Wiltshire Domestic Homicide Review

EXECUTIVE SUMMARY OF THE OVERVIEW REPORT

Into the death of Adult Y on 20th November 2012

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Section One: Introduction

1.1 This Domestic Homicide Review examines the circumstances surrounding the death of Adult Y in Wiltshire.

1.2 Circumstances leading to the Review being undertaken:

At approximately 0420hrs on Tuesday 20th November 2012 Wiltshire Ambulance received a telephone call from a male that his friend Adult Y (the victim) had suffered a serious assault and was bleeding heavily.

Police and Ambulance arrived at the scene; Adult Y was being treated by the informant. He had sustained injuries that had caused significant blood loss. The informant stated that the injuries had been caused by the perpetrator, Adult Z who had left the address.

Police officers located Adult Z at the railway station where she was arrested on suspicion of attempted murder.

Adult Y died as a result of his wounds on arrival at hospital; consequently Adult Z was charged with his murder and remanded into custody. On 15th May 2013 she was convicted of murder and sentenced to life imprisonment, with a recommendation to serve a minimum of 14 years. Her legal advisors have lodged an appeal.

1.3 The background is:

At the time of his death Adult Y was 51 years of age and the perpetrator Adult Z was 46 years of age.

Adult Y and Adult Z did not live together; each had their own rented accommodation. Over a period of 3 months from August 2012 they gradually formed a relationship, after meeting in a local Park. They gathered there most days to drink alcohol with a group of likeminded 'mates' *(as described by the victim's family)*.

Adult Y's family, while not aware when exactly the relationship started, understood it was a very casual 'on-off' type. They believed a key factor in it was that both were alcohol dependent. They would usually meet at Adult Z's flat every other Tuesday and at Adult Y's flat fortnightly on a Thursday, *(these were the days when they received their "benefit money")*. They would drink alcohol and according to Adult Y's family it was on those days that they were intimate.

Section Two: The Review Process

2.1 This summary outlines the process undertaken by the Wiltshire Domestic Homicide Review Panel in reviewing the murder of Adult Y.

2.2 A Domestic Homicide Review (DHR) was recommended and commissioned by the Wiltshire Community Safety Partnership in line with section 9 of the Domestic Violence, Crime and Victims Act 2004 and the expectations of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2011.

2.3 The Home Office was informed of the intention to conduct a DHR on the 14th December 2012.

2.4 On 18th February 2013 the DHR process began with an initial review panel meeting of agencies that potentially had contact with the victim Adult Y and the perpetrator, Adult Z prior to the point of death.

2.5 The families of both the victim and perpetrator were involved with the Review from the start and provided key information and questions which the Panel and Individual Management Report (IMR) authors considered. They were consulted by the Independent Chair during the preparation of the reports and the family of the victim attended the final review panel meeting. Both families have been shown the overview report and have expressed their satisfaction with the conclusions and action plans to address lessons learnt.

2.6 The victim's family were provided with specialist support from both the Homicide Support Service and by the charity "Advocacy After Fatal Domestic Abuse" (AAFDA).There was no such support available for the family of the perpetrator.

2.7 Twenty-four agencies/multi-agency partnerships were contacted about this review:

- Alcoholics Anonymous*
- Alabare Drop In*
- Avon & Wiltshire Mental Health Partnership. NHS Trust (AWP)
- Community 4 (housing support partnership)
- Crown Prosecution Service (CPS)
- Curo Housing (previously Somer Housing)
- NHS Wiltshire
- St. Thomas Church Trowbridge*
- Splitz Support Service*
- Swindon and Wiltshire Alcohol and Drug Service (SWADS)
- Trowbridge Town Council*
- Wiltshire Police
- Wiltshire Council – Housing Allocations & Options
- Wiltshire Council – Revenue & Benefits
- Wiltshire Council (Safeguarding Vulnerable Adults)*
- Wiltshire Council Substance Misuse Commissioning Team
- Wiltshire Fire & Rescue Service
- Wiltshire Probation Trust
- Victim Support
- Swindon & Wiltshire Integrated Targets for Change (SWITCH)
- Wiltshire Anti Social Behaviour Reduction Conference(ASBRAC)
- Wiltshire Community Safety Partnership (CPS)*

- Wiltshire Multi- Agency Risk Assessment Conference (MARAC)
- Wiltshire Multi-Agency Public Protection Arrangements (MAPPA)

*Denote agencies that responded as having had no contact with either Adult Y or Adult Z.

