Overview Report:

Domestic Homicide Review into the Death of

‘Holly’

Death: 2016

Commissioned by: Bournemouth Community Safety Partnership

November 2017

List of Contents Page

1. Timescales

1.1 The Bournemouth Community Safety Partnership was informed of a domestic homicide by Dorset Police on 23 September 2016. The first Panel meeting concerning "Holly's" murder was held on 14 March 2017. This determined that the relevant agencies included the Dorset HealthCare University NHS Foundation Trust, Dorset Police and Adult Social Care. The second panel meeting of 16 May 2017 considered the information that was known to the agencies. There were two further Panel Meetings on 1 August and 21 September 2017. Feedback, including suggested amendments, was received from agencies on 26 January and from Holly's family on 17 February 2018. The review was concluded during February 2018.

2 Methodology

2.1 The decision to undertake a Domestic Homicide Review (DHR) was made by Tanya Coulter the then Chair of the Community Safety Partnership. The circumstances of Holly's murder were revealed during the trial. Her circumstances and an undated statement to the police by Holly's mother shaped the decision.

2.2 The DHR process is set out by the Home Office.[1] The Review is based on information from Bournemouth Borough Council, Dorset Clinical Commissioning Group, Dorset HealthCare University NHS Foundation Trust, Dorset Police and information from Holly's parents and sister.

2.3 The Bournemouth Community Safety Partnership determined that the scope of the DHR should include relevant events prior to, and including, the final 12 months of Holly's life.

3 Involvement of Family, Friends, Work Colleagues, Neighbours and Wider Community

3.1 Holly's family wanted to be involved in the review process. The Chair and Community Safety Partnership Officer established and maintained regular contact with Holly's parents and sister through a series of telephone calls and home visits. In addition, information was exchanged through police liaison officers and a Victim Support domestic homicide worker. The family have been told about the submissions and responses of the organisations known to Holly and contributed valuable family knowledge. Also, Holly's father met with the Chair, the DHR author and the Partnership Officer of Bournemouth Borough Council on 16 May 2017, and Holly's mother and sister agreed to talk to the DHR author by telephone on 24 and 25 July 2017 respectively.

3.2 John was estranged from his family. Although the Chair and the DHR author sought to engage with John by telephone during October 2017, he declined to participate.

[1] Home Office (2016) *Multi Agency Statutory Guidance for the Conduct of Multi-Agency Reviews*

4 Contributors to the Review

4.1 The Internal Management Review (IMR)[2] authors are independent of (i) the individuals named in this review and (ii) from the line management and supervision of the staff involved:

Stewart Balmer	Force Review Officer, Dorset Police
Fiona Grant	Director of Public Protection, Dorset Police
Jo Booth	Operations Manager, PAS Ltd
Verena Cooper	Designated Adult Safeguarding Manager, Dorset Clinical Commissioning Group
Lisa Ferrie	Commissioning Assistant, Drug and Alcohol Team, Bournemouth Borough Council
Simon Harridge	Revenues and Benefits
Caroline Telford and Sian Jenkins	Policy and Service Development Officer and Partnership Officer for Community Safety respectively at Bournemouth Borough Council
Ben Tomlin	Housing Services Manager
Sandra Wood and Fiona Holder	Safeguarding Adults Advisor and Safeguarding Lead respectively at Dorset HealthCare University NHS Foundation Trust

5 Review Panel Members

Andrew Clowser	Independent Chair
Stewart Balmer	Force Review Officer, Dorset Police
Joan Carmichael	DCI Adult Public Protection, Dorset Police
Caroline Garrett	Note taker, Dorset Police
Fiona Holder	Safeguarding Adults Lead, Dorset HealthCare University NHS Foundation Trust
Anne Humphries	Bournemouth and Poole Adult Safeguarding Board
Sian Jenkins	Partnership Officer, Bournemouth Borough Council

[2] An Internal Management Review summarises relevant files and case records, discusses these with the professionals involved and identifies areas where professional practice may be improved

Pam O'Shea	Head of Quality Improvement, Quality Directorate Dorset Clinical Commissioning Group
Tonia Redvers	Independent Domestic Abuse Advisor
Hayley Verrico*	Service Manager, Adult Disabilities and Long Term Conditions
Karen Wood	Senior Commissioner, Drug and Alcohol Commissioning Team, Bournemouth Borough Council

*Replaced by Sarah Webb after April 2017

6 Chair/Author of the Overview Report

6.1 The review was Chaired by Andrew Clowser, he is a retired Detective Superintendent who retired from Dorset Police in 2015 where he was Head of Public Protection. He is not currently employed by any of the statutory agencies involved in the DHR process. He has had no previous involvement or contact with the family or any of the other parties directly involved in the events under review.

6.2 Margaret Flynn is a former academic researcher. She Chairs the National Independent Safeguarding Board in Wales and is a co-editor of the Journal of Adult Protection. She has undertaken Serious Case Reviews, Safeguarding Adult Reviews and latterly a review commissioned by the First Minister of Wales. She had no prior connection with the Community Safety Partnership or any of the agencies which contributed to this review.

7 Parallel reviews

7.1 A Significant Event review meeting was held by Holly's GP practice to "highlight any areas of good practice and any lessons that could be learnt."

7.2 An internal *Serious Untoward Incident Requiring Investigation Process* was undertaken by Dorset HealthCare University NHS Foundation Trust. The SUI formed the basis of the Trust's Internal Management Review.

8 Equality and Diversity

8.1 Holly was White Caucasian. She had a learning disability, that is, a lower intellectual ability and a significant impairment of social or adaptive functioning. John is White Caucasian. He has been brain injured since 2007.

9 Background Information (the facts)

9.1 Holly was 38 when she was murdered at her Bournemouth flat during 2016. Her death resulted from severe head injuries - skull fractures and swelling to the brain. She had been hit repeatedly with a lump hammer. John, her partner[3] of a few months, was convicted during 2017.

To make sense of events in Holly's life, this section begins with a brief outline of what is known about Holly and the world she inhabited. Although services could not provide a concise personal history, her parents and sister set out the principal themes.

9.2 As a child Holly and her family moved around Poole. By the time that she was 11, she had had six addresses which included those of relatives. Holly had a small build and required speech therapy as she was growing up. Her mother said that although Holly had "lots of problems as a child. She had everything wrong with her really," she had "a happy childhood with lots of friends." At school, she was "below average in most of her subjects…wanted to have fun…which resulted in her not concentrating at school much…she struggled through school life…preferred not to be in school." [4]

After school, Holly secured employment as a hotel chamber maid and subsequently at a care home "for possibly a few years." Having had "a few" boyfriends at school, Holly had a boyfriend when she worked at the hotel. It was when Holly worked at the care home that she began "going out nightclubbing…[she] met some unsavoury people…[and] never really worked after this…she got in with the wrong crowd…she was here, there and everywhere."

9.3 Holly left home as a teenager and, when her parents separated, she briefly shared accommodation with her mother. Holly used to drink with her father who noted, "I think she had issues with alcohol for about 10 years. I don't think she was alcohol dependent…more of a binge drinker." Holly's father acknowledged that although there were periods when she did not drink, "it was the alcohol" – her excessive drinking in combination with "some bad relationships" that placed her in harm's way.

9.4 Holly moved to Manchester in her 20s and she remained there for around five years. An ex-partner explained that "when she was on alcohol she would divulge things…[she said that] she had been kidnapped when she was living in Manchester…she was left with some men and they used and abused her…when she was sober [she repeated it]."[5] Since she "was a very private person" Holly initiated infrequent contact with her family because she sensed that her relatives were "prying." Contacts with her family became sporadic. She began a relationship with Dev which was disfigured by violence, that is, "Holly had been the victim of domestic abuse at the hands of Dev for many years."[6] Holly's family acknowledged that with Dev "she became more secretive…because of the violence she suffered. Her whole attitude as a person changed with her becoming more withdrawn and nervous…Dev didn't like her ringing and he'd snatch the phone out of her hand…could hear

[3] Although Holly described John as her "boyfriend" to the police and social workers during August 2017, her family do not accept that he was her partner since he was unlike the previous partners they had known
[4] Holly's family were surprised and worried that an IQ test undertaken during 2016 revealed that she had a learning disability
[5] Witness statement
[6] Dorset Police IMR

him…Dev caused a lot of problems for her. [He] had a hold over her. He caused her so much hassle and problems over the years it doesn't make sense that he's got away with it…She changed when she met Dev. He destroyed her mentally. She had to stand up to him and he wouldn't leave her alone." The relationship and harassment survived Holly's return to Poole where she changed address on at least six occasions. She was troubled by her neighbours and felt unsafe at some of these addresses. Lily became a flatmate at one address until Holly became troubled by Lily's behaviour. Holly allowed John to move in with her. (He was ultimately convicted of murder.) John had known Holly when she was in Manchester.

9.5 Holly's ectopic pregnancy during her 20s did not diminish her wish to be a mother. She talked with her family about having IVF treatment and was referred for this during 2009 and 2013. She had a long-standing problem with her left eye which Holly incorrectly explained was the result of having been kicked as a child. It was noted in GP records as having resulted from *excess skin around the eye*. As an adult, she developed skin problems and had "several skin grafts." From being "gorgeous looking" her mother explained that her skin became "terrible and she looked a mess most of the time."

9.6 Holly became known to the police during 1999 when she was charged with credit card offences. Her medical records revealed a "previous history of homelessness, sexual assault…reported to be experiencing flashbacks, nightmares, low mood and insomnia. History of alcohol related problems [and] cannabis use in 2006." The first reported domestic abuse incident occurred in 2007. This and the "large number" of subsequent ones involved four different partners, Holly's father[7] and Dev. During March 2008, Holly was arrested at Dev's home having assaulted his girlfriend. The following month she made "a complaint of molestation against Dev on three occasions." During 2010, Holly made a complaint to Dorset police about its inaction in relation to allegations she had made about Dev. Although the resulting review determined that Holly was seen as "a very difficult victim to engage with" because she was "regularly drunk," it was acknowledged that one allegation triggered "a below standard investigation." This removed Holly's faith in the work of the police. She became "very anti-police and would not engage."[8] It was with prescience that the police reviewing documentation during 2010 noted, "…this is the very type of scenario which has the potential to end in domestic homicide."

9.7 Holly's mother believed that Holly began a hairdressing course towards the end of her life (the services known to Holly have no knowledge of this or of Holly's ambition to be employed). Also, Holly had talked to her mother about studying nursing "online." However, Holly's ambitions were displaced by her deteriorating living circumstances which were associated with a "general decline" in her appearance. Holly's mother noted that when Holly became depressed, "she always presented as if nothing was wrong. She was very good at putting on a front, making everything seem like it was ok…She really needed help and she couldn't get it. If she got cross or upset she'd drink. It was her way of blocking things out. That's why she did it…It was a real problem that she couldn't find anywhere to live. The only places she could get were the shared houses where there were people on drugs and people who drank…no one cared." Holly's sibling confirmed that Holly had been "in contact with Shelter. She wanted a place of her own."

[7] Holly's father had not been violent to Holly. He had *never shown any violence to either of his children*
[8] Dorset Police IMR

9.8 Holly had registered with a GP practice during 2008. Correspondence from the Department of Work and Pensions to Holly's GP stated that she "proclaimed to have a history of alcohol related problems, depression, panic attacks, anxiety." She was known to have "a history of alcohol abuse…episodes of being homeless… was described as gravitating towards difficult relationships that were often dysfunctional." Holly was "offered an alcohol programme [during 2010]…but did not engage."[9]

9.9 Holly was referred to a Community Mental Health Team during 2011 and 2012. She was discharged because she "failed to engage." During 2012, two episodes of domestic abuse were recorded in Holly's medical record concerning a "previous partner." One led to her arrest and a "strip search"[10] and another resulted in a referral to Multi-Agency Risk Assessment Conference (MARAC).[11] The GP set out "support options and Domestic Violence care supplied." Just months later, she visited her GP having sustained facial bruising. This glimpsed the "regular violence" to which she was subject. During September 2014, Holly approached housing services and stated that she had been "homeless for three years since leaving supported accommodation in Bournemouth" which she left due to harassment from an ex-partner. She had been confirmed as a "rough sleeper" by the Rough Sleeper Team. Holly was offered financial assistance and moved into private rented accommodation during February 2015. She moved again during December 2015 and during February 2016, she was provided with further finance to move to X Road. Her final address was known to the police due to "nuisance, drug use, domestics etc." Holly was assessed as having a learning disability and an IQ of 57 during the last year of her life.

