FDCNH/14

Domestic Homicide Review Overview Report in respect of:

Ms G - Born: January 1987 - Died: May 2014

Marion Wright

Independent Overview Author

Date: October 2015

DHR – FDCNH/14

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1. Introduction

Preface

1.1 This Domestic Homicide Review (DHR) examines the circumstances surrounding the death of Ms G in Derbyshire in 2014. It examines agency responses and contact with Ms G and Mr F prior to the point of Ms G's death. Those involved in the review would like to express their sympathy for the family and friends of the victim for their sad loss in such tragic circumstances.

1.2 The purpose of the review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the ways 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 upon, and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate.
- Prevent domestic homicide and improve service responses for all domestic abuse victims and their children through improved intra and inter agency working.

1.3 DHRs were established on a statutory basis under Section 9 of the Domestic Violence Crimes and Victims Act 2004. The provision for undertaking the reviews came into force on the 13th April 2011. The death of the victim in this case met with the criteria for a statutory DHR in that the victim died as a result of being assaulted by her partner at his home. The Home Office criteria for reviews includes "a review of the circumstances in which the death of a person aged 16 or over has or appears to have resulted from violence, abuse or neglect by:

a) A person to whom he or she was related or with whom he or she was or had been in an intimate relationship."

It is recognised that a domestic abuse incident which results in the death of a victim is often not a first attack and is likely to have been preceded by psychological, emotional abuse, coercive control and possibly other physical attacks.

1.4 This review is held in compliance with the legislation and follows guidance for the conduct of such reviews issued by the Home Office. I would like to thank those individuals from the different agencies for their contribution to the review and for their significant time, openness and commitment. Also the families and others for their input and their willingness to share information at such a difficult time.

1.5 Domestic Homicide Review Panel Members

FDCNH 14 Panel Members	
Tony Blockley	Independent Chair of the Review Panel
Marion Wright	Independent Overview Report Author
Sally Goodwin	Assistant Director Community Safety (inc. Emergency Planning) Health & Communities Department Derbyshire County Council
Chief Inspector Malcolm Bibbings	Public Protection –Derbyshire Constabulary
Bill Nicol	Head of Safeguarding Adults Derbyshire County and City Clinical Commissioning Groups
Rena Evans	Crown Prosecution Service
Christopher Rollings	Emh homes
Jane Brooks	Safeguarding and Specialist Services – Children and Younger Adults Derbyshire County Council
Lisa Morris	Commissioner of DV Services-Derbyshire County Council

1.6 To reinforce the impartiality of this report it is confirmed that the Independent Chair and the Independent Overview Author are not employed by Derbyshire agencies in any other capacity and have not previously had any direct involvement in this case. Neither have they had any line management responsibility for those who have been providing services or for those managing the provision of those services. The Independent Chair is a retired Detective

Chief Superintendent of Police who had responsibility for all major and serous crime including homicide. He has widespread experience in reviewing homicides, in commissioning Serious Case Reviews and has previously chaired and written Domestic Homicide Reviews. The Independent Overview Author is a retired Assistant Chief Officer of Probation with 33 years' experience. She had strategic lead for Public Protection including Domestic Abuse. She has experience of providing Serious Case Reviews for MAPPA (Multi Agency Public Protection Arrangements) and Domestic Homicide Reviews.

1.7 Both the agency review panel members and the Individual Management Review (IMR) report authors who have provided agency evidence considered by the review are independent from any direct involvement in the case or direct line management of those involved in providing the service.

1.8 In line with the National Domestic Homicide Review Guidance the decision was taken to undertake a DHR within four weeks of the homicide. The Home Office were notified of the decision on the 4th June 2014. The first full review panel meeting took place on the 9th July 2014. Given that the alleged perpetrator, at that stage, denied the charge of murder, the review process was temporarily paused until after the conclusion of the criminal trial. This eventually took place on the 21st October 2014 and the outcome was that Mr F was found guilty of manslaughter and sentenced to 6 years imprisonment on the 23rd October 2014. The review process was immediately resumed.

1.9 The view of the review panel was that to interview the perpetrator and family members prior to the conclusion of the legal proceedings, was inappropriate. However, any lessons to be learnt by agencies regarding practice which required immediate attention were to be taken forward by the agencies without delay.

1.10 Following the conclusion of the criminal proceedings which resulted in Mr F being sentenced to six years imprisonment for manslaughter, contact was offered to the perpetrator and identified family members who may wish to have their voice heard within the process and could provide insight and information.

1.11 Parallel processes included the criminal trial and the Coroner's Inquest. Liaison took place throughout the criminal proceedings and the Derby Coroner's Office was contacted by the Police IMR author and it was confirmed that there will be no further Coroner's proceedings following the conviction for manslaughter.

Circumstances that led to the review being undertaken

1.12 At 21.02 hours on the 4th May 2014 the Police and Ambulance service were called to attend a flat in Derbyshire following a call from a neighbouring member of the public reporting that a female was suffering from stab wounds.

1.13 Upon arrival at the address, the emergency services found Ms G in the hallway outside Mr F's flat with stab wounds. Her partner Mr F was present and attempting to administer first aid. Two blood stained knives were found in the hallway. Ms G was transferred to hospital but was pronounced dead at 22.00 hours the same day. A post mortem examination identified the cause of death as a stab wound to the abdomen.

1.14 Witnesses at the scene informed the Police that Mr F was responsible for inflicting the injuries to Ms G and he was subsequently arrested on suspicion of murder and charged with the offence on the 5th May 2014.

1.15 The Derbyshire Community Safety Partnership, along with other agencies who had contact with the individuals, met on the 2nd June 2014 to consider the case and concluded that the case met the criteria for a DHR and the Home Office were notified accordingly.

Scope of the review

1.16 The scope of the review will include information available on Ms G the victim, Mr F the perpetrator and the victim's partner between 1st January 2012 and the 4th May 2014 which is the period covering their relationship. Information in relation to Mr F's previous partners is to be considered only so far as it relates to their association with Mr F and any previous concerns re domestic abuse. However, if any agency felt there was relevant information outside the time period under review it was agreed that the information should be included in their IMR. As well as the IMRs, each agency provided a chronology of interaction with the identified individuals including what decisions were made and what actions were taken. The IMRs considered the Terms of Reference (TOR), whether internal procedures were followed,

whether on reflection they were considered adequate, arrived at a conclusion and where necessary, made a recommendation from the agency perspective.

Terms of Reference

1.17 In order to address the key issues, agencies were charged with answering the questions set out below and providing analysis for their answers.

Issues to be addressed:-

1) Are there any specific considerations around equality and diversity issues

such as ethnicity, age and disability that may require special consideration?

2) Was the victim subject to a MARAC?

3) Was the perpetrator subject to Multi Agency Public Protection Arrangements (MAPPA)?

4) Was the perpetrator subject to a Domestic Violence Perpetrator Programme (DVPP)?

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

6) Did anyone in contact with the victim know whether or not the victim was aware of domestic violence services available locally? If yes but not used were there any barriers to the victim accessing these services?

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

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

9) Consideration should also be given to whether either the victim or the perpetrator was a 'vulnerable adult'. The term vulnerable adult will be subject of change under the Care Act 2014.

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

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

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

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

14) What were the key relevant points/opportunities for assessment and decision making in this case in relation to the victim and perpetrator. What was the quality of any multi-agency assessments?

14) Was the impact of domestic violence on the victim recognised?

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

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

17) Could the homicide have been anticipated or prevented?

Methodology

1.18 The Review Panel was convened by the Derbyshire Community Safety Partnership (CSP) and included representatives from the relevant agencies and the Independent Chair and Overview Report Author. The Review Panel commissioned a chronology and IMRs from each agency. Family members and the perpetrator were contacted to make a contribution.

1.19 A total of four meetings were held with the Review Panel. The first was to consider information available and agree that a DHR was appropriate the second to agree the Terms of Reference, commission the IMRs and further consider the information available. The third meeting was also attended by the IMR authors and enabled agencies to present their information and give time for others to ask questions and make comment. The fourth meeting was to consider the draft Overview Report and the family information in order to ensure it accurately reflected the information provided by the agencies in a full and fair way.

1.20 In order for agencies to prepare their contribution they were asked to consider contact and practice in providing a service measured against agency policy and procedures and to identify any shortfalls or indeed where current policies or procedures required improvement.

