domestic violence cases."*

15.6 Much of this is true in the case of the relationship between Adult A and Adult B. A number of agencies were aware of the violent nature of the relationship, responded to alleged assaults and, in the case of Adult A, treated his injuries. Neighbours also reported violent altercations to the police on a number of occasions. The incidents documented in this report and known to the various agencies are likely to represent only a small minority of the attacks on Adult A. For example, Adult B is now known to have beaten Adult A frequently with his walking stick. On this basis, it could be argued that it was entirely predictable that Adult A's life would end in the way it did or as a result of some other traumatic event. In fact, Hampshire Police received intelligence from a source in April 2009 predicting this outcome as being likely.

15.7 Police in Surrey and Hampshire responded to 18 domestic incidents involving Adult A and Adult B. Nine of these involved allegations by Adult A that he had been assaulted by Adult B, a number of which had resulted in significant injury. In most cases, Adult A would not pursue a formal complaint or consent to the use of relevant medical evidence and there were no witnesses to support a prosecution. In some cases, counter-allegations were made by Adult B and both were always drunk. After each alleged assault, Adult A would resume his relationship with Adult B. Given these circumstances, it is extremely unlikely that Adult A would have cooperated with any prosecution and his willingness and ability to testify at a trial is highly questionable. The police, therefore, had little option other than to close investigations rather than seek prosecutions against Adult B.

15.8 However, there was evidence of a clear risk of serious harm to Adult A that was not identified by relevant agencies, shared with others or acted upon in accordance with agreed procedures. Adult A was an alcoholic and persistent drug user, who was rarely seen sober. He experienced a weakness to the right side of his body and walked with a stick. He was unsteady on his feet, extremely so when drunk, and often fell over in public places. When drunk, he was not able to get up again without help. Over the years, he had been assaulted frequently in public places in Aldershot and suffered persistent attacks by Adult B. He always had facial injuries, including black eyes, cuts and bruises, due to falls, fights and assaults. Despite this, there is little evidence to suggest that agencies recognised his vulnerability and opportunities to implement appropriate safeguarding procedures were repeatedly missed.

15.9 Whilst Adult A's death may have been largely predictable, the timing might be considered less so. Following his alleged assault by Adult B at home on 23 October 2010, the frequency of domestic and other incidents reported to Surrey and Hampshire Police reduced dramatically. At the same time, there is some indication that Adult B was doing more to reduce her alcohol and illicit drug use.

15.10 However, during this period, neighbours continued to hear arguments between Adult A and Adult B several times a week. The argument on the day of his death, which included shouting for three or four hours, threats to kill and loud bangs, was not considered exceptional. During her trial, Adult B also admitted that she regularly hit Adult A with his walking stick. Adult A also told an old friend on 1 March 2012 that he left the house early each day because Adult B would start hitting him once she started drinking.

15.11 Fights between Adult A and Adult B would also have become increasingly one-sided with his deteriorating health and increased vulnerability. Adult A's lack of access to a telephone and reduced ability to notify neighbours would have made it increasingly difficult for him to inform the police of assaults by Adult B. This, together with the reluctance of neighbours to get involved, is likely to be part of the explanation for the reduced reporting of incidents to the police rather than of the relationship becoming less volatile and violent.

15.12 The chaotic and violent nature of the lifestyles of Adult A and Adult B meant that they had extensive contacts with various public services, including Surrey Police, Hampshire Police, Frimley Park Hospital and South East Coast Ambulance Service. As such, there were many potential opportunities for agencies to intervene and, in particular, to reduce risks arising from the relationship and Adult A's vulnerability.

15.13 Despite the large number of incidents and extensive and frequent injuries received by Adult A, Surrey Police failed to refer the case to the West Surrey MARAC on multiple occasions despite it clearly meeting the necessary criteria. On only one occasion did Surrey Police act upon Adult A's vulnerability by forwarding a 39/24 (Vulnerable Adult) form to Surrey County Council's Adult

Social Care Team. However, due to errors in the way this was handled by Surrey County Council, this opportunity to implement multi-agency safeguarding arrangements was missed.

15.14 Hampshire Police appeared to treat alleged assaults by Adult B on Adult A in Aldershot town centre as drunken brawls rather than domestic abuse. No domestic abuse risk assessments were completed by Hampshire Police following these incidents and details of alleged assaults were not forwarded to Surrey Police to enable action to be taken on the basis of the fullest available information.

