A Domestic Homicide Review into the Death of Adam

Executive Summary

A report for the Chiltern and South Bucks Community Safety Partnership and Wycombe Community Safety Partnership

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I would like to express my sincere condolences to the family and friends of Adam.

I also extend my gratitude to the professionals, agencies and panel members who supported me through this Review by giving their time, commitment and persistent attention to detail throughout the Domestic Homicide Review.

[1] MARAC – Multi Agency Risk Assessment Conference

REPORT INTO THE DEATH OF ADAM

Report produced by Gillian Stimpson, Independent Consultant, Lime Green Consultancy Services Ltd on behalf of South Bucks and Wycombe District Councils

Date 19th July 2016

1. ***INTRODUCTION***

This report of a domestic homicide review examines agency responses and support given to Adam, a resident of High Wycombe prior to the point of his death on 22nd August 2015.

The review will consider agencies contact/involvement with Adam (deceased), Tracy (ex-partner and initially charged with conspiracy to murder but later changed to murder).

The case also involves Darren (friend of Tracy and charged with conspiracy to murder but later changed to murder) and Samantha (short term partner of Adam at the time of his death). The review will cover the period from August 2014 to 22nd August 2015. In addition, there is reference to Mark, who was charged with Adam's murder. After the review was commenced the decision to concentrate only on Adam and Tracy was taken as the other listed acquaintances had little information available that had any impact on the review.

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

1.1 Terms of Reference

Purpose of the review

The purpose of the review is to:

- Establish the facts that led to the homicide on 22nd August 2015 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked individually and together to safeguard the victim of the homicide.
- Identify what those lessons are both within and between agencies; how and within what timescales they will be acted upon and what is expected to change as a result.
- Establish whether the agencies or inter agency responses were appropriate leading up to and at the time of the incident in High Wycombe.
- Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the review process.

Specific issues to address

- Was there evidence of a risk of serious harm to the victim or perpetrators that was not recognised or identified by the agencies in contact with the victim and/or perpetrator?
- Was information or were any opportunities available that might have identified that there was a serious risk of harm to either the victim or perpetrator that was not shared with other agencies?
- If information or opportunities were available and shared were they acted upon in accordance with the agencies' recognised best professional practice?
- Did any agency or professional feel the need to escalate a concern and were the right policies in place for escalation and were they followed?
- Did the MARAC correctly identify and manage the risk with both victim and perpetrators in this case?

- What services did the victim have contact with? If no known connections is there a need to promote/raise awareness of local provision?
- Does the homicide appear to have any implications or reputational issues for any of the agencies or professionals?
- Does the homicide suggest that national or local procedures or protocols may need to be changed or are not adequately followed or understood?

Domestic homicide reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

The full Terms of Reference are at Appendix 1

1.2 Timescales

This review began on 10th September 2015 and was concluded on 19th July 2016.

1.3 Confidentiality

The findings of each review are confidential. Information is available only to participating officers/professionals and their line managers.

1.4 Dissemination

- Thames Valley Police
- Chiltern Clinical Commissioning Group
- Buckinghamshire Healthcare Trust
- Frimley Health NHS Foundation Trust
- South Central Ambulance Service
- South Staffordshire and Shropshire Healthcare NHS Foundation Trust – STARS Service (OASIS)
- L&Q Housing
- Oxford Health (Area) Mental Health Team
- Buckinghamshire County Council – Children and Adult Services
- Wycombe Women's Aid – Independent Domestic Violence Advocate (IDVA)
- South Bucks District Council
- Wycombe District Council
- SMART
- National Probation Service
- Family

2. EXECUTIVE SUMMARY

2.1. ***The Review Process***

This summary outlines the process undertaken by the South Bucks Domestic Homicide Review Panel in reviewing the murder of Adam.

Mark, Darren and Tracy were charged with murder and conspiracy to pervert the course of justice. In addition, Mark was charged with possessing a bladed article in a public place. The trial started on 26th January 2016 at Reading Crown Court. All three pleaded not guilty to all charges.

On Wednesday 16th March, after a 7-week trial, Tracy, the ex-partner of Adam, was found guilty of his murder along with perverting the course of justice, being sentenced to life imprisonment with a recommendation of serving 20 years. Mark was found guilty of murder, perverting the course of justice and of carrying a bladed article. He was sentenced to life imprisonment with a recommendation of

serving 25 years. Darren was found guilty of manslaughter and not guilty of perverting the course of justice. He was sentenced to 10 years' imprisonment

The process began with an initial meeting on 8th October 2015 of all agencies that potentially had contact with Adam prior to the point of death.

Agencies participating in this case review are:

- Thames Valley Police including MARAC
- Chiltern Clinical Commissioning Group
- Buckinghamshire Healthcare Trust
- Frimley Health NHS Foundation Trust
- South Central Ambulance Service
- South Staffordshire and Shropshire Healthcare NHS Foundation Trust – STARS Service (OASIS)
- L&Q Housing
- Oxford Health (Area) Mental Health Team
- Buckinghamshire County Council – Children and Adult Services
- Wycombe Women's Aid – Independent Domestic Violence Advocate (IDVA)
- South Bucks District Council
- Wycombe District Council
- SMART
- National Probation Service
- Family
- A Private Landlord was contacted but unwilling to engage.

Agencies were asked to give chronological accounts of their contact with the victim prior to his death. Where there was no involvement or insignificant involvement, agencies advised accordingly. Each agency's report covered the following:

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

The accounts of involvement with this victim cover different periods of time prior to their death.

Some of the accounts have more significance than others. The extent to which the key areas have been covered and the format in which they have been presented varies between agencies.

A request was sent to 25 services and agencies and, of the 25 sent, responses were received from them all. In total, 12 agencies have responded as having had no relevant contact with either the victim or the suspect or with any children involved. These included:

Community Rehabilitation Company; Paradigm Housing, Red Kite Housing, Wycombe District Council Housing and South Bucks District Council Housing; South Bucks and Wycombe District Councils' main services and Antisocial Behaviour teams; Buckinghamshire Youth Offending Team; Prison Service (HMPs Aylesbury and Grendon); Solace/SARC (Sexual Assault Referral Centre); Rape Crisis and Victim Support.

13 have responded with information indicating some level of involvement with the victim and/or perpetrator: These are Thames Valley Police; National Probation Service, L&Q Housing; Buckinghamshire County Council Children and Young People Service; Wycombe Women's Aid- IDVA Service; Oxford and Frimley Health NHS Foundation Trusts; Buckinghamshire Healthcare Trust; South Central Ambulance Service; SMART; OASIS (STARS); Connection Floating Support and Adult Social Care.

The police report shows there were 22 domestic incidents between Adam and Tracy since 2011. During the period of the review there were 30 occasions between August 2014 and 22nd August 2015 when the police had contact with both Adam and Tracy. These included incidents where they were both the victim and the perpetrator and several general contacts not specifically relating to abuse.

2.2 Equality and Diversity Statement

This diversity statement was written following consideration of The Equality Act 2010 which came into force on 1 October 2010 to legally protect people from discrimination in the workplace and in wider society. The Equality Act 2010 replaces all existing equality laws with one single act, making the law easier to understand for individuals and strengthening protection in some situations.

Adam- (the deceased) was a white British National. He was 26 years old at the time of the homicide. He had no known physical disability but in custody he did claim he needed help reading and had dyslexia. He did however, suffer from bouts of depression and anger caused using drink and drugs which was identified by Mental Health services. Oxford Health did not diagnose any significant mental illness but suggested a dissocial personality disorder that required further investigation. This did not take place before his death. There is no suggestion that any of these concerns impacted on Adam's understanding and ability to function daily and Oxford Health considered Adam capable of making decisions around his health.

Tracy- (the perpetrator) is 36 (at the date of this report) and is also a white British National. Tracy does not have a physical or learning disability. Adam and Tracy were not married but were in a relationship for approximately 6 years. Tracy is the mother of 3 children from previous relationships who were no longer in her care.

Neither Adam nor Tracy had/have ever undergone any gender reassignment.

Adam and Tracy's religion was not recorded by any agency

There is no evidence that Adam or Tracy were directly or indirectly discriminated against by any agency based on the nine protected characteristics of people who use services under the Equality Act 2010 e.g. Disability, Sex (gender), Gender reassignment, Pregnancy and maternity, Race, Religion or belief, Sexual orientation, Age, Marriage or Civil partnership.

2.3 Family and Friends

Involvement in the Review

Attempts have been made through the Thames Valley Police Family Liaison Officers to engage with Adam's father and Samantha who was his current girlfriend. Letters were delivered to them with contact details and offers of a variety of ways that communication could be made. Adam's father has been approached a couple of times but at the time of this Review being completed has chosen not to engage. Samantha has said she does not want to be involved or contacted. Once completed further attempts to engage with the family will be made prior to the publication of the report.

Adam's Paternal Grandmother agreed to be contacted by email and to give her thoughts. She attended the 7-week trial on a daily basis. Adam used to live with her in Scotland.

She provided the review with a statement as follows:

> *Hi Gillian*
>
> *Thanks for the email. I am glad with the verdict that the 3 got. I know it won't bring back my grandson but I am glad they have not got any freedom. I did not know Tracy but heard plenty about her. Also Adam used to say he wanted to get on with his life but she kept pestering him.*

But is that the reason she got someone to kill him as she did not want him to go with anyone but herself?

But to be honest I feel it for their family as it is not just us that is suffering – it is the other three families – so sad.

**** and *** were very good to us and also *** in fact everyone. And for the jury they did well and my heart goes out to them as well as this will be with them for a long time.*

Also I have good memories of Adam in the 21 years he was in Scotland. As I said thanks for the email and bless you all xx

Family and Friends of Adam

Adam has a brother and sister and it is understood he did not have a strong relationship with them. His mother is living in Scotland and it is believed that Adam thought she had died and he had no links with her. Adam's father lived locally and they had a reasonable relationship with Adam often staying with him for short periods. Adam's paternal grandmother had good links with Adam. Adam had two sons who did not live with him but in Scotland with their mother, who is the estranged wife of Adam and has no contact with Adam.

Adam was not working and the Review is not aware of any friends other than those involved in the Review.

Tracy

The review has not established if Tracy has any siblings or parents still alive. There weren't any members of her family at the trial. Tracy has had three sons, none of whom were in the care or custody of Tracy. The Police had no contact with any relatives during their investigation.

The eldest son lives with long term foster carers in Hillingdon. It is believed that he is now 18 years old.

Tracy lived with Mark several years ago and they had a child, who is the middle son and at the time of the homicide lived with his birth father, Mark. He had recently reconnected with Tracy but was not living with her.

The youngest, born in 2003, was placed with his step father through a special guardianship order made on 15th December 2011.

At the time of the murder Adam was seeing Samantha as his girlfriend. Samantha had recently split up from John and she was soon to be a MARAC referral because of domestic abuse by John.

Darren was a friend of Tracy often staying with her. The nature of the relationship they had is unknown.

Tracy did not work.

3. KEY ISSUES ARISING FROM THE REVIEW

This domestic homicide, and indeed in the lead up to the death of Adam, has been a very complex and sad case. Within their relationship both Adam and Tracy experienced being both a victim and perpetrator of domestic abuse. It was recognised in the review that they could not live together but equally could not live apart from each other. Both had experienced mental health issues and were also users of drugs and alcohol.

On occasions, incidents including assaults, thefts and abuse would be reported but then very often, when the police arrived, they would refuse to give statements or withdraw their complaint and on one occasion

they were then found hand in hand denying any problems. On another occasion, Tracy said she had lied about the report she had made.

Adam was admitted to Whiteleaf Hospital as a voluntary patient for mental health issues. He is recorded by mental health services as being an 'inconsistent historian' requiring further assessment in relation to a personality disorder. Similarly, there is evidence in the review of Tracy telling Adam several times that she was pregnant when she was not.

Both also used drugs illegally and as a result both had visits to accident and emergency departments for drug overdoses and Adam for allegedly swallowing bags of heroin.

The Review Panel received very comprehensive IMRs from the agencies that had significant engagement with both Adam and Tracy. The Panel identified a number of key issues throughout the review which will be referenced in the following paragraphs. The Panel is however very keen to emphasise that one of their overriding observations was with the continuing support and contact all the services had with both Adam and Tracy as well as the improvements identified during the review process that can be made within services.