Agencies sourced and reviewed a range of information from a variety of systems and interviewed some staff shown to have had direct involvement with Ms G and Mr F.

1.21 The agencies completing IMRs and the profile of their involvement with the individuals were as follows:

Derbyshire Constabulary – who responded to calls in relation to three domestic abuse incidents between Ms G and Mr F during the scope period and had some previous information relevant to the case.

Crown Prosecution Service **–** who provided advice to the Police in June 2013 in relation to a possible charge of common assault by Ms G on Mr F where a decision of 'No further action' was given.

Emh homes – who provided accommodation to Ms G from October 2010 and to Mr F from January 2004.

NHS Southern Derbyshire and Erewash Clinical Commissioning Group – who provided General Practitioner services to both Ms G and Mr F, hospital services following a broken ankle to Ms G and ambulance services at the time of Ms G's fatal assault.

1.22 Whilst it is recognised that there were incidents of domestic abuse, no domestic abuse agencies were referred to or had any contact with Ms G or Mr F.

1.23 In preparing the Overview Report the following documents were referred to:

1) The Home Office Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews.

2) The Home Office Domestic Homicide Review Tool Kit Guide for Overview Report Authors.

3) Call an End to Violence Against Women and Girls HM Government published 25th November 2010.

4) Barriers to Disclosure –Walby and Allen 2004.

5) Incidents of Abuse before Domestic Abuse is reported to the Police – Jaffe 1982

6) Home Office Domestic Homicide Reviews –Common Themes Identified and Lessons Learned November 2013.

7) Links between Alcohol Abuse and Domestic Abuse –World Health Organisation.

8) Substance Abuse and Women Abused by Male Partners –Larry W. Bennett 1997

9) Agency IMRs and Chronologies.

10) Individual agency Internal Operational Policies and Procedures

1.24 Where confidential information has been detailed in relation to Ms G and Mr F, it has been gathered and shared in the public interest and in line with the expectation of the National Guidance for the conduct of DHRs.

1.25 The victim's parents and brother were contacted offering them the opportunity to contribute to the review and the perpetrator and his parents were also written to in relation to contributing to the DHR process. Once the draft Overview Report was completed, the families and the perpetrator were contacted again to consider the Overview Report and comment on the content prior to publication. As a result, interviews were undertaken by the Independent Overview Report Author with the victim's mother and extended family members. The perpetrator's parents were interviewed and the perpetrator was seen in prison where he is serving his sentence.

1.26 Subjects included in the scope of the DHR

Victim Ms G – Partner of the perpetrator.

Perpetrator Mr F – Partner of the victim.

Previous partners of the perpetrator only in relation to relevant domestic abuse information.

Ms A - Previous partner of the perpetrator

Ms B - Previous partner of the perpetrator

Family and others Involvement

1.27 The panel would like to thank Ms G's mother and family members and also Mr F`s parents for their contribution to the review and for helping to achieve greater understanding of the nature of the relationship between Ms G and Mr F. Mr F was also interviewed for the purpose of this review.

1.28 Ms G's mother reported that whilst she and the family were of the view that Mr F and Ms G were" not good for each other" as he undermined her confidence and did little to

encourage her, they were unaware that domestic abuse was a feature of her daughter's relationship. They were not aware of the extent of the police involvement. On one occasion in September 2012 police did take Ms G to her mother's home following the first domestic abuse incident recorded. However the police did not give details of what had occurred. Ms G was drunk at the time and the family thought that it was as a result of her intoxication that the police escorted her to her mothers.

1.29 The family`s view was that Mr F was a regular daily drinker, drinking cans of beer at home. Ms G drank a couple of times a week when the couple went out to visit local public houses. Ms G and Mr F often drank to excess on these occasions; Ms G could become what they described as "rowdy" when drunk but they consider this fell short of aggressive. The family were aware money was tight for the couple and they mainly drank on Thursdays when they received their benefits.

1.30 The family had previously had concerns about Mr Fs behaviour towards Ms G in terms of verbal abuse, in that in their view he said things to belittle and embarrass her and also said things specifically to goad her. They gave examples of this e.g. whilst at a family party he said unkind things regarding her weight about which she was very sensitive and embarrassed. They were not aware of physical abuse towards Ms G but did see scratch marks on Mr F`s face on one occasion which Ms G admitted doing, when she had been upset by something he had said.

1.31 Following the incident of the broken ankle the couple separated and the family were very disappointed when the relationship resumed some months later.

1.32 What the family describe as verbal abuse may with hindsight possibly be considered to be indicators of coercive control. However this was not recognised in such clear terms at the time and may indeed have been designed to get a reaction rather than to control. Mr F admitted that he had not met anyone like Ms G before and one of her attractions for him was that she was feisty and would challenge others if she did not like what they were saying, in a way that he did not feel able to do and that he admired.

1.33 Ms G's father was contacted but felt he did not wish to contribute towards the review at this stage.

1.34 Mr F`s parents were interviewed at their home. Whilst they were aware Ms G lost control and could be aggressive when she had been drinking (apparently Mr F`s father had witnessed this towards others in a local public house and they had seen marks on Mr F`s face) they never considered the behaviour amounted to domestic abuse and therefore did not seek advice or assistance. They were not aware that Mr F ever retaliated. They had been concerned about this aspect of their son's relationship and had advised him to end it. Their view was that the difficulties were directly linked to alcohol use and at other times the couple were happy and content, planned to marry and have a family.

1.35 Mr F does not view his relationship with Ms G as one that was defined by violence and that whilst they did have arguments that led to physical violence, these were few and far between. He identifies that in the time they were together, there were five occasions where there were fights when Ms G lost her temper, all followed drinking binges. On the fateful evening he would say that they had both consumed 9 pints of alcohol. He maintains that the stab to Ms G was not intended to seriously hurt her. He would say he is devastated by the outcome. As Mr F did not see that their relationship amounted to domestic abuse he does not consider any other agencies could have identified it in this way and therefore intervened. He does recognise the role alcohol played and that with hindsight the need that there was to control their pattern of drinking to excess.

2. The Facts

2.1 Ms G and Mr F had been in a relationship for a little over two years. Whilst they both had their own independent council accommodation, Ms G spent much of her time at the flat of Mr F. In August 2012 the couple had applied for a joint transfer to alternative accommodation stating the reason for this as needing an extra bedroom for Mr F's [redacted] children [redacted], to be able to stay the night. It was stated that the fact that there was only one bedroom caused his [redacted] to object to [redact] staying over. Although Ms G and Mr F were then eligible to bid for suitable properties on the 'Choice Based Lettings System', no bids were made by them. [redacted] children resided with their mothers but visited Mr F on a regular basis.

2.2 It was at Mr F's flat that the stabbing resulting in Ms G's death took place. It has been established that on the evening of the 4th May 2014, Police and Ambulance were called by a neighbour to attend the flat following a report of a female with stab wounds. Upon arrival the emergency services found Ms G in the hallway outside the flat with stab wounds. Mr F was

present attempting to administer first aid. Two blood stained knives were found in the hallway. Ms G died from her injuries within the hour.

2.3 It was accepted by the Court that on the evening in question Ms G and Mr F had been out drinking together and returned home where an argument ensued. Mr F went to a neighbour's flat to ask for assistance in dealing with the situation. It is accepted that Ms G had got two knives and was threatening to harm herself. Mr F reported he was jabbed with one of the knives by Ms G. He wrestled the knives away from her and used one of them to stab her as he wanted her to know how it felt. She died from a stab wound to her abdomen. Mr F again sought help from a neighbour following the stabbing. Whilst charged with murder, a plea of manslaughter was accepted by the Judge on the 21st October 2014 due to a variety of factors including; the fact that the perpetrator had sought help from a neighbour, the defence given was provocation, Mr F having been stabbed first, also known history had shown Ms G to be as equally aggressive and volatile as the perpetrator.

Victim Information

2.4 Ms G spent much of her life living in the local area. [Redacted] She was in receipt of medication from her GP for depression. Following analysis of information supplied by health practitioners it was apparent that Ms G's involvement with health agencies was routine in nature. [Redacted]

2.5 [Redacted]

2.6 In March 2013, twelve months into her relationship with Mr F, Ms G reports to her GP that the anti-depressants are not working and she is offered a course of Cognitive Behavioural Therapy (CBT). In August 2013 Ms G reports to her GP that she has undertaken a six week CBT course which helped a little but she requests anti-depressants again. Ms G remains on this medication until her death in May 2014.