15.15 The review highlights the need for a mechanism for sharing information and intelligence relating to domestic incidents between police forces. This is particularly relevant where incidents occur outside the police force area where the people involved live. Surrey Police and Hampshire Police will introduce appropriate information sharing procedures to notify other police forces of such incidents. However, a similar approach is required at a national level to ensure that the relevant force has full knowledge of a case when determining the most appropriate course of action and a recommendation is made to the Home Office to this effect.

15.16 Frimley Park Hospital and South East Coast Ambulance Service also dealt with Adult A on numerous occasions following falls and domestic and other assaults. Again, despite frequent contacts and attendances, together with Adult A's alcohol and substance misuse problems and overall deteriorating health, his vulnerability was not recognised and appropriate safeguarding procedures were not instigated.

15.17 Adult A did not disclose any domestic abuse to his GP and Frimley Park Hospital did not notify the practice of his attendances at its Emergency Department following alleged domestic assaults. However, given the existence of various known risk factors, including Adult A's alcohol and drugs misuse, poor and deteriorating health and frequent injuries, there may have been opportunities for GPs to have been more proactive in enquiring about potential domestic abuse.

15.18 Relevant agencies did have policies and procedures in place for dealing with domestic violence and vulnerable adults, although some changes have been recommended as part of this review. However, the review demonstrates a failure of the operation of such procedures. The evidence suggests that policies and procedures were either not adequately understood or followed (or both) and that staff from various agencies were not aware of what to do if they had concerns about domestic violence.

15.19 Clearly, Adult A was not an easy person to deal with, often being abusive to staff trying to help him and failing to engage with any support being offered. However, his drug and alcohol misuse and chaotic lifestyle appear to have acted as a barrier to him being identified as vulnerable and treated accordingly by police, health and caring professionals. This is a cultural issue to be addressed by agencies as part of domestic abuse and safeguarding training and awareness.

15.20 The question of gender also needs to be addressed. In this case, the victim was a man and the principal perpetrator of the domestic abuse in the relationship was a woman. It is widely accepted that domestic abuse against men is an under-reported problem, especially by victims themselves. Reasons for the apparent reluctance of men to report domestic abuse may include a fear of not being believed and a perceived prejudice against male victims in the criminal justice system. Despite this and whilst estimates vary, the British Crime Survey suggests that men were the victims of just over a quarter of incidents of domestic violence in 2010.

15.21 In this particular case, lack of reporting was not the primary issue. Adult A reported several alleged assaults to police in both Surrey and Hampshire. However, the Panel is of the view that his gender, together with agencies' perceptions of him and his lifestyle, played a part in the failure

to recognise Adult A's vulnerability and implement appropriate safeguarding arrangements. Given the number of domestic incidents and the level of violence involved, it is inconceivable that the case would not have been referred to the West Surrey MARAC had the victim been a vulnerable woman. This is a further cultural issue which needs to be addressed in training and guidance provided to staff of relevant agencies.

15.22 Whilst there were clearly opportunities to instigate multi-agency arrangements to manage risks in this relationship, it is clear that there were not necessarily any easy solutions to prevent Adult A's death. Any strategy put in place would have required some engagement by Adult A (and possibly Adult B) and there are few signs that this would have been forthcoming.

15.23 Arguments between Adult A and Adult B had led some neighbours to believe that their relationship had ended about 18 months before Adult A's death and that Adult B wanted him out of the flat. The fact that Adult A submitted 40 unsuccessful bids for social housing, principally to Rushmoor Borough Council and Guildford Borough Council, between 19 February 2010 and 12 March 2011 provides evidence that he was looking for a place of his own. When asked by a friend on the day of his death why he put up with being hit by Adult B, Adult A also responded that he had nowhere else to go and was looking for a one bedroom flat.

15.24 If the case had been referred to the West Surrey MARAC in accordance with the agreed criteria, it is not clear whether a difference could have been made, but at least housing issues could have been explored, including his apparent desire to secure his own accommodation. This might have resulted in a different outcome by precipitating the end of the relationship or, at least, by offering a release from moments of increased tension.