2.8 Agencies were asked to give chronological accounts of their contact with the victim and perpetrator prior to the death of Adult Y. Where there was no involvement or insignificant involvement, agencies were advised accordingly. In line with the Terms of Reference, the DHR has covered in detail the period from 1st January 2010 to 20th November 2012. Several agencies including AWP, CPS, NHS Wiltshire, Wiltshire Police, Wiltshire Council Revenue & Benefits, Wiltshire Probation Trust and MAPPA have highlighted a number of significant individual contacts with Adult Y and Adult Z relating to domestic abuse type offences with other people, prior to that date.

2.9 Four agencies responded with information indicating some level of involvement with Adult Y. They were:

- NHS Wiltshire
- Wiltshire Police
- Wiltshire Council (Housing)
- Wiltshire Council (Revenue and Benefits)

The Wiltshire Council Housing Allocations and Options, and the Revenue & Benefits Departments' contacts were of no direct relevance to the events that led to his death.

The NHS Wiltshire contacts related to his health and problematic alcohol consumption. He was last seen by his GP in October 2012 when he was referred for a second time to New Highways drug and alcohol service (he had previously not attended an earlier appointment).

2.10 Sixteen organisations responded with information indicating some level of involvement with Adult Z:

Adult Z had been referred to Swindon and Wiltshire Alcohol and Drug Service, (SWADS)[1] which could have provided a variety of support services for her alcohol issues but she rarely attended.

NHS Wiltshire GP service had regular contacts with Adult Z, but none had any relevance to the events that led to the death of Adult Y.

Other services, including AWP, Community 4, CPS, Curo Housing, Wiltshire Council's Housing, Benefits & Revenue, Wiltshire Fire & Rescue Service, Wiltshire Probation Trust, Victim Support, ASBRAC, MAPPA, and MARAC were aware of her violent history and alcohol problems, however the focus of their contact had no specific relevance to the Adult Y's death.

Wiltshire Police and SWITCH[2] had contacts with Adult Y and Adult Z which were directly relevant to the homicide.

[1] Due to contractual changes, from 1st April 2013 SWADS no longer provides a service in Wiltshire, therefore the Wiltshire Council Substance Misuse Commissioning Team has completed that part of the IMR relating to recommendations and action plans

[2] SWITCH is a multi agency partnership, which focuses on changing the behaviour of repeat or prolific offenders.

Section Three: Terms of Reference

3.1 Purpose:

The purpose[3] of the Domestic Homicide Review is to:

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

3.2 Overview and Accountability:

The decision for Wiltshire to undertake a Domestic Homicide Review (DHR) was taken by the Chair of the Wiltshire Community Safety Partnership and the Home Office was informed on 14th December 2012.

The Home Office Statutory Guidance advises where practically possible the DHR should be completed within 6 months of the decision made to proceed with the review.

Due to the criminal trial not being listed until the beginning of May 2013, it was agreed in conjunction with the Home Office to adjourn the review following an initial meeting on the 18th February 2013 and to re-commence following the trial's conclusion. Wiltshire concluded the Domestic Homicide Review on 11th July 2013.

This Domestic Homicide Review, which is committed, within the spirit of the Equalities Act 2010, to an ethos of fairness, equality, openness, and transparency, will be conducted in a thorough, accurate and meticulous manner.

3.3. The Domestic Homicide Review will consider:

Each agency's involvement with Adult Y (the victim) aged 51 and Adult Z (the perpetrator) aged 46, between 1s January 2010[4] and the homicide of Adult Y on 20th November 2012 at a flat in Wiltshire.

The full terms of reference can be referenced in Appendix one.

[3] Paragraph 3.3 Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews

[4] For the purpose of informing this Review of significant domestic violence type offences on other people, the Avon & Wiltshire Partnership, Crown Prosecution Service, NHS Wiltshire, Wiltshire Police, Wiltshire Council Revenue & Benefits, Wiltshire Probation Trust, and MAPPA have included a number of earlier contacts prior to 2010.

Section Four: Key Findings

4.1 The DHR provided an opportunity to analyse information across agencies and from family members.

4.1.1 The first indication that agencies had that Adult Z knew Adult Y was on 12th September 2012, when Wiltshire Police, SWITCH and Wiltshire Council (ASBRAC) records show that Adult Y accompanied Adult Z to her Anti-Social Behaviour Contract (ABC) breach meeting at a Police Station, although she claimed not to know his name or address.

4.1.2 Adult Y spent many of the previous 15 years working abroad, the DHR is indebted to his family for an insight into his personality. They described him as an introvert who was more relaxed working than mixing with people. They felt that in current times he could have been classified as autistic, as he displayed the behavioural characteristics of someone suffering from that condition. He tended to take things said to him literally and this often resulted in his misunderstanding the intentions of others.

4.1.3 In the early 2000s Adult Y was in a relationship for approximately three to four years and had a daughter. After the birth of the daughter, the relationship fell apart and he was arrested for assaulting his partner, who then left him. He moved abroad for work, prior to the court case. The Police records show that he was arrested and appeared before court for this offence on 24th January 2011. He was sentenced to 8 months imprisonment.