2.7 The only other relevant medical information regarding Ms G relates to a broken ankle which was sustained on the 2nd June 2013 during an altercation with Mr F at his home. The Police were called to this incident and details will be included under significant events below. Whilst Police transported Ms G to hospital to have her ankle treated there were some

discrepancies in the story of how the injury occurred. Ms G told Police she had fallen over a child's pedal cycle in the hall, at the hospital she repeated this to staff however later she said she was unsure how her injury had happened. During the course of the murder investigation Ms G's family informed Police that Ms G later said her ankle injury was caused by Mr F pushing her over. As a result of this incident Ms G and Mr F ended their relationship but reunited several months later and in November 2013 became engaged to be married.

2.8 It would appear, although not recorded in health records but from Police information, that alcohol consumption played a significant role in Ms G's relationship with Mr F. There are at least three events recorded by Police where excessive use of alcohol by both Ms G and Mr F impacted upon events and either fuelled aggressive incidents or acted as a disinhibiter to their behaviour. Whilst having been in other relationships there is no previous record of domestic abuse concerning Ms G. Ms G was arrested for an offence of assault against another female in a local Public House in 2006 for which she received a caution.

Perpetrator Information

2.9 Father of [Redacted] children from different relationships Mr F maintained regular contact with his [Redacted] and his [Redacted] at the time of Ms G's death. [Redacted] children's mothers referred to Mr F as being a good father and they had no concerns about the children visiting. He has a close bond with his [Redacted] who was interviewed by Police following the killing and indicated [Redacted] had a good relationship with [Redacted] father and Ms G and that whilst [Redacted] witnessed arguments between them [Redacted] had never witnessed violence.

2.10 Mr F spent his life living in the Derbyshire area and remains close to his parents and [Redacted]. It would appear he has largely been unemployed having only had two periods of employment in a foundry and roofing. GP notes indicate Mr F had been prescribed anti-depressants since 2000. In September 2011 he presented as having mixed anxiety with a depressive disorder. On his visits to his GP he does share information about his anxieties about his finances and his relationship with his current partner (Ms G). In March 2013 he states he is unhappy in his current relationship and plans to terminate the partnership. In October 2013 he advises his GP his relationship had ended and that he was emotionally upset to the point of experiencing suicidal thoughts. He declines counselling. There is no

indication of violence existing within the relationship and there is reference to only using minimal amounts of alcohol.

2.11 There is some discrepancy in what is told to the GP about alcohol use and what is recorded by Police when they are called to the incident at Mr F's home where excessive use of alcohol appears to be a feature. It is admitted by Mr F that he and Ms G drank excessively when they went out to visit Public Houses approximately twice a week. They would drink at home first, both to save money and to "gain confidence" to go out and socialise.

2.12 There was an offence of threatening behaviour recorded against Mr F in 1996 some eighteen years ago for which he received a twelve month conditional discharge and a further offence of disorder in 2003 for which he also received a conditional discharge.

3. Chronology

3.1 Chronology of agency contact with Ms G and Mr F is attached at Appendix A. Relevant and significant events are highlighted in the synopsis below.

Synopsis of critical events

3.2 The first known incidents of what we would now consider as domestic abuse, according to police records involving Mr F occurred [Redacted] in 2002. Following the breakdown of their [Redacted] relationship there were three separate incidents of domestic abuse over a two month period. It is alleged the relationship ended due to Mr F's excessive drinking and unwillingness to settle into family life. The couple had [Redacted]. Mr F maintained contact with his {Redacted] however when his ex-partner began a new relationship Mr F's behaviour became problematic and the incidents occurred.

3.3 On the 14th October 2002 a member of the public called the Police to report a domestic incident where Mr F was trying to snatch his [Redacted] from his mother. He was not interviewed in relation to this incident; his ex-partner was provided with information and support. She denied any physical assault by Mr F.

3.4 On the 23rd October 2002 Mr F was arrested and appeared in Court for throwing a rock through the ground floor window of his ex-partners home. He received a twelve month conditional discharge for criminal damage.

3.5 On the 21st November 2002 Solicitors acting on behalf of his ex-partner contacted the Police to complain that she had received an abusive phone call from Mr F the previous night.

3.6 As a result of these problems his ex-partner moved away from the area and Mr F lost contact with his [Redacted]. [Redacted] There were no further allegations of Mr F being abusive. Mr F's relationship with the mother of his [Redacted] ended before the child was born in [Redacted] They never lived together.

3.7 Ms G and Mr F began their relationship in March 2012 and subsequently came to the notice of the Police on three occasions for domestic abuse incidents prior to the killing. They all occurred after they had been out drinking alcohol together in the town centre and were reported by third parties either neighbours or independent witnesses of the events.

3.8 The first of these incidents occurred on the 13th September 2012. The couple had been out drinking together. Whilst walking home they began fighting with each other and the Police were called by a member of the public. No arrests were made and it was dealt with by means of Restorative Justice (RJ).

3.9 On the 2nd June 2013 Police were called by a neighbour to Mr F's home and as a result Ms G was arrested. She was suffering a broken ankle allegedly having fallen over a child's bicycle in the hall. She admitted assaulting Mr F however following advice from the CPS, a prosecution did not take place.

3.10 On the 13th April 2014 Ms G was arrested by Police for being drunk and disorderly in the town centre. CCTV staff contacted the Police. Footage showed Ms G was acting aggressively towards Mr F and staff at a Public House. She was held overnight to sober up and then dealt with by way of a Fixed Penalty Notice (FPN) for disorder. In line with current policy information was sent to Ms G to attend an alcohol intervention scheme as an

alternative to paying the full FPN. Ms G had taken advantage of this and was booked on the alcohol course for the 7th June 2014 but was killed before she had the opportunity to attend.

3.11 The last incident of the 4th May 2014 resulted in the death of Ms G and of Mr F being convicted of manslaughter.

4. Analysis of Involvement

Individual Management Reviews (IMRs)

4.1 In this section practice is analysed and evaluated against agency policy and procedure via the IMRs. Further analysis takes place in the next section directly answering the TOR questions.

Police IMR

4.2 The Police IMR was conducted using a range of records that were available, several policy documents and discussion with staff to explain policies and procedures.

The three incidents that took place in 2002 between Mr F and his previous partner whilst with hindsight provided evidence of domestic abuse, at the time were identified and dealt with differently failing to capture the pattern of abuse that appears to have taken place at that time.

4.3 The first incident on 14th October 2002 where a member of the public reported 'the man has been quite violent towards her, she is upset, he tried to snatch her baby from her' was identified as domestic abuse and graded as a priority. No offences were disclosed by the victim when interviewed. The incident was appropriately marked for the attention of the DV unit and a marker put on the home address. However there is no information that indicates Officers obtained an account from the reporting member of the public or interviewed Mr F and no evidence of any further action. Now this would be considered to be inappropriate and would fall short of expectations of practice.

4.4 The incident of the 23rd October 2002 some nine days later involving Mr F smashing the window at his ex-partners home was classed as 'damage' and resulted in Mr F being arrested within thirty minutes and later receiving a conditional discharge. He was given bail with conditions not to contact his ex-partner or go near her house. Whilst classed as damage the DV unit were informed, although there is no record of any further action as a result.

4.5 The abusive phone call from Mr F to his ex-partner was reported on the 21st November 2002. The Police interviewed the ex-partner however there is no information which indicates that the DV Unit were made aware of this incident or that Mr F was arrested for breach of bail or warned about his conduct or whether his ex-partner was provided with information about DV support services.

4.6 The three incidents took place twelve years ago and since that time working practices and policies involving domestic abuse have changed significantly. Current procedures would define all three incidents as domestic abuse and would therefore require completion of a Domestic Abuse Stalking and Honour Based Crime (DASH) risk assessment and referral to the Central Referral Unit. From the information available it is likely that the incidents would be graded as standard risk. Standard risk levels are defined as ‘current evidence does not indicate the likelihood of serious harm being caused. Standard cases are managed by the Divisions and referred to the local Beat Officer for information. This would not involve referral to a Multi- Agency Risk Assessment Conference (MARAC).