15.25 It should be noted though that Adult A's search for housing did not involve him disclosing that he was the victim of domestic violence and this was never given as a reason for his need for accommodation. It is also clear that some form of domestic relationship and arrangements continued with Adult B and that Adult A's main place of residence remained at their home in Ash.

15.26 The terms "love-hate relationship" and "can't live together, can't live apart" were heard frequently during the review and in court by Adult A's own mother. This gives a sense that the end was almost inevitable and that agencies could have done nothing to prevent Adult A's death. However, what is also clear is that procedures and opportunities to avert this tragic conclusion were not tested in this case.

16. RECOMMENDATIONS

General

16.1 That training and guidance provided to staff of relevant agencies on domestic abuse and safeguarding vulnerable adults, including training recommended by this review, cover issues relating to woman-on-man violence and the identification of vulnerable adults in the context of alcohol and drug abuse.

Surrey Police

16.2 That Surrey Police ensure that:

(a) training on the DASH risk assessment process is undertaken by all Surrey Police staff new to frontline duties or to the Public Protection Investigation Unit Supervisor role;

(b) all Public Protection Investigation Unit Supervisors have received the requisite DASH risk assessment process training and are able carry out effective risk assessments, including the identification of cases that should be referred to a MARAC;

(c) all officers employed in the role of Public Protection Investigation Unit or Central Referral Unit Supervisor carrying out DASH risk assessments recognise that domestic incidents involving either partner as a victim within the previous 12 months would meet the repeat incident criteria for a MARAC referral;

(d) Police Public Protection Investigation Units report all incidents of domestic abuse that take place in Surrey involving persons who do not normally reside in the county to their home area police force using the intelligence reporting system; and

(e) the definition of vulnerable adults (adults at risk) used by Surrey Police in its policies and procedures is amended to use the definition set out in the Surrey Safeguarding Adults Multi-Agency Procedures, Information and Guidance 2011 and that appropriate guidance and training be provided to all relevant staff.

Hampshire Police

16.3 That Hampshire Police ensure that:

(a) restraining orders are recorded and flagged on its database to highlight the existence of all live court orders to officers and staff, including those from other police forces;

(b) it is made explicit to all frontline officers and staff that the requirement to complete DASH risk assessments includes domestic incidents where the victim is unable or unwilling to respond to the risk assessment questionnaire, in which case the officer or staff member should make the assessment using professional judgement taking into account the circumstances of the incident and by using historical information from recording systems;

(c) when police officers deal with incidents between partners that take place in a public place, these are recognised and treated as domestic incidents and the relevant domestic abuse policy is applied, including the completion of risk assessments and the taking of positive action; and

(d) when domestic incidents occur in the Hampshire Police area involving one or more parties who live in another police force area, the details of the incident, including any risk assessments, should be reported to that other force to enable them to understand the full extent of the risk, provide appropriate support to the victim and recognise repeat offending by the perpetrator.

Home Office

16.4 That the Home Office be made aware of issues raised by this review in relation to the lack of sharing of information between relevant police forces on incidents of domestic abuse and be requested to ensure that a system is established at a national level to address this matter.

Frimley Park Hospital NHS Foundation Trust

16.5 That Frimley Park Hospital NHS Foundation Trust:

(a) ensure that notifications to patients' GPs following attendances at the Emergency Department detail all relevant information, including safeguarding considerations and instances of alleged domestic abuse;

(b) ensure that staff within the Emergency Department record details of advice given to patients on available services, such as drug and alcohol and domestic abuse support;

(c) review the Emergency Department's guidance to staff on safeguarding vulnerable adults to ensure that it is consistent with Trust-wide policies and procedures;

(d) ensure that nursing and medical staff in the Emergency Department receive training on the safeguarding procedure for vulnerable adults, including the requirement to refer domestic abuse cases to the Trust's Lead for Vulnerable Adults; and

(e) ensure that frequent attendees at the Emergency Department are identified as being at high risk to enable appropriate safeguarding procedures to be considered and implemented.

South East Coast Ambulance Service NHS Foundation Trust

16.6 That South East Coast Ambulance Service NHS Foundation Trust be strongly urged to:

(a) review its safeguarding policy and procedure to ensure that domestic abuse is identified as a standalone factor in assessing the vulnerability of adults;

(b) ensure ambulance staff receive guidance and training on the application of its safeguarding procedures in relation to incidents of domestic abuse, including:

(i) the requirement to make safeguarding referrals in appropriate cases regardless of the actions or interventions of other agencies; and

(ii) the identification of vulnerable adults, including victims of domestic abuse, in the context of alcohol and substance misuse regardless of gender.