These were clients that challenged the services they were in contact with. Both failed to attend appointments, could be very difficult to deal with, had substance and mental health issues and were considered to place significant demands on services. There is strong evidence of the tenacity of the practitioners involved to support both individuals despite difficulties in engaging with them.

The key issues that arose from the Review, other than those raised for individual agencies are:

- Complex nature of case – Mental health, substance abuse and the links domestic abuse (perpetrator vs victim and vice versa)
- Gender issue – the difference between a male and female victim of abuse – is this fully recognised by agencies?
- Communication – in particular information available to health professionals; letters sent to GP and the lack of multi-agency meetings
- Registering at a GP surgery
- MARAC – referrals and re-referrals – who should refer?
- The grading and changing of grading of risk for domestic abuse victims
- Recording of information
- Policies and procedures

3.1 Complex nature of case – Mental health, substance abuse and the links domestic abuse (perpetrator vs victim and vice versa)

These three issues often co-exist as they did in this case, and when they do are very complex.

The 2010 Department of Health report, *Confident Communities, Brighter Futures: A framework for developing wellbeing*, defines good mental health as 'a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community'.

AVA – Against Violence and Abuse[2] refers to this matter in its training package for Complicated Matters - Domestic and Sexual Violence, Problematic Substance Use and mental ill-health as follows:

> ***A toxic trio?***
>
> *The past few years has seen an increased awareness of the frequency with which domestic and sexual violence, problematic substance use and mental ill-health co-exist, particularly in the context of safeguarding children and young people.*

The Review identified that when these three things exist it makes it very difficult to engage in a meaningful way with both perpetrators and victims. This was particularly the case in this Review as both were penetrators and both were victims.

SMART referred to Adam as being a 'revolving door client' as he was known to the treatment system and had multiple and complex needs and frequently linked to the criminal justice system. Typically, clients with a similar presentation have chaotic patterns of drug use and can often respond better to light touch treatments involving harm reduction through targeted proactive outreach. The review found examples where Tracy found it difficult to get to appointments because of the area these appointments took place in. She was concerned on occasions she would have to meet those who have supplied drugs to her and so be tempted to use again. SMART has recognised this problem and has started a new Open Access and Outreach Service which is able to go to locations nearer to their clients.

This case was further complicated by this issue as both Adam and Tracy both had substance misuse problems, both were being treated for mental health issues and both were the abuser and the victim of domestic abuse.

A Report called 'Preventing Domestic Violence and Abuse: Common Themes and Lessons Learned from West Midlands' DHR[3]s by Dr Lucy Neville and Dr Erin Sanders-McDonagh With Vivian Latinwo-Olajide, George Lewis, and Hayley Tustin[4] contains sections on Complex Needs of Perpetrators and Failure to engage with services offered (Pages 39 – 43). This report highlights that is vital to ensure people requiring support from more than one service get coordinated and consistent responses and appropriate priority from a range of agencies.

The Review has established that whilst in most cases there was good engagement and coordination between a wide range of services to support both Adam and Tracy, there were however, some opportunities where it might have been helpful to have a multi-agency meeting. This is covered below under communication.

Panel Recommendation 1

Services which deal with clients who may have links with the 'Toxic Trio' are signposted towards the e-learning package for Complicated Matters - Domestic and Sexual Violence, Problematic Substance Use and Mental Ill-Health

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[2] Against Violence and Abuse – E-learning http://elearning.avaproject.org.uk/

[3] DHR – Domestic Homicide Review

[4] Preventing Domestic Violence and Abuse - Common Themes and Lessons Learned from West Midlands http://www.westmidlands-pcc.gov.uk/media/346469/13-spcb-11-sep-14-domestic-homicide-reviews-research-appendix-2.pdf

3.2 Gender issue – the difference between a male and female victim of abuse – is this fully recognised by agencies?

Many service areas are very used to dealing with female victims of domestic abuse and are familiar with the signs and symptoms that may indicate a woman is possibly a victim of abuse. This allows the service to support the woman with appropriate services and where ever possible to enable consultation to take place without the perpetrator being present.

In the case of Adam, he was a victim of abuse on occasions but this was not identified by any service other than Thames Valley Police. He presented at the Accident and Emergency Department at Wexham Park Hospital with a cut to his head and was not given the opportunity to be seen without his partner to discuss how he received the injury as he was adamant he had caused it himself. Had Tracy presented with similar injuries, it is very likely that staff would have seen her alone and followed the flowchart displayed in the Department which covers a process to follow, if they suspect, using their professional judgement, that the injuries may be as a result of domestic violence.

Frimley Health NHS Foundation Trust recognises that whilst it is up to professional judgement to consider if injuries are likely to be as the result of abuse, it is not standard practice to routinely enquire about how injuries have been caused. The Trust is going to re-examine how the organisation supports victims who access its services and may otherwise go unnoticed.

With the drug treatment services that engaged both with Adam and Tracy, they are reliant on self-disclosure and so, whilst Tracy often referred to the fact that she was experiencing domestic abuse at times, Adam never disclosed similar information and so the services were unaware that he too was a victim of abuse.

Adam was not registered with a GP in England and only accessed a local surgery on a temporary basis and so did not build up a patient/GP relationship that may have enabled a disclosure about being the victim of abuse. The surgery was aware of the abuse that Tracy experienced but only towards the end of the review period when they were informed that Tracy was subject to a MARAC meeting. Following this information, the surgery had arranged for Tracy to be discussed at the vulnerable patients meeting at the surgery although she was arrested before this took place.

Buckinghamshire Healthcare Trust has identified that there is a need to have a space available where patients feel safe and confident to talk to healthcare professionals who would need to use their professional judgment about the best approach to allow a patient to talk to the professional without their partner being present and that does not then put the patient in further danger following the consultation. The Panel considers that both healthcare trusts should review their Chaperoning Policy to ensure that gender based domestic abuse is considered and suitable arrangements put into place to enable safe consultations.

Panel Recommendation 12

Review Chaperoning Policy to ensure that all domestic abuse victims, regardless of gender, have an opportunity to have a private consultation.

3.3 Communication – in particular information available to health professionals; letters sent to GP and the lack of multi-agency meetings

During the period of this review the DHR Panel had several discussions about the lack of patient information being shared between hospitals and health care professionals. At present, it appears there is limited information available to hospitals and other health professionals about the patients they see and

so will not know if they have been a patient at another hospital. The Panel recognised a risk of 'hospital shopping' if a patient is trying to avoid a clear picture to be seen about injuries or illnesses which they may have suffered and been treated for at another hospital. There was also concern that a perpetrator may take a victim to different hospitals to avoid questions being asked and to avoid recognition and professional curiosity of their previous attendance at a hospital emergency department. At present, there is limited information available that can be accessed by health professionals and is contained on the Summary Care Records if a patient is registered with a GP practice in England.[5] The Panel suggest for patient protection and to enable the best care to be offered to patients, there ought to be a national/central database where information can be accessed regarding hospital attendances and treatments. This is equally as relevant for any patient and not just those who may have suffered or experienced abuse.

Panel Recommendation 2

Department of Health to consider a central database for hospitals to access accurate and timely information about treatments and medications a patient has received when attending either their GP or another hospital.

The DHR Panel noted that letters were documented as having been sent to Adam's GP but he only appears to have been a temporary patient at the surgery in Beaconsfield. Adam wasn't registered with a GP in England. The GP surgery has only one record of any of these referrals and there is no evidence available to indicate where the referral letters might have been sent to. The Panel considers that GP surgeries which receive referrals letters for people who are not registered at that surgery they alert the referring agency to the fact that the person is not registered there.

Panel Recommendation 3

GP practices which receive correspondence about patients who are not registered with them should contact the sender to advise them of this.

The Panel considers that, whilst there is no real evidence of agencies not sharing information when required, there is still a need to recognise that agencies can call multi-agency meetings to discuss clients they are dealing with who are or may be working with other agencies. This joint way of working would be very beneficial not only for the clients but also the services, enabling a far better and coordinated response to be given.

Panel Recommendation 4

Any agency can arrange a professionals' meeting when there is a need for a collaborative response.

3.4 Registering at a GP surgery

Despite staff at the Surgery encouraging Adam to join the practice he declined saying he was a patient in Scotland. The Panel raised the issue of how easy it was to register if a person had learning difficulties or mental health issues and what support can be offered to help and encourage registration. The Panel were assured that help would be provided by a GP practice and/or other support services to complete the enrolment/registration form. The form can also be accessed online.

3.5 MARAC – referrals and re-referrals – who should refer?

[5] Summary Care Records - http://www.nhs.uk/NHSEngland/thenhs/records/healthrecords/Pages/overview.aspx

The Buckinghamshire MARAC Operating Protocol states the following in relation to repeat referrals: 'A repeat is defined as an incident where any of the following types of criminal behaviour has taken place within 12 months of the first referral to MARAC: violence or threats of violence, where there is a pattern of stalking or harassment or where rape or sexual abuse is disclosed.'

There were examples identified during the Review process where it was considered that a referral or repeat referral to the MARAC could have been made. This was relevant following a harassment incident in late May 2015 when the matter should have been referred back to the MARAC as the incident occurred after the initial MARAC meeting for Tracy.

There was confusion within TVP's DAIU[6] and the MASH there was some confusion as to who should be making the referral and Thames Valley Police has a service recommendation which will clarify this situation to staff.

SMART acknowledged that the MARAC referrals were timely and appropriate but has recommended that they provide in-house training to all SMART teams to ensure a broader understanding of domestic abuse and MARAC referral pathways.

Oxford Health identified during their review that a consultant dealing with Adam stated she would consider making a referral to MARAC for Tracy as a result of the domestic abuse towards her, but there is no evidence of this having been done and so may have been a missed opportunity.

There has been a concern identified by the Panel about agencies not making repeat referrals or failing to refer if they think that another agency has already made a referral. This is an issue which needs to be addressed by all agencies who come into contact with those who are experiencing abuse. If there is a concern or evidence of abuse all agencies should make a referral as each agency may hold slightly different information and so may help complete the jigsaw.

Panel Recommendation 5

Individual Agencies are responsible for submitting MARAC referrals regardless of whether other agencies have referred.

3.6 The grading and changing of grading of risk for domestic abuse victims

The grading of risk for domestic abuse victims appears to undergo three processes before the final risk grading is confirmed by Thames Valley Police. The initial officer/s dealing with an incident will make a suggestion around the appropriate grading following an incident. This seems to be generally based around what the officers find at the incident and on what is completed in the DOM5[7] form. Once officers have attended and assigned a risk grading to a domestic abuse victim, this is reviewed by their sergeant before the end of their tour of duty. The incident is again reviewed[8] by a TVP Domestic Abuse Risk

[6] DAIU- Domestic Abuse Intelligence Unit

[7] DOM5 - Domestic Abuse Risk Assessment Tool used by Thames Valley Police

[8] For all medium and high risk incidents and if there have been three incidents in the last 6 months for a standard risk incident

Assessor within the Multi Agency Safeguarding Hub (MASH).[9] They will either concur with the grading or amend it and provide a rationale as to why.

The Panel is satisfied that the gradings for Tracy were correctly undertaken and on each occasion, once she had been graded as a high risk, were always reverted back to a high-risk grading if officers attending had graded incidents at a lower risk level.

However, in respect to Adam the Panel has some concerns. The chronology identifies the incidents where Adam was the victim and in hindsight it might be recognised that the incidents and threats to Adam were intensifying and were of a nature that might have indicated some increased risk. That being said, and with the officers having experience of dealing with both Adam and Tracy and of how they often made complaints about each other but then almost instantly were back being friends, it is understandable how the threats may not have been viewed as being seriously intended by Tracy.

Examples of this increase in threats and incidents include the alleged theft of property on 21/4/15 where attending officers after completing a DOM5 in which Adam alleged that Tracy had punched him and threw things at him and tried using a meat cleaver. Adam said that Tracy was very jealous of his contact with other women. Officers graded Adam as at medium risk of harm from Tracy but the MASH downgraded this to standard risk on 22/4/15.