4.7 However under current practice Mr F would have met the criteria to be identified on the Police system as a repeat domestic abuse perpetrator. The definition of repeat is two or more incidents of domestic violence against an intimate partner within the previous twelve months. A monthly list of repeat perpetrators is recorded on the Guardian crime recording and intelligence system. The top 10 subjects on the list are managed by the specialist units. They are then subject of a tasking process resulting in proactive targeting, which is where officers are aware of the perpetrating behaviour and are able to monitor the individuals whenever they are seen. Officers will gather intelligence relating to the perpetrator on a regular basis and consider how to prevent the subject from committing further offences or being involved in criminal activity. The Divisions target a number of the next highest on the list in order that front line officers are able to target their offending. This targeting sits within Section and Divisional tasking. The lists are refreshed bi-monthly and are also shared with a number of partner agencies. For the officer attending a domestic abuse incident, having that knowledge at the scene from real time intelligence that the perpetrator/victim is flagged as a serial/repeat, allows the officer to use professional judgement on how they gauge the risk assessment.

4.8 Current procedures would also highlight potential safeguarding issues in relation to Mr F's then young son and a referral to Children's Social Care would be considered to protect his welfare.

4.9 In relation to the three domestic abuse incidents involving Ms G and Mr F, the first on the 13th September 2012 was reported by a member of the public who had witnessed Ms G and Mr F fighting near to Mr F's flat. Mr F was seen to pin Ms G down by the throat and Ms G knee Mr F in the groin, push him up against a wall and drag him to the ground.

4.10 When the Police arrived the couple had stopped fighting but were both highly intoxicated on alcohol. The parties were interviewed separately and admitted assaulting the other. They had been out drinking together and whilst walking home had begun to argue over Ms G's previous relationships with other males.

4.11 The incident was graded as domestic abuse and the initial response considered as immediate. Two crime numbers were allocated identifying both parties as victims as Police found it impossible to differentiate between them. The matter was dealt with by way of Restorative Justice (RJ) with both parties apologising to the other, this received approval in line with policy, from the Duty Inspector. In September 2013 Her Majesty's Inspector of Constabulary (HMIC) conducted an inspection of all forces to consider the effectiveness of the Police approach to victims of domestic abuse. As a result of the inspection a number of recommendations were made to Derbyshire Constabulary e.g. "The Force should consider the appropriateness of using Restorative Justice for offences involving intimate relationships, particularly with regard to how any action will prevent further offences of domestic abuse or reduce the risk to the victim."

4.12 As a result of the HMIC recommendation Derbyshire Constabulary withdrew the use of RJ in all intimate partner related domestic abuse with effect from 1st April 2014.

4.13 A DASH risk assessment was carried out promptly identifying Ms G as the victim and identifying the risk as standard. Following referral to the Central Referral Unit (CRU) for a risk assessment evaluation, the assessment of standard risk was confirmed.

4.14 If there is doubt as to who is the victim and who is the perpetrator best practice would have been to complete 2 DASH forms, one for each party. Although the submission of a second form may seem bureaucratic it would have identified both parties as perpetrators and victims of domestic abuse which would have been important intelligence when conducting any future risk assessments. It is the ACPO DASH National Guidance that if two people proclaim to be a victim then both should have a DASH completed.

4.15 The quality of the DASH form on this occasion was insufficient in that Ms G had answered 'Yes' to the question about children/step children in the household. However no information was recorded to identify the children, this lack of information prevented any potential referral to Social Care in relation to the welfare of the children.

4.16 Following a recommendation from the HMIC inspection in September 2013 all domestic abuse incidents are now subject to a quality check by the attending Officer's Sergeant and the Command and Control incident cannot be closed until this has been completed. One of the questions to be answered by the Sergeant is 'Have your Officers recorded full details of all children connected with the parties/household. Is a referral to Children's Social Care required?' The policy was implemented in January 2014 (after the incidents took place). This closure process will be updated as from 5th January 2015 replacing the four child focussed questions with three others to be answered by the Supervising Sergeants.

4.17 It is now the case that in every domestic abuse incident where there are children who have contact with the victim or perpetrator that the incident is referred to Social Care, Education and Health for consideration in terms of safeguarding the children. This process is awaiting ratification.

4.18 All front line staff who are likely to be involved with domestic abuse are undergoing refresher training. This is recorded as already showing improvements in the quality of DASH forms submitted by attending Officers. The new Domestic Abuse Toolkit now includes giving information to the victim and perpetrator about services available. This was not the practice when the incidents in this case took place.

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4.19 At 00.31 on the 2nd June 2013 the Police were called by a neighbour who reported that a male had assaulted a female, she was lying on the floor screaming and the male had run off.

4.20 When Police arrived a female voice could be heard from within the flat shouting. Mr F opened the door; he had no top on and had numerous scratches to his face and chest. Ms G was lying on the floor within the flat unable to get up with a suspected ankle injury. Mr F informed the Police that they had been drinking and when they got back Ms G began causing problems outside the flat. He let her in where she assaulted him and ripped his shirt. He refused to make a complaint. Ms G was arrested at the scene for assaulting Mr F and transported to hospital where she was treated for a broken ankle. There is no evidence Police shared information with the hospital staff in relation to the domestic abuse or that hospital staff queried the attendance of the Police.

4.21 Ms G was bailed until 4th June 2013 when she was interviewed and admitted assaulting Mr F. She said she had suffered the ankle injury falling over a child's cycle in the hallway and made no complaint of assault; despite initially telling Officers at the scene 'he punched me so I punched him back'.

4.22 The incident was identified as domestic abuse with Mr F being the victim and Ms G being the perpetrator.

4.23 There are various discrepancies in the investigation of this incident that question the thoroughness and the appropriate use of exploratory questions and professional curiosity.

These include:

- The original caller identifies that the assault was male on a female. There is no information to indicate that this person was contacted to verify the information.
- Initially Ms G had informed Police that she was assaulted first by Mr F and retaliated. When Police arrived she was on the floor with a broken ankle yet Mr F's version of events was believed without obviously exploring the alternative version of events.
- The Police failed to use professional curiosity when completing the DASH form to further explore the comment that Ms G had tripped over a child's cycle when Mr F failed to give a positive answer to 'any children in the household'

4.24 The DASH form identified Standard Risk. This was subject to an assessor evaluation with no change to the assessment.

4.25 The third incident on the 13th April 2014 involved Police being called to a Public House in the town centre at 00.13 hours by local Close Circuit Television (CCTV) Operators. On arrival they found Ms G drunk and aggressive after being refused entry (following an assault on door staff a few weeks previously). Mr F was present and managed to move Ms G away from the premises. A few minutes later Officers were called following a report that a male and female were arguing with the female appearing to be the aggressor.

4.26 At the scene Officers found Ms G lying on the floor waving her arms shouting and swearing. She was arrested at 00.35 hours for being drunk and disorderly. Ms G was held overnight and issued the following morning with a Fixed Penalty Notice (FPN) for being drunk and disorderly. The risk assessment undertaken on her arrival at the custody suite identified that Ms G had consumed half a bottle of vodka and two pints of lager. She answered 'No' to the question about alcohol dependency and 'No' to whether she wished to be contacted by an Independent Alcohol Referral Worker.

4.27 Since March 2011 Derbyshire Police have introduced that eligible offenders receiving an FPN for being drunk and disorderly are automatically contacted by Drug Link charity with a view to attending an alcohol awareness course The purpose is to gain understanding of the long term effects of drinking and the risks to themselves and others in alcohol fuelled situations. An incentive to attend is provided in that if a person completes the three hour interactive course the FPN fine is reduced by 50% and the Penalty Notice is cancelled. Enquiries made with Drug Link confirmed Ms G had been contacted and was due to attend a course in Derby on the 7th June 2014. Sadly she died before this could take place.

4.28 The Officers attending the incident identified it as being domestic abuse based upon CCTV footage showing Ms G pushing Mr F down the steps leading to the Public House. However it was finally recorded on Command and Control as anti-social behaviour. Officers correctly recognised that a DASH form was required from Mr F however they were unable to complete one at that time as he had left the scene whilst Officers were struggling to contain Ms G. An effort was made to contact him by telephone at 2.53am but there was no reply.

The Command and Control incident identifies that Mr F was to be contacted at a more suitable time for DASH details but there is no information to show whether this was followed up.