4.1.4 When sober he was described as quiet and mild, but after losing his job through a work related injury to his hands and back, he became depressed and drank heavily. When drunk he could be loud and argumentative. Shortly before his death he was referred to an alcohol support service for help with this, however he died before he received an appointment.

4.1.5 Adult Z's parents both had alcohol related problems and she was sexually abused at the age of 8 by her father, who according to Adult Z's mother, also had a personality disorder and self harmed. When she was 17 she was the victim of a rape.

4.1.6 For over twenty years she received regular support from medical services. Over that time she has been medically diagnosed as suffering from a personality disorder, anxieties, panic attacks and alcohol problems. She married and became both a victim of domestic abuse and a perpetrator. She had four children two of whom were adopted and the older two spent much of their childhood years either fostered or in care.

4.1.7 After the marriage broke down she had several other volatile relationships with both men and women, most of whom had similar alcohol related problems. The relationships all contained violence, often to her and always by her. Her assaults were characterised by always carrying and using a weapon, usually a knife but often the one side of a pair of scissors. The violence normally occurred when she was intoxicated and was always directed to people she knew, including her partners, her children and her mother.

4.1.8 Over a 10 year period prior to the murder, the police attended numerous incidents involving her and she was arrested no less than 26 times for various offences including arson, violence, racist conduct, and disorderly conduct. During this period she only appeared before a court on 14 occasions, primarily because it was judged that there was insufficient evidence to proceed, due to victims refusing to support a prosecution or elements of self-defence.

4.1.9 Her contact with support services have been characterised by her failure to keep appointments or to engage; consequently she has not always received the benefit of the full range of support available.

4.2. There is a danger, in reviewing this information with hindsight, of forming conclusions that were not possible for the participants to see at the time. However there are issues that arise from the DHR which need to be considered;

4.3. Adult Z was the subject of regular SWITCH engagement, the relationship between Adult Y & Adult Z was of such a short duration, that other than the initial indication of it, on 12th September 2012, it was only on 10th October 2012 that Adult Z confirmed she was in an "on-off" relationship with Adult Y, although not living with him.

4.3.1 By the 2nd November she had told her SWITCH offender supervisor that she had finished with Adult Y. Consequently most agencies knew nothing of the relationship. Those that did (the Police and SWITCH) whilst having little time to evaluate its significance, did not properly record, assess or action the information they received.

4.3.2 The opportunity to consider the Domestic Violence Disclosure Scheme[5] (DVDS) was missed.

4.3.3 It appears that Adult Z, being streetwise, viewed the "relationship" as a way to obtain alcohol. (She informed the SWITCH offender supervisor on 5th November 2012 "she was only using him for his alcohol..."). Adult Y tended to take everything he was told literally, did not understand this, and reacted badly by sending her numerous offensive texts, at the ending of the "relationship". The SWITCH IMR author's opinion is that, in view of Adult Z's history of violence to partners, a violent response could have been anticipated.

4.3.4 On the 15th November 2012 Adult Y told a Police Community Support Officer (PCSO) he saw on patrol, that since his relationship with Adult Z had ended, she was behaving as if she was obsessed with him. She was sending him explicit text messages and had tried to attack him with a knife. Whilst these incidents were properly recorded, no other action was taken at that time.

4.4. Over a period of 20 plus years Adult Z was properly referred to agencies that could have provided her with support, however because she either missed appointments or did not engage, opportunities to help her were not maximised.

4.5. There were four multi-agency partnerships that had dealings with Adult Z at one time or another, gathering significant amounts of information, yet on occasions it was not clear if she was being viewed as a victim or as a perpetrator. Either way opportunities to take positive action were missed.

[5] DVDS is a scheme being piloted in Wiltshire whereby a perpetrator of domestic abuse starts a new relationship, agencies can consider the risks involved and if appropriate arrange for the new partner to be informed about the perpetrator's history of domestic abuse

4.6 Three individuals can be highlighted for the way they not only regularly engaged with Adult Z but also for the actions they took.

a) Her GP who saw her on an almost daily basis and made many attempts to guide her into services even when she failed to turn up to meetings e.g. Primary Mental Health Team. The GP's persistence saw a temporary, marked reduction in her alcohol consumption.

b) A psychologist who saw her for over a period of 8 years and for whom she appeared to have developed a healthy respect- she only once attended an appointment intoxicated, whereas that was the norm when meeting with other officials. She was diagnosed with a personality disorder and consequently Wiltshire Probation Trust and AWP have introduced Personality Disorder Programmes. (Adult Z's mother has said this psychologist was the only official Adult Z respected).

c) A Curo Housing (then Somer Housing) tenancy officer who visited her on 37 occasions over a 4 month period, to address her endless behavioural and accommodation issues and the concerns of her neighbours. As a consequence of her actions Adult Z was referred to the Wiltshire ASBRAC.