A further incident where it was alleged that Adam was assaulted by Tracy took place on 22/4/15. Again, attending officers graded the risk for Adam as medium and this was reduced to standard on 23/4/15 by the MASH.

The incidents against Adam quietened down after this period but then re-started in July 2015. On 23/7/15 it was alleged by Adam that Tracy had punched him in the face the night before. Later that day she had ripped up his provisional licence and threatened to 'get him killed if he went anywhere near her'. She also made threats to have him beaten up. The officers dealing with the incident graded Adam as at standard risk because when Adam was eventually seen by officers he was hand in hand with Tracy and saying, 'It's sorted'.

On 10/8/15 Adam telephoned police and reported that his ex-partner Tracy, had smashed a window at the address (a friend's address), threatened to kill Adam and his female friend (Samantha) and had hit Adam. Officers graded this incident as medium risk for Adam and it was reduced to standard risk by the MASH on 11/8/15.

On 11/8/15 hours Samantha telephoned police and reported that her ex-partner (John) had let Tracy into Samantha's room that morning (he still had a key) and they had stolen clothing and prescription medication. Tracy had threatened to kill her and to come back with more people.

On 17/8/15 Adam alleged he had been talking to his friend when his ex-partner, Tracy, was being verbally abusive towards him, she then spat in Adam's face and threw some coins in his face. Adam confirmed to officers that Tracy had punched Adam in the past and smashed glass bottles over his head; she recently smashed a pint glass over his head but Adam said that he had done it to cover for her; Tracy had tried to strangle Adam during arguments but he managed to fight her off; Tracy had threatened to kill Adam and due to her mental state, he was 50/50 on whether he believed her; Incidents had been getting worse since Adam and Tracy split a month before.

[9] There are a number of MASHs within Thames Valley Police covering the three counties. They co-locate safeguarding agencies leading to better information sharing and decision making. They receive and process all safeguarding referrals.

Officers graded this incident as putting Adam at medium risk of harm from Tracy. The MASH downgraded the risk to standard.

The DHR Panel however considers that Adam should have been recorded as being at medium risk of harm from Tracy for the last few weeks which would have resulted in Adam receiving a telephone call offering safety planning, and an IDVA referral would be made, however it is doubtful whether he would have engaged in these processes as he had demonstrated on several occasions that he would not engage with services. The Panel doesn't consider this would have affected the outcome of the murder of Adam. TVP in Buckinghamshire now operate a system called Operation Delegation. Delegation is a monthly multi-agency approach for supporting, targeting, and empowering the most prolific low and medium risk DV victims and offenders. Delegation is based on MARAC principles, used to manage the most at risk members of the community.

Several of the services linked to this Review undertake DASH assessments but it appears there were slight variations in the form used and so raised this as a concern. The Panel understands that the DASH is being reviewed by the Thames Valley Police Domestic Abuse Operational Group considering best evidence and this will then be shared with other organisations to ensure that the DASH is consistent.

3.7 Recording of information

The process of undertaking an IMR by each agency has identified a number of occasions when recording of information could be improved. STARS identified the importance of documenting risk and multi-agency communication on the clients' records following there being no record of the outcome of a MARAC meeting that was attended by the Service.

Wycombe Women's Aid recognised that notes were not recorded following group case management meeting where Tracy was discussed on 25/6/15 and so the Service has made a recommendation to ensure this happens. The Service also recognised that there was a need to record contacts and attempts at contact on a client's record.

SMART identified inadequate recording in the quality of the case notes and in the consistency of the information recorded in case notes. There were some examples in the case notes where this was not the case specifically from a student social worker working on a placement with SMART who had completed good case notes. This issue had been recognised by the service before this Review and improvement measures to help quality assure notes have already been introduced. This Review has a couple of recommendations for SMART in respect to risk assessments and record keeping.

The issue of recording of information was highlighted in the Buckinghamshire County Council Children's Services records. The IMR writer found it very difficult to find out information about children and the adults in this case. There is no cross referencing between records and so recommends that when an adult is subject to assessment in relation to their parenting and significant decisions made as an outcome that their file should hold a summary that indicates where the records are held.

Furthermore, it has been identified that there were several instances when referrals about concerns about a suspected unborn child were raised and these concerns were sent to Children's Social Care. The County Council can't find any record of these referrals and so it is recommended that a review of the process of recording and indexing information received or referrals made is undertaken by the Service to ensure that key information is recorded and acted on appropriately.

Panel Recommendation 11

BCC Children's Services undertakes a review of the processes for recording and indexing information received and of referrals made, to ensure that key information is recorded and acted on appropriately.

This review should also consider how any concerns about an adult with an unborn child are submitted to the County Council as, in a case like this, it is unclear to other services where such a referral should be made as equally it could have been made to adult social care as a concern about the mother as the child had not been born.

3.8 Policies and procedures

The Review considered whether each agency had appropriate policies and procedures in place and were satisfied that the relevant agencies had policies and procedures that were in the main appropriate to deal with domestic abuse and that they were used effectively. There were, however, some examples where improvements can be made.

The Review Panel was concerned that the Thames Valley Police Safeguarding Policy referred to in their IMR was dated 2009. This means that there will have been updated guidance and best practice which should have been considered and included to ensure that the Force is using current best practice. It does not take into account the changes in national guidance following the Care Act of 2014. The Panel was advised that national guidance for Safeguarding Adults was due to be published by the College of Policing in 2015 but that it is unlikely to be available until late 2016. Once published this will replace the Thames Valley Police's Policy. As an interim measure guidance has been drafted for the Knowzone[10] and safeguarding training for front-line staff was put into place from January 2016. This training will cover both adults and children.

Frimley Health NHS Foundation Trust acknowledged that as part of its review it was suggested that its current Domestic Violence Policy is updated in line with current legislation and good practice. The Trust highlighted that due to the short amount of time that patients are in the department it is very difficult to get a full assessment of family and environmental factors and that the domestic abuse policy and flowchart are used when health practitioners used their professional judgement if they are concerned about an injury or circumstances for being in the hospital. The trust is going to re-examine how it supports victims who access its services and may go unnoticed.

Wycombe Women's Aid has Operating Standards it works to. Each client is an individual and so the standards are there as guidance and are used as appropriate for each client. During the review the Service identified that the Service would benefit from having a check list of activities which should be carried out or followed up. This would lead to an improvement in practice, recording on clients' records will improve and the client will be ensured that all opportunities and support are offered and followed up.

SMART as part of its review referred to there being a lack of local domestic violence procedures and SLAs with local partners. However, these are under development as part of the implementation of the Complex Needs Domestic Violence Pilot Project in Buckinghamshire. SMART began running the pilot on 1/10/15. The pilot employs two IDVAs to work with complex service users across Buckinghamshire. The project aims to support service users to overcome any barriers preventing them from accessing mainstream DV services, and ultimately transfer them into mainstream domestic violence services. This has been acknowledged by the DHR Panel as a good development.

[10] Thames Valley Police Intranet page containing guidance for officers in all areas of policing

4. CONCLUSIONS AND RECOMMENDATIONS FROM THE REVIEW

This Review has been a comprehensive enquiry into how the services connected and worked with Adam and Tracy. Both had very complex needs and both were victims and also perpetrators of abuse.

The Review concludes that there are areas where services could have been better and there are recommendations within the Report which will address these areas.

Several of the services taking part in this review had multiple engagements with both Adam and Tracy. Due to their chaotic lifestyles, they were often very difficult to engage with, failed to engage consistently with services, missed appointments and were often demanding.

Despite this the Review was satisfied that the services generally were very supportive and were consistent in their engagement and provided evidence of their persistence in trying to engage with their clients.

One of the questions the review set out to find the answer to was if the death of Adam could have been predicted and therefore possibly prevented. The Panel is satisfied that the death of Adam could not have been predicted and so not preventable. The Review covers the fact that Tracy had more recently started to increase her threats to Adam. Despite this it is still the majority view of those who were aware of the violence and abuse between Adam and Tracy that despite the threats, they found it difficult to live without each other and after previous incidents they had always made up. There were also references in the Police IMR of one officer thinking that it would have been more likely that Tracy would have been the victim rather than Adam.

Tracy had been police risk assessed as being at high risk from Adam, whilst Adam was risked as being at standard risk of harm from Tracy. The Panel felt that in hindsight the risk to Adam should have been increased following the last incident and threats.

The Action Plan for the Review contains detailed recommendations for Services taking part in the Review. The Action Plan has been divided into themed areas and these include:

- County Wide and National
- Gender
- Policies and Procedures
- Training
- Information sharing and Record keeping
- Client Engagement.

5. DOMESTIC HOMICIDE REVIEW PANEL CONCLUDING REPORT

5.1 Introduction

This review report is an anthology of information and facts from 13 agencies, most of which were potential support agencies for Adam. Essentially, only 11 agencies had records of contact with Adam prior to this death. They are:

Thames Valley Police; National Probation Service, L&Q Housing; Oxford and Frimley Health NHS Foundation Trusts; Buckinghamshire Healthcare Trust; South Central Ambulance Service; SMART; OASIS (STARS); Connection Floating Support and Adult Social Care. The only report that has an account that bears any relationship to Adam's murder is the Thames Valley Police Report. This report had the last

involvement with Adam and Tracy as being on 17th August 2015, when Adam reported that Tracy had assaulted him. The officers graded this incident as putting Adam at medium risk of harm from Tracy but the MASH reviewed the incident the following day and downgraded Adam's risk to standard. Tracy had not been arrested for this offence at the time of the murder, but the reporting officer's log entry stated that he intended to arrest and interview Tracy. This officer was unavailable at the time of the report to be interviewed about this incident and investigation.

5.2. The Facts

On 22nd August 2015 at approximately 8.50pm on Church Street, High Wycombe, Adam was murdered, by Mark. This Review is complicated by the inter relationships of several of the key people.

At the time of the murder Adam was the partner of Samantha, both residing at an address in High Wycombe owned by a private landlord and which is one of several properties in the area often used to house individuals with substance misuse issues. This relationship had been in existence for about 1 month prior to the death of Adam. The premises were rented by Samantha but with Adam living with her on occasions.

The relationship between Adam and Tracey had been particularly violent and volatile for some time with both experiencing domestic abuse; both being known to drug treatment services; health services and to police. Adam is recorded by mental health services as being an inconsistent historian requiring further assessment in relation to a personality disorder. Similarly, there is evidence in the review of Tracy telling Adam several times that she was pregnant when it appears she was not. Several services had her shown as not pregnant (TVP in March and following the murder; Midwife at MARAC meeting and Oxford Health on 20/4/15 when she also confirmed she had not recently had a miscarriage) but the Police reacted to the possibility by making a referral to Children's Social Care due to concern over an unborn child. However, when latterly arrested, Tracy said she wasn't pregnant.

Tracy was considered as a high risk domestic violence victim and was referred to the MARAC in May 2015. However, more recently, there had been counter allegations by Adam and it was apparent that Adam was also subject to violence and increased threats from Tracy and that he was subsequently listed as a standard risk victim but had not been referred to the MARAC. On several occasions, he was listed as at medium risk of harm from Tracy by attending officers at incidents, however, on each occasion the grading was reduced to standard when the case was reviewed by the MASH.

On the day of the murder Adam, Samantha (Adam's current girlfriend), Tracy, Darren and John (both friends of Tracy) were at All Saints Church in High Wycombe where there is a support service that assist with providing food to the homeless community, which by the nature of the service, acts as a gathering point.

At this venue, there was an altercation between Tracy and Samantha. It is believed this incident which was quite verbal, aggressive and threatening was because of the relationship that Adam now had with Samantha. Samantha had also been in a previous relationship with John. She had been subject to domestic abuse by John and was assessed as high risk and was due to be discussed at the next MARAC meeting.

Tracy, Darren and John returned to Beaconsfield. On the way back to Beaconsfield or once back at her home address, Tracy self-harmed by scratching at her face. Once back in Beaconsfield, Tracy contacted Mark, who had been her partner about 14 years ago and was the father of her middle son. It is thought that she suggested to Mark that Adam had caused these injuries.

Tracy and Mark hadn't been in communication for many years until recently. Tracy had re-established contact with Mark's brother and sister-in-law following a chance meeting with his brother on a bus. This chance meeting had taken place over a year ago, but it was only in recent months that Mark and Tracy had begun to communicate again. It was as a result of this contact that Mark had permitted Tracy contact with their son.