4.29 The incident was closed without a DASH form being completed it being coded as anti-social behaviour rather than domestic abuse. This was a missed opportunity to intervene with Ms G and Mr F and provide information about prevention and of domestic abuse services available.

4.30 The IMR author is of the view that had a DASH form been generated it is likely it would have been classified as standard. However had the DASH been completed it would have identified Ms G as a repeat perpetrator having committed two domestic abuse incidents against an intimate partner within the previous twelve months. As such the incident would have gone on the monthly repeat perpetrators list on the Guardian intelligence database and would have been the subject of proactive targeting. Had this been the case the focus and intervention of the Police may have had an impact on circumstances that led to the crisis that occurred on the 4th May.

4.31 A Domestic Violence Investigation Toolkit was introduced in 2014 which Police Officers use as a template for their investigation to improve practice. It now includes legislation introduced in June 2014 concerning the Domestic Violence Protection Notice (DVPN) and Domestic Violence Protection Orders (DVPO) scheme which provides an alternative method of dealing with ongoing domestic related issues. Also following the HMIC recommendations there is now an Independent Multi-Agency Domestic Abuse Scrutiny Panel across Derbyshire that sits quarterly and considers the quality of the management of domestic abuse incidents.

CPS IMR

4.32 The Crown Prosecution Service (CPS) considered the case of Ms G assaulting Mr F on the 2nd June 2013 causing scratches and grazes to his upper torso. She was taken to hospital with a sore ankle which was found to be broken so was released on bail. Mr F refused to make a statement at the time. He was asked again the following day and confirmed his stance. On the 25th June 2013 Derbyshire Constabulary sought advice from CPS Direct regarding a charge of common assault. CPS in line with policy and practice

applied the Full Code Test and the charge was refused and a decision of No Further Action (NFA) given.

4.33 In interview at the Police Station on the 4th June 2013 Ms G voluntarily admitted that she and Mr F had been out drinking and she was very drunk. On returning home they argued and she recollected that she struck him recalling that a passer-by shouted at her to stop. She did not have a clear recollection of events due to her being drunk. She thought she struck him again in the flat but that Mr F had not assaulted her or retaliated. She thought her ankle injury had been caused by falling over a pedal cycle in the hallway of the flat.

4.34 The decision to advise ‘no further action’ was made because the evidence did not pass the evidential stage of the code test and there was not a realistic prospect of a conviction. The Full Code Test has two stages, the evidential stage and the public interest stage. If the case does not pass the evidential stage the case must not proceed. The reason why the evidence did not pass was that the initial 999 call from a third party (not identified by the investigation) indicated that a male had assaulted a female in the street, the female remained in the street on the floor screaming and the male had run off. No complaint of assault was made by Ms G. Mr F presented as the victim. The prosecution view was that the refusal of Mr F to support the prosecution meant that in the event of Ms G later raising the defence of self- defence this defence could not be refuted. The prosecution has to prove beyond all reasonable doubt to the criminal standard of proof that it was not self-defence. The conclusion was that for this reason there was not as realistic prospect of conviction. It is considered by the IMR author that the code test was applied in line with CPS Policy.

4.35 CPS has a policy for prosecuting cases of domestic violence and in advising the Police on the 2nd June 2013 the prosecutor applied this policy.

Emh homes IMR

4.36 Note Three Valleys Housing (TVH) became East Midlands Housing (EMH) in September 2013 following amalgamation. Mr F first became a tenant of TVH in January 2004 when he took the tenancy of his current one bedroom flat, prior to this he was lodging with his family. There were no estate management incidents recorded regarding this tenancy.

4.37 Ms G first became a tenant of TVH in October 2010; this was a one bedroom flat. This was Ms G's first tenancy with TVH before this she was in private rented accommodation. There were no estate management incidents recorded regarding the tenancy.

4.38 Mr F made a joint application with Ms G in August 2012 to transfer to alternative accommodation with an extra bedroom to enable is children to stay. Despite the fact they were eligible to bid for suitable properties no bids were made by them.

4.39 Evidence suggests that whilst Ms G maintained her own independent accommodation she spent much of her time at the flat of Mr F.

<u>NHS Southern Derbyshire and Erewash Clinical Commissioning Groups IMR</u>

4.40 Both Ms G and Mr F saw their GP on a regular basis. Both attended the same GP practice. Ms G changing hers in March 2013 to attend the same one as Mr F. Both were being treated for depression by way of medication. Ms G had been encouraged to self- refer to Cognitive Behavioural Therapy which she did, attending six sessions, however she felt the benefits were limited and requested a continued prescription for anti-depressants.

4.41 [Redacted]

4.42 Mr F had been prescribed anti-depressants for some fourteen years since 2000. He talked to his GP about being unhappy in his relationship (which would appear to have been with Ms G) but also being devastated when the relationship apparently ended for a period of time in October 2013. He described suicidal thoughts but that concern for his son stopped him from acting on his thoughts.

4.43 Mr F disclosed to his GP he felt caught in the benefits trap feeling there would be no financial gain in being employed but feeling frustrated by this. His GP had a wider discussion about options available in terms of volunteering and occupying his time constructively with fitness and sport.

4.44 At no time did either Ms G or Mr F specifically disclose domestic abuse to the GP nor that they were drinking alcohol to excess. They were not identified as vulnerable adults in line with the official definition included in 'No Secrets' published in 2000 by the Department of Health and the Home Office. This has been overtaken by the Care Act 2014 which comes into effect after Ms G's death in April 2015.

4.45 Whilst Mr F did discuss being unhappy in his relationship it would not appear the possibility of domestic abuse was considered or discussed. To have used greater professional curiosity and explorative questions may have uncovered the sometimes aggressive and volatile nature of their relationship and enabled the GP to provide information on domestic abuse services and options in how best to manage the situation. Research shows that the breakdown of a relationship together with alcohol and drugs use are indications of increasing risk where domestic abuse is an issue. This was not recognised by the GP.

4.46 The IRIS (Identification and Referral to Improve Safety) Programme is a general practitioner based domestic violence and abuse (DVA) training and support referral programme currently running as a pilot in one area of Derbyshire. Core areas of the programme are training and education, clinical enquiry, care pathways and an enhanced referral pathway to specialist domestic abuse services. It is aimed at women who are experiencing domestic violence and abuse from a current partner, ex-partner or adult family member. IRIS also provides information and signposting for male victims and for perpetrators. IRIS is a collaboration between Primary Care and 3rd Sector organisations specialising in DVA. An Advocate Educator is linked to GPs and based in a local specialist DVA service. The Advocate Educator works in partnership with a local Clinical Lead to co-deliver the training to practices.

4.47 Ms G had contact with medical staff at the hospital following the incident of the 2nd June 2013 when she was treated for her broken ankle. Despite discrepancies in the explanation for her injury and the attendance of the Police plus the level of intoxication in the incident, hospital staff did not appear to explore with Ms G events leading up to her hospital admission and did not obviously apply professional curiosity in attempting to make a holistic assessment of the patients circumstances. There was no documentation of a targeted enquiry with regard to domestic abuse and therefore no evidence of any support offered.

Given the benefit of hindsight it is unlikely that Ms G would have disclosed the actual details of what occurred.

4.48 The IMR disclosed that there were various omissions in the completion of hospital records e.g. No answer recorded to the question 'Is this a complex discharge'. No evidence that the patient was asked whether there were any other injuries. A social history was taken but no enquiry about relationships evident and no mention of a challenge regarding how the injury occurred. A reminder to staff regarding the importance of quality record keeping may be beneficial.

4.49 At the time of the hospital visit although accompanied by the Police, hospital staff did not appear to question why and in what circumstances Police were in attendance nor did Police offer any information or explanation as to their presence or events leading up to that point. Had there been greater communication and information sharing between the two agencies it may have provided an opportunity for the circumstances of the violence within the relationship to be explored in a safe environment where there was an absence of any coercive control. This is turn could have led to the provision of domestic abuse service information and safety advice.

5. Analysis of involvement relating to the specific Terms of Reference Questions

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

5.1.1 Both Ms G and Mr F identified themselves previously as white British. The review has not identified any equality and diversity issues.