4.7 When Adult Z was brought to MAPPA as a perpetrator there was no perpetrator programme suitable for a woman, available in the Wiltshire area.

Section Five: Lessons Learned

5.1. A universal lack of knowledge and understanding of data sharing and in particular what can be shared to prevent serious harm to an individual or third party. This has inhibited information sharing between agencies, has put frontline staff at risk and has limited the options available in dealing with the perpetrator.

5.2. There is a wide variety of risk assessments being used by agencies and some have been utilised in a limited way. This has meant that some agencies were not clear as to the risks being posed by Adult Z, to herself, to those close to her or to officials with whom she came into contact. There is little evidence of sharing information between agencies about the range of risks Adult Z posed.

5.3. Organisations have a responsibility to ensure their staff understand Wiltshire and Swindon's Safeguarding Adults Policies and Procedures and know how to recognise a vulnerable adult and refer to the most suitable agency. Organisations therefore need to ensure staff who come into contact with the public receive the appropriate level training about safeguarding vulnerable adults

5.4 To enable agencies to share information about vulnerable adults and assess risks at the earliest stage better, there is a need to consider building on the MASH model currently being implemented in Children's Services to include adults at risk.

5.5. If a violent client consistently fails to engage, agencies should always explore any possible alternative action that may be necessary to manage the risk rather than closing the case.

5.6 Adult Z's numerous incidents of anti-social behaviour, criminal conduct, her constant health and housing issues were in the main, dealt with on an incident by incident basis rather than as part of a sequence of behavioural events. This limited the options available to address her behaviour.

5.7 There is a need to ensure staff know how to balance gaining a client's trust, against the need to take action when they gain information about an offence having been committed or to prevent an offence being committed.

5.8 While Wiltshire is one of the areas piloting the Domestic Violence Disclosure Scheme (DVDS), opportunities to consider its use were missed.

5.9 There was no domestic abuse perpetrator programme suitable for women offenders in Wiltshire.

5.10 Agencies have identified the need to have a system whereby supervisors regularly review collected information and staff decisions.

5.11 While criminal justice agencies and housing organisations understand the value of seeking information and support from health and drug and alcohol agencies, there is a need to review what information is provided to health, substance misuse and other support organisations.

5.12 The Review has found that whilst Wiltshire has a wealth of public sector organisations and voluntary agencies with effective policies for the delivery of

services for local people, there is evidence that the delivery of those policies have on occasions fallen short, due to inadequate supervision and/or training.

5.13 Whilst there are excellent multi-agency partnerships to:

- Support Victims of domestic abuse – the MARAC
- Manage high risk offenders –MAPPA
- Engage with persistent offenders- SWITCH
- Deal with anti-social behaviour- ASBRAC
- Safeguard children and vulnerable adults- Safeguarding Boards

The review has identified a lack of understanding regarding which partnership to refer to and when to refer or re-refer a case.

5.14 There is no support available for the families of the perpetrator as there is for the family of the victim, yet both sets of family are traumatised by the incident.

Section Six: Conclusion

6.1 In reaching their conclusions the panel focused on the questions:

- **Have the agencies involved in the DHR used the opportunity to review their contacts with Adult Y and Adult Z in line with the Terms of Reference (ToR) of the review and to openly identify and address lessons learnt?**
- **Will the actions they take improve the safety of domestic abuse victims in Wiltshire in the future?**
- **Was the homicide of Adult Y predictable?**
- **Could it have been prevented?**

6.2 The review panel commends the manner in which organisations have used their participation in the Review, to not merely identify and address lessons learnt from their contacts with Adult Z and Adult Y, beyond the periods required in the Terms of Reference; but have gone further to arrange the introduction of new ways of working individually and together to ensure that victims of domestic abuse and other persons at risk are provided with more efficient services

6.3 The review panel acknowledges that there is a comprehensive range of Domestic Abuse Services available in Wiltshire and most partnership agencies have confirmed that their staff are aware of domestic abuse and the local support services available.

6.4 There was widespread knowledge and a wealth of intelligence recorded about Adult Z's personality disorder, her long standing alcohol issues, anti-social behaviour, use of violence and carrying of weapons when she was drunk, but there was little done to engage with her to change her behaviour. What actions there were, were in the main reactive to individual incidents, with the notable exceptions of Adult Z's GP, Clinical Psychologist, Tenancy officer and Adult Y' family.