As a result of the call to Mark, he made his way from Northolt to Beaconsfield. The group decided to go back to Wycombe to harm Adam. On the way to Wycombe the group went via Sainsbury in Beaconsfield where Mark was seen by staff as he tried to buy gloves. He was also seen by a taxi office, hitting his fist into his hand whilst at the railway station.

The group made their way to Wycombe and walked to Samantha's address. Adam and Samantha were not at home. Mark and Tracy went into the property into the flat and caused considerable damage. When they came out of the property, John left them to go off to obtain drugs. It is believed that Darren stayed outside.

The three perpetrators then made their way into the Town Centre. Adam was found in the Churchyard. There was apparently an exchange of words and Adam then ran off, being chased by the group, where he slipped and it was at this point that he was struck multiple times with a large knife by Mark. Whilst Tracy and Darren did not strike Adam they were nearby during the attack. Parts of this incident were captured on CCTV. Mark and Darren apparently returned to Beaconsfield but Tracy returned to another property in High Wycombe. Tracy had been wearing a distinctive green dress and she discarded this garment in a hedge nearby.

Tracy went to High Wycombe Police Station on the morning of 23/08/15 apparently to report that her ex-partner had been involved in an incident the preceding evening and that she had heard that he had died. She was arrested at the police station.

Darren and Mark went back to Tracy's address in Beaconsfield where they were arrested by police at approximately 03.30hrs.

Mark's clothing and a knife were found concealed (but not buried) in the communal garden of the block of flats that Tracy's flat is within.

5.3 Details of the Post Mortem and inquest and Coroner's inquiry

Death was confirmed at 2130 hrs on 22nd August 2015. The next day a pathologist conducted a post mortem examination. He identified at least 15 separate stab wounds, predominantly grouped down the left side of his body. Two were identified as fatal injuries. One stab wound to the area of the left shoulder cut the sub-clavicle artery causing massive bleeding. A second stab wound had punctured his lung. The cause of death was multiple stab wounds.

The Coroner's Office was contacted and confirmed that an inquest was opened and adjourned on the death of Adam[11].

[11] Where a person has been sent for trial for causing a death, for example by murder, manslaughter, infanticide or certain types of road traffic deaths, the inquest is adjourned until the criminal trial is over. On adjourning an inquest, the Coroner sends the Registrar a certificate stating the particulars needed to register the death and for a death certificate to be issued. When the trial is over and the Coroner informed of the outcome, he/she will decide if to resume the inquest. There may be no need if all the facts surrounding the death have emerged at the trial and, in such cases the Coroner will send another certificate to the Registrar of Deaths, confirming the outcome of the Crown Court trial. If

5.4 Properties linked to Review

Tracy was the sole tenant at The Flat, Beaconsfield, a property she rented from L&Q Housing. Adam stayed with her frequently but did not have any legal links to the property. During her time there, it appears she had different people staying there, including Adam, Darren and John at various times. None of these people had any tenancy rights to the property. Tracy's children did not live there as she did not have custody of them. It is believed her eldest son, did stay with her for a short period during 2015 but was not resident at the time of the murder. Mark had custody of the eldest son. The property, a room, in High Wycombe, was rented by Samantha. Again, Adam stayed there occasionally but had no direct links to the property. At times, it is believed that Adam was a rough sleeper. Adam also stayed for periods with his father at another address in High Wycombe. These were always temporary stays and Adam had no legal links to the property.

6. CHRONOLOGY

This review covers the period from August 2014 to Adam's death on 22nd August 2015. This is a particularly complex case with abuse being encountered on and by each party. Both Adam and Tracy had significant contact with a wide range of services and on a very regular basis. For this reason, the chronology is long and detailed. It is purposefully left like this to enable the reader to fully understand just how many contacts with agencies there were and the complex nature of this Review.

Chronology of Significant Events

August 2014

SMART and STARS are both engaging with Adam

19/8/14 – TVP – Domestic Assault - At 04.07 Adam complained of assault by Tracy – Police attended. **Adam assessed as standard risk.** Case reviewed by TVP and considered not appropriate to pursue prosecution.

October 2014

STARS – Closed case for Adam and refer back to SMART due to lack of engagement

13/10/14 – GP - Adam was given a review of his drinking and given advice about his antibiotics.

18/10/14 – TVP –– Domestic Incident – At 21.35 * The Flat, Beaconsfield, Tracy called TVP about argument with boyfriend who forced her out of her home. Premises visited and Adam seen. Tracy had left – Adam was packing belongings and left address. TVP unable to contact Tracy

19/10/14 – TVP – Domestic Incident – At 05.10 police were called by a male to ***** Road in Wycombe as Adam was smashing at door in effort to find Tracy. Police attended but Adam had left. Tracy denied making call previous evening and refused to complete DOM5. **Tracy rated as standard risk.**

23/10/14 – TVP - Domestic incident- ** ***** Road, High Wycombe - At 2019 hours Adam telephoned TVP and stated that he had had an argument with his partner, (name refused), and that other people had become involved. At approximately 2045 hours officers attended the address. Adam refused to name who he had argued with. He refused to provide a statement or complete a DOM5 form with officers.

Officers graded **Adam as standard risk of serious harm from Tracy.**

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the inquest is resumed the finding of the inquest as to the cause of death cannot be inconsistent with the outcome of the criminal trial.

23/10/14 – South Central Ambulance Service – Call at 22.21 SCAS received a 999 call from friend of Tracy as Tracy had allegedly overdosed on heroin. Tracy was found to be slumped on a bench next to her friend. Tracy was transported by ambulance to Wexham Park Hospital under emergency conditions.

23/10/14 – Frimley NHS Trust – 02.40 Tracy attended hospital reporting heroin overdose. Refused to stay and self-discharged saying she regretted taking heroin.

November 2014

1/11/14 – TVP – **Domestic Incident** - **The Flat, Beaconsfield – At 10.04 Tracy called TVP and alleged a fight with Adam three days earlier and he had hit her hard. Tracy had left to stay with friends. On her return, Adam had allegedly stolen property including a lap-top. **Tracy assessed as medium risk** and handover pack suggested Domestic Violence Notice/Order[12]

2/11/14 – TVP –Adam arrested on suspicion of assault – confirmed argument but denied assault. Released on Police bail. Tracy then admitted she had lied about theft but everything else was true. Whilst Adam was in police custody he told the custody sergeant that he was an alcoholic and a drug user: cocaine and heroin. He also stated that he needed help with reading. He did not disclose any mental health problems and did not require an Appropriate Adult.

3/11/14 – TVP – Telephone call - Tracy rang TVP and stated she wanted to withdraw statement.

4/11/14 – TVP – Release from Bail - Adam released from police bail as Tracy had admitted lying and there was insufficient evidence to support a prosecution. No further action

Between 6/11/14 and 26/11/15 - STARS - made weekly attempts to engage with Adam and he failed to attend medical review with his keyworker. On an occasion when STARS did manage to communicate with Adam he claimed he couldn't attend appointments as he had no money to get to Wycombe.

17/11/14 – GP – Adam was seen for a prescription of his anti-depressants and had a conversation about support from SMART

January 2015

12/1/15 – TVP – Domestic incident – The Flat, Beaconsfield - At 21.19 Tracy rang 999 as Adam had 'started' on her. Tracy was concerned he would use a knife. TVP attended. Both were drink and blaming each other. Adam went into kitchen and picked up a knife and pointed at one of the officers and told him he was going to fight them. Adam arrested and charged with assault on police constable. Tracy refused to complete DOM5 – **Tracy rated as standard risk** (prosecution for this assault was still outstanding at time of death)

29/1/15 – 15/4/15 – Oxford Health – Tracy self-referred to Complex Needs Service but discharged back to GP after being offered several appointments by Complex Needs Service but failing to keep them.

February 2015

4/2/15 – TVP – Missing person report – At 20.30 Tracy reported Adam missing. He had gone to work and not returned. **Adam rated as low risk of serious harm**. Adam was found at father's address in Wycombe on 6/2/15 but he did not state where he had been.

[12] A DVPN is a notice served by the police against an individual who is aged over 18, where the police reasonably believe that he or she has been violent or has threatened violence against you and that you need to be protected from him or her.

10/2/15 – TVP - **Domestic Incident** At Adam father's address in Wycombe. At 10.35 Adam rang police to say Tracy had stolen his money and clothes. He was advised to attend the Police Station. At 12.47 control room sergeant reviews DASH[13] risk assessment for Adam and Tracy – **Risk for Adam from Tracy would be standard.** Adam failed to make 4 appointments for statement and DOM5 completion

12/2/15 – TVP – Domestic Incident - The Flat, Beaconsfield – At 12.21 Tracy rang TVP about providing a character statement for court appearance re the assault on police constable. Tracy stated she was willing to provide witness statement in relation to attempted stabbing. Tracy stated she was 12 weeks pregnant. TVP attended and Tracy refused to complete DOM5. Officer graded **Tracy as standard risk from Adam** and gave her advice.

13/2/15 – TVP – Review of Incident - Incident on 12/2/15 was reviewed by Protecting Vulnerable People Referral Unit (PVPRC) and raised **Tracy up to medium risk**. A Detective from DAIU rang Tracy and discussed safety planning. Tracy not sure if she was going to allow Adam to be part of baby's life. Referral made to Children's Social Care re unborn baby- *Panel note- BCC has been unable to trace this referral*

16/2/15 –WWA- Referral from TVP to IDVA[14] service and allocated to a worker.

17/2/15 – WWA – Attempts to contact Tracy on three telephone numbers were made with only one being accessible. No message was left for security reasons.

17/2/15 – L&Q Housing – Flag re DV placed on Internal Tenancy Management System at request of TVP – via an email explaining heavy heroin user, allegedly beaten up two weeks ago. Police deemed Tracy as medium risk and possibly pregnant. The Neighbourhood Support Officer (NSO) for L&Q – was happy to change locks and would visit to do a risk assessment but TVP advised NSO not to attend without police assistance due to historical assault on police.

17/2/15 – TVP – Review of Incident - The incident on 10/2/15 was reviewed by a sergeant and **Adam's risk of harm was increased to medium risk from Tracy.**

18/2/15 – TVP – 2nd Review of Incident - Protecting Vulnerable People Referral Unit reviewed the incident on 10/2/15 again and **graded as 'Standard'**. No further police action.

19/2/15 – WWA – Further attempt to contact Tracy with no response

20/2/15 – TVP – Miscellaneous - ** ***** Road, High Wycombe – At 21.25 Adam rang TVP and reported drug dealing to children from two neighbouring addresses. He sounded intoxicated. Adam alleged he had been to one of addresses with girlfriend and was threatened with knife. He also alleges he saw a crossbow, machete and sword in the property. Adam seen but drunk. No further action by TVP but intelligence report submitted about drugs and weapons at the address.

23/2/15 – L&Q – Meeting held with Tracy and L&Q. Tracy declined to take part in L&Q risk assessment

23/2/15 – L&Q – NSO attempts to contact Tracy to advise that her locks will be changed. (Locks were changed on 26/2/15)

March 2015

[13] DASH - Domestic Abuse, Stalking and Honour Based Violence (DASH) Risk Identification, Assessment and Management Model means that all police services and a large number of partner agencies across the UK will be using a common checklist for identifying and assessing risk.

[14] IDVAs are Independent Domestic Violence Advisors

L&Q and WWA - make numerous attempts to engage with Tracy but with negative result.

12/3/15 – TVP – Domestic Incident - ** The Flat, Beaconsfield – At 11.55 Tracy rang TVP and said home from holiday and found ex-partner Adam had been in flat and stolen bank cards and power tools and it appeared he had been living there. DOM5 completed and disclosed that Adam had threatened to kill Tracy an abuse was worsening; he was controlling; using drugs and was mentally unstable but had not been diagnosed with any mental condition.

Tracy was graded to be at standard risk of serious harm from Adam. A referral was made on 12/3/15 to Children's Social Care (no record of this has been kept at BCC) – This appears to be based on information from previous report that Tracy was pregnant although she answered no to the question about having been pregnant in the last 18 months. A referral was also made to IDVA service.