Guildford and Waverley Clinical Commissioning Group

16.7 That the strategic lead for domestic abuse of Guildford and Waverley Clinical Commissioning Group ensures that general practices maintain effective procedures and arrangements for dealing with cases of domestic abuse, including to encourage GPs to be pro-active in enquiring about possible domestic abuse in appropriate cases.

Surrey County Council

16.8 That Surrey County Council introduces a process to ensure that Adult Social Care receives confirmation of the correct receipt of a safeguarding referral from relevant service teams.

Surrey and Borders Partnership NHS Foundation Trust

16.9 That Surrey and Borders Partnership NHS Foundation Trust:

(a) require all relevant practitioners to attend mandatory domestic abuse training on a three yearly basis; and

(b) review existing risk assessment processes to ensure that care records and risks are updated to reflect clients' evolving and changing circumstances.

SAFER GUILDFORD PARTNERSHIP
DOMESTIC HOMICIDE REVIEW ACTION PLAN

Recommendation	Scope	Action	Lead Agency	Key Milestones	Target Date	Date of Completion and Outcome
That training and guidance provided to staff of relevant agencies on domestic abuse and safeguarding vulnerable adults, including training recommended by this review, cover issues relating to male victims of domestic abuse and the identification of vulnerable adults in the context of alcohol and drug abuse.	Local	To address the issues raised by the review as part of multi-agency courses provided by Surrey domestic abuse outreach staff on behalf of Surrey County Council.	Surrey County Council	Confirmation that courses incorporate relevant issues received.	March 2013	February 2013 (Completed)
That training on the DASH risk assessment process be undertaken by all Surrey Police staff new to frontline duties or to the Public Protection Investigation Unit Supervisor role.	Local	To confirm that DASH training is delivered to all new frontline staff and Public Protection Investigation Unit Supervisors.	Surrey Police	Confirmation received that training is received by relevant staff. A new internal classroom based domestic abuse course for PPIU specialists is also expected to be implemented by the end of 2013, which will cover risk assessments and MARAC referrals. This will support the implementation of other recommendations arising from this review.	January 2013	January 2013 (Completed)
That all Surrey Police Public Protection Investigation Unit Supervisors have received the requisite DASH risk assessment process training and are able carry out effective risk assessments, including the identification of cases that should be referred to a MARAC.	Local	To confirm that all Detective Sergeants currently employed as PPIU/CRU Supervisors have undertaken DASH training and are fully conversant with the criteria for a domestic abuse victim to be referred to a MARAC and the process for making a referral.	Surrey Police	This has been confirmed through a series of meetings by PPIU and CRU managers with all supervisors in the period November to December 2012. PPIU Detective Inspectors will ensure that any new supervisors have read and fully understand the processes.	February 2013	February 2013 (Completed)

Recommendation	Scope	Action	Lead Agency	Key Milestones	Target Date	Date of Completion and Outcome
That all Surrey Police officers employed in the role of Public Protection Investigation Unit or Central Referral Unit Supervisor carrying out DASH risk assessments recognise that domestic incidents involving either partner as a victim within the previous 12 months would meet the repeat incident criteria for a MARAC referral.	Local	To communicate this recommendation to all PPIU and CRU Detective Inspectors at their regular weekly meeting and ensure that this is cascaded to all PPIU and CRU staff members through weekly office general meetings.	Surrey Police	DCI Public Protection has met all PPIU and CRU supervisors during the period November to December 2012 to raise this specific learning point. All PPIU and CRU staff members have now been advised through their respective managers that they must take reports from both parties into account as part of the risk assessment and MARAC referral processes.	February 2013	February 2013 (Completed)
That Surrey Police Public Protection Investigation Units report all incidents of domestic abuse that take place in Surrey involving persons who do not normally reside in the county to their home area police force using the intelligence reporting system.	Local	To communicate this recommendation to all PPIU and CRU Detective Inspectors at their regular weekly meeting and ensure that this is cascaded to all PPIU and CRU staff members through weekly office general meetings.	Surrey Police	DCI Public Protection has met all PPIU and CRU supervisors during the period November to December 2012 to raise this requirement. All PPIU and CRU staff members have now been advised through their respective managers that they must report all incidents of domestic abuse that take place in Surrey involving persons who do not normally reside in the county to their home area police force area.	February 2013	February 2013 (Completed)