5.2 *Was the victim subject to a Multi- Agency y Risk Assessment Conference (MARAC)?*

5.2.1 All three domestic abuse incidents referred to in the review were or would have been assessed as standard risk domestic abuse. The two where DASH forms were completed, one identified Ms G as the victim and one identifying Mr F as the victim. In these circumstances it was in line with policy and practice that neither were referred to a MARAC.

5.3 *Was the perpetrator subject to Multi Agency Public Protection Arrangements (MAPPA)?*

5.3.1 The perpetrator was not subject to MAPPA and had never been convicted of an offence that indicated serious harm to others nor had displayed behaviour that indicated serious harm was likely.

***5.4** Was the perpetrator subject to a Domestic Violence Perpetrator Programme (DVPP)?*

5.4.1 There had been one recorded incident of domestic abuse against the perpetrator in 2012 and one recorded against the victim in 2013. There were also three incidents of what would now be classed a domestic abuse in 2002 also recorded against the perpetrator. All would be considered standard risk. As a result the perpetrator had never been considered for a referral to a statutory Domestic Violence Perpetrator Programme (DVPP). This would appear appropriate. In 2013 Derbyshire introduced a voluntary Domestic Abuse Programme for perpetrators. This is now available to all domestic abuse perpetrators in Derbyshire irrespective of risk assessment. This came into being after the incident in June 2013.

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

5.5.1 There is no evidence that Ms G saw herself as a victim of domestic abuse or had any contact with a domestic abuse organisation or helpline. No agency had specifically provided information about domestic abuse support services. Such information is now part of the Police Domestic Abuse Toolkit and is given routinely where domestic abuse is identified and investigated.

***5.6** Did anyone in contact with the victim know whether or not the victim was aware of domestic violence services available locally? If yes but not used were there any barriers to the victim accessing these services?*

5.6.1 Ms G's family did not think Ms G saw herself as a victim of domestic abuse and was not to their knowledge aware of domestic abuse services locally.

5.6.2 In terms of barriers in accessing services it is likely that Ms G's failure to see herself as a victim or to see Mr F's behaviour as abusive would have been the greatest barrier. A qualitative study by a team of scientists from the Institute of Psychology was undertaken into barriers and facilitators of disclosing domestic abuse by mental health users and appeared in the British Journal of Psychiatry in 2011. It found service users described barriers to disclosure as being fear of consequences, including fear of Social Services involvement, fear that disclosure would not be believed, fear that disclosure would lead to further violence,

self- blame, shame and embarrassment. There were also barriers to staff asking questions, the dominant issues were to do with whether to enquire about domestic abuse was part of their role and also within their competence. Disclosure is a key but complex issue in relation to domestic abuse and one which all agencies have to work to improve practice.

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

5.7.1 The Independent Author has had Contact with the victim's family which was facilitated by the Family Liaison Officer. A lengthy interview took place with Ms G's mother and other family members. Interviews have also taken place with the perpetrator's parents and the perpetrator himself. Their views have been included in the Domestic Homicide Review under 'Family Involvement' at 1.27.

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

5.8.1 The Community Safety Partnership (CSP) will take responsibility in liaison with the Chair of the DHR. There will be a media strategy and the review will be published on the Safer Derbyshire website and will be available to the public. Identified friends and family will be informed when the report is complete and when publication is due to take place.

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

5.9.1 According to the Law Commission's definition used within 'No Secrets' (DOH 2000) the victim nor perpetrator would meet the accepted definition of a vulnerable adult. However both parties were being treated for depression so this may in practice have increased any levels of vulnerability. The Care Act 2014 sets out a clear legal framework for how local authorities and other parts of the health and care system should protect adults at risk of abuse or neglect. This comes into force in April 2015.

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

5.10.1 Liaison took place between the Panel and the Senior Investigating Officer throughout the criminal proceedings which finalised in October 2014. Disclosure issues were considered. The Coroner's Office have been contacted and informed the Police IMR author that there will be no further proceedings following the conviction of Mr F for manslaughter.

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

5.11.1 The Independent Review Author has looked at a range of relevant research; previous DHRs (that are available on the internet post publication) and has read the Home Office Domestic Homicide Reviews- Common themes Identified as lessons to be learned November 2013.

5.11.2 It has become apparent since her death that Ms G disclosed to her father that Mr F was responsible for the injury to her ankle, having pushed her over. As a result the couple did separate for some months but reunited and became engaged to be married in November 2013. The reasons for Ms G not being honest about the injury is unclear but is likely to relate to pressure not to disclose for fear of the consequences. Research regarding this issue is included in paragraph 5.6.2 page 27 above and related to barriers to disclosure.

5.11.3 Research would suggest women experiencing domestic abuse sometimes turn to alcohol or drugs as a response to and an escape from abuse or can be introduced to the use of alcohol by their partner**.** Research also shows women experiencing domestic abuse are up to fifteen times more likely to misuse alcohol than women generally. What is important is that where there is domestic abuse the use of alcohol should not detract from the issue of domestic abuse. Abusers are keen for us to believe the cause and effect myth of alcohol and domestic abuse as it gives them a ready excuse to deny responsibility for their abusive behaviour promoting alcohol as being the cause**.**

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

5.12.1 When Ms G was escorted to the hospital with a broken ankle, and was later considered for a charge of common assault of Mr F, there was a lack of information sharing

between the Police and medical staff at the hospital. No information was given about the circumstances of domestic abuse that led to the Police involvement and it would appear medical staff did not ask any exploratory probing questions to better understand the circumstances. Relevant questions may have encouraged Ms G to share information about the relationship and any abuse that was taking place. It is a recommendation of the review that Police and Health together consider how information sharing can be improved in practice in order to intervene to help protect individuals when appropriate.

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

5.13.1 From the information available there were shortcomings in terms of the quality of the DASH forms completed by the Police particularly in relation to the questions about children involved. Also following the incident in April 2014 the month before the killing, Police recognised that the incident was domestic by nature and initially attempted to complete a DASH. When they could not locate Mr F on the first attempt it was identified that they should try again. However the case was closed as anti-social behaviour which appeared to remove the necessity for a DASH form. If the case had been maintained as domestic abuse it could not have been finalised until a DASH was completed and the Sergeant had quality assured the investigation and the incident had been reviewed by the District Management meeting. (DMM)

5.13.2 Health professionals both in terms of GP and hospital staff could have asked more probing exploratory questions e.g. the GP in connection with relationships when Ms G reported ongoing sleeplessness, fatigue and feelings of depression and the hospital staff in relation to the broken ankle and the discrepancy in terms of cause.

5.13.3 It is unlikely Ms G or Mr F would have disclosed the abuse within the relationship however it may have triggered recognition that all was not well and they needed assistance from outside to attempt to resolve difficulties.

5.14 *What were the key relevant points/opportunities for assessment and decision making in this case in relation to the victim and perpetrator. What was the quality of any multi-agency assessments?*

5.14.1 The key relevant points/opportunities for assessment and decision making were the three incidents of domestic abuse, the hospital assessment in relation to the broken ankle and the contact with the GP in relation to feelings of depression. Mr F did share with the GP that he was unhappy and wished to end his relationship.

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5.14.2 The Police completed two DASH risk assessments one with Ms G as the victim in September 2012 the second with Mr F as the victim in June 2013. When the one was completed with Ms G as the victim best practice would indicate a second form with Mr F as the victim should have been completed as both admitted assaulting each other, The case was dealt with by way of Restorative Justice which would not now be considered appropriate as it does not provide any intervention to reduce the likelihood of repeat behaviour.

5.14.3 Both forms were considered to indicate a standard risk which appeared reasonable given the information available. The third time a DASH should have been completed it was not and the case was closed as a non- domestic anti-social incident despite previously having been considered domestic in nature. Ms G was issued with a FPN fine for drunk and disorderly and later agreed to attend an alcohol awareness course.

5.14.4 Neither Ms G nor Mr F disclosed the abusive nature of their relationship to health professionals apparently not viewing it as such nor were indicators pursued by staff to explore whether domestic abuse was a possibility e.g. Mr F did disclose relationship problems; he was suffering depression, unemployment and had financial issues. Unbeknown to the GP he also was drinking to excess.

5.14.5 Assessments made by Police suggested this was a couple in a volatile relationship where arguments followed excessive drinking sprees and resulted in fights where both were aggressors. The role of coercive control which may have led to the arguments does not appear to have been explored in any detail and the use of alcohol may have distracted from the underlying abusive relationship.