16/3/15 – TVP – Safety Plan Telephone call - Domestic Abuse Investigation Unit telephoned Tracy to discuss her safety plan. Tracy stated that she had not seen Adam since the incident on 12/03/15.

17/3/15 – TVP- Miscellaneous Disorder - ** ***** Road, High Wycombe – At 16.53 Adam telephoned police and reported that he had been attacked and threatened by a named male at the address who had a big knife. He was worried about his ex-girlfriend who was still at the address.

PNC[15] confirmed that Adam was wanted for a fail to appear warrant, without bail, for an offence of assaulting a police constable. At 1712 hours officers attended the address. At 1744 hours officers contacted Adam who stated that he was fine and did not want to be seen. He refused to give his location.

At 1752 hours the duty inspector reviewed the log and instructed officers to re-attend the original address as officers suspected that Adam had returned there. His welfare should be checked and if he was medically fit he could be arrested for the outstanding warrant. At 22.44 duty sergeant reviewed the log and concluded that the log could be closed as Adam had not been seen by police.

17/3/15 – TVP – Adult Protection – The Millstream, High Wycombe – At 18.56 member of the public called TVP and reported a girl had been attacked in parkland. At 19.03 TVP established girl was Tracy. Members of public had detained a 14-year-old male on a bike. It was established that Tracy had been seen by an ambulance 20 mins earlier for a suspected overdose and had refused treatment. It appears that Tracy had been scared by the male approaching on his bike and had fallen. She had been scared further when he tried to help her. Adult Protection Incident for Tracy. The MASH noted that there was no indication in the report whether Tracy had consented to the referral and therefore it does not appear that one was completed[16].

17/3/15 – South Central Ambulance Service – At 17.39 SCAS received a 999 call from a 'friend' of Tracy. On arrival found friend doing CPR [17]. Tracy was found to be breathing and started to become verbally aggressive and did not want to go to hospital. Mental Capacity assessment form completed. From the

[15] PNC – Police National Computer

[16] Page 271 -DoH Care & Support Statutory Guidance issued under the Care Act 2014 explains the issue of consent. Adults need to give their consent for information to be shared about them unless the professional feels that there is information available to suggest the non-consent should be overridden.

[17] CPR - cardiopulmonary resuscitation. An emergency procedure in which the heart and lungs are made to work by compressing the chest overlying the heart and forcing air into the lungs. CPR is used to maintain circulation when the heart has stopped pumping on its own.

answers given by Tracy the crew assessed her suicide risk was low. A Safeguarding referral was made to Social Care - no record has been kept of this referral at BCC

18/3/15 – Adult Social Care – At 15.18 referral received report from SCAS. Referred to Adults First Response and to Tracy's GP.

18/3/15 – TVP – Miscellaneous Call – The Flat, Beaconsfield – At 15.50 Tracy called TVP and made a complaint stating that the day before she had reported a male trying to rape her and officers told her there was nothing that they could do. The PEC Operator advised Tracy of the officers' shoulder numbers and names and advised her to make a complaint to the Independent Police Complaints Commission.

20/3/15 – BCC Adult Social Care – report from SCAS – asking that ambulance report is sent to Tracy's Dr so her Dr can talk to Tracy about ambulance report.

20/3/15 – GP - GP was alerted by the Local Authority safeguarding team that Tracy had had a cardiac arrest due to heroin overdose.

22/3/15 – L&Q – The NSO and a Police Officer attended Tracy's property as some concerns had been raised by the police regarding her safety from her ex-partner. Tracy became very defensive and said that she did not want to discuss her sex life with a stranger. During the visit the NSO noticed that there was a fist sized hole in the bedroom door. The NSO asked Tracy how this had happened. Tracy said the door was damaged when she moved into the property 5 years ago. The NSO immediately raised her concerns advising Tracy that L&Q would not let the property with the door like that. However, Tracy was adamant that it was damaged when she moved in.

28/3/15 – TVP – Domestic assault – **** Road, Beaconsfield. At 21.01 Adam rang TVP and reported his wife (note: Tracy and Adam were not married) Tracy smacked him in the face and kicked him out of 'Revolutions' a nightclub/bar. 21.15 TVP arrive and found Tracy and Adam together. Officer spoke to them separately. Adam disclosed an assault by Tracy but would not support police proceedings or complete DOM5. Officers graded **Adam as standard risk from Tracy.** It was established that Adam was wanted on the warrant for fail to appear. Adam was arrested at 22.21. While in police custody Adam told the custody sergeant that he was an alcoholic and a drug, cocaine and heroin addiction. He stated that he needed help reading and was dyslexic. An interview was not required and he did not have an Appropriate Adult. Following this incident, The Neighbourhood Team SPOC[18] for Tracy emailed DAIU in relation to a conversation he had had with Adam while he had been in hospital. Adam stated that Tracy had miscarried and that she had routinely been binge drinking and using drugs while pregnant.

28/3/15 – South Central Ambulance Service – At 23.36 SCAS received a 999 call from TVP as it was believed that Adam had swallowed/taken three bags of heroin. They also had found some more bags in his sock in his police cell whilst in custody. SCAS clinicians report that Adam had consumed five bags of heroin Adam was also complaining of abdominal pain. After assessment by SCAS clinicians, Adam was transported to Wexham Park A&E for further assessment.

29/3/15 – TVP – Miscellaneous - At 0242 hours Adam was taken from police custody to Wexham Park Hospital, Slough by ambulance after stating that he had swallowed three bags of heroin. He was treated and taken back into police custody on 31/03/15.

[18] SPOC – Single Point of Contact

He was again transferred to WPH later that day (31/03/15) as he was suffering from alcohol and drug withdrawal. The warrant was eventually withdrawn and replaced with a warrant allowing for bail which was served on Adam when he returned to police custody on 02/04/15.

29/3/15 – Frimley Park NHS Foundation Trust – Adam admitted to Wexham Park Hospital following unwitnessed ingestion of heroin in police custody. Adam reported this was an attempted suicide. Adam reported abdominal pain and haematuria[19]. A letter was sent to the GP surgery that Adam claimed was his.

31/3/15 – South Central Ambulance Service – At 11.33 SCAS received a 999 call from TVP - Adam was transported by ambulance to Wexham Park Hospital for further assessment. Police travelled to hospital with Adam as he was still currently under arrest. Safeguarding Form completed by SCAS crew after incident. Concern for welfare as Adam had stated he had taken the heroin to kill himself.

31/3/15 – Frimley Health NHS Foundation Trust - Inpatient assessment by psychiatric liaison team. Adam stated he took the alleged overdose in police custody with suicidal intent. Reported that he was going to SMART in High Wycombe but erratic attendance. Denied suicidal thoughts, plans or intentions. Discharged from Psychiatric Liaison Service; Encouraged to engage with SMART to address drug and alcohol issues. Discharged to GP and GP advised to refer to Talking Therapies for alleged abuse that Adam was not willing to discuss in hospital.

31/3/15 – Frimley Health NHS Foundation Trust – Adam discharged back to police custody at 2.37pm

31/3/15 - Frimley Health NHS Foundation Trust - 11.20pm - Ambulance brought Adam back to ED after complaining of further abdominal pain on police custody. Police doctor was concerned that there was a potential risk for seeping heroin from the bags he had allegedly swallowed. Adam reports that he took a Paracetamol overdose a few weeks ago but did not go to hospital at the time. Adam also states that he now has suicidal ideas and thoughts. Laxatives prescribed to help pass the remaining bags and stools monitored using a commode.

April 2015

2/4/15 - Frimley Health NHS Foundation Trust - Adam self-discharged and signed Trust self-discharge form.

10/4/15 – WWA- No response from Tracy so case closed after discussion with Line Manager

14/4/15 – BCC ASC- Safeguarding Referral received from SCAS – dated 31/3/15. Referral forwarded to Adults First Response and saved to client 'efile'.

16/4/15 – TVP – Domestic Incident - The Flat, Beaconsfield - At 1323 hours Tracy telephoned police and reported that her partner, Adam, had been drinking and was being abusive and aggressive. He had threatened to break her jaw and was smashing up the house. At 1330 hours officers attended and found Tracy locked out. Adam had locked himself inside and was threatening to kill himself, holding a 15-inch knife and then a meat cleaver to his throat. After an hour of negotiations officers forced entry to the address and discharged a Taser gun on Adam. He was arrested for a public order offence, as members of the public had seen him holding the knife to his throat whilst he had been stood by a window. Officers completed a DOM5 form with Tracy who disclosed the previous injuries caused by Adam hitting her with a Skybox. It was also recorded that Adam had threatened to kill Tracy and put his hands around her neck but did not squeeze however he said that if she left him for someone else he would go to prison for it.

[19] Haematuria – presence of blood in urine

Tracy also said that Adam had stabbed people before and was very jealous. When Adam takes drugs/alcohol he loses control and Tracy believed he was capable of hurting/killing her.

Following this, officers graded **Tracy to be at high risk of serious harm from Adam.** Their supervisor reviewed the DOM5 form and concurred. Adam received a mental health assessment whilst in custody and although he was not sectioned, but offered accommodation with Mental Health Services on a voluntary basis. Officers created an 'Adult Protection Incident' following these events which was sent to Adult Social Care On 17/04/15 Domestic Abuse Investigation Unit telephoned Tracy to discuss risk management. Tracy stated that she could not talk as she was out and about. An appointment was made to attend her home address on 18/04/15. On 18/04/15 officers from the DAIU attended Tracy's address to discuss her safety. Adam was bailed for the public order offence. Adam told officers that he dreams about stabbing strangers and fears that he might one day whilst under the influence of drink/drugs.

16/4/15 – South Central Ambulance Service – At 13.44 SCAS received a 999 call from TVP - After assessment by SCAS where it was found that Adam has minor wounds to hands consistent with the barbs on Taser which did not require further assessment at hospital. Adam was left with police already on scene.

16/4/15 – Oxford Health Foundation Trust – Contact with TVP – Maidenhead Custody – need for inpatient bed after Adam arrested for domestic incident and at high risk of suicide and agreed to voluntary admission to hospital. OHFT had been advised that Adam had held a knife to throat and required 3 x taser to detain.

17/4/15 – L&Q – NSO visited Tracy who presented as jolly and positive and explained incident of previous day. Whilst talking to NSO Tracy started to feel it was her fault he was arrested and felt guilty. NSO agreed new action plan and confirmed weekly contact arrangements. New Risk Assessment completed with score of 36 (very high risk). NSO will be preparing a case for Panel to consider Priority transfer. NSO also sent email and rang TVP (new local case officer) to discuss incident.

17/4/15 – TVP Referral - MASH made a referral to Adult Social Care in relation to this incident. Another referral was made to IDVA. Tracy was also referred to MARAC.

18/4/15 – TVP - DAIU officers attended Tracy's address. She was informed of IDVA and MARAC referrals. She was receptive to this and engaging.

20/4/15 – Oxford Health Foundation Trust – Contact with Tracy to discuss risks to her and to gain collateral information on Adam. Advised Tracy to contact WWA. Tracy advised team that Adam had previously been to prison and was violent towards her.

20/4/15 – WWA – Referral from TVP for Tracy due to high risk perpetrator Adam

21/4/15 – TVP – Bail - Adam answered bail on 21/05/15 he had only 12 minutes left on his PACE detention clock and was released without charge with a hope to interviewing him about the offence voluntarily. Adam refused and the decision was made for no further police action in relation to the public order offence.

21/4/15 – TVP – Telephone Call - The Whiteleaf Centre, Aylesbury - At 1224 hours Adam telephoned police from hospital reporting that his ex-partner, Tracy, would not give him his belongings or his money. She was at their address of The Flat, Beaconsfield. Police liaised with the hospital who confirmed that Adam was going to be released the following day.

Later that day officers attended and took a report from Adam. They completed a DOM5 form with him. He disclosed that Tracy had punched him and threw things at him and tried using a meat cleaver. Adam said that Tracy was very jealous of his contact with other women, especially when he was at work[20]; there were also suggestions that Tracy had threatened suicide if Adam left her so he stays. Adam also stated that he had suicidal thoughts and that he had a personality disorder and used drugs.

Attending officers graded **Adam as being at medium risk of serious harm from Tracy**. No further police action

Officers also liaised with Tracy to inform her that Adam was being released. She confirmed that she had arranged to return Adam's property to his father.