9.10 Holly had been receiving (i) the Employment and Support Allowance (ESA) – a benefit for people who are unable to work due to illness or disability, (ii) the Personal Independence Payment (PIP) – a benefit that helps with the extra costs of a long term health condition or disability (the ESA and PIP provided Holly with £170.20 per week), and (iii) Housing Benefit – which covered the full cost of her rent.

9.11 Although little is known about John within the relevant timeframe, a great deal was known about his previous offending history. He was 50 when he was convicted of Holly's murder. He had a complex medical history and a "diagnosed…brain injury" associated with "mini strokes caused by temporary disruption to the blood supply to parts of the brain." He was "flagged" in his medical records as "a *vulnerable* [emphasis added] patient with a history of excessive alcohol consumption and long-term conditions." John was known as "non-compliant and non-engaging with medical services." For example, he did not attend appointments for haematology, phlebotomy and ophthalmology and declined smoking, alcohol and drug cessation treatments. He had sought medical assistance for sexual dysfunction during 2015. He was estranged from his family. Police records revealed that he was "a serial perpetrator of domestic abuse against four previous partners." Holly was not warned about John's history of violence.

[9] Bournemouth BC chronology

[10] The decision to do so would have been made by the front-desk officer on a case by case basis if a person is believed to be a danger to self or others

[11] Although these conferences share information concerning the highest risk domestic abuse cases, the outcomes in terms of managing the risks to which Holly was exposed are not known. It is not clear from the chronology when Holly was identified as a vulnerable woman requiring support

9.12 John had received housing support from PAS Ltd before he moved in with Holly. Its assessments determined that he was a "very high risk to others" because of his excessive drinking and known violence towards former partners (which included two allegations of rape). The social workers who visited Holly's flat were aware of these allegations. PAS Ltd had witnessed John's verbal aggression when he was under the influence of alcohol and drugs. He downplayed his "inappropriate sexual references" to staff and women visitors claiming that he was "only joking." A diagnosis of thrombocythaemia[12] was made days before John abandoned his room and ceased contact with the service. PAS Ltd had unsuccessfully sought to encourage John to secure mental health support for his self-reported (i) anxiety and (ii) diagnosis of schizophrenia.

9.13 John was sentenced to life imprisonment with a minimum term of 20 years which was reduced to 18 years after an appeal.

10 Summary Chronology from October 2015

10.1 *2015*

During October 2015, Holly sought a learning disability assessment via her GP since "she felt she had not achieved at school." She was noted to be "struggling with learning, possible disability and dyslexia." She was referred to the Community Team for People with a Learning Disability. The Team noted that "Holly had been attending college to try to improve her maths and English." The GP was advised that "patients with dyslexia are not covered by the [Community] Learning Disability team."

Separately, John was checked by the police as part of an ongoing policing investigation where all rough sleepers are roused and checked. He was known to be a regular user of homeless facilities.

10.2 *January 2016*

On 23 January 2016, John was checked again as a rough sleeper.

On 27 January, Holly had a "psychology assessment" which noted that she "had an IQ score of 57 which places her in the 'mild learning disability' category and eligible to receive support from the CTPLD." Holly accepted this referral and admitted she was struggling to manage things at home." One of the recommendations was that, "*Holly may benefit from having information presented visually and broken down into simple steps in order to help her remember what she is expected to do. Holly may find larger quantities of information overwhelming and may struggle to understand and remember new information."*[13]

10.3 *February 2016*

On 9 February 2016, John received a banning order for shoplifting.

On 17 February, John was checked by the police as a rough sleeper.

10.4 *March 2016*

[12] A rare, chronic blood clotting disorder

[13] http://www.mhldcc.org.uk/contents/4-learning-disability/a-what-is-a-learning-disability.aspx (accessed 19 June 2017)

During March 2016, Holly "was offered occupational therapy and a support worker." She had check-ups at the GP surgery on two occasions.

John was diagnosed with Hepatitis C. He moved into a supported tenancy at the beginning of the month. He was inattentive to rules concerning women visitors, he was "heavily under the influence" on one occasion and he was given a "verbal warning." John's GP referred him to Mental Health services.

On 28 March 2016, the police "receive a complaint from a female [not Holly] who is receiving threatening texts from" an ex-partner of Dev.[14] Holly "had been the victim of domestic abuse at the hands of Dev for many years."

10.5 *April 2016*

On 26 April 2016, an "initial Occupational Therapist (OT) visit revealed that Holly was nervous of others in the housing block and avoided contact with them. She believed they were dealing drugs and made her feel anxious. Holly requested that professionals stay away from her accommodation because she was concerned that her housemates thought they were the police and that she would *get them into trouble."*[15]She was referred to a social worker "as a vulnerable person with *learning difficulties* [emphasis added].

During April 2016, John's drinking and use of legal highs persisted resulting in "verbal altercation" and observed agitation and anxiety. He told staff that he had "not slept for three days" and that he felt "mentally unwell."

10.6 *May 2016*

At the beginning of May 2016, John was supported to see his GP and to discuss a referral to Mental Health services. PAS Ltd (Housing support) noted that "GP felt referral to Mental Health not appropriate at this time."

On 9 May, Holly's social worker arranged a meeting via text message. Since Holly did not confirm, the meeting was cancelled.

On 10 May, Holly had an inconclusive Community Care Assessment based on "a 10-minute conversation." Holly had not wanted to meet her social worker at her flat so they spoke in the social worker's car parked away from her flat. Holly disclosed that she was "scared and unhappy in [her] home…drug use in communal areas and outside. I meet the wrong people when I am on my own and bad things happen." Also she disclosed depression, migraines, sleeping difficulties, noisy neighbours and wariness of strangers since she was "involved with a man [who was] not very nice to her."

On 15 May, Holly met her neighbour Adrian. They "decided we liked each other…and this progressed into a sexual relationship."[16]

[14] From whom she had separated in 2008
[15] From Dorset HealthCare University NHS Foundation Trust's IMR
[16] Witness statement

On 17 May, the social worker and team assistant sought to visit Holly since "numerous attempts" to contact her had been unsuccessful. Because Holly "ran inside without explanation" the social worker spoke to a neighbour who said that a relative was "in a relationship" with Holly. The social worker persisted unsuccessfully in attempts to talk to Holly and "left a note for her."

On 18 May, a referral was made to the police. A multi-disciplinary team meeting (MDT) hosted by Dorset HealthCare University NHS Foundation Trust (involving a Clinical Lead, social worker and OT) stated that Holly had "no activities during the day…cannot cook in her room…socially isolated…[there are] problems engaging with Holly due to the people that hang around her flat…all visits to be 2:1…to contact Police and set up a Conference of Concern meeting[17]…also…Drug and alcohol team." Holly's "self-identified goals" included "having her own front door where she can cook her own food, learn how to cook and *feel safe* [emphasis added]."[18]

On 19 May, Holly phoned the social worker to explain that she "feels ill and doesn't want the family getting involved." The social worker had received a text from Holly, "IT'S HOLLY CAN U CAL ME ON THIS NUMBA TANKS." On the phone, Holly explained that she was "feeling really low, I need to move, [and explained] I am not going out with [neighbour's relative…they asked her for money but she said no."

On 20 May, the police receive a telephone call from social worker reporting "concern for welfare of Holly [and the fact that her flatmate Lily] is taking advantage…a *vulnerable* female [emphasis added] with *learning difficulties*[19] [emphasis added] and financially incapable." Police records state "no requirement for police involvement." Holly was not referred to the "Adult at Risk" desk in the Safeguarding Referral Unit. The police acknowledge that "the matter should have been looked at more *intrusively*."[20]

During May 2016, John was referred by his GP for alcohol detoxification. He disclosed to his GP that he was misusing drugs. He received treatment for an infected foot ulcer. John left his tenancy during May 2016.

10.7 *June 2016*

On 1 June 2016, the OT left a phone message, sent a text and wrote a letter to Holly requesting contact "to discuss moving [accommodation] and difficulties in contacting her…"

On 7 June, the OT left messages for Holly "on both possible numbers."

[17] This should have been a Multi-Agency Risk Management Meeting (MARMM)

[18] The social worker recalled that "the flat was noisy and several of the neighbours in the block were involved in the use of drugs…considered to be vulnerable to financial abuse and to being coerced and bullied…due to her lack of understanding and constant desire to please. She would also change her mind regularly…I suspected…she was being manipulated

[19] The Police IMR narrative states that the social worker "identifies within the call that Holly is a *vulnerable* adult with a diagnosed learning disability…advice is given that the social worker should consider convening a multi-agency meeting."

[20] It was explained that this means "someone should have followed it up"

On 10 June, the social worker discussed Holly's circumstances "in MDT" and "contacted police to raise Conference of Concern…unsure of her care and support needs [Holly] is a *vulnerable* adult [emphasis added] …to discuss in supervision. Double cover visits noted to property."

On 16 June, the OT and social worker visited Holly, "a note was posted through Holly's door asking her to contact us…to let us know if she still wants our input…to write again…and to her mother…we are not able to provide support if she chooses not to engage or whether there are other issues…"

On 17 June, Holly sent a text to the OT stating "…I hav new fone it was gave to me. A betta fone. can we make a appointment pleese. I bin in bed for 3 days wiv migraine. And the note u put throu me letter box has one digit missin…yur numba is wrong on the paper post thru my door..."

On 18 June, the police attended an address where [Holly] was "shouting and screaming at an ex-partner because he would not let her in. Neither would "engage with police." (No Single Combined Assessment of Risk Form (SCARF) was completed, that is, one which "would undoubtedly have been shared with Adult Social Services."[21])

On 20 June, the OT drafted "care plans" for Holly and a new mobile number for her was uploaded onto the service system. She gave consent to the OT to request information from the mental health service to which she was referred in 2011 and 2012. The OT speculated that "if too many people are involved…" Holly may resist being supported. The OT requested information from Holly's GP (who was not part of the Multi-Disciplinary Team) and considered a "nursing referral to MDT" and "housing transition," that is, an application for alternative housing.[22]

On 30 June, the OT and social worker discussed Holly's "missed appointments…which is holding any progress on goal setting and evaluation leading to support from LD team [Community Team for People with a Learning Disability]" Holly's explanations included, "ill health, being busy [and] happy where she is living." The OT discussed Holly's circumstances with the Clinical Lead and was "advised to bring to MDT."

Also on 30 June, the police received three calls from an ex-partner of Holly at his address, (i) stating that "Holly is kicking the front door and demanding her property back…wants to live [there but she cannot] because she drinks." (ii) The police were told that Holly was "being racist and abusive." (iii) Holly was "kicking front door…left then returned later…left again. The police attended and gave her "words of advice."

During June 2016, the social work notes (including those of a MDT meeting) state that Holly would "only reply to texts" and that not all of these appeared to have been written by Holly. She was noted to be "a *vulnerable* adult, unable to hold tenancy without support." Three subsequent attempts to contact Holly on her three mobile numbers were unsuccessful and confirmed the perception of her as "difficult to engage."

[21] Additional police feedback stated that *if completed, would have had Holly as the perpetrator. These would not have provided any support for her as a victim of domestic abuse.*

[22] It was known that Holly was living in a red-light area in accommodation which congregated "DSS [people receiving welfare benefits] and/ or vulnerable tenants" and the multi-occupancy house address was associated with prostitution, drug dealing and anti-social behaviour

John's final contact with his GP occurred during June 2016. It focused on support with housing and a visit with a housing officer was arranged.

10.8 ***July 2016***

On 4 July 2016, the OT made another request to Holly's GP for information. This was logged on 13 July as including "no reference to mental health referrals." Also on 13 July, the OT and social worker (at a MDT meeting) requested a police welfare check and advised that a police presence "could impact on Holly and response from neighbours."