5.14.6 There was no referral to MARAC or for any other multi-agency assessment in line with the standard assessments?

***5.15** Was the impact of domestic violence on the victim recognised?*

5.15.1 The Police were aware of the domestic abuse that took place, together with the neighbour and a member of the public who witnessed it. On the occasion that Ms G was identified as a victim she was also recognised as a perpetrator having also admitted to assaulting Mr F. On the other two occasions she was seen as the perpetrator even though she had a broken ankle on the second occasion and admitted to the Police being the aggressor to Mr F. She later told her mother this was untrue and that Mr F was responsible for her broken ankle. On the third occasion CCTV indicated she was the aggressor however the circumstances leading to the outburst was not explored. Therefore it is unlikely that the full impact of domestic abuse on Ms G was recognised or considered in terms of intervention and protection.

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

5.16.1 There was a failure by Police to fully explore whether children visited the property where Mr F and Ms G resided and may therefore have been at risk and may have required safeguarding. This was an omission that newly developed processes and practice should ensure could not happen in the future. E.g. the attending Officer's Sergeant now quality assures completion of the DASH to ensure that the Command and Control incidents cannot be closed until child information is fully completed. As from the 5th January 2015 three child focussed questions will need to be answered by the supervising Sergeant before the incident can be closed. All incidents of domestic abuse where a child permanently lives with, or occasionally resides or has access with either the victim or the perpetrator will be referred to social care, health and education for consideration in terms of safeguarding.

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

5.17.1 Senior managers or other organisations and professionals were not involved in the case. However, concerning the incident on the 13th April 2014, had it been identified and coded by the Police in line with their initial thinking i.e. that it was a domestic abuse incident, a DASH would have been completed and assessed by a Sergeant and domestic abuse scrutiny panel and have been reviewed by the daily management meeting. The DASH form would also have meant that Ms G was considered a repeat perpetrator and would have been

subject of a tasking process resulting in proactive targeting. There is a possibility that the intervention may have impacted in a positive way identifying the risks for this couple of their behaviour and perhaps reducing the likelihood of continuing abuse.

5.18 *Could the homicide have been anticipated or prevented?*

5.18.1 It is unknown what information would have been uncovered if the final DASH of the 13th April 2014 had been completed and subsequently the couple had been subject to proactive targeting. However the Police IMR author considers the outcome of the DASH would have been standard risk on the information available. This would not have initiated a multi-agency approach. Contact with the families and the perpetrator would suggest that even if a DASH had been completed that they would not have considered the relationship fitted the definition of domestic abuse but that it was an alcohol fuelled incident that did not require intervention like the incidents that had occurred previously.

5.18.2 Whilst there had been three incidents of domestic abuse reported over a one and a half year period there may had been more incidents that had gone unreported. Research suggests that less than 24% of domestic violent crime is reported to the Police. (Walby and Allen 2004) Over the past few years, there has been a general trend of lower volumes of crime in Derbyshire, contrasting with an increase in the volume of domestic abuse crimes. Consequently, domestic crimes now account for more than one in ten of all crimes, and for over half of all violent crimes. Similarly, there has been a trend of an increasing volume of domestic abuse incidents being reported to the Police, although these levelled off in 2014. The proportion of these incidents that resulted in a crime being recorded continued to increase during 2014, however, so that now over a quarter of incidents are recorded as a crime.

Derbyshire	2012	2013	2014
All incidents	246,087	247,966	242,256
All crimes	53,088	52,011	51,842
All violent crimes	10,086	9,272	9,717
Domestic related incidents	19,574	19,971	19,909
Domestic related crimes	4,830	5,053	5,229
Domestic incidents as % of all incidents	8.0%	8.1%	8.2%
Domestic crimes as % of all crimes	9.1%	9.7%	10.1%
Domestic crimes as % of violent crimes	47.9%	54.5%	53.8%
% of domestic incidents that result in a crime	24.7%	25.3%	26.3%

5.18.3 Given the nature of the reported abuse in this case with both parties being victims and perpetrators, together with the unwillingness of both to disclose information or indeed to see themselves as involved in a domestic abuse relationship and with no indication of escalation in serious harm, it is reasonable that Ms G's death could not have been anticipated. There was no previous evidence of use of weapons or serious assault. As her death was not anticipated it is difficult to see how it could have been prevented. The limited number of agencies who had contact were either unaware of abuse or as in the case of the Police, assessed the situation as standard risk which means that the evidence available did not indicate a likelihood of serious harm being caused.

6. Lessons to be learned from the review

6.1 There was evidence that the Police investigation lacked the use of probing and exploratory questions to gather information to ensure a robust risk assessment e.g. on the 2nd June 2013 following an incident that was reported to the police when Ms G initially said she had been punched first the presenting issue of her as the abuser was accepted, also despite the fact she had a broken ankle which she said had been caused by falling over a child's cycle in the hallway, there was no information included in the DASH form concerning children at the address. The response of 'no children' was accepted at face value rather than further questions being asked to clarify why there was a child's bicycle in the hall.

6.2 Similarly hospital staff did not explore the discrepancies in the story provided as to how the broken ankle was caused in order to complete a full assessment.

6.3 Whilst Mr F disclosed to the GP relationship difficulties there is no evidence that the possibility of domestic abuse was considered or explored. Where relationship difficulties are disclosed it may assist further disclosure if the health providers applied professional curiosity in an attempt to diagnose and provide preventative and safety information.

6.4 The completion of and the quality of the DASH risk assessments were inconsistent e.g. both Ms G and Mr F were considered victims of domestic abuse following the incident of September 2012. However there was only one form completed regarding Ms G. Best practice would indicate two forms should be completed then information from the second form concerning Mr F as the victim could have provided useful intelligence for any future incident. Whilst the incident of the 13th April 2014 was considered to be domestic abuse by

the attending Officer the DASH form was not completed the incident being signed off as drunk and disorderly anti-social behaviour. Had the DASH been completed, the incident would have then been dealt with under the repeat domestic violence perpetrator management plan and may have been subject to proactive targeting.

6.5 Information sharing and communication between the Police and hospital staff when Ms G was taken to A & E with a broken ankle was lacking and the domestic abuse known about by Police was not disclosed. Police did not provide information and hospital staff did not question Police attendance with Ms G. It is important information is shared in order to provide a consistent approach in applying domestic abuse policies and to ensure all assessments are based on full information and a complete social history.

6.6 The use of alcohol with both parties drinking to excess may have complicated Police assessments and distracted from the recognition of a pattern of domestic abuse that was emerging. Alcohol use increases the occurrence and severity of domestic abuse but should be excluded as a mitigating factor for violent acts. It is important that we continue to raise awareness of the links between alcohol use and domestic abuse and ensure closer working together of domestic abuse and alcohol support services at every opportunity.

6.7 The first incident of domestic abuse in September 2012 was dealt with by way of Restorative Justice (RJ). The HMIC inspection in 2013 recommended ‘the Force should consider the appropriateness of using restorative justice for offences in intimate relationships particularly with regard to how any action will prevent further offences of domestic abuse or reduce the risk to the victim’. Following this recommendation Derbyshire Constabulary appropriately withdrew the use of restorative justice in all intimate partner related domestic violence crimes as from 1st April 2014.

6.8 The quality of recording by hospital staff was variable in terms of accuracy and in identifying who was responsible for the entry. A reminder of the importance of quality recording would be beneficial.

7. Conclusion

7.1 Ms G and Mr F had been in an intimate relationship for a little over two years when she died. A verdict of manslaughter was given in October 2014 with Mr F being sentenced to six years imprisonment for her killing.

7.2 There was very little agency involvement with the couple, contact being recorded with the Police, hospital and the GP. The Police were aware and had identified three domestic abuse incidents including September 2012, June 2013 and April 2014. No other agency had recognised or were aware of domestic abuse in the relationship neither had Ms G nor Mr F disclosed to professionals other than the Police that domestic abuse was a feature of their relationship. They had not sought assistance from any domestic abuse support agency.