6.5 As Adult Z was a SWITCH nominal and her many relationships were known, opportunities were missed to initiate the process for the Domestic Violence Disclosure Scheme (DVDS) so that a new partner could be notified about her repeated violent attacks on those close to her. However in this case it is recognised by the review panel that even if Adult Y had been notified, through a disclosure, it would have been unlikely that he would have stopped associating with her, as his family have confirmed that he was aware of her violence to previous partners.

6.6 Wiltshire has a wealth of efficient services able to provide help for the kind of problems experienced by Adult Z, however she has chosen not to engage with them and those that she did engage with i.e. her GP, psychologist, housing key worker and SWITCH offender supervisor were unable to have a sustained influence on her to stop drinking.

Adult Z did not want to stop drinking and said so on a number of occasions, yet it was drink which brought her into contact with people who also had severe alcohol problems and this often resulted in her being vulnerable in volatile relationships. She carried weapons initially to protect herself, but increasingly used them to attack or threaten people who were no danger to her, e.g. her mother, her son, her daughter, and her neighbours.

Whilst the Review has found that errors were made by front line staff and that there were, areas where policies and inter-agency working could improve; it will never be certain that if those errors had not been made or if things had been done differently Adult Z would not have killed Adult Y.

6.7 **Was the death of Adult Y predictable and/or preventable?**

In view of the perpetrator's long history of using weapons and violence to those close to her, it was predictable that she may kill someone. However, this is only obvious with the benefit of the whole picture.

The panel therefore concluded that whilst there have been numerous lessons identified and are being addressed as a result of the review, ultimately it was Adult Z who killed Adult Y, she had suffered the most traumatic of childhoods, but so had her siblings who are law abiding. What makes Adult Z different is that she has a personality disorder, suffers anxieties and has serious alcohol problems.

The Review sets out recommendations which when implemented will reduce the risks of such a situation in the future; but it is essential that they are implemented promptly because the review has found evidence that Adult Z is not unique.

Section Seven: Recommendations

7.1 The following recommendations are those agreed by the panel, as these relate to cross-cutting issues affecting more than one agency.

7.2 **Wiltshire Assembly's Public Services Board**

The Wiltshire Assembly's Public Services Board should be commended for having introduced a multi- agency Strategic Agreement to Share Information in April 2011 and for having reviewed its effectiveness 12 months later. The panel recommends;

1. The wording of its Strategic Agreement to Share Information to include that signatory organisations know the 7 golden rules for information sharing and in particular understand that information can be shared to prevent harm to an individual and third parties including front line staff.
2. The organisations who are invited to be signatories to the Agreement are reviewed to include organisations both statutory and voluntary that have contact with the public in Wiltshire. The Review is aware that this has already been actioned.
3. A training programme to ensure that senior and middle managers receive appropriate training and that all staff have the opportunity to complete information sharing e-learning training

7.3 **Wiltshire wide partnership recommendations**

Wiltshire Police, Wiltshire Council, Wiltshire Probation Trust, Avon & Wiltshire Mental Health NHS Partnership and NHS Wiltshire and Wiltshire Fire and Rescue;

1. Work together to agree a protocol whereby information is shared with and from GPs about issues which relate to patients being a risk to themselves or others. This would include, sharing information relating to domestic abuse, drink driving, firearm applications/reviews, drug or alcohol abuse, and use of violence or weapons. Once this protocol has been piloted it should be sent to the Home Office and Dept of Health as a model of good practice.
2. All organisations to ensure staff understand Wiltshire and Swindon's Safeguarding Adults Policies and Procedures and know how to recognise a vulnerable adult and refer to the most suitable agency, through appropriate training about safeguarding vulnerable adults
3. In order to share information about vulnerable adults and assess risks at the earliest stage partners should consider building on the MASH model currently being implemented in Children's Services to include 'adults at risk'. Wiltshire Safeguarding Adults Board oversees the development of a pilot "MASH "programme in Wiltshire.
4. That Victim Support should explore with the Homicide Support Service what can be done to provide support to the families of perpetrators, who are innocent of any crime and are traumatised by the homicide.

Recommendations of the individual agencies;

7.4 **Avon & Wiltshire Mental Health Partnership NHS Trust (AWP)**

Effective working with personality disorders;

1. To further develop care pathways for individuals with personality disorders, with explicit entry/exit criteria in Wiltshire
2. To improve the awareness of practitioners of the evidence base in relation to working effectively with people with personality disorders in Wiltshire

Recent Trust developments

3. In 2012 the Trust developed training pathways for mental health staff in relation to working with personality disorders. These pathways define the level

of training required by staff, and include intensive specialist psychological therapies.

4. AWP has developed and now delivers in-house training in a range of evidence-based approaches and interventions for working with personality disorders.

Risk Information Management

5. AWP Wiltshire services should obtain and review previous case records and copies of risk assessments prior to completion of an assessment where these are available.