Recommendation	Scope	Action	Lead Agency	Key Milestones	Target Date	Date of Completion and Outcome
That the definition of vulnerable adults (adults at risk) used by Surrey Police in its policies and procedures is amended to use the definition set out in the Surrey Safeguarding Adults Multi-Agency Procedures, Information and Guidance 2011 and that appropriate guidance and training be provided to all relevant staff.	Local	To review and amend relevant policies and procedures.	Surrey Police	The Association of Chief Police Officers (ACPO) and the College of Policing published new guidance for the police on safeguarding and investigating the abuse of vulnerable adults in January 2013. Surrey Police has adopted the national police definition of vulnerable adults included in this guidance. Therefore, this recommendation will not be implemented.	January 2013	January 2013 (Completed)
That restraining orders are recorded and flagged on the Hampshire Police database to highlight the existence of all live court orders to officers and staff, including those from other police forces.	Local	To agree and implement a process for the appropriate recording of restraining orders.	Hampshire Police	New process introduced in January 2013, which improves the visibility of restraining orders on the records management system	March 2013	January 2013 (Completed)
That it is made explicit to all Hampshire Police frontline officers and staff that the requirement to complete DASH risk assessments includes domestic incidents where the victim is unable or unwilling to respond to the risk assessment questionnaire, in which case the officer or staff member should make the assessment using professional judgement taking into account the circumstances of the incident and by using historical information from recording systems.	Local	To ensure that: (a) the Hampshire Police domestic abuse policy is updated; and (b) frontline officers and Public Protection Unit staff receive appropriate training on the required procedures.	Hampshire Police		March 2013	
That when Hampshire Police officers deal with incidents between partners that take place in a public place, these are recognised and treated as domestic incidents and the relevant domestic abuse policy is applied, including the completion of risk assessments and the taking of positive action	Local	To ensure that frontline officers, Public Protection Unit and Control Room staff receive appropriate training on responses to domestic incidents in public places.	Hampshire Police		March 2013	

Recommendation	Scope	Action	Lead Agency	Key Milestones	Target Date	Date of Completion and Outcome
That when domestic incidents occur in the Hampshire Police area involving one or more parties who live in another police force area, the details of the incident, including any risk assessments, should be reported to that other force to enable them to understand the full extent of the risk, provide appropriate support to the victim and recognise repeat offending by the perpetrator.	Local	To ensure that officers forward details of domestic incidents to the police force in which the victim and/or perpetrator live where applicable.	Hampshire Police	All Central Referral Unit officers were advised of this requirement in December 2012.	January 2013	December 2012 (Completed)
That the Home Office be made aware of issues raised by this review in relation to the lack of sharing of information between relevant police forces on incidents of domestic abuse and be requested to ensure that a system is established at a national level to address this matter.	National	To highlight the issue on submission of the domestic homicide review overview report to the Home Office.	Home Office	Submission of overview report to the Home Office.	April 2013	
That notifications to patients' GPs following attendances at the Frimley Park Hospital Emergency Department detail all relevant information, including safeguarding considerations and instances of alleged domestic abuse	Local	To include safeguarding considerations and any alleged incidents of domestic abuse in letters to GPs from the Emergency Department.	Frimley Park Hospital	Electronically generated letters to GPs now require this information.	January 2013	January 2013 (Completed)
That staff within the Frimley Park Hospital Emergency Department record details of advice given to patients on available services, such as drug and alcohol and domestic abuse support	Local	To remind all staff to give relevant patients advice regarding drug, alcohol and domestic abuse, including information leaflets, and to record such advice in nursing documentation.	Frimley Park Hospital	All staff have been reminded of this requirement.	February 2013	February 2013 (Completed)
That the Frimley Park Hospital Emergency Department's guidance to staff on safeguarding vulnerable adults be reviewed to ensure that it is consistent with Trust-wide policies and procedures	Local	To develop an Emergency Department protocol for safeguarding referrals in line with Trust policies and procedures.	Frimley Park Hospital	The Emergency Department Consultant Lead on Safeguarding has developed a new protocol. This is available on the Trust's intranet site and in hard copy within the department.	February 2013	February 2013 (Completed)