On 8 July, John moved into Holly's bedsit.[23] A neighbour recalled that "the first weekend he was there they had a party which lasted about four days…Holly had been taking drugs and hadn't been sleeping or eating…told me she had tried crack cocaine…had been snorting coke and taking ecstasy."[24]

On 13 July, an Occupational Therapist telephoned 101 to request a welfare visit to Holly and was advised that this would be passed to the duty sergeant who would allocate to an officer who would attend, "hopefully today." The OT informed the social worker[25] of this via email. The OT "documented a plan to follow-up with the police if a response not received [by the] following day."

The police noted that Lily "stated that she had spoken to Holly that day and she was staying with friends…the social worker was updated and was content that Holly had not been seen." [On 20 May 2016, the police had received a call from Holly's social worker expressing (i) concern for Holly's welfare and (ii) Lily's alleged role in *taking advantage* of Holly's vulnerability. It is surprising therefore that Lily's assertion that Holly was "staying with friends" led the police to conclude its welfare enquiries.]

On 14 July, Holly sent text messages to the OT stating that she did "not want to move" and did "not want support." Holly also sent a text to the Social Services stating that she was "safe and needs no support." It was speculated that these resulted from the police visit. The social worker's telephone contact with the police confirmed that "they saw Holly as requested…she is fine…no cause for concern."

On 18 July, the police left a voicemail message on the CTPLD telephone concerning the call to the police on 13 July stating that officers had attended Holly's address and "Holly wasn't there but her housemate was…Holly was staying with a friend. Holly [was] advised to contact her social worker." The message contradicted 14 July information from the police.

On 20 July, The clinical lead at the Foundation Trust advised not to respond to Holly's texts, because a *professionals meeting* was being arranged. The Trust explained that since Holly's text messages were "fraught" it was believed that responding would "complicate matters and make her feel more fraught."

[23] Holly's family believe that she had moved into a flat in a multi-occupancy house
[24] This information is sourced from a neighbour's Witness Statement and from information which the neighbour shared with a social worker. Holly's family do not believe that she was an active drug user and noted that "no drugs were found in her system at the point of death."
[25] The same social worker who had met Holly

On 21 July, Holly reported "harassment by neighbours" to the police. The attending officers described Holly as "very anti-police…stated nothing has happened…female has *learning difficulties* [emphasis added] and presents as anxious." Holly reported that "a male threw a drink at her in front of the officers and they didn't arrest him." She is frightened; the officers stated they would speak with the male first and then…Holly. Holly made a "further call stating that officers have arrested the wrong people; the male who threw the drink in her face has not been arrested and no one has spoken with her." The police explained that the complaint was recorded and closed down because Holly was not present when they called.

On 24 July, a "disturbance" at Holly's flat was reported to the police by one of Holly's neighbours. "There are two males and one female and the males are shouting at the female." Although officers attended, Holly "would not engage…[she] was very aggressive, repeatedly swearing." A second call was from a man wanting to visit Holly but "a group of people wouldn't let him ring the doorbell to see [her]." He was advised to return later.

On 29 July, the *Difficult to Engage* guidance was discussed at a professionals meeting (including the social worker, practice manager, a clinical lead and the OT) in relation to Holly. She "was not returning calls and did not seem to want support." (See the decision of the clinical lead on 20 July.) The OT sought information from a psychology assistant concerning Holly's "ability to manage risks…degree of vulnerability from others and her capacity related to her ability to engage with services." It was decided that there would be "a Multi-Agency Risk Management (MARM) meeting [for which] a full chronology" would be prepared, not least because of "concern raised regarding coercion."[26] The OT undertook to write "an easy read discharge letter…stating that if [Holly] has health needs in the future" she should be re-referred to the Community Team for People with a Learning Disability.[27] "Care Plan will now be closed and Holly discharged from OT input."

10.9 *August 2016*

On 1 August 2016, the social worker invited the Police to identify a date on which to host a MARM.

On 4 August, the social worker emailed the GP, asked about Holly's "capacity to make decisions" and sought times and dates to meet during the week commencing 23 August.[28] Holly was "invited by letter" to attend a MARM.[29]

The OT closed Holly's "healthy eating plan…as needs met [Dorset Healthcare University NHS Foundation Trust explained that the plan "concerned high intake of energy drinks. Holly agreed to reduce her intake and then reported that she had stopped.]…care plan regarding Model of Human Occupation Screen Tool (Mohost) assessment and financial capacity closed as Holly declined interventions…due to previous experiences and choices in past relationships, Holly is potentially vulnerable to abusive relationships with future partners…risk of harm from others raised from low to medium."[30] The discharge summary was sent to Holly and her GP.[31]

[26] The MARM is a component of the Multi-Agency Safeguarding Adults Procedures
[27] A specialist, multi-disciplinary, health service for adults with learning disabilities which does not include GPs
[28] There is no GP record of a communication stating the date of the MARM
[29] Since there is no copy of the letter to Holly it is not known whether or not it was an easy-read letter
[30] This suggests that it was up to Holly to address these known risks
[31] There is no GP record of the discharge

On 5 August, Holly's neighbour, Adrian, telephoned Care Direct, Social Services to express his concern that "Holly is a *vulnerable* adult [and] Social Services are not supporting her adequately," because she is currently "living with another adult…who is unsuitable [and there are] drugs in the property." Adrian recalled that he was told he "was doing the right thing not phoning the police…as we didn't want to upset Holly." Holly's social worker recalled that the neighbour said that "there were drugs involved…Holly's housemate had been attacked by an individual living at the address and had subsequently moved out."[32]

On 15 August, the social worker from the Learning Disability team reported "concern for Holly's welfare" to the police since Adrian [neighbour] had contacted the Social Services once again to explain that although the "social worker had been seen knocking…Holly does not answer door…[she is using] crack cocaine[33]…man [John] has recently moved in …telling her what to do…has bruising to her arm…needs to be moved somewhere where she can't be manipulated." He also reported that during a 3.00 a.m. altercation with "neighbours' partners," Holly had threatened to stab them.

Another neighbour also rang Care Direct on 15 August stating that "John had moved in…Holly was being controlled…he was not letting Holly do anything…Holly is covered in bruises…there were two men, John and [Dev] who comes every other day to collect money from Holly." This was referred to the duty social worker who then contacted the police."[34]

A "welfare check with social services took place. Holly explained that the men who had been with her had left. She had no visible injuries. She said that because her neighbours were "causing…problems…[she] didn't want to stay at the flat." The police noted "all in order" and no SCARF was completed. The police subsequently noted that "This effectively makes the fact that Holly and John are in a relationship "*unknown*" for the purposes of checking records.[35] It meant that Holly's circumstances on 15 August were not added to the police records concerning John and specifically his violence to four previous partners. Had the records been checked then a multi-agency response should have resulted including the assessment and mitigation of risks to Holly and the introduction of safeguarding measures.

The social worker made a complaint to Dorset Police about the challenges of requesting another police welfare check and being left "on hold for 50 minutes."[36]

The Service Users Support Network[37]/ Holly's neighbour [not Adrian] contacted the Social Services to report that Holly was "off her head with crack cocaine…John has moved in…Holly [is] covered in bruises…being manipulated…aggressive with neighbours…has music blasting from 7.00 a.m. to 3 a.m…verbally attacking people…nasty…not the same person she was 3 or 4 weeks ago." Also, a man was "visiting every other day to collect money" owed by Holly.

[32] Evidence of assault and yet it was not investigated as a potential crime

[33] Holly's family do not accept that she used drugs

[34] It does not appear that potential theft and extortion invoked either a police investigation or a safeguarding response

[35] This means that the fact of Holly's relationship with John was not known to the police and specifically that they were not linked on police databases

[36] There were significant problems when the 101 number was introduced. These have since been rectified

[37] This is a coding label which refers to people's friends, family and support networks

The Social Services were unable to make contact with Holly's neighbours. Their contact details were shared with the police. [It is not clear why it was 10 days before social services took any action.]

On 16 August, a social worker spoke to Adrian by telephone. He confirmed that Holly was living with John, that she "does not see her family any more" and that a previous partner Dev, who used to "beat her up badly [was] hanging around." The social worker also spoke to Holly's mother who explained that Holly had "always been difficult…had sent her a text calling her a *shit mum."* However, she had just received a text from Holly stating "I'm depressed, don't know what to do. I have a new boyfriend." Holly's mother confirmed that Dev "used to beat [Holly] up." She explained Holly's reticence about trusting the police, that is, Holly "ended up getting arrested for the fights" which involved Dev and a previous boyfriend. Holly's mother advised her daughter to "engage with social services" and said that she "believes she has capacity to make choices but that she chose bad choices." The social worker also advised Holly's mother that Holly "was writing some strange things on Facebook. [This scrutiny of Holly's Facebook account would appear to having happened on a single occasion. It is not referenced in case notes.]

The social worker undertook to "speak to [supervisor] for advice as there is a conflict [of interest] as the social worker knows John.[38]

Also on 16 August, the social worker contacted the police for "an update" because they were "considering a MARM…Holly…covered in bruises and smoking crack…[and] a neighbour may be bullying her."

On 17 August, [the supervisor] was updated and the social worker, practice manager and two police officers visited Holly. She did not answer the door immediately because she was unhappy with the police presence and the possibility of neighbours overhearing. Against the backdrop of "neighbours shouting *get rid of the crazy lady*," Holly admitted her visitors. John was present and in response to the social worker's concern, Holly explained that she did not want Dev at the flat and wanted to move out with John. *John explained that Holly sustained bruises as she sought to protect John from Dev* [emphasis added]. The social worker undertook to "look into options" and explained that "an assessment [to determine] eligibility for social care support" was required. [No MARAC was considered.] "Police state they believe Holly had capacity to make unwise decisions."[39]

Subsequently, it was established that the police determined that the "threat risk" was "low" to the police, neighbours and Holly and "medium to social worker." It is not clear how these assessments were determined since they did not take account of John's previous violence. Once Holly invited them in, the police recalled that "she was not black and blue…[she] stated that her new partner John" was also in the flat. Since she did not want the conversation to be overheard she led the visitors into a room "which had a mattress on the floor…she stated that she was happy with John and that they were helping each other. The social worker and Holly went into another room and closed the door so they could have a private conversation…both gave the impression that they were in a good place in their relationship…on leaving, the social worker mentioned that she knew John. We asked if she needed us to complete any form or paperwork [including a SCARF]…and she stated

[38] - having worked with him in a previous role in alcohol addiction services. It is not known what decisions, if any, resulted

[39] Bournemouth Borough Council's IMR

we didn't…we believed that Social Services were the lead agency…we believed that our primary role was to prevent any possibilities of a breach of the peace. We were not made aware at any point of any concerns for the welfare or well-being of Holly."[40]

The social worker recalled that Holly's "flat appeared very clean and there was food…Holly said that she was stressed as her neighbours were picking on her and bullying her…knocking at all times of the night and asking for money…she was living with her boyfriend John…she felt safe with John…he was looking after her…he had moved in with her. They went into the bedroom, where John was with the police officers, and the social worker recognised him from previous work in a service for people with alcohol addiction, where he was known to be violent. The social worker saw that Holly's "arms were covered in bruises [that appeared to have been] caused at separate times…she let John do all the speaking…seemed submissive to him…he brought up Holly's bruises…he had confronted Dev and they had a scuffle. Holly tried to intervene…this was how she got the bruises." Since Holly left the room the social worker followed her to check that she was alright. "She said that she was fine but needed to move."[41] It does not appear that anyone asked Holly how she came to be bruised.

On 20 August, the police received calls from a neighbour of Holly's and from Holly. The first call was allocated to the neighbourhood policing team and, as a result of the second call, Holly was arrested[42] and "charged with threats to kill [a neighbour] and assault a police officer." Information provided to the police by a psychiatric nurse from the Custody Liaison and Diversion Service stated that "Holly has difficulty with verbal comprehension and processing and increased impulsivity when problem-solving. Police advised…that Holly *may need an appropriate adult* [emphasis added][43]…a MARM meeting has been arranged due to Holly's *vulnerability*." No appropriate adult was available. Holly was discharged from the Custody Liaison and Diversion Service.