Recent Trust developments:

6. With the implementation of an electronic case record system, historical information will be more readily accessible.

Root Cause Analysis

7. Commission a Root Cause Analysis review under the AWP Incident Management policy, alongside any future Domestic Homicide Reviews and implement any actions that arise.

7.5 **Community4 (Housing Support Partnership)**

1. To sign up to the Wiltshire Strategic Agreement to share information.
2. An appropriate member of the Community4 team in the North and West to attend partnership agency meetings (ASBRAC, MARAC, SWITCH) as a method of joined up working and for sharing information relating to the risk to Community 4 workers and partnership agencies alike.
3. All appropriate staff and new starters to attend DASH / MARAC, training within the next twelve months 2013/14
4. All staff to be aware of the safe guarding children and vulnerable adults policies and procedures for Wiltshire and to attend appropriate training.
5. To review its “Lone Working” procedure on an annual bases and ensure all new staff are aware of the procedure at induction

7.6 **Curo Housing (previously Somer Housing)**

Risk Assessment

1. Ensure a risk assessment is completed in all cases on victims of Anti-Social Behaviour so that risk can be identified and the appropriate support put in place.

Robust monitoring of case

2. Robust monitoring of the progression of cases at “1:1” meetings to avoid lengthy delays and duplications.

‘Pre Tenancy Process’

3. Introduce a pre-tenancy process, to provide more information about prospective tenants.

7.7 **NHS Wiltshire**

Information Sharing

1. NHS Wiltshire considered, how agencies involved should share information, for example if a person is charged with driving over the limit should a GP be informed? There could be a possible list of events in which a GP would be notified; this could include violent incidents, incidents with weapons or drug and alcohol.

- Develop list of events in which a GP would be notified

Update of mental health liaison role and responsibilities

2. NHS Wiltshire believes that on-going moderate mental health concerns should be managed by primary mental health liaison services. This service is just being established in Wiltshire.
   - Monitor referral activity
   - Triangulate with reduction in other agencies involvement.

Violent Patient Programme

3. NHS Wiltshire will explore how to develop a violent patient programme which would support patients who are known to have abusive behaviour.

Multi-Agency Safeguarding Hub (MASH)

4. NHS Wiltshire will work with other key Wiltshire agencies to extend the Multi-Agency Safeguarding Hub (MASH) to adults. The MASH is staffed with professionals from a range of agencies including police, probation, fire, ambulance, health, education and social care. These professionals share information to ensure early identification of potential significant harm, and trigger interventions to prevent further harm.

7.8 **Swindon and Wiltshire Alcohol and Drug Service (SWADS)/Wiltshire Council Substance Misuse Commissioning Team**

1. The new Wiltshire Substance Misuse Service will build links and participate, when appropriate in the MARAC, MAPPA and ASBRAC boards.
2. A need for a common risk assessment to include on the referral any history of violence and/or alcohol fuelled behaviour. This would enable staff to refine the scope of interventions/support a client requires whilst improving staff safety.[6]

7.9 **Wiltshire Council – Housing Allocations & Options**

Staff Training

1. Staff will receive annual domestic abuse training - the importance of communication and cross-referencing cases will form part of this training and monitored by regular one to ones and team meetings.

Safeguarding Case Studies

2. Safeguarding is a static item on the Team meeting's agenda and case studies will be discussed to ensure staff understand the importance and take the responsibility for recording, communicating and escalating issues through day to day advice and through their link officer roles.

7.10 **Wiltshire Council – Revenue & Benefit**

Engagement by staff in the MARAC process

1. Housing Benefit Staff to attend MARAC meetings and share any concerns with their team.

Training on Data Protection and Information Sharing

2. Training provided to remove misconceptions and misunderstandings surrounding the data protection act so as not to paralyse staff from sharing information across services and with key stakeholders in these types of cases.

[6] This recommendation is no longer necessary as from 1st April 2013 a single service provider was commissioned to provide specialist substance misuse services, where previously there had been four. The new Wiltshire Substance Misuse Service will be delivering a system which simplifies and makes the referral system much quicker.

Records of Violent and/or Threatening behaviour

3. Ensure records are updated in a consistent way regarding any threatening or violent behaviour of claimants/customers/known associates.

Sharing information

4. Concerns about the vulnerability of customers are shared with other departments and services, particularly Adult Social Services and the homelessness teams.

7.11 **Wiltshire Police/Multi Agency Risk Assessment Conference (MARAC)**

Identification of a Persistent Offender in either MARAC or MAPPA.

1. Persistent offenders identified in the MARAC or MAPPA process, the chair ensures that a case Officer is appointed. Following this appointment a thorough investigation should be instigated into the reported offences, and an effective witness strategy implemented to secure evidence.