Recommendation	Scope	Action	Lead Agency	Key Milestones	Target Date	Date of Completion and Outcome
That nursing and medical staff in the Frimley Park Hospital Emergency Department receive training on the safeguarding procedure for vulnerable adults, including the requirement to refer domestic abuse cases to the Trust's Lead for Vulnerable Adults.	Local	To provide: (a) safeguarding awareness training to all nursing staff; and (b) specialist targeted training to Emergency Department medical and nursing staff.	Frimley Park Hospital	Safeguarding awareness training is provided to nursing staff as part of their annual patient safety training. All Emergency Department medical and nursing staff are currently receiving targeted training related to their emergency environment.	April 2013	
That frequent attendees at the Frimley Park Hospital Emergency Department are identified as being at high risk to enable appropriate safeguarding procedures to be considered and implemented.	Local	To implement a structured system of reviewing frequent Emergency Department attendees, including action planning and monitoring.	Frimley Park Hospital	System established by Clinical Matron.	January 2013	January 2013 (Completed)
That South East Coast Ambulance Service NHS Foundation Trust review its safeguarding policy and procedure to ensure that domestic abuse is identified as a standalone factor in assessing the vulnerability of adults.	Local	To update safeguarding policies and procedures, including to address domestic abuse associated with other vulnerabilities.	South East Coast Ambulance Service	Domestic abuse project lead in post in March 2013. Current arrangements, policy and procedures on domestic abuse to be reviewed.	July 2013	
That South East Coast Ambulance Service staff receive guidance and training on the application of its safeguarding procedures in relation to incidents of domestic abuse, including: (a) the requirement to make safeguarding referrals in appropriate cases regardless of the actions or interventions of other agencies; and (b) the identification of vulnerable adults, including victims of domestic abuse, in the context of alcohol and substance misuse regardless of gender.	Local	(a) To address the issues raised in face-to-face training on the safeguarding and referral process for vulnerable individuals scheduled for all frontline staff in 2013/14. (b) To include an article in the internal weekly bulletin to remind staff of their responsibilities regarding the identification and reporting of vulnerable people.	South East Coast Ambulance Service	Agreement of the content of face-to-face training to commence in April 2013. An article for the weekly staff bulletin to be prepared in March 2013.	April 2014 March 2013	

Recommendation	Scope	Action	Lead Agency	Key Milestones	Target Date	Date of Completion and Outcome
That the strategic lead for domestic abuse of Guildford and Waverley Clinical Commissioning Group ensures that general practices maintain effective procedures and arrangements for dealing with cases of domestic abuse, including to encourage GPs to be pro-active in enquiring about possible domestic abuse in appropriate cases.	Local	The executive lead within the safeguarding team for Guildford and Waverley Clinical Commissioning Group and primary care liaison team to ensure that practices have in place and maintain effective procedures and arrangements for dealing with cases of domestic abuse.	Guildford and Waverley Clinical Commissioning Group	Dissemination of policy and guidance, engagement with practices and monitoring through the CCG's safeguarding processes. Liaison with neighbouring CGGs with practices in Guildford Borough regarding their policies and procedures.	September 2013 (Review)	
That Surrey County Council introduces a process to ensure that Adult Social Care receives confirmation of the correct receipt of a safeguarding referral from relevant service teams.	Local	To revise internal procedures, including to address the referral of safeguarding alerts to other teams, the requirement for acknowledgements and the retention of records.	Surrey County Council	Revision of internal procedures.	May 2013	
That Surrey and Borders Partnership NHS Foundation Trust require all relevant practitioners to attend mandatory domestic abuse training on a three yearly basis.	Local	To ensure that domestic abuse training is incorporated into mandatory safeguarding adults training	Surrey and Borders Partnership NHS Foundation Trust	To be ratified by SABP scrutiny panel	March 2013	
That Surrey and Borders Partnership NHS Foundation Trust review existing risk assessment processes to ensure that care records and risks are updated to reflect clients' evolving and changing circumstances.	Local	To review risk assessment processes	Surrey and Borders Partnership NHS Foundation Trust	To be ratified by SABP scrutiny panel	March 2013	