21/4/15 – BCC ASC – Police report received following incident 16/4/15 about Adam explaining he is in need of mental health intervention. Forwarded to Community Adult Mental Health

22/4/15 – TVP – Review of Grading - The MASH reviewed the risk grading **for Adam changing the grading from medium to standard.** On 19/04/15 the NHPT SPOC for Tracy emailed Domestic Abuse Engagement Officer and suggested consideration of a Domestic Violence Protection Order for Tracy. On 20/04/15 he followed this up with an email to an officer from the DAIU also suggesting a DVPO.

22/4/15 – TVP - Domestic assault - ****, ******, High Wycombe - At 1822 hours Adam telephoned police and reported that he had just been released from Whiteleaf Hospital and had gone straight to his father's address which was where he was going to be living. When he arrived, he found his ex-partner, Tracy, was there with his father, and they were both drunk. A verbal argument took place between Adam and Tracy. Tracy hit Adam 4 times causing a 'bust cheek'. Due to Adam's recent history of violence to officers, police asked Adam to attend a police station to make a report. Adam refused stating that he didn't like police and didn't want to go to a police station. He then stated that he didn't care anymore and hung up. At 2003 Adam telephoned police stating he was wandering around in an intoxicated daze and saying that he was a danger to other people because he was hearing and seeing voices and he was worried he would react. He thought he may cause harm to himself or his father. Adam refused to meet with officers stating that he had 'fears'. Instead he just wanted police to arrest Tracy. He then stated that he didn't care anymore and hung up. Police contacted Whiteleaf Mental Health Unit which confirmed that Adam had been reluctant to be discharged earlier that day but that their assessment had been that he would be best treated in the community. Adam was eventually located at approximately 2300 hours in a local car park. Officers did not see any visible injury to Adam even when they asked to look inside his mouth. He told them to 'Fuck Off' and refused to confirm what had occurred.

Officers completed a DOM5 form with Adam.

Officers graded **Adam as being at medium risk of serious harm from Tracy.**

23/4/15 – TVP – Welfare Visit and Review of Grading - Officers attended Tracy's address to assess her welfare given the fact that she was deemed to be at high risk of serious harm from Adam. She denied any altercation and stated that she had been with Adam and stayed with him overnight at his fathers and left him there at 0800 hours that morning. Officers spoke to Adam's father, who stated that nothing had happened. They completed house to house enquiries but none of the neighbours saw or heard a disturbance. **On 05/05/15 the MASH reviewed the risk to Adam and changed it to standard risk.**

[20] It has been suggested that LG worked at a Hospice in Windsor but checks with the Hospice said he was unknown to them.

27/4/15 – WWA – Tracy was contacted by WWA but not by case officer – Tracy asked to meet but the officer couldn't make the date Tracy requested and so agreed to pass to a colleague. This was not recorded on MODUS.[21] The officer states that the failure to record on Modus was a mistake and that she spoke with Tracy who confirmed it was safe to leave messages on her mobile.

28/4/15 – WWA – Case officer texted and got text back on 29/4/15 requesting a meet on 5/5/15

30/4/15 – Connection Floating Support – Outreach worker recalls casual conversation with Adam whilst working with rough sleepers. Adam does not wish to engage with support and is expecting to be going back to partner's place. No file opened.

May 2015

3/5/15 – South Central Ambulance Service – At 00.39 SCAS received a 999 call from friend of Tracy as Tracy had overdosed on heroin and was in cardiac arrest. Tracy was transported to Wexham Park Hospital for further assessment.

3/5/15 – Frimley Health NHS Foundation Trust - 1.53am Tracy attended Wexham Park Emergency Department following an alcohol and heroin overdose. Following treatment by the ambulance crew, blood tests and medical observations in ED, Tracy was assessed as medically fit for discharge on the same day at 05.11. Discharge summary sent to Tracy's GP

5/5/15 – SMART – Tracy attended a drop-in session at Beaconsfield outreach as a self- referral. SMART believe that Tracy will need a joined-up package of support from Women's Aid, SMART, Housing and Health Services in order to be able to move forward. Consideration was given to multi-professionals meeting and referral to MARAC. (The case was listed for a MARAC meeting)

Worker to meet Tracy on 6/5/15 at Beaconsfield drop-in.

7/5/15 – Buckinghamshire Adult Social Care – Information sent to BCC from TVP re Adam being released form Whiteleaf Centre and known to mental health team. The information was passed to Oxford Health to be given to allocated worker. OHFT responded that Adam and Tracy had been referred to MARAC. Adam was identified as pathological liar by psychiatrist from in-patient unit at Whiteleaf Centre.

7/5/15 – WWA – Phone calls exchanged between WWA and SMART and Tracy. It was agreed to set up meeting when Tracy returned from break away. Email received from SMART with a DASH form and Safety Plan. DASH score was 19 which is high. *Panel note – The DHR Panel expressed concern that there does not appear to be a single DASH form and established that the TVP Domestic Abuse Operational Group are reviewing the DASH in light of best evidence*

SMART, L&Q and WWA - continued to try engaging with Tracy, but with little success.

21/5/15 – TVP – Adult Protection - Adam attended the police station to be interviewed regarding a public order offence from 16/4/15. The officer observed that he looked healthier, he was smartly dressed and said he had been off heroin for four days.

21/5/15 – STARS - Tracy attended service for part three assessment Tracy informed the Doctor that she had been injecting 2-3 times per week, maybe more. The risk assessment carried out classed Tracy as high risk.

[21] The multiagency system developed for use by agencies involved in dealing with domestic abuse survivors, children and alleged perpetrators. It is a government approved software used by UK DV agencies.

27/5/15 – TVP - South Bucks MARAC – MARAC meeting held where information was shared and discussed. The minutes from this meeting indicate that the following information was shared and discussed and it was agreed that Tracy's risk level was to remain as high.

28/5/15 – TVP - Domestic Harassment - **The Flat, Beaconsfield - At 1106 hours Tracy telephoned police and reported harassment. She had split from her partner, Adam, 6 weeks earlier. Since then Adam had been constantly in contact with her (50 texts a day) being threatening and abusive towards her. When Tracy had been on holiday Adam had broken into her house and removed some property. Tracy stated to the call taker that due to Adam's behaviour towards her she felt that he was going to kill her. At 2050 hours officers attended Tracy's address and took a statement from her. They also completed a DOM5 form with her. **Officers graded Tracy as being at medium risk of serious harm from Adam.** The DOM 5 form was reviewed by a sergeant who amended the grading from high to medium.

Officers identified Tracy as a repeat victim of domestic abuse.

28/5/15 – STARS – Tracy attended for key work session and presented with stress and anxiety and tense from ex-partner who is harassing her constantly via phone, threatening her and insulting her. Tracy stated that she had contacted the police to try and get a barring order following the tasering incident on 16/4/15. Discussed Women's Aid and getting support to change her locks, Tracy had contacted them and she stated that they are in the process of replacing her door with a new securer door. Tracy stated she was also going to attend the Freedom Programme in High Wycombe and was waiting for dates. Tracy stated that she felt sick with stress regarding her situation, wanted to see Dr for a prescription for Valium. Stated she had not used for the last 4 weeks. Completed Outcome STAR / Recovery Plan. Discussed mental health, feeling lots of stress and self-hatred, state when she looks in the mirror she sees her parents 'vile, hates it'.

28/5/15 – WWA – After text sent to Tracy she contacted caseworker. Tracy had reported harassment from Adam to the Police. Felt she was going crazy and wanted Adam to leave her alone. Meeting with Police that evening at Oasis after her first meeting with her support worker. Tracy said she had not used alcohol for 3 weeks. Housing Association (L&Q) will be fitting a new front door. Tracy to inform police that Adam has a key to her property. Tracy to telephone caseworker tomorrow to check in and start safety planning

29/5/15 – WWA – Caseworker telephoned Tracy for support session. It was agreed that Tracy would call police if she hears from Adam. She was feeling less chaotic and her appointment with OASIS (STARS) had gone well. Tracy said she had made a statement to police and they would be serving Adam with a Harassment PIN and confirmed there was a flag on her address. Safety issues were discussed with Tracy. Caseworker would refer Tracy to WWA Counselling Service, Sanctuary scheme and speak to Tracy on 1/7/15.

29/05/15 – TVP – Grading Review - The MASH reviewed this incident and changed the grading for **Tracy back to high risk**.

June 2015

1/6/15 – L&Q - Tracy advised the NSO that her ex-partner Adam had been issued with a harassment order by the police and that she had not had any contact with Adam. Tracy mentioned that she was waiting for the door to be replaced and that she was looking at remaining at the property and was no longer interested in a priority transfer.

1/6/15 – WWA - Referral made to WWA Sanctuary Scheme for Tracy

2/6/15 – TVP – Arrest for Harassment - Adam was arrested on suspicion of harassment. Adam was released without charge but issued a Police Information Notice in relation to his future conduct. Tracy was also advised not to have contact with Adam. Adam was seen by the Liaison and Diversion Team[22] whilst in custody. He expressed suicidal thoughts whilst in custody and stated that he was homeless. L&D made a referral to the Mental Health Team. Adam, whilst in custody was vomiting blood but declined an ambulance. On release officers drove him to the Minor Injuries Unit at Wycombe Hospital. It is unknown if Adam actually went into the MIIU as the unit has no record of his attendance.

2/6/15 – WWA- Caseworker called Tracy who was feeling anxious over weekend and to contact her GP. Caseworker agreed to find out if Adam had been served with Harassment PIN and agreed to ring Tracy on Friday. It was confirmed that referrals had been made to WWA Sanctuary and Counselling. Tracy confirmed she had an appointment with OASIS (STARS) on 4/6/15. She had not heard from Adam.

3/6/15 – Oxford Health Foundation Trust – Appointment to be offered to Adam following the arrest for harassment on 2/6/15. Liaison and Diversion involvement had been requested as Adam had expressed thoughts of self-harm but he had been released before team could make contact.

3/6/15 – L&Q – Permission given for Safe Partnership team which run the Sanctuary Programme, to carry out additional security works to Tracy's property in Beaconsfield.

4/6/15 – STARS - Tracy DNA appointment. STARS rang at 5pm to discuss her welfare. It was arranged Tracy could come to STARS following week if she could get lift

5/6/15 – WWA - Adam had been served with the PIN on 3/6/15 which he accepted. He was arrested on 2/6/15 for harassment but the case had been NFA (No further action) due to lack of evidence. Caseworker phoned Tracy as agreed – no response so Caseworker sent text asking her to get in contact.

8/6/15 – WWA – Safe Partnership sent email to say that Tracy did not go ahead with appointment booked and changed to 15/6/15. The reason for change was that Tracy said her son was staying with her and refusing to go home to his father.

11/6/15 – Oxford Health Foundation Trust – Pathfinder Service discharged Adam as he made no contact with them

15/6/15 – WWA – Tracy texted the caseworker who then rang her. Tracy advised her son was now living with his grandmother and she was still sober, prescribed Prozac by GP; hadn't heard for Adam and that he had been served with Harassment PIN. Sanctuary had fitted window alarms and new lock to front door. New door will be fitted on 15/7/15. A WWA Counsellor rang Tracy but with no answer. Message left confirming appointment booked for 7/7/15

25/6/15 – TVP - Neighbour Complaint - The Flat, Beaconsfield - At 13.33 hours Tracy telephoned police and reported her elderly neighbour for constantly watching her and making inappropriate sexual comments. She also thought that he was responsible for spreading rumours that she was a prostitute.

[22] Liaison and Diversion services are intended to improve health and justice outcomes for adults and children who come into contact with the youth and criminal justice systems where a range of complex needs are identified in their offending behaviour. Liaison and Diversion is a process whereby people with mental health problems, a learning disability and other vulnerabilities are identified and assessed as early as possible as they pass through the criminal justice systems. This service stems from the Bradley Report published in 2009. Thames Valley Police is running a pilot in some force areas. This is a health led service.

At approximately 1430 hours officers attended and spoke to the neighbour who stated he was just trying to be friendly. He was given suitable words of advice.