Systems Flagged

2. Police should ensure that Niche is flagged, when persons are MAPPA or MARAC nominal's, to enable information to be shared with relevant agencies.

DASH Risk Assessment Training and Referral Pathways

3. Police Officers, and most importantly Supervisors should receive refresher training in the DASH Risk Assessment model and the MARAC and MAPPA referral process. The training should include raising Officers awareness in identifying Domestic Abuse Incidents.

Review of Staffing levels

4. Staffing levels within the Intelligence Department are reviewed to enable stop and search forms to be inputted.

Update Domestic Abuse Policy and Procedure

5. Policy and Procedures for dealing with Domestic Abuse to be updated, and policies that are no longer relevant should be removed from the intranet site.

7.12 **Wiltshire Probation Trust (WPT)**

Staff Training

1. Provide training to all staff on basic mental health within their first year in post to enable staff to recognise and refer service users to appropriate agencies to both address the mental health need and manage the level of risk presented. Additionally, existing staff will have access to this training.

Personality Disorder Service

2. Utilise the recently implemented Personality Disorder Service for all service users assessed as High Risk of harm and having the profile for Personality Disorder (as per the guidance) to enable improved Offender Management of these particular cases.
3. Address the issues that impact on behaviour and offending.

Assessment and Analysis of the totality of an Offender's Behaviour

4. Staff to continue to develop skills in assessing and analysing the totality of an offender's behaviour and working effectively with other agencies in order to achieve positive outcomes.

7.13 **Victim Support**

Awareness Training

1. Additional reinforcement to be introduced in Victim Support training delivered to other agencies on the importance of identifying other people at risk from a perpetrator, through use of a case study.

The Multi–Agency Partnerships:

7.14 **Swindon & Wiltshire Integrated Targets for Change (SWITCH)**

DASH Training and Referral Pathways

1. Training on the DASH Risk Assessment Tool, incorporating MARAC and MAPPA awareness and referrals.

Refresh of Policy

2. Refresh and adhere to the RAAG Policy.

Robust Management of Migration Meetings

3. The Migration Meeting needs to be robustly managed, new evidence and risks highlighted and the appropriate status applied and targeting of AMBER ALERT and RED. Management should form part of this process.

Training in the identification and management of Risk

4. SWITCH Staff needs to be adequately trained to identify and deal with RISK and the strategic lead in force needs to ensure that staff has the requisite skills. Consideration should be given by the police to adopt a tenure policy for SWITCH police staff in line with the Wiltshire Probation policy.
5. To be addressed with CID Officers and other specialist units to prevent Domestic Abuse incidents from being incorrectly identified, to be reinforced with staff and appropriate training delivered. Wiltshire Police need to address and remind staff of the escalation process to CPS in particular in cases of DA or by Perpetrators of serious or potential serious violence.

MARAC and MAPPA processes

6. DAIT should have a holistic approach to the history of DA Perpetrators and the risks they represent. The MARAC and MAPPA Processes need to be firmly embedded with staff to recognise the risks.

Intelligence v's Crime Recording

7. Wiltshire Police to address what is intelligence and what is crime recording? A system needs to be developed whereby intelligence is assessed and reviewed within the Intelligence Unit and highlighted to management in appropriate cases, which should then be investigated. Capacity to deal with and review the intelligence should be explored. Consideration for a mechanism to ensure this is done to highlight intelligence involving weapons and risks of serious harm need to be developed.

Ownership of Information

8. Wiltshire Police need to instil ownership of information and investigations. Has everything been done to reduce the risks; a list of tactical options for risk management needs to be made available for all officers to consider?

7.15 **Wiltshire Anti-Social Behaviour Reduction Conference (ASBRAC)**

Perpetrator Risk Assessment

1. To have a formal perpetrator risk assessment that takes into account previous behaviour, current issues and any threats for identifying the level of risk that is

posed to the victims and others. This should be initiated by the referring agency and then shared through the ASBRAC network for other agencies to contribute.

Training for Log Sheet Recording

2. Awareness training to be developed to raise the importance of recording the decision for an action or inaction in relation to log sheets sent in..

Links with Drug and Alcohol Services

3. Explore improving links with drug and alcohol service providers. This action should be shared with the drug and alcohol commissioning team, Wiltshire Council.

7.16 **Wiltshire Safeguarding Adults at Risk**

Understanding of Safeguarding Adults Policy

1. All organisations have a responsibility to ensure their staff understand Wiltshire and Swindon's Safeguarding Adults Policies and Procedures and know how to recognise a vulnerable adult and refer to the most suitable agency.

Safeguarding Vulnerable Adults Training

2. Organisations need to ensure staff who come into contact with the public receive appropriate level training about safeguarding vulnerable adults.