Later on 20 August, John attended the police enquiry office and stated that he was "the person who is wanted, not Holly." He was advised to go home.[44]

On 21 August, Holly rang the police to report that although a man had thrown a drink at her "in front of the officers they didn't arrest him." She said that she was "frightened." She repeated this message later in the day. The attending officers had witnessed Holly shouting abuse at her neighbours - from her window – "she then came outside and continued shouting and screaming."

Holly rang the police to report a disturbance next door and said that she had "been threatened and [had] a week to leave her property. Her boyfriend John had been assaulted and then arrested. It was noted that Holly and the neighbours appeared "intoxicated." No one would speak to the attending officers. Holly was advised to attend the police station the following day if she wished "to

[40] Since the immediate concerns had dissipated the police's (uncorroborated) account would suggest that they perceived themselves to be supporting a visit. It does not appear that the officers were proactive in either safeguarding a vulnerable woman or checking records of previous police contact with Holly. Had they done so, 34 "domestic incidents" with four previous partners would have been revealed

[41] Witness statement

[42] As a result of this arrest the police added an entry to Holly's record which indicated a warning marker as "Educational Special Needs"

[43] www.gov.uk/government/uploads/system/uploads/attachment_data/file/117682/appropriate-adults-guide.pdf (accessed 11 July 2017)

[44] It is not known why John was advised to go home, most particularly since Holly clearly had support needs and was known to require assistance in describing the relevant events

make any formal complaints." The police noted that "the matter was not crimed and no SCARF was completed" concerning Holly. Holly's social worker emailed the police reiterating that Holly had a learning disability and that there had been no contact since Holly's arrest.

On 22 August, the social worker left three messages on Holly's phone [it is not known whether or not messages were left on all of Holly's phones or even whether Holly had access to her own phones[45]]. Although she did not return the calls, when the social worker was off duty, Holly was seen drinking and dancing with John in public gardens during the day. "Holly was very animated, throwing her arms around John and kissing him…she did this over and over…sometimes sitting on John's lap…she was also singing and dancing. This was not the Holly I had previously seen."[46]

On 24 August, Holly's circumstances were discussed at a MDT and during social work supervision. The OT updated information from the social worker: at their meeting on 17 August, Holly confirmed that she wanted "support again…she may be using drugs and drinking alcohol and at risk from *boyfriend* [Dev] *who is widely known to the police"* [emphasis added]. During a "handover" to another social worker [the handover was scheduled to take place on 6 September.] (Holly's social worker was pregnant and the risks of continuing work with Holly were deemed too great) it was envisaged that "Holly's capacity to make choices regarding her boyfriend" would be assessed at the joint hand-over visit. A multi-disciplinary team meeting identified a social worker for Holly. There was "no progress" in arranging a MARM and it was agreed that there should always be two professionals at meetings with Holly, "due to risks associated with recent arrest and Holly threatening to harm others…next meeting will be to assess capacity and any risks to Holly and check MARAC referrals." The social worker left telephone messages on Holly's phone [or possibly phones] on 25 and 30 August.[47] Two matters were not considered: a referral for substance abuse treatment and the possibility that Holly's aggressive behaviour was masking the fact of her learning disability.

On 31 August, Holly was discussed at social care led MDT meeting. The learning disability social worker contacted Holly's GP expressing concern that Holly was "not keeping appointments, had changed her address and the police had been contacted." The GP was advised that Holly was residing in "an awful building…involved with drug and alcohol…crack cocaine…[Holly] is at risk, known to be in a partnership with John.

Social services' records state that emails were sent to the police and Holly's GP concerning a MARM. The GP could not attend a MARM but provided information relevant to the MARM during a telephone conversation. [There is no record of this statement or associated emails in the practice records.] Calls made to Holly's phone "everyday" were not recorded by social services.

10.10 ***September 2016***

On 1 September 2016, the social worker spoke to Holly by telephone. Holly was upset because she was "in trouble with the police [having been] attacked by neighbours…[Holly was] arrested and [handcuffed] for four hours." She resisted an intimate physical examination [see footnote 9], "kicked off and went to attack police officer" and said that she was "scared" and wanted to move. In a

[45] Holly's family suggested that the control to which Holly was subjected was likely to extend to her use of her own phone

[46] Witness statement

[47] The case notes do not specify whether or not messages were left on the three phones

telephone call to Holly 45 minutes later, she was confused, distressed and "seemed intoxicated…scared she will go to prison as has been before."

On 2 September, John was arrested on suspicion of criminal damage. "The victim heard a window being smashed…and saw a male who stated he was being chased and needed to get into the property." John was intoxicated and although "concerns were expressed about his mental health…it was not possible to assess at that time." The Court Diversion Schemes and Criminal Justice Mental Health Liaison Schemes (CJLDS) invited the police to re-refer on 3 September, "if they still had concerns." John was "charged with criminal damage and bailed to appear on 6 October 2016."

On 3 September, John was "chased by a group calling him a *paedophile*…did not know the group and could not give a description…advice given [by the police]." He was admitted to St Ann's psychiatric hospital "threatening to slash his wrists if he was not detained." John was "unkempt and malodorous…hostile when asking questions about his drug and alcohol use…showed a cigarette burn on his arm as proof of his intent to hurt himself… [he] described how he had been homeless for six days after a row with his girlfriend of seven weeks following an argument about them trying to have a baby…he had been sleeping in the park. He is adamant he does not want to return to the house…main immediate risk is vulnerability." John was "not deemed detainable under the Mental Health Act…[he was] assessed to be at low risk of self-harm but to be at medium risk of harm from others…[he] was offered two nights Bed and Breakfast and signposted to housing."

On 5 September, the social worker rang Holly to remind her about their appointment on 6 September. There was no facility to leave a message. Since Holly did not turn up for the appointment a letter was sent. Holly's neighbour Adrian complied with Holly's request to bring her some cannabis.[48]

On 6 September, Holly did not turn up for the introduction to her new social worker/ "handover" meeting.

On 7 September, a police officer visited Holly for "about 20 minutes." Holly did "not report any issues."

On 8 September, Holly was "arrested for a failure to appear" [at the Magistrates Court concerning her threatening behaviour on 6 September.]

Also on 8 September, John refused to pay a taxi fare and was "acting aggressively…taken to two cashpoint machines [by the taxi driver]."

On 11 September, Holly rang the police to report that her ex-boyfriend Dev had rung her, threatening to kill her and "her boyfriend John.[49] Advice [was] given." In another call, Holly said that Dev had "smashed his way in…making threats to kill," and background shouting was audible. The arrival of attending officers coincided with Dev driving away "with another male." Holly and John had "locked themselves in the toilet." They had received "numerous contacts from Dev" who had

[48] Witness statement

[49] John's name was known to the police

also stolen Holly's mobile phone. In Holly's third call she stated, "this is ridiculous…could be dead by now." Holly and John were taken to a hotel "so they could get away from the property."

On 12 September, the police "detained" Dev with a No Further Police Action outcome and "updated Holly."

Also on 12 September, a SCARF was created as a result of Dev's "unexpected" visit to Holly on 6 September when Dev and two friends "took [Holly's] mobile phone." A referral was made for a Domestic Abuse Advisor (DAA) to make contact. This was solely in relation to Dev.

On 14 September, the social worker requested an "update" from probation tasked with preparing a court report. It was explained that Holly, "was not eligible for [a] service."[50]

Also on 14 September, Holly rang the police to report that Dev was "possibly trying to get in" since someone was "banging at her door." Officers attended "the following day," and spoke to Holly and John. Holly was "not engaging and not willing to proceed [because she had] been badly let down in the past by Dorset Police." A SCARF was completed which was linked to the previous referral and "arrangements were made for target hardening[51] and continued contact with the DAA."

On 15 September, the Magistrates Court issued a restraining order to prevent Holly from having contact with her neighbour (with whom she had had a dispute on 20 August). Holly was "in contact with Independent Domestic Violence Advocacy[52]…[days before her murder] upset that "nothing ever seems to happen to Dev…[who had] continued to contact her and John…[she had] fallen out with neighbours and would like to move away to an unknown address." With Holly's permission a referral was made to Outreach[53] for support and advice [was] given re 999 and safety."

On 16 September, a SCARF was created. Holly contacted the police to report that Dev "had been banging on her door and sending threatening text messages." Dev "would not engage due to previous allegations [Holly] had made."

Also on 16 September, John presented "at Bournemouth Police Station where he was arrested for the murder of Holly having made disclosures to officers outside the police station."

11 Overview

11.1 Holly was 38 and had been diagnosed as having a learning disability eight months before she was murdered by John. It is not clear that all agencies understood the implication of Holly's learning disability. John was "a serial perpetrator of domestic abuse against four previous partners," and he

[50] Holly's family do not understand why, at a time of significant concern for Holly and her vulnerability, neither they nor her GP were not informed

[51] A term used by the police referring to protectively enhancing the security of a property using fire-proof letter boxes, extra door locks and lighting for example

[52] This is a misnomer since Holly made contact with the Maple Project. This merged the IDVA Service with the police Domestic Abuse Officers, see https://www.bournemouth.gov.uk/councildemocratic/CouncilMeetings/CommitteeMeetings/CommunityOverviewScrutinyPanel/2016/04/05/Reports/8-domestic-abuse-strategy-and-action-plan.pdf (accessed 23 August 2017)

[53] This is a domestic abuse support service which provides advice and safety planning and may signpost to other services

had a brain injury. Holly had been introduced to John by Dev, a violent ex-partner with whom she had remained reluctantly in contact. Their contact was characterised by violence, potential theft and Holly's distress. When Holly came to the attention of the police (which since 2007 has records of 34 "domestic incidents" concerning Holly and four different partners, not including John) she was frequently intoxicated and perceived as uncooperative. John had a history of alcohol and poly drug use and yet he declined treatment for his considerable medical problems. He had been homeless before he moved into Holly's accommodation.

11.2 Little is known of Holly's life when she moved to Manchester in her 20s. It is not clear that she was employed, only that her family feared that she was drawn towards "bad relationships" from which she could not extricate herself. The impetus for her homelessness, the changes of address and use of several mobile phones towards the end of Holly's life appeared to have arisen from a desire to escape from hostile neighbours and from Dev. During May 2016, Holly's revealing "self-identified goals" were "Having her own front door, learn how to cook and *feel safe"* [emphasis added]. In spite of these goals and the fact that her risk of harm from others was documented as "medium," Holly was discharged from the CTPLD service (on 29 July) and the Criminal Justice and Liaison Service (on 20 August).

11.3 There were two, joint "welfare checks" concerning Holly within the relevant timeframe. Adult Social Care contacted the police to express concern about Holly on at least six occasions and Holly herself made at least seven calls for police assistance. These contacts are not suggestive of a woman who was perceived as "difficult to engage." Also, Holly's neighbours contacted Adult Social Care on three occasions to express concern about her. It is striking that no association was made between John's presence at Holly's accommodation and his history of domestic violence.

11.4 Holly's circumstances did not result in a Section 42 enquiry.[54] There is nothing automatic about invoking safeguarding or any other procedure even when the stakes are high. The failure to identify a date to host a multi-professional discussion about Holly appeared to close off the identification of interim "workaround" solutions supported by senior managers.

12 Analysis

The terms of reference for this DHR included the following questions:

- *Was the victim known to local domestic abuse services, was the incident a one off or were there any warning signs? Could more be done to raise awareness of services available to victims of domestic abuse?*

Dorset Healthcare University Foundation Trust regarded *the incident* as a *one off* because Holly was not seen as *a current risk at the time because* [she] *was not in a relationship.*

[54] Action that is taken by a LA under the Care Act 2014 concerning an adult with care and support needs who is at risk and unable to protect themselves. See also, https://www.local.gov.uk/sites/default/files/documents/adult-safeguarding-and-do-cfe.pdf (accessed on 20 August 2017)

Dorset Clinical Commissioning Group noted that Holly's GP had "flagged" her as vulnerable after the identification of her learning disability. Her circumstances were discussed at the Practice's vulnerable adults meetings. Holly's last appointment with her GP was on 24 April 2016 and concerned surgery on her eye. She did not disclose that she was either having a relationship or that she was subject to domestic abuse. However, her medical records recorded the fact that Holly gravitated "towards difficult relationships that were often dysfunctional."