An Antisocial Behaviour Risk Matrix was completed for Tracy at standard risk. Housing Association notified of situation. No further police action

25/6/15 – WWA - Worker telephoned Tracy. WWA counselling appointment booked on 7/7/15. Tracy to speak to key worker at OASIS (STARS) to ask if appointments could be a different location

29/6/15 – L&Q - Tracy phoned into the office to talk with her NSO on 25/6/2015, Tracy had a very aggressive manner over the phone. Tracy said that she had been to High Wycombe and was approached by Adam. Tracy said that Adam started shouting at her. Tracy also advised the NSO that the tenants at No * The Flat, had been telling other neighbours that Tracy was a prostitute and that they had seen different men visiting her property. Tracy was very distressed at this point of the conversation and was shouting/swearing. Tracy suggested she would be contacting the Police as to her concerns about the neighbour. Home visit carried out. Tracy had calmed down considerably. Tracy denied prostitution and stated that she was getting on with her life and was attending counselling and was off the drugs and drinks. She stated that the police had attended and spoke with No.* The Flat and told him that he was not allowed to approach Tracy or spread malicious gossip about her. The NSO informed Tracy that she would be visiting No.* to investigate the allegations. Tracy gave her consent for her to investigate this matter further. Appointment made with No * to discuss matter on 8/7/15

30/6/15 – TVP - Domestic Incident - The Flat, Beaconsfield - At 1402 hours Adam telephoned police and reported that his ex-partner Tracy, had stolen his benefit money. She had also thrown his clothes out of the house. She was there and Adam was asking police to attend.

At 14.09 hours officers attended the address. Adam explained that his money had been accidentally paid into Tracy's account. He was refusing to leave until he had been paid his money.

Officers were aware that Adam had been advised on a number of occasions to open his own bank account or arrange for his benefit to be paid into his father's account. Therefore, there were no offences.

Adam refused to leave so the officers gave him a section 35 Antisocial Behaviour, Crime and Policing Act 2014 dispersal notice to leave, which he complied with and left.

Tracy refused to complete a DOM5 but officers completed one using the information known to them. **They graded her as being at medium risk of serious harm from Adam. On 01/07/15 the MASH reviewed this incident and amended Tracy's grading to high.**

July 2015

1/7/15 – L&Q - Tracy phoned the NSO to see if the date could be brought forward for her door to be fitted. Tracy stated that Adam had just been round trying to kick her door in and had just been taken away by the police. Tracy stated that Adam wanted his money which used to go into her bank. The NSO contacted contractor but as this door was a fire door it had to be specially made therefore they could not fit any earlier. NSO informed Tracy of this.

2/7/15 – STARS - Telephone call with Tracy stated she didn't want to engage in High Wycombe due to feeling unsafe from the ex-partner and his threating behaviour. Disclosed alcohol lapse 30/06/15, but stated she hadn't drank prior to this for one month. Discussed the difficulties in dealing with her son and his father which had left her feeling guilty and thus drinking. Stated ex-partner has been abusive and threatening and she now felt that she was at the place where she had moved on and state she didn't want that lifestyle anymore.

6/7/15 – L&Q – Call from No * cancelling appointment as they were going away. Rescheduled for 14 July. Tracy was phoned and confirmed she did not want to move 'Why should I let people drive me out of my home' She stated she was getting her life back and was working with STARS and Women's Aid Team. Additional security was in place.

6/7/15 – TVP - Missing Person - **The Flat, Beaconsfield - At 23.00 hours Adam telephoned police and reported Tracy missing.

Police identified that Tracy was graded at high risk of serious harm by domestic violence from Adam and were aware that this may have been an attempt to locate her when she perhaps did not want to be found by him. Officers met with Adam and took a full missing person report from him.

Following this the officers graded Tracy as being at low risk of harm whilst missing. However, this appears to have been amended on the form to medium risk following a review by the attending officer's sergeant.

Officers informed Adam that he would not be informed when Tracy was located due to the fact that she was at high risk of domestic harm from him. Adam accepted that he would not be told when Tracy was found and said he was just concerned about her safety.

6/7/15 – TVP – Stop check At 04.15 in *** Street High Wycombe Adam was stopped with another male and had bags and possessions with them and gave impression of being homeless. Both searched No further action

7/7/15 – TVP – Welfare Call - At approximately 08.30 hours Officer from the Domestic Abuse Investigation Unit contacted Tracy by phone. She informed him that she was with friends in Brighton and was fine. She refused to allow police to meet with her and repeatedly told Adam to leave her alone. She believed that Adam was using this as a way of getting to her. However, the report remained open until officers could meet with Tracy and confirm her welfare.

7/7/15 – WWA – Tracy didn't attend appointment. Tracy was telephoned and arrangements made for an appointment on 14/7/15

8/7/15 – TVP - Domestic Incident -** The Flat, Beaconsfield. At 20.41 Tracy called police following a domestic incident with Adam and was seen by officers then. She was reluctant to engage and would not tell officers where she had been whilst away. She stated that her ex-partner Adam, was trying to kick her door in. She then stated that he had smashed through the door.

Tracy became abusive to the call taker and hung up. The call taker could not hear any sounds in the background which would indicate a disturbance. At 20.53 hours officers attended the address. Adam had left. There was no damage to the door and no offences were disclosed. Tracy refused to complete a DOM5 with officers.

They graded her as being at standard risk of serious harm from Adam. This was reviewed by a sergeant who concurred with the grading.

Officers noted that Tracy was a repeat victim.

9/7/15 – TVP - MASH reviewed this incident and **changed Tracy's grading to high risk.**

9/7/15 – L&Q – NSO speaks with Tracy who had made a decision to go into residential rehabilitation. Tracy felt she needed to 'bite the bullet' as she was struggling with attendance at meetings. Tracy claimed that Adam was trying to get into her property again the previous day. Tracy also stated that she

wanted to move away to get away from Adam and get a fresh start in a smaller property. NSO arranged to carry out home visit on 20/07/15

9/7/15 – STARS – contacted Tracy to say she needed to re-engage if she wanted to go into residential re-habilitation.

STARS, WWA and L&Q - continue to try engaging with Tracy but with minimal success.

17/7/15 – TVP – Intelligence Report - Tracy had frequent male guest staying for short periods and may be working as a prostitute

17/7/15 – STARS – Tracy called and spoke to a worker and stated she missed her appointment. She was distressed and stated she felt like killing herself. When explored she confirmed her suicidal intentions. Key information faxed to GP and mental health services contacted.

17/7/15 – Oxford Health Foundation Trust - Information for STARS had been received and Tracy contacted by Chiltern Assessment Function as Tracy stated feeling suicidal. Tracy did not want input from mental health (despite being offered several appointments) stating she wanted a residential rehabilitation placement. Case handed back to STARS.

20/7/15 – L&Q – NSO attended Tracy property as arranged and despite texting and calling prior to visit Tracy did not answer or stay in for appointment. NSO confirmed to Police (local officer) at a partnership meeting that Tracy was no longer engaging with them and that apparently Adam was moving to Scotland and he had not been seen for a while.

NSO met with No* about allegation around prostitution and No* denied these allegations but did state the Tracy had a lot of men coming and going. NSO gave the police the information regarding the prostitution allegation.

20/7/15 – STARS – Telephone to Tracy to discuss options. She disclosed having used heroin and alcohol over weekend and was out of money and felt like withdrawing. Tracy didn't want to engage with services in High Wycombe but request that someone pick her up and take her to rehabilitation. She disclosed that *** from Mental Health Team had contacted her and encouraged her to look after health and not kill herself. No further contact from them. Tracy agreed to attend an appointment with STARS on 6/8/15

20/7/15 – GP - Adam was seen for eczema and mentioned he had stopped his anti-depressants and had split up with his girlfriend. He was encouraged to become a permanent patient.

23/7/15 – TVP - Domestic assault - **The Flat, Beaconsfield - At 10.39 hours Adam telephoned police from the public phone at High Wycombe police station and reported that Tracy had punched him in the face the night before. He had left their address for the night and that morning he had seen her in High Wycombe town centre. She had ripped up his provisional licence and threatened to 'get him killed if he went anywhere near her'. She also made threats to have him beaten up.

Adam wanted Tracy to be arrested.

Adam could not wait at the police station as he had a SMART appointment to attend in order to collect his prescription so he agreed to return to the police station straight after. Adam failed to return to the police station. There followed attempts by officers to locate Adam to take the report.

At 1639 hours an officer came across Adam and Tracy walking hand in hand. Adam refused to engage with the officer only saying, 'It's sorted.' Tracy confirmed that Adam would be staying at her address as a guest while she was in residential rehab which was due to begin on the following Monday.

Adam refused to complete a DOM5 but officers completed one using the information known to them from previous incidents/dealings. **They graded him as being at standard risk of serious harm from Tracy.**

23/7/15 – South Central Ambulance Service – At 18.16 there was a 999 call from Tracy - Adam had smashed a glass over his head. Tracy stated that Adam was showing violent tendencies towards her. SCAS clinicians on scene reported that Adam has a history of depression and mental health problems. Adam had an argument today, got frustrated and smashed a pint glass on his forehead. Following clinical assessment, Adam was found to have some lacerations to his forehead which required treatment so was transported by ambulance to Wexham Park Hospital.

23/7/15 – Frimley Health NHS Foundation Trust – at 19.10 Adam attended ED with his partner and was seen by the ED Dr. to whom he stated he had hit himself on the head with a pint glass. A superficial laceration was treated. No indication for a CT scan and he was not suicidal. Treated and discharged at 05.24 on 24/7/15. It was not noted if Adam was medically assessed on his own or with partner.

31/7/15 – STARS – Tracy attended recovery café

August 2015

L&Q - continue to try to contact Tracy.

6/8/15 – STARS – Tracy attended keyworker session – she was early and keen to engage. Tracy looked tired but sober and stated she hadn't used crack or heroin in two weeks. Last alcohol on 2/8/15. Stated she wanted to be abstinent during the week but cannot commit to not using at weekends. She also attended a recovery group session.

10/8/15 – TVP - Domestic assault - * ***** Road, High Wycombe - At 1906 hours Adam telephoned police and reported that his ex-partner Tracy, had smashed a window at the address (a friend's address), threatened to kill Adam and his female friend (Samantha) and had hit Adam on the head with a dog toy causing lumps to his head. Tracy had threatened to 'bring people round'.

At 19.15 hours Adam rang back stating that Tracy and another (John) were trying to get into the address and he was trying to stop them from getting in the door. He said that they had blades and knives and had smashed a window. While on the phone Adam heard that they had gained entry. Adam and Samantha were hiding in the bedroom. Adam updated to say that Tracy had 'shitted on the door step'. Attending Officer advised the Review that she had seen what she assumed to be dog faeces on the front door and nearby on the wall. She asked Adam about it and he initially stated that it was human poo and that Tracy had done it but he was laughing while he said this so the officer challenged him on the point and he admitted that he was actually not sure who had done it.

At 19.30 hours officers attended the address and arrested Tracy for assault against Adam.

Adam refused to complete a DOM5 but officers completed one using the information known to them. **They graded him as being at medium risk of serious harm from Tracy.**

Adam refused to provide a statement and officers could not see any injury. He stated that he still loved Tracy and did not want to get her into trouble. Samantha also refused to give a statement.

In interview Tracy denied any assault. She stated that she had discovered that Adam had been cheating on her with Samantha behind both her and Samantha's boyfriend's (John) back. They had gone to confront them and caught them having sex. Adam tried to get her to leave and when she refused he called the police and said that she had hit him.

At 2124 hours Tracy was released from custody without charge.

At 2203 hours Adam telephoned 999 reporting that Tracy had turned up at the address again and was refusing to leave. He said she was making further threats to kill and being verbally aggressive. He thought that she was under the influence of drugs.

At 2215 hours officers attended the address again and ascertained that Tracy was there on the invitation of another resident (it was a multi-occupancy address). Other people at the address informed officers that Tracy had not been aggressive or abusive. Tracy was waiting for a lift home. Officers advised Adam of this and gave advice about staying away from each other until then.

11/8/15 – TVP – Grading Review -This incident was reviewed by the MASH and **Adam's risk grading was changed from medium risk to standard risk** The Reviewing Officer informed this review that he had not seen any indication of escalation, the incident was minor in nature and Adam was planning to go to Scotland for the next week, which would give the couple some time apart. He did not think that there was any indication that Adam was at risk of serious harm from Tracy.