7.3 Both Ms G and Mr F were recorded as both the perpetrator and victim of domestic abuse. There were no prosecutions against either for domestic crime. Members of the public, a neighbour and the town centre CCTV footage had reported abusive events. Both partners were reticent to make complaints and wished to understate abuse apparently not recognising it as a feature of their relationship. In June 2013 although Ms G was seen as the aggressor by Police following information given by the couple, it may be that with the benefit of hindsight this was inaccurate and Ms G's ankle injury was perhaps the result of Mr F pushing her over. It would appear physical abuse would follow arguments where Mr F may have goaded Ms G. e.g. There is evidence from the family that they witnessed Mr F using verbal abuse to undermine and embarrass Ms G in public and Ms G told her mother of other occasions where Mr F wrongly accused her of having relationships with other men.

7.4 Alcohol abuse would appear to have played an important role in the relationship and both Mr F and Ms G drank to excess on occasions. The domestic abuse that came to the attention of the Police followed drinking bouts. It is recognised that alcohol can distract from the issue of domestic abuse and it should be recognised that alcohol use increases the occurrence and severity of domestic abuse but is not the cause and should be excluded as a mitigating factor.

7.5 Both Ms G and Mr F were being treated by their relevant GP for depression and were prescribed anti-depressant medication. It is unlikely that had they informed the GP of their alcohol use that they would have continued to receive the same medication for depression,

medication and alcohol being potentially incompatible. Whilst Mr F disclosed that he was unhappy in his relationship neither Ms G nor Mr F disclosed domestic abuse to the GP. Domestic abuse was not explored as a possible feature in their lives that could have led to the feelings of low self- esteem and helplessness often associated with depression.

7.6 Although Mr F did not have custody of his [Redacted] children from previous relationships he did have regular contact at weekends. Whilst Ms G had her own independent accommodation the couple spent most of their time together at Mr F's flat. The involvement of children and the possible impact upon them of the abuse was not identified by Police and there was no liaison with Social Care. The Think Family agenda promotes the importance of a whole family approach. It is crucial in domestic abuse circumstances that the implication on family and in particular children is considered by all agencies involved in service delivery. [Redacted]

7.7 The lessons learned identify areas for improvement that have come to light during the preparation of this review. Neither party disclosed the domestic abuse in their relationship as it would appear neither recognised it in those terms. This review explores some of the possible reasons for this. The domestic abuse that was reported to and assessed by the Police would appear appropriately classified as standard risk and therefore, in line with policy, would not require referral to multi-agency assessment. The domestic abuse was seen as low level alcohol fuelled and as a result Ms G's death was neither anticipated nor therefore considered predictable given the information that was available.

8. Relevant changes in policy and practice already made by Agencies since the domestic abuse incidents occurred and before the review was finalised

Derbyshire Constabulary

8.1 In December 2014 Derbyshire Constabulary introduced a Domestic Violence Scrutiny Panel which assesses the quality of domestic abuse assessments and shares good practice and any learning points across the force.

8.2 During 2014 Derbyshire Constabulary have introduced a Serial and Repeat Domestic Violence Perpetrator Management Plan. A monthly list of serial and repeat perpetrators is

recorded on the Guardian Intelligence system database. Those on the list are then prioritised and those considered at greatest risk are subject of a tasking process.

8.3 Since June 2014 a Domestic Violence Investigative Toolkit has been created which Officers use as a template for their investigation. This includes detailed information on how best to investigate domestic abuse incidents, provides information regarding the key objectives of prevention, intelligence gathering and enforcement. It has a ‘built in’ information log recording any activity against the perpetrator. There is also an action plan which records the date an action was raised through to its completion. There actions incorporate legislation introduced in June 2014 concerning Domestic Violence Protection Notices (DVPN) and Domestic Violence Protection Order (DVPO) scheme which provides an alternative method of dealing with ongoing domestic related issues.

8.4 As from the 1st April 2014 Derbyshire Constabulary have withdrawn the facility to use restorative justice to resolve intimate partner related domestic violence crime.

8.5 Following the HMIC inspection all domestic abuse incidents are now subject of a quality check by the attending Officer’s Sergeant. Also the Command and Control incident cannot be closed until this has been completed. This came into force in January 2014.

8.6 One of the questions to be answered by the Sergeant’s quality assurance is about the recording of full details of all children connected with all parties/household and whether a referral to Children’s Social Care is requested. This process will be updated in January 2015.

8.7 From January 2015 every domestic abuse incident investigated by the Police where children are involved is referred to Social Care, Education and Health for consideration. This process is awaiting ratification.

8.8 All front line staff who are likely to be involved with domestic abuse cases are undergoing refresher training; this is already showing improvements in the quality of the DASH forms submitted by attending Officers.

9. Recommendations

Derbyshire Constabulary

9.1 Where both parties in an intimate relationship assault each other and appear equally to be responsible for the incident, best practice would be to submit two DASH forms. Although the submission of a second form may seem bureaucratic it identified both parties as perpetrators and victims of domestic abuse which may prove useful when conducting future risk assessment on those individuals. Derbyshire Constabulary should include guidance relating to this issue within their Domestic Violence Investigation Toolkit.

9.2 Police Officers investigating domestic abuse incidents should be reminded of the importance of using exploratory and probing questions to gather information. It is important to ensure underlying issues are considered when making a full assessment of the situation and to guard against presenting issues being accepted at face value. It is recognised that many victims have to overcome several barriers before they are able to disclose abuse.

9.3 In line with the Think Family agenda Police Officers should be reminded of their duties in relation to safeguarding children when attending incidents of domestic abuse. Full details of children including other family names and addresses should be obtained. Officers should also engage with any children present at the address in order to comment upon their demeanour. When Officers do not see children they should look for signs of children such as toys, clothing etc. Positive action should be taken to safeguard children and where there are concerns as to their welfare then referrals should be made to Social Care.

9.4 If there is a history of domestic abuse linked to alcohol abuse or excessive alcohol consumption consideration should be given to referrals to alcohol support agencies as well as domestic abuse services. Perpetrators arrested for domestic abuse should be actively encouraged to engage with substance misuse staff based within the custody suite.

NHS Southern Derbyshire and Erewash Clinical Commissioning Groups

9.5 Remind hospital staff of the importance of accurate and timely recording to ensure relevant information is available to underpin a full and holistic assessment.

9.6 Remind health staff, including GPs, of the importance of using professional curiosity and probing questions when relationship issues are disclosed.

9.7 Remind GPs of the significant indicators of domestic abuse that increase risk, including relationship breakdown and the use of alcohol and drugs and the importance of information sharing and referral on to specialist domestic abuse services.

NHS and Police

9.8 Review and clarify the information sharing protocol in relation to Police providing information to hospital staff about domestic abuse where Police accompany an individual to A&E department following an incident. Confirm what NHS staff should do in order to gather this information where it is not forthcoming.

Community Safety Partnership

9.9 Promote greater awareness of the links between alcohol abuse and domestic abuse and work towards excluding alcohol as a mitigating factor for violent acts. Promote closer working together of domestic abuse and alcohol support services.

9.10 Share the anonymised conclusions and learning from this review with other partners to remind agencies of the importance of recognising and intervening in domestic abuse cases in an attempt to protect the victim.

9.11 Continue to consider how the barriers to disclosure of domestic abuse can be overcome for victims, perpetrators and staff to improve practice and prevention of ongoing abuse.

Multi-Agency

9.12 Domestic Violence/Sexual Violence Governance Board to seek an update on the IRIS pilot and consider how to take forward the outcomes to improve the GP's role in identifying and responding to domestic abuse and in sharing relevant information with other key agencies to improve safety.

Marion Wright.

10. Glossary of Terms

CCGs	Clinical Commissioning Groups
CCTV	Close Circuit Television
CPS	Crown Prosecution Service
CSP	Community Safety Partnership
DA	Domestic Abuse
DASH	Domestic Abuse Stalking and Honour Based Crime
DHR	Domestic Homicide Review
DMM	Police Duty Management Meeting
DOH	Department of Health
DV	Domestic Violence
DVA	Domestic Violence and Abuse
DV PP	Domestic Violence Perpetrator Programme
DVPN	Domestic Violence Protection Notice
DVPO	Domestic Violence Protection Order
FPN	Fixed Penalty Notice
GP	General Practitioner
HMIC	Her Majesty's Inspector of Constabulary
IRIS	Identification and Referral to Improve Safety
IMR	Individual Management Report
MAPPA	Multi Agency Public Protection Arrangements
MARAC	Multi Agency Risk Assessment Conference
NFA	No Further Action
NHS	National Health Service
RJ	Restorative Justice
TOR	Terms of Reference