Bournemouth Borough Council's Adult Social Care/ CTPLD acknowledged that "there was no indication that a specific Domestic Abuse related risk management approach was taken."

Dorset Police had records of Holly's allegations of domestic abuse concerning Dev and of her "problem with alcohol" which inhibited her "ability to explain with some clarity the events which made [her] a victim." Holly was described as *well known within the domestic abuse arena*.[55] She had been dealt with as a victim of her previous partners' violence. The failure to link police information to new incidents reported to the police is a recurring theme. Each call operator and officer attending was unfamiliar with the police records.

Re John - Dorset Healthcare University Foundation Trust had *no records of John being known to domestic abuse services.* Although he was at Holly's accommodation during a joint visit with the police and he was known to the police *the context of this is not detailed in the clinical notes.*

Dorset Clinical Commissioning Group noted that John's GP had "flagged" him as vulnerable. His circumstances were discussed at the Practice's vulnerable adults meetings. The implications were that when John missed health related appointments, contact was made with him to re-establish engagement and offer support to ensure his health needs were being met. It was not known that John posed a risk to partners.

Dorset Police held recorded allegations from four of John's previous partners. He was "a serial perpetrator of domestic abuse."

12.1 Holly had not had contact with domestic abuse services until the very end of the relevant period. Although her GP had explored such provision during February 2012, Holly did not follow this up. Domestic abuse services were suggested to Holly in relation on a single occasion during 2016, a day before her murder. This was solely in relation to her ex-partner Dev. Holly acknowledged violence in her cohabiting relationships in terms such as meeting the "wrong people when I'm on my own…not very nice [and] bad things happen" [May 2016]. On the day before her murder Holly was contacted by a Domestic Abuse Advisor. The action was target hardening and further DAA contact.

12.2 The incident was decisively not a "one off" since Holly, her family and the police acknowledged that she had endured abusive relationships for many years; and the police records revealed her involvement in "a large number of domestic abuse related incidents since 2007," prompting the reviewing officer in 2010 to state of Holly's circumstances, "this is the very type of

[55] It is not clear that she was *well known* since no agency was fully appraised of the risks to which she was exposed; attuned to the implications of being an unsupported, learning disabled woman subject to domestic assault, pursued by a violent ex-partner; and living in accommodation associated with anti-social behaviour

scenario which has the potential to end in domestic homicide." It is not known what measures were taken to "flag" Holly in terms of risk from ongoing or future relationships. Similarly, adult social care acknowledged that Holly was subject to "coercion [and] bullying," her living circumstances were concerning, and she required an appropriate adult[56] when she was arrested. The risk posed by John was not recognised. On 24 August it was decided that it was too dangerous for a pregnant social worker to visit Holly and John – a decision which resulted in the transfer of her case to another social worker.

12.3 It is remarkable that Holly was not made known to domestic abuse services until the end of the relevant period. Although she had a learning disability, her circumstances concerned her social worker and Occupational Therapist and she was very visible to the police, she was not directed to specialist services for victims of domestic abuse.

- *Was the victim involved in the MARAC or other multi-agency processes?*

Dorset Healthcare University Foundation Trust stated that there was "much evidence of close joint working and discussion between the Social Worker, Occupational Therapist and police," attempts to gather information about Holly and acknowledged the *regrettable* delay in identifying a date for a MARM meeting.

Dorset Clinical Commissioning Group confirmed that Holly's GP was willing to attend a MARM meeting, "but did not receive an invite or any further information or outcome from this meeting if it took place."

Bournemouth Borough Council's Adult Social Care/ CTPLD confirmed that "no MARAC referrals were made from ASC. Other multi-agency approaches were considered in line with the *Adults at Risk who do not wish to engage with services protocol.*" Although "Holly and her mother were…invited to attend the proposed MARM,[57] the…meeting never took place…due to the absence of other agencies responding to a request/ or unable to attend a MARM[58]…There was no evidence that further options were being considered/ explored such as changing route from a MARM to a safeguarding alert[59] or a MARAC referral, especially after the [17 August] visit to Holly where bruises were noted and concerns raised by neighbours."

Dorset Police Holly had been referred to MARAC previously but not with John. The outcome of the referral is not known.

12.4 Holly's circumstances during the final months of her life triggered the prospect of

1. A Conference of Concern Meeting
2. A Safe Lives Risk Assessment Meeting
3. A Multi Agency Risk Assessment Conference (MARAC)

[56] Appropriate adults are called to the police station as an important safeguard providing independent support to detainees who are aged under 17 or maybe mentally disordered or mentally vulnerable www.gov.uk/government/uploads/system/uploads/attachment_data/file/117682/appropriate-adults-guide.pdf (accessed 11 July 2017)
[57] There is no evidence that Holly was sent a copy of this letter or that it was an *easy read* letter
[58] The invitation requested individuals to specify the dates they were available for a MARM
[59] The MARM features in safeguarding guidance. However, an alert is required to trigger action

4. A Multi Agency Risk Management Meeting (MARMM)[60]
5. A Single Combined Assessment of Risk Form (SCARF)
6. Mental Capacity assessment concerning specific decisions and "choices"
7. A DASH risk assessment
8. A risk management action plan

12.5 With the exception of the SCARF,[61] (which was completed on two occasions just days before her murder, it was *not* completed on 18 and 30 June[62], 24 July and 17 August), it is noteworthy that none of the listed meetings or assessments occurred. There were Multi-Disciplinary Team meetings during June, July and August 2016 and these hinged primarily on sharing concerns, information searches and securing a date for a MARMM. It is curious that risk "management" appeared to trump risk assessment: "risk management actions were reactive and based on asking Dorset Police to carry out welfare checks…*There is not a specific domestic abuse protocol* [emphasis added] but a wider safeguarding adult procedure which refers to domestic abuse."[63]

12.6 Holly's medical records recorded a single episode of domestic abuse during 2012 which was referred to a MARAC. Subsequently she was not involved in the MARAC or any other multi-agency process. Discussions concerning a Multi-Agency Risk Management (MARM) process, which began in May 2016,[64] did not result in any credibly focused action addressing Holly's deteriorating circumstances. Although social services' records reveal that Holly had a learning disability and was subject to domestic violence, she was without a support network, was frequently intoxicated, was evasive or perhaps scared, and was living in a flat in an unsafe dwelling in a "chaotic"[65] neighbourhood [which suggests a hot-spot for frequent police call outs] - where one neighbour was particularly worried about her. An *Adults at Risk Who do not Wish to Engage Protocol* [66]was invoked. Neither MDT meetings nor the oversight of the Learning Disability Team triggered an *Interim Risk Management Plan,* a *Conference of Concern Meeting,* a MARAC referral, a safeguarding referral or a decisive professional response.[67]

- *Are family, friends, colleagues participating in the review, were they aware of any abuse that may have been taking place?*

[60] Dorset HealthCare's IMR also refers to a "pre-MARM meeting" which did take place but there was no consensus concerning the outcome. The MARMM process was described as "new to all professionals"
[61] This should have been completed on 18 June, 30 June, 15 August and 21 August. It was completed on 12, 14 and 16 September
[62] The police view is that it did not fit the criteria
[63] Bournemouth Borough Council's Adult Social Care/ CTPLD's IMR
[64] Dorset Police IMR
[65] Dorset HealthCare University NHS Foundation Trust's IMR
[66] This is separate from the *Guidance on Difficult to Engage Patients or Patients who do not Attend Appointments in Secondary Care (Mental Health and Learning Disability Services*
[67] The Director of Adult Social Care Services noted on 13 September that "The confusion around the purpose, structure and circumstances in which a MARM should be used has been brought to the attention of the Policy and Procedure Subgroup of the Safeguarding Adults Board in Bournemouth, Poole and Dorset. [work has been commissioned] to reach a clear and common understanding…and reflect this in adult safeguarding procedures"

Holly's family were aware of the violence which characterised her relationships. Independently they described her as making "bad choices," engaging with "unsavoury people" and entering into "bad relationships."

Dorset Healthcare University Foundation Trust noted that its efforts to involve Holly's mother had been unsuccessful and also that Holly had had "no friends."

Dorset Police stated that Holly's mother, father and sister have been contacted by the Chair and they supplied statements to the homicide investigation team. [A witness statement taken during the police investigation was considered during the review process.] The Chair has also been passed details of a witness who made a statement to the investigation team. He had been in a relationship with Holly and was concerned about her relationship with John.

12.7 Holly's family contributed to the review in person to person meetings and telephone conversations throughout the review.

- *Were there any barriers experienced by the victim or family, friends and colleagues in reporting the abuse?*

Dorset Healthcare University Foundation Trust identified the possibility that Holly "lacked awareness and experience of healthy relationships" and "her fear of having a police presence at the property…a poor relationship with her mother and social isolation."

Bournemouth Borough Council's Adult Social Care/ CTPLD noted that Holly's "learning disability could have been a potential barrier as it may have increased her vulnerability…can be very difficult to address when there is a lack of engagement whilst balancing the right to a private life of the individual."

Dorset Police highlighted the incidents that were reported and how they went on to be investigated. Holly had a long history of disaffection with the police which had been subject of a complaint.

12.8 Holly had a learning disability, that is, she had an impairment that started before adulthood with a lasting effect on her development; she had a significantly reduced ability to understand new or complex information and to learn new skills and a reduced ability to cope independently.[68] She had an assessed IQ of 57. There appeared to be a single acknowledgement of Holly's learning disability when on 29 July 2016, she was sent an "easy read" discharge letter from the CTPLD's OT.

12.9 Holly's status as a woman with a "mild learning disability" was confirmed seven months before her murder. On 26 April, 20 May and 21 July, Holly was described as a woman with a learning *difficulty.* It is possible that this label downplayed the fact of her life-long support needs. Although her usual appearance would not have suggested that she might have had a learning disability, she was assessed as having an IQ of 57. A recommendation arising from the IQ test was:

[68] Department of Health (2001) *Valuing People: A new strategy for learning disability for the 21st century.* Cm 5086. London: Department of Health

Holly may benefit from having information presented visually and broken down into simple steps in order to help her remember what she is expected to do. Holly may find larger quantities of information overwhelming and may struggle to understand and remember new information.

12.10 Crucially there was no mental capacity assessment concerning, *inter alia,* Holly's living circumstances. Although all agencies made reference to Holly's "capacity," this was not queried. It was not established that Holly had the mental capacity to make particular decisions. There was neither timely nor effective scrutiny of her decision-making. Not even in the light of Holly's deteriorating circumstances did any professional question her assumed "choices." DHUFT state that "throughout there was a principle of assumed capacity."

12.11 The Guidance concerning difficult to engage patients was invoked but not followed:

Patients who are at risk…but who do not wish to engage with treatment should have as a minimum before they are discharged:

a) An assessment of capacity…(paragraph 6.13).

12.12 Holly was known to be a frequent victim and sometimes an offender. Although there is no settled definition of violence, Holly was a recipient of verbal abuse and she was also responsible for verbally abusing and threatening others, most particularly when she was intoxicated. She was physically assaulted and threatened by some of the men in her life. It does not appear that Holly had any experience of ways in which conflicts might be peacefully resolved. Although alcohol is an important factor in describing and explaining the situations which became familiar to Holly – violent relationships, problems with neighbours, reluctance to engage with the police (perhaps because such situations contained the potential of escalating violence after the police had left) and a nomadic lifestyle – so too is her learning disability and mental capacity to make specific decisions.

- *Was abuse present in any previous relationships, did this affect the victim's decision on whether to access support?*

Dorset Healthcare University Foundation Trust confirmed that its "risk summary" identified previous relationships which were abusive which "could make her vulnerable to further abuse."

Dorset Clinical Commissioning Group confirmed that Holly's medical records revealed that an episode of domestic violence during 2012 was known to her GP and although she was encouraged to access support, she did not do so.