Development of the MASH model to include adults

3. In order to share information about vulnerable adults and assess risks at the earliest stage partners should consider building on the MASH model currently being implemented in Children's Services to include adults at risk.

7.17 **Wiltshire Multi-Agency Public Protection Arrangements (MAPPA)**

Increase Awareness of MAPPA to agencies

1. The findings of the DHR to be formally put to the MAPPA Strategic Management Board with a view to increasing the awareness and use of MAPPA by agencies in appropriate high risk of serious harm cases.

Develop referral pathway processes for use by Agencies to MAPPA.

2. The Quality Assurance and Serious Case Review Sub-Group of MAPPA to consider together with the relevant agencies how processes for MAPPA referral are imbedded in agency practice.

Multi-Agency Training

3. The Training Sub-Group of MAPPA to consider how awareness of the potential for MAPPA involvement in high risk of harm cases can be promoted with management and practitioners via Multi-agency Training and e-learning.

Development of Referral Pathways and inclusion in local Protocol/Policy

4. The SWITCH Manager, MAPPA Co-ordinator and the MARAC Chair to review protocols and practice arrangements on referrals and potential re-routing of referrals to the most appropriate arrangements.

Appendix One: Terms of Reference

3.1 Purpose:

The purpose[7] of the Domestic Homicide Review is to:

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

3.2 Overview and Accountability:

The decision for Wiltshire to undertake a Domestic Homicide Review (DHR) was taken by the Chair of the Wiltshire Community Safety Partnership and the Home Office was informed on 14th December 2012.

The Home Office Statutory Guidance advises where practically possible the DHR should be completed within 6 months of the decision made to proceed with the review.

Due to the criminal trial not being listed until the beginning of May 2013, it was agreed in conjunction with the Home Office to adjourn the review following an initial meeting on the 18th February 2013 and to re-commence following the trial's conclusion.

This Domestic Homicide Review, which is committed, within the spirit of the Equalities Act 2010, to an ethos of fairness, equality, openness, and transparency, will be conducted in a thorough, accurate and meticulous manner.

3.3. The Domestic Homicide Review will consider:

1. Each agency's involvement with Adult Y aged 51 and Adult Z aged 46, between 1st January 2010[8] and the homicide of Adult Y on 20th November 2012 at a flat in Wiltshire:

2. Whether the alleged perpetrator had any previous history of abusive behaviour towards the victim, and whether this was known to any agencies.

3. Adult Y had no known contact with any specialist domestic abuse agencies or services. The Review will look to address whether the incident in which he died was a 'one off' or whether there were any warning signs and whether more could be done in Wiltshire to raise awareness of support services available to victims of domestic violence.

[7] Paragraph 3.3 Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews

[8] For the purpose of informing this Review of significant domestic violence type offences on other people, the Avon & Wiltshire Partnership, Crown Prosecution Service, NHS Wiltshire, Wiltshire Police, Wiltshire Council Revenue & Benefits, Wiltshire Probation Trust, and MAPPA have included a number of earlier contacts prior to 2010.

4. Whether family, friends or colleagues want to participate in the review. If so, ascertain whether they were aware of any abusive behaviour from the perpetrator to the victim, prior to the homicide.

5. Whether, in relation to the family members, were there any barriers experienced in reporting abuse?

6. Could improvement in any of the following have led to a different outcome for Adult Y;

   (a) Communication and information sharing between services
   (b) Information sharing between services with regard to the safeguarding of adults
   (c) Communication within services
   (d) Communication to the general public and non specialist services about available specialist services

7. Whether the work undertaken by services in this case are consistent with each organisation's:

   (a) Professional standards
   (b) Domestic abuse policy, procedures and protocols

8. The response of the relevant agencies to any referrals relating to either Adult Y or Adult Z, concerning domestic abuse or other significant harm from 01/01/2010[2] It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:

   (a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards with either victim or perpetrator.
   (b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.
   (c) Whether appropriate services were offered / provided and/or relevant enquiries made in the light of any assessments made
   (d) The quality of any risk assessments undertaken by each agency in respect of Adult Y and Adult Z.

9. Whether thresholds for intervention were appropriately calibrated and applied correctly, in this case.

10. Whether practices by all agencies were sensitive to the personality characteristics set out in the Equalities act 2010 in relation to the victim and perpetrator and whether any specialist needs on the part of either of the subjects were explored, shared appropriately and recorded.

11. Whether issues were escalated to senior management or other organisations and professionals, as appropriate, and completed in a timely manner.

12. Whether the impact of organisational change over the period covered by the review had been communicated well enough between partnership agencies and whether that impacted in any way on agencies' ability to respond effectively.

13. Whether, any training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse processes and/or services.

14. The review will consider any other information that is found to be relevant.