Bournemouth Borough Council's Adult Social Care/ CTPLD was aware that domestic abuse featured in Holly's relationship with Dev, she "felt she had not been believed by the police when reporting previous domestic abuse and had been arrested herself *for the fights..."* This "may have transferred to lack of engagement with other public agencies."

Dorset Police confirmed that Holly had been subject to abusive relationships. She had a very poor perception of the police as a result of previous dealings, that is, during 2007-2008 there were six reported domestic incidents concerning Dev; between 2008 and 2001, there were 18 concerning

another partner (1); between 2009 and 2011, there were six concerning Holly's father; and during 2012, there were four concerning another partner (2).

12.13 Holly's experience of domestic violence and, specifically, of reporting Dev's domestic violence and harassment diminished her faith in the police. She is known to have experienced violence in the form of threats to kill. As Holly explained in a telephone call to the police on 11 September, "…this is ridiculous…could be dead by now." Although requests for police assistance on 30 June, 21 July, 20 and 21 August, it was not always clear that Holly wanted the police on the scene. For example, on 21 July she reported harassment by her neighbours. The police noted, "Female spoken with very anti-police and would not engage. Stated nothing had happened. Flat checked not evidence of disturbance. Female alone she has learning *difficulties* and presents as anxious." This is a familiar domestic abuse scenario: women withdrawing complaints because of fear. The denial that police assistance is required does not signal the restoration of domestic harmony. Holly was expected to manage her deteriorating circumstances. A lot hinges therefore on the presence of the police officers, their ability to calm things down, their tenacity in (i) assisting women with known support needs to make complaints and (ii) directing them to supportive services. [69]

- *Were there any opportunities for professionals to routinely enquire about any domestic abuse experienced by the victim that were missed?*

Dorset Healthcare University Foundation Trust noted that "professionals had very limited opportunity to engage in discussion with Holly…due to her lack of engagement…at no point did Holly disclose domestic abuse from John [or others and] made a request on 24 August 2016 that she be rehoused with John."

Bournemouth Borough Council's Adult Social Care/ CTPLD stated that "engagement with Holly was sporadic and difficult." However, "During one joint visit (with social worker and police) the offender was present and his version of the reason for Holly being bruised was accepted…[later] the social worker clearly recognised the need to speak to Holly alone so tried to arrange to see her without John…Holly did not attend."

Dorset Clinical Commissioning Group acknowledged that "there may have been opportunities to ask routine questions about domestic abuse but these were not taken because Holly did not present at the surgery with any issues that would have raised concern."

Dorset Police acknowledged the opportunities that were missed in exploring the relationship between Holly and John and assessing the risk - from 15 August until her murder 33 days later.

[69] The College of Policing's (2015) *authorised professional practice on domestic abuse* emphasised *the importance of getting the basics right – an effective investigation to build a strong case which can progress even without victim support, and the safeguarding of victims…there needs to be a better management of risk, by targeting and managing perpetrators, and developing improved safety planning with victims.* (*www.app.college.police.uk/app-content/major-investigation-and-public-protection/domestic-abuse/introduction/* accessed on 18/2/18)

Re John - Dorset Healthcare University Foundation Trust regarded the Criminal Justice Liaison and Diversion Service's contact with John on 2 September 2016, and its invitation to the police "to re-refer the following morning if they still had concerns" as a missed opportunity. Similarly, his Mental Health Act assessment of 3 September 2016 did not ask questions about domestic abuse.

12.14 Holly initiated contact with the police on 21 and 24 July, 20 and 21 August, 11, 14 and 16 September – the date of her murder when her "risk [was] assessed as high." On 21 August and 11 September, Holly contacted the police on more than one occasion. The police had person to person contact with Holly on 30 June, 21 July, 15, 20 and 21 August, 6, 7, 11 and 14 September. The social services made six calls to the police expressing concern about Holly on 20 May, 13 and 14 July, 1, 15 and 16 August. Also, a friend of Holly's contacted the police because access to Holly's flat was obstructed (on 24 July). "Bystanders," such as two of Holly's concerned neighbours, formed an opinion about her deteriorating circumstances and contacted social services and yet professional intervention appeared to be preoccupied with securing a date for a meeting and unmerited respect for Holly's "choices."

12.15 There do not appear to have been any occasions when the police documented the names of the people present when contact was made with Holly. John had a police record for violence towards four former partners. Although information concerning John's violence was also known to Holly's social worker, the Domestic Violence Disclosure Scheme[70] was not considered. More significantly, the MARAC was not invoked. In the absence of any proactive intervention, Holly was left without any tangible means of support.

- *Are there any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of the services available?*

Dorset Healthcare University Foundation Trust proposed that the Community Team for People with Learning Disabilities would find "additional training on further elements of domestic abuse…helpful."

Dorset Clinical Commissioning Group confirmed that although Holly's GP "did not miss any indications of domestic abuse…the surgery themselves have identified the need to have some additional training for the whole practice around the identification, assessment and referral for Domestic Abuse."[71] Neither Holly nor John disclosed to their GPs that they were in a relationship.

Bournemouth Borough Council's Adult Social Care/ CTPLD stated that Holly's social worker "had only just finished her *Assessed and Supported Year in Employment…*perhaps did not have the range of experience to do this without supervisory management guidance and support…when the social worker escalated the difficulty organising a multi-agency meeting to their supervisory manager a

[70] This enables people to find out if their partner or potential partner has a history of abuse or violence. It is commonly known as Claire's Law. The scheme includes a "Right to ask" and a "Right to know" whereby the police make a proactive decision to disclose details when they receive information that a person may be at risk (see https://mappa.justice.gov.uk/connect.ti/MAPPA/view?objectID=263219 accessed 20 August 2017)

[71] Dorset CCG's IMR noted that "there is a plan in place…to increase awareness of domestic abuse and the requirements of primary care to address this…will include facilitated sessions around identification, assessment and referral as well as identifying a Domestic Abuse lead in each surgery

more proactive approach should have been taken…" Also, "a DASH risk checklist was not completed…may indicate a need for refresher training."

Dorset Police stated that domestic abuse…*the 13 strands of public protection* [emphasis added], and as a direct result of Holly's circumstances, *identifying and dealing with victims who have a learning disability, understanding and arranging mental capacity assessments, understanding and applying professional curiosity, at all incidents, researching and using police information to inform risk assessments and proposed actions, understanding and applying non-engaging victim procedure, the importance of good quality Public Protection Notices (the updated SCARF process) and understanding and attending MARM meetings* are now priorities for Dorset Police. Training aids are available to all officers on line and regular messages are shared through force forums. There is an expectation that staff are conversant with what is required of them when attending incidents as described within this review.

12.16 Holly was disadvantaged by assertions that she "had capacity" on the basis of questions and statements such as:

- sought information…concerning Holly's "ability to manage risks…degree of vulnerability from others and her capacity related to her ability to engage with services." (29 July 2016)
- the social worker contacted the GP and asked about Holly's "capacity to make decisions" (4 August 2016)
- "assessment and financial capacity closed as Holly declined interventions" (4 August 2016)
- "Police state they believe Holly had capacity to make unwise decisions." (17 August 2016)
- The Community Team for People with Learning Disability noted Holly's "tendency to make unwise decisions…there was no indication that she lacks capacity to make choices about her relationships and where she wished to live. She did demonstrate during conversation and via text messages that she had insight into these choices which indicated that she had the capacity to make these decisions"(DHC)[72]
- Holly's mother…"believes she has capacity to make choices but that she chose bad choices."
- it was envisaged that "Holly's capacity to make choices regarding her boyfriend" would be assessed[73]…"next meeting will be to assess capacity and any risks to Holly and check MARAC referrals." (24 August 2016)
- "Consideration was given to Holly's capacity in respect of the goals identified at the start of engagement with the OT and when new risks emerged requiring a decision." (DHC IMR)
- "…there was no concern around her mental capacity…" (Dorset CCG IMR)

12.17 Holly did not benefit from decision-specific, mental capacity assessments. This was a significant omission. ." DHUFT state that "throughout there was a principle of assumed capacity."

12.18 The urgency surrounding Holly's deteriorating circumstances was lost since no date was identified for professionals to pool their knowledge. It is not clear why police procedures concerning

[72] "Insight" is not synonymous with mental capacity

[73] The capacity to consent to sexual relations is a vexed issue: is it act-specific or person-specific? Unlike many questions concerning a person's mental capacity, questions concerning a person's capacity to consent to sexual relations largely provide a yes/ no answer. Section 27 (1) (b) of the Mental Capacity Act provides no ability to consider whether it is in a person's best interests to have sexual relations

the SCARF were not followed on 17 August given Holly's high-risk history, her learning disability and its knowledge of John's violent history.

12.19 The risks revealed during April and May 2016 did not result in any form of risk assessment. Neither was Dev's persistent harassment the subject of a Domestic Abuse Stalking and Harassment process. It is concerning therefore that during July 2016, the Foundation Trust advised staff not to respond to Holly's texts because a professionals' meeting was being arranged.

12.20 Since Holly and John were not linked via the police's SCARF process the risk to Holly was not recognised. No searching questions were asked about her ownership of multiple phones (bearing in mind the possibility that these were being taken from her), Dev's long term stalking and trespass, and her judgement/ faith in John whom she regarded as her protector. Holly had only known abusive relationships. What was the likelihood that John would have been different?

- *Give appropriate consideration to any equality and diversity issues that appear pertinent to the victim, perpetrator and dependent children.*

Dorset Healthcare University Foundation Trust noted that Holly was eligible to receive a service from the Community Team for People with Learning Disabilities and that professionals were responsive to her concerns about *not* meeting at her address. Also they made "numerous attempts" to contact Holly by telephone, texting, letters (using *easy read*) and leaving a message with her mother.

Dorset Clinical Commissioning Group confirmed that "the vulnerability of the victim and perpetrator was identified and [the GPs were] sensitive to the needs of both. If John did not attend hospital appointments, this was "followed up by the hospital or the GP by phone or letter to try and re-establish engagement."

Bournemouth Borough Council's Adult Social Care/ CTPLD revealed that the way in which information was shared with Holly was pertinent, however, "…following a partially completed Community Care Assessment, no significant further needs were identified. The assessment was partially completed as Holly was not comfortable with the service." The assessment pre-dated the social worker's awareness that Holly was in a relationship with John.

Dorset Police noted that although Holly was described as a vulnerable adult with a learning disability by other professionals this was not always recognised by those dealing with the situations that were being responded to, e.g. the control room.

12.21 Holly – a learning disabled woman in receipt of welfare benefits - lived in poverty, was frequently intoxicated, had endured successive, abusive relationships, was "socially isolated" and had an undesirable tenancy in a "chaotic" household. Professionals undertook to visit her in pairs, most particularly once John had moved in with her. Professionals' anxiety about her living circumstances was not translated into tangible action because it did nothing to address her own ambition to "feel safe." Given Holly's history – 34 recorded domestic violence incidents - there was arguably a pattern of overlooking her long term support needs.

12.22 John – a brain damaged man was known to homeless people's services and to the police for his history of domestic violence. He was estranged from his family. He did not attend to his own considerable medical problems and he drank to excess.

12.23 Holly and John experienced episodic attention from services. Neither Holly nor John benefitted from attention to mental capacity or the fact of John's violent history.

- *An understanding of the context and environment in which professionals made decisions and took or did not take actions, for example culture, training, supervision and leadership.*

Dorset Healthcare University Foundation Trust believed that staff were responsive to Holly's circumstances by limiting the likelihood that (i) her neighbours would not be suspicious or (ii) place her "at risk of harm." The OT closed Holly's case "on the advice of the Team Leader" because a referral for an OT assessment was "inappropriate."

Bournemouth Borough Council's Adult Social Care/ CTPLD acknowledged that "supervisory oversight and management appeared not to explore in enough depth or give direction in dealing with the complexity that arose with Holly…there were some management issues at the time…which have been addressed."

Dorset Clinical Commissioning Group noted that "the GP acted appropriately within the 10 minutes of the appointment time."

Dorset Police noted that they have clearly defined policies for Domestic Abuse and the expectations of officers. When the matters dealt with are clearly Domestic Abuse related this should be recognised as requiring a SCARF form. When the SCARF is not completed it is for matters that fall outside of the definition of Domestic Abuse... These incidents required a SCARF because of Holly's vulnerabilities.

Re John - Dorset Healthcare University Foundation Trust confirmed that although he was "not detainable [he was] at medium risk of harm from others due to his vulnerability." John was "signposted to housing."

12.24 The individual agencies' accounts convey little of the context and environment. A professionals' meeting became a receding aspiration even though Holly's social worker and latterly the police knew of John's history. Holly's increasing visibility and deterioration did not result in urgency in addressing her changing support needs. Holly's living circumstances were significant insofar as she was in a "chaotic" neighbourhood in which she felt "unsafe." Holly's co-operation (see 17 June) was interspersed with periods when she did not respond as professionals expected her to and claims that she required no assistance. Although there were glimpses of credible professional analysis (see 20 June), it is not clear why 10 days after a call from a concerned neighbour that social services contacted the police, that is, after the neighbour made a second call.

- *Going beyond focusing on whether policies and procedures were followed to evaluate whether or not they were sound and appropriate.*

Dorset Healthcare University Foundation Trust noted the contact with the police to undertake a "welfare check" on Holly and that the *Difficult to Engage* guidance was invoked.

Bournemouth Borough Council's Adult Social Care/ CTPLD acknowledged that although the social worker "followed an appropriate route in the *Protocol for working with adults at risk who do not wish to engage with services,* it is possible that the language and terminology regarding the MARM was not well understood by partner agencies and the safeguarding route is better understood…"

Dorset Clinical Commissioning Group recognised that the GPs did not have adequate systems in place to address domestic violence. The practice has since joined the Identification and Referral to Improve Safety (IRIS) programme[74] and has reviewed its policies.

Dorset Police acknowledged that the policy in relation to Domestic Abuse is well understood. It is the guidance in relation to Vulnerable Adults or persons with a recognised learning disability that does not seem to have been recognised in this case. It should be recognised that there is not a single recorded incident of Domestic Abuse between Holly and John recorded in this case although people clearly had concerns about John and him forming a relationship with Holly. Holly never voiced to anyone any concern regarding John. Overall there was a lack of professional curiosity by the initial call handlers and the officers attending incidents involving Holly and John. This meant that crucial information was not obtained, linked or researched to enable a credible risk assessment.

Re John - Dorset Healthcare University Foundation Trust noted that Section 136[75] of the Mental Health Act 1983 was adhered to even though, "the report had not been shared to be uploaded onto John's clinical records."

12.25 Retrospectively, the police have stated that on 17 August, officers asked the social worker whether or not a SCARF should be completed.[76] This would incorrectly imply that (i) police procedure was contingent on the request of a social worker; (ii) the police officers believed that they were attending to prevent a breach of the peace. They did not recognise the need to complete a domestic abuse report.

- *Consideration of the victim and perpetrators housing status and its impact on identifying abuse.*

Dorset Healthcare University Foundation Trust regarded professionals as responsive to Holly's anxiety about her neighbours (who she stated "were dealing drugs and made her feel anxious") and the importance of not being visited at her address. It was noted that they "displayed insight into the limitations at Holly's home to prepare a meal…her lack of possessions or equipment to create a reasonable living space."

Bournemouth Borough Council's Adult Social Care/ CTPLD noted that Holly's views about her accommodation "seem to relate to her neighbours…The neighbours did indicate…that a male had

[74] A General Practice based, domestic violence and abuse training support and referral programme
[75] Where a police constable finds a person in a public place who appears to be suffering from a mental disorder, he may remove him to a place of safety. The constable must be of the opinion that the person is in need of care and control and that removal is necessary in that person's interest or for the protection of others
[76] This is not police procedure

moved in with Holly but as a private tenant there was no role for the ASC," that is, there was not believed to be scope for liaising with housing officers for example.

Dorset Police acknowledged that the address was well known and was having an effect on Holly who made several complaints about her neighbours. There were numerous calls for attendance at Holly's address and repeated attendance led to a "fire-fighting" approach. [77]

Re John - Dorset Healthcare University Foundation Trust was aware that he had been "homeless on a long term basis and …known to the homeless team with whom he chose not to engage." The Trust acknowledged that John's homelessness might have been a consideration in his association with Holly. Also, the Trust acknowledged the possibility that John was "drawing attention to himself, possibly to gain accommodation either in custody or in hospital."

Dorset Clinical Commissioning Group noted that the GP working with John "supported him with his housing requirements taking his wishes into consideration and arranging for a contact with the housing officer."

12.26 Holly was disadvantaged by having a tenancy in a substandard, multi-occupancy house. Professionals took no action to address her feeling of being unsafe. Her flat was accessed via windows, as well a front door, and she felt plagued by her neighbours.

- *Consider especially any working arrangements regarding how out of hours contact is shared back into daytime services.*

Dorset Healthcare University Foundation Trust noted that the Court Diversion Schemes and Criminal Justice Mental Health Liaison Schemes could not "respond to a request for an appropriate adult [for Holly] due to insufficient staff being available…" and the CTPLD was updated accordingly. Also, the Single Combined Assessment of Risk Forms "were not accessible to the Liaison Schemes at the time of Holly's murder."

Bournemouth Borough Council's Adult Social Care/ CTPLD stated that "the Out of Hours Service will in most circumstances fax information relating to their contact with a client to Care Direct…[which] will then update this information to RAISE or generate a new alert if the individual does not have an allocated social worker. Where there is [one] both they and their manager will receive an automated notification…and it is their responsibility to open RAISE and review." Holly had a single involvement with the Out of Hours Service within the Review's timeframe that hinged on a request for an appropriate adult after her arrest. "Out of Hours were not able to fulfil this function…as no staff were available…Adult Social Care reported that…[this] was a single incident and…very rare that the Out of Hours Service is not able to fulfil its contract."

Dorset Clinical Commissioning Group stated that "there is a robust information sharing system in place between the GPs and Out of Hours."

[77] The Neighbourhood Policing Team undertook longer-term problem solving with other agencies including housing and community safety which led to this *house of multiple occupancy* being closed down

13 The Conclusions

13.1 During 2010, a police reviewing officer wrote of Holly's circumstances, "…this is the very type of scenario which has the potential to end in domestic homicide," that is, officers anticipated that Holly might be killed by a partner in the future. Holly was disadvantaged by being labelled as "difficult to engage" although the evidence for this is not compelling. On two occasions she was discharged from services in the knowledge that she had a learning disability; she was at "medium risk of harm from others;" her accommodation was associated with anti-social behaviour, drugs and prostitution; and she told professionals that she did not "feel safe." It does not appear that she benefitted from anyone setting out for her the characteristics of healthy, acceptable and safe relationships.[78] It would appear that since public services failed Holly in terms of keeping her safe, she relied on her most recent partner.

13.2 "Coercive control" indicates that women will typically seek help when their immediate safety is threatened but will then step back once that appears to have been addressed. This "stepping back" may adversely shape organisational thinking and the consequent response of front line staff.

13.3 The existence of different approaches to responding to domestic abuse, with different interpretations and implications for practice across Dorset's local authorities, placed a heavy burden on practitioners across sectors. Neither urgency nor direction for multi-agency working is evidenced from Holly's experience. How can professionals be expected to process and judiciously integrate practice when their practice decision-making is shaped by different protocols and guidance, the evidence basis of which is not known? Safeguarding procedures were not invoked. Although no single organisation nominated pan-Dorset procedures in the recommendations, that is necessary if interventions are to be effective.

14 Lessons to be Learned

14.1 In terms of Effective Practice:

Dorset Healthcare University Foundation Trust states that the *"IMR has evidenced that the CTPLD provided a good service to Holly. This was demonstrated by:*

- *Giving consideration to Holly's mental capacity*[79]
- *The potential for previous MARAC referrals was investigated* [80] *Considerable evidence of joint working with other agencies and via MDT*
- *Plan to use the MARM process*

[78] See for example, O'Connell-Higgins, G. (1994) *Resilient Adults: Overcoming a Cruel Past,* San Francisco: Jossey-Bass Publishers; and Lawrence-Lightfoot, S. (1999) *Respect: An Exploration* USA: Perseus Books

[79] Giving consideration is not enough. The Trust should have established whether or not Holly had capacity to make particular decisions. It did not do so

[80] What did this achieve? A 'yes' there were previous referrals? It would have been more helpful to know what the outcome of the referrals was in terms of managing the risks to which she had been exposed

- *Attempts to engage with Holly's mother* [81]
- *Listening and responding to Holly's requests, to meet away from her property and to dress down to avoid suspicion from neighbours*
- *Professionals demonstrated tenacity in making numerous attempts to contact Holly, using a variety of methods of communication."* [82]

14.2 Additional information provided during October 2017 stated that having secured advice from Dorset County Councils' Mental Capacity Act team, *They have confirmed that the presumption of capacity is the first principle and that this doesn't have to be documented…a formal assessment of capacity wouldn't be needed unless there was a reason to suspect that that there was an issue with the person's ability to make a decision…one would be indicated if the person's behaviour or circumstances cause doubt as to whether they have the capacity to make a decision. This could be applicable to Holly as she chose to remain in accommodation that was known to be "risky"…professionals may have a view about a person's capacity to make a decision even with minimal contact.*

14.3 This explanation is not reassuring. The Mental Capacity Act 2005, requires that the incapacitated person must be unable to understand the reasonably foreseeable consequences of deciding one way or another and of failing to decide (S.3 (4)). This includes the reasonably foreseeable risks and benefits flowing from the various decisions possible, or of failing to make a decision. No agency explored Holly's wishes, choices and decision-making in situations of significant and growing risk. While the presumption of capacity was followed without question the wider duty of care to Holly was not considered.

14.4 Preston Shoot[83] notes the failure of mental capacity assessments to consider executive capacity, that is,

…even when an individual appears to have a good understanding of the potential consequences of decisions this does not mean that they necessarily have the ability to follow through with actions to effect change…Safeguarding Adult Reviews have found a failure to assess situational capacity and undue influence (p58).

14.5 **Bournemouth Borough Council's Adult Social Care/ CTPLD** stated that "despite the lack of engagement and refusal of service by Holly, it was evident that the social worker continued their best to maintain contact through texting, arranging to meet in alternative locations in line with the *Protocol for working with adults at risk who do not wish to engage with services…*[and also persisted] in arranging welfare visits when concerned about Holly's immediate safety.

14.6 **Dorset Healthcare University Foundation Trust** noted the importance of (i) identifying a timescale with in which a MARM (a process that is now widely known across Dorset as multi agency training is provided) should occur and (ii) reviewing risk assessments "promptly in response to a

[81] How many? More credible would be "Having attempted to engage with Holly's mother via telephone messages on (i) her landline (ii) her mobile (i.e. X were left on dates Y&Z), letter (i.e. x were sent on dates Y&Z) and email (i.e….) visits were undertaken on (xy&z) and notes left

[82] How many attempts in total? How many of the attempts used easy to understand language?

[83] On self-neglect and safeguarding adult reviews: diminishing returns or adding value? *The Journal of Adult Protection* (2017) 19, No.2, 53-66

change in circumstances." Also, the Criminal Justice Liaison and Diversion Service require access to the SCARF and methods for these services to share information with CTLD remains to be developed.

14.7 Dorset Healthcare members of the learning disabilities team's interpretation of Holly's mental capacity is that a Mental Capacity Act assessment was not required as there were no indications that she did not have capacity…The team did not consider [Holly's] change of mind to be an indicator of lack of capacity[84]…there should have been clear documentation to reflect the team's view that no formal assessment was required as the concerns were not deemed sufficient to cast doubt on Holly's capacity.

14.8 **Dorset Healthcare University Foundation Trust** identified the following **lessons learnt re John**, assessments completed by the Mental Health Team which have been completed Out of Hours should "become routine." However, the local authority Out of Hours Services do not have any administrative support…to notify a person's GP. Also, "risk to others was not recorded as part of John's Mental Health Act assessment" and S.136 records should "be shared and uploaded so that legislative requirements are fulfilled."

14.9 **Bournemouth Borough Council's Adult Social Care/ CTPLD** proposed the possibility that the focus of the social worker and supervising manager on the *Protocol for working with adults at risk who do not wish to engage with services,* closed off the consideration of more timely approaches "such as MARAC….Adult Social Care is "clear regarding the status of a MARM…it is possible that culturally [it] is not well understood as a safeguarding enquiry meeting…There was an oversight in relation to risk assessments…the focus was on getting agencies to attend a MARM rather than getting a MARAC referral completed or interim risk management plan in place…supervisory managers did not guide the social worker to create an interim plan or explore other options in their management capacity…the social worker and their supervisory managers were repeating the same unsuccessful route to achieve a risk management plan…"

14.10 **Dorset Police** acknowledge that "the risk presented to **Holly** from **John** was not fully recognised as no one actually establishes that he is now living with her and involved in a relationship. The risk was somewhat masked by the involvement of Dev …which came back to the fore on 11/09/2016. The investigation into these threats seemed to indicate that John was a protective factor in supporting Holly."

14.11 **Dorset Police** also highlighted the lesson arising from "the general chaotic nature of [Holly's accommodation] block where neighbours are constantly falling out with each other and repeated calls for anti-social type crimes and it is easy to see how the situation becomes confusing and difficult to differentiate between victims and suspects."

14.12 **Dorset Police** acknowledged that during the joint visit on 17 August to **Holly**'s accommodation, they spoke to **John** "but did not link him with the occurrence and so police systems did not identify him as living at the address or as being a serial perpetrator of Domestic Abuse against four previous partners. Had this background been identified then consideration would have

[84] "Unwise decisions are specifically mentioned in the MCA [Mental Capacity Act] (S.1(4)). These do not indicate a loss of capacity (although repeated unwise decisions may call capacity into question)" Office of the Public Guardian (2017) *Safeguarding Strategy: Protecting People at Risk*

been given to…disclosure to Holly which would have given her an informed choice…the same visit lacked clear control by one agency …there were clearly some concerns about **John** that don't appear to have been acted upon by either agency." Dorset Police questioned the adequacy communications from social care.

14.13 Since Holly's murder, the SCARF has been replaced by a Public Protection Notice; a Detective Sergeant works 24/7 in the Force Command and Control leading on intelligence development for incidents. This work is supported by the Risk Management Unit that researches police information systems for relevant background information that is shared with officers attending an incident; the completion of a *Public Protection Notice Domestic Abuse Stalking and Harassment* is a mandatory requirement for all domestic abuse incidents; training has been delivered, including training on the National Decision-Making Model; there are analysts and researchers identifying repeat victims and offenders; there is a Adult Safeguarding Team; the MARAC process has been developed to instigate a MARM for repeat MARAC cases and complex cases; and a *Lessons Learnt Bulletin* is published regularly. This includes the learning arising from Domestic Homicide Reviews.

14.14 In addition, Dorset police is implementing the NPCC and College of Policing National Vulnerability Action Plan 2017 – 2019. This is aimed at supporting police forces to operationalise seven themes;

1) early intervention and prevention
2) protecting, supporting, safeguarding and managing risk
3) information, intelligence, data collection and management information
4) effective investigation and outcomes
5) leadership
6) learning and development
7) communications.

14.15 Holly's learning disability appears to have been downplayed from the point of the psychologist's assessment just eight months before her murder. Arguably also, the determination that her learning disability was "mild" may have led professionals to believe that she was wholly responsible for her living circumstances and her long-standing reliance on alcohol and, latterly, possibly drugs. (Holly's GP recorded *a new relationship where there was a history of drug abuse.)* A learning disability is defined by three core criteria: lower intellectual ability (usually an IQ of less than 70), significant impairment of social or adaptive functioning, and onset in childhood. Learning disabilities are different from specific learning difficulties such as dyslexia, which do not affect intellectual ability (p.6).[85]

14.16 With reference to Holly's mental capacity, Section 2(1) of the Mental Capacity Act 2005 states:

For the purposes of this Act, a person lacks capacity if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.

[85] Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges NICE guideline Published: 29 May 2015, nice.org.uk/guidance/ng11

Section 3 (1) states:

For the purposes of Section 2, a person is unable to make a decision for himself if he is unable –

(a) to understand the information relevant to the decision
(b) to retain that information
(c) to use or weigh that information as part of the process of making the decision, or
(d) to communicate his decision (whether by talking, using sign language or any other means).

14.17 Although all services used the language associated with the Mental Capacity Act, none demonstrated credible working knowledge. It is not clear from the "lessons to be learned" that Holly would receive the sustained attention of all services or even a mental capacity assessment in 2017-18. As the House of Lords Select Committee (2014) concluded:

The presumption of capacity…is widely misunderstood by those involved in care. It is sometimes used to support non-intervention or poor care, leaving vulnerable adults exposed to risk of harm. In some cases this is because professionals struggle to understand how to apply the principle in practice. In other cases the evidence suggests the principle has been deliberately misappropriated to avoid taking responsibility for a vulnerable adult (p8).[86]

14.18 Holly's nomadic lifestyle and her perception of her "prying" family meant that she was critically unsupported when she most needed help. It was acknowledged that Holly had been subjected to hidden violence in her own home for many years. She was "socially isolated" (18 May 2016) unable to enlist the help of others since she was perceived as "difficult to engage.[87]" In the light of descriptions of Holly in terms of: *unable to hold tenancy without support* (June 2016)…*concern raised regarding coercion* (29 July)…*risk of harm from others raised from low to medium* (4 August)…*may need an appropriate adult* (20 August), and although a multi-disciplinary team meeting satisfied the requirements of Dorset Healthcare University NHS Foundation Trust's Guidance,[88] there were no tangible benefits for Holly. She continued to be pursued and harassed by Dev.

14.19 Holly's circumstances reveal an under-developed approach to responding to domestic violence across the statutory sector. Although she felt "unsafe" she remained in her tenancy, professional responses were not characterised by urgency or credible collaboration and her "case" was closed to the Community Team for People with Learning Disabilities.

15 Recommendations from the Review –

[86] House of Lords Select Committee on the Mental Capacity Act 2005: Report of Session 2013-14, *Mental Capacity Act 2005: post legislative scrutiny* HL Paper 139, London: The Stationery Office Ltd
[87] Holly's family are saddened that services were unaware of how to work with Holly. The acknowledge that she was *a private person,* but cannot understand why not thought was given to engaging with her in different and more imaginative ways
[88] Dorset Healthcare University NHS Foundation Trust (2014) *Guidance on difficult to engage patients or patients who do not attend appointments in secondary care (Mental Health and Learning Disability Services)* Version Number 8

15.1 **Dorset Healthcare University Foundation Trust** identified:

- Every question with the Mental Health Act (MHA) assessment should be completed and uploaded to provide a comprehensive report on the all aspects that have been assessed, including risk to others.
- Health staff should have a checking mechanism in place to ensure that all assessments that are completed as part of a MHA assessment are uploaded onto clinical records.
- A protocol for sharing information between out of hours services and in hours services for patients subject to MHA assessment who are not known to services is developed.

15.2 **Bournemouth Borough Council's Adult Social Care/ CTPLD** identified

Request to be made to change the Pan Dorset Safeguarding Procedures to strengthen the role of the MARMM, in particular:

- All elements of a person's circumstances should be considered as part of a MARMM, including living arrangements
- All parties invited to meetings to provide information even if they cannot attend and to receive full minutes from the meeting subsequently
- Each MARMM clearly identifies a lead agency/ co-ordinator role to ensure continued oversight of the case.

- Amendment to "Protocol for Working with Adults at Risk" should be reviewed and amended by Policy and Service Development to consider all issues that may affect/ impact upon an individual's ability to engage, including coercion and control, fluctuating capacity (both substance misuse and disability) and their understanding of the situation(s) due to learning disability/ cognitive function.

- The trainers of MARAC procedures should advise practitioners to use the DASH tool to evidence and inform professional judgement. If high risk is identified a MARAC should always be made.

- Annual refresher training for ASC staff should recommend the use of the DASH tool to evidence and inform professional judgement.

- Case notes must be clear, consistent in tense and state rationale in case recording why a course of action has been taken or rejected.

15.3 **Dorset Clinical Commissioning Group**

- Primary care to engage with multi agency meetings including timely provision of reports to inform the meeting if requested. If primary care is unable to attend the meeting the outcome of the meeting should be confirmed and recorded on the patient's records.

- There is a plan in place within the CCG to increase the awareness of domestic abuse and the requirements of primary care to address this, which will include facilitated sessions around identification, assessment and referral as well as identifying a domestic abuse "lead" in each surgery who will disseminate information and champion awareness within the practice.

15.4 **Dorset Police**

- Reinforce guidance concerning how external agencies raise alerts to Dorset Police.[89] In addition, police officers dealing with domestic abuse events which also involve adults with considerable support needs, should be guided by refreshed procedures informed by knowledge and skills. Since accountability for all professions is expressed by a commitment to demonstrating that practice is effective, "Holly" will feature in police and multi-agency learning events.

15.5 The Panel Meeting discussion on 1 August 2017 determined that:

- the issue of low awareness of the Mental Capacity Act 2005 among professionals remains to be addressed.
- A poster campaign targeting the parents and siblings of people who are receiving controlling texts and are believed to be at risk of physical assault may have promise
- there was merit in ensuring that other adults known to the Community Team for People with Learning Disabilities whose relationships render them at risk of harm are prioritised by all agencies.

15.6 Although the social worker was troubled enough by the content of Holly's Facebook to contact Holly's mother, it is not clear that there was routine monitoring of social media. This would appear to be credible practice regarding a woman who is perceived as "non-engaging."

15.7 During September 2017, the review author identified topics for agencies to consider shaping into recommendations for action. These have been drawn together into a single action plan by the CSP Lead.

1) a pan-Dorset, evidence based approach to domestic abuse is adopted which puts victim safety at the centre, reduces bureaucratic fragmentation and uses consistent names for services, for example community team for people with learning disability
2) a repeat, "High risk" victim of domestic violence should always trigger a referral to a Multi-Agency Risk Assessment Conference
3) since the *Single Combined Assessment of Risk Form* /PPNs system, procedures and training did not work, Dorset Police need to set out what has changed since Holly's death[90]
4) a credible, pan Dorset approach to risk assessments is adopted
5) there is an audit of all referrals into the Multi Agency Risk Assessment Conference
6) the proliferation of approaches and protocols is "reality-checked" by women with experience of domestic violence and families with experience of attempting to protect their relatives
7) the agencies that had supported Holly re-visit their protocols concerning non-engagement. Holly sent texts (which a clinical manager advised should be ignored), had a Facebook account and rang the police for help – and yet was described as "non-engaging"
8) the combination of having a learning disability and being subject to domestic abuse should automatically result in a SafeLives Risk Assessment, that is to say, an evidence based approach and credible assistance
9) there is purposeful exploration with women with learning disabilities of the characteristics of a reciprocal and loving relationship. It is not clear that Holly had any support in this area

[89] At the end of the review process the police reviewer made a single reference to a MASH. This information was subsequently confirmed to be incorrect

[90] The changes are set out in the *Lessons Learnt*

10) the support of women whose circumstances are seen as so dangerous that professionals visit in twos and/or require police attendance is routinely prioritised
11) a pan-Dorset approach is adopted to respond to men with known medical problems and/or brain injuries and substance abusers who are also known to be dangerous[91]
12) information about repeated visits to addresses associated with anti-social behaviour and domestic abuse is triangulated with data held by Adult Social Care, the NHS and housing providers

The Appendices set out the action plans which include these recommendations.

[91] See for example www.brainline.org/article/substance-abuse-and-traumatic-brain-injury; www.ncbi.nlm.nih.gov/pmc/articles/PMC1315633/; www.mja.com.au/system/files/issues/178_06_170303/kha11095_fm.pdf; http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.670.2174&rep=rep1&type=pdf; (accessed on 18/2/18)