11/8/15 – TVP - Domestic incident - * ***** Road, High Wycombe - At 08.59 hours Samantha telephoned police and reported that her ex-partner (John) had let Tracy into Samantha's room that morning (he still had a key) and they had stolen clothing and prescription medication. Tracy had threatened to kill her and to come back with more people.

Samantha stated that she could not be seen until after midday due to appointments.

At 1638 hours CID officers attended Samantha's address. She explained that the threats had been made by Tracy as part of the incident the night before but did not wish to make a complaint in relation to that.

Samantha then reported that John had assaulted her the previous Sunday by punching, kicking and choking her also holding a knife to her throat. He also threatened to kill her.

Samantha refused to provide a statement but did complete a DOM5 form. On this form she disclosed that Tracy had said to her 'I'm going to f**king kill you, you little c**t.' Officers graded her as being at high risk of serious harm from John.

Later that day officers attended Tracy's address * The Flat, High Wycombe and arrested John for the assault against Samantha. Tracy allowed officers to search the address for the clothing and prescription medication but nothing was found.

13/8/15 – STARS – Tracy attended a session of the recovery network

14/8/15 – STARS – Tracy attended both am and pm sessions of the recovery network

17/8/15 – TVP - Domestic assault - Adam approached an officer on patrol at 12.15pm and reported an incident which had occurred earlier that day at 11.25am. Adam alleged he had been talking to his friend when his ex-partner, Tracy, was being verbally abusive towards him; she then spat in Adam's face and threw some coins in his face.

Officers suggested that Adam accompany them back to High Wycombe and he agreed. He gave them a statement and completed a DOM5 form. He disclosed the following:

Tracy had punched Adam in the past and smashed glass bottles over his head; Tracy recently smashed a pint glass over his head but Adam said that he had done it to cover for her;

Tracy had tried to strangle Adam during arguments but he managed to fight her off; Tracy had threatened to kill Adam and due to her mental state he was 50/50 on whether he believed her; Incidents had been getting worse since Adam and Tracy split a month before;

Tracy had told Adam's family that he was a junkie;

Tracy was four and a half months pregnant, though he did not know if the baby was his or not;

Tracy had threatened to kill herself by taking a drug overdose the week before; Adam had been suicidal 4-5 months before.

Officers graded Adam as being at medium risk of serious harm from Tracy. Downgraded to Standard by MASH – see 18/8/15

17/8/15 – STARS – Tracy did not attend appointment. Telephone contact made and text message sent with new appointment date and separate appointment for Health MOT

18/8/15 - TVP – Grading Review - The MASH reviewed the incident and downgraded Adam's risk to standard risk.

18/8/15 – L&Q – Team Leader reviewed case and summarised that NSO is managing case well and needs to prepare paperwork for closure meeting.

18/8/15 – STARS – Telephoned Tracy after DNA on 17/9/15. Tracy very upset and stated she had broken up with partner – Adam. He had new partner and they were harassing her making false allegations which had resulted in her being arrested on two occasions. Tracy stated she was going to see GP to try and get Valium. She stated she would be back in treatment next week.

18/8/15 – GP - Tracy was last seen by her GP on 18/8/15 for anxiety

19/8/15 – STARS – Tracy attended women's group

20/8/15 – STARS – Tracy attended the morning Recovery Programme and was reported as being in a 'high mood'.

22/8/15 – South Central Ambulance Service – At 22.07 SCAS received a 999 from member of public - a bystander witnessed Adam being stabbed multiple times whilst in the High Street and the assailant had ran off. Other by-standers started CPR while initial call taker stayed on the line until SCAS arrival. Police on scene prior to SCAS arrival were already carrying out CPR on Adam. SCAS clinical assessment showed that Adam had sustained multiple stab wounds and had lost a large amount of blood. Adam was declared dead at the scene.

22/8/15 – TVP – Murder – All Saints Church, Church Square High Wycombe – At 20.48 hours reports were made to police of an incident. Officers attended and found Adam with significant injuries. At 21.30 Adam was pronounced dead. Mark, Tracy, and Darren subsequently charged with murder. While in custody for this offence, Tracy answered 'no' to the question of being pregnant which forms part of the assessment and did not mention any recent miscarriage.

7. TERMS OF REFERENCE - ANALYSIS OF INVOLVEMENT

The following section will address the specific things to consider as detailed in the terms of reference for this review. Full and detailed IMRs were received from the agencies that had an involvement with Adam and Tracy, which have been considered in depth and have been used to consider the key questions this Domestic Homicide review set out to establish and consider. The Full Report has the analysis from each service included and has been shared with all the participating services.

7.1 Was there evidence of a risk of serious harm to the victim that was not recognised or identified by the agencies in contact with the victim and/or perpetrator?

7.1.1 Thames Valley Police

Tracy:
The risk of serious harm was recognised. Tracy was appropriately graded as high following a concerning incident which involved Adam barricading himself inside their address with a knife to his throat.

***Adam*:**
The risk of harm was recognised by the officers attending the incidents reported by Adam and he was graded as medium risk. However, the MASH staff reviewed this grading and amended it to standard. At times the rationale for this was questionable:

- In previous domestic abuse incidents Tracy has predominantly been the victim with Adam as the aggressor
- Tracy was currently flagged as being at high risk from Adam
- Adam had previously been graded as standard risk following domestic abuse incidents with Tracy

This has highlighted the difficulties inherent in dealing with dual perpetrators of domestic abuse. The Police Review concluded that generally the risk assessments and decisions made about this couple were based on the evidence available to them at the time and their personal experience of the couple, which indicated that Adam was the primary aggressor posing risk to Tracy. The Panel, however, is cognisant that the last incidents reported to Police were all from Adam complaining of assaults and abuse from Tracy. In hindsight, this might have indicated that there was a change of emphasis from Tracy having previously been predominantly the main victim. Regardless of this, Thames Valley Police would not have considered that Tracy was likely to arrange the murder of Adam.

7.1.2 STARS
Adam had little involvement with STARS other than two periods during 2014, the first of which was for a month during August and September when he attended 7 appointments which were mainly group work and then was referred but never attended appointments between October and November 2014. There was no indication during these periods of Adam being at risk of harm from Tracy.

7.1.3 Frimley Health NHS Foundation Trust
During the period of the review Adam had a few contacts with the Trust but the Trust did not recognise that there was any indication of serious harm by Tracy on Adam. He was taken to the hospital after a suspected ingestion of heroin whilst he was in police custody and there was no suggestion of domestic abuse at this visit. He also had appointments with out-patients but never attended these bookings. The only incident where there may have been an indication of abuse was when he attended A&E after allegedly smashing a glass on his head. He gave no indication that this was anything other than self-abuse. However, the Review recognises that Adam was displaying behaviours and physical signs that could have alerted staff that he may have been a victim of abuse and so in accordance with the good practice guidance should have been asked. A recommendation about updating the current DV Policy is made by the Trust.

7.1.4 Oxford Health NHS Foundation Trust
When Adam was latterly admitted to Whiteleaf Hospital, Oxford Health was aware of the possible abuse by Adam on Tracy because the Dr met with Tracy when she was described as Adam's partner. The service was also present at the MARAC meeting when Tracy and Adam were discussed.

Tracy had limited links to Oxford Health for the period of the review. She was referred by STARS in July 2015 but she refused to engage. Her only link was following her arrest following the homicide.

7.1.5 Wycombe Women's Aid – IDVA

WWA had no direct links to Adam. It is acknowledged though that the IDVA service would have been open to Adam as a male victim of abuse if he was identified as medium or high risk. Tracy liaised several times with WWA but there was never a face to face meeting. Tracy was difficult to engage with but the service was aware of the abuse that Tracy received from Adam and did offer her support. The referral to WWA mentioned an unborn child and WWA has acknowledged that it would have been useful to have spoken to Tracy about the pregnancy as there could have been an increased risk of abuse. WWA has a recommendation to consider the development of a check list of activities to be carried out or followed up.

7.1.6 SMART

The review carried out by SMART revealed that staff both identified risk for each of the service users and acted upon this risk appropriately.

7.1.7 Connection Floating Support

Due to the very limited links to this review it would not be expected that Connections would have been identifying the risk of abuse.

7.1.8 L&Q Housing

The IMR from L&Q shows that the risks of abuse for Tracy were recognised and dealt with appropriately. Adam had no tenancy rights on the property and so the Housing Association was not involved with him.

7.1.9 South Central Ambulance Service (SCAS)

The SCAS IMR identifies that there was evidence of the attending crews and emergency call centre staff recognising that there may have been abuse on and by both Adam and Tracy. This was managed appropriately.

7.1.10 GP

The GP for Tracy provided information considered as relevant to the review in respect to Tracy. Limited information about the treatment of Adam was provided by the same surgery as he had used the surgery on a temporary basis. The information provided by the GP about both Tracy and Adam did not identify any links to domestic abuse other than one incident of abuse on Tracy in 2012 which was outside the review period and the fact that Tracy had been referred to MARAC. Tracy was about to be discussed at the surgery as part of the vulnerable patients list. Tracy has not given permission for her records to be shared and the fact the Adam did not have a permanent Dr it is not possible to recognise if there is evidence of the GPs not recognising that the victim or perpetrator were at risk of serious harm of abuse**.**

7.1.11 Panel observation

Several of the services linked to this Review undertake DASH assessments but it appeared that there were slight variations in the form used and so this was raised as a concern. The Panel understands that the DASH is being reviewed by the Thames Valley Police Domestic Abuse Operational Group considering best evidence and this will then be shared with other organisations to ensure that the DASH is consistent.

7.2 Was information available that might have identified that there was a serious risk of harm to either the victim or perpetrator that was not shared with other agencies?

7.2.1 Thames Valley Police
Repeat referral to MARAC:

Following the MARAC on 27/05/15 Tracy reported a further incident which was recorded as harassment:

Adam had been constantly in contact with Tracy (50 texts a day) being threatening and abusive towards her. When Tracy had been on holiday Adam had broken into her house and removed some property. He had also hacked into her email account, got her address book and sent emails and made abusive calls to her friends. Tracy stated to the call taker that due to Adam's behaviour towards her she felt that he was going to kill her. On 02/06/15 Adam was arrested on suspicion of harassment. He admitted to text message contact but stated it was both ways. His phone was downloaded which corroborated this. There were also texts between the two discussing getting back together and being intimate. Adam was released without charge but issued a Police Information Notice[23] in relation to his future conduct. Tracy was also advised not to have contact with Adam.

This incident should have resulted in a repeat referral to MARAC. This did not happen and this review has highlighted confusion over whose responsibility within Thames Valley Police this is. Therefore, the information gathered during the harassment investigation was not shared with the MARAC agencies which would have provided a further opportunity for agencies to share information and formulate further actions as part of the risk management plan.

7.2.2 STARS

Whilst there is no evidence of information or opportunities being identified with the contacts of Tracy and STARS, it was recognised that there was no evidence of a follow up by the service after a MARAC meeting after concerns were expressed by Tracy on 5th June and 2nd July. A recommendation has been made by the service in respect to the recording of MARC discussions about the client on the ILLY and then to feedback to key workers.

7.2.3 Frimley Health NHS Foundation Trust

There is no evidence that The Trust failed to share any information with other agencies in respect to the risk of harm to either the perpetrator or victim.

7.2.4 Oxford Health NHS Foundation Trust

On 20/4/15 Tracy was seen in her capacity as the partner of Adam by a Dr that Tracy disclosed that she was a victim of abuse from Adam but it seemed she was referring to the abuse as historic. The Dr however, recalled that Tracy 'seemed terrified of him' but blamed herself for her position and that she 'deserved it when he hit her'. Whilst it is accepted that Tracy was given information about WWA and advised to seek support from them, the Panel feel this was a missed opportunity to make a MARAC referral for Tracy, which would have alerted other agencies to the issues that Tracy was facing. The IMR from the Trust stated that the Dr would consider making a referral to MARAC for Tracy, however there is no evidence of this having been done.

Panel Recommendation 5

Individual Agencies are responsible for submitting MARAC referrals regardless of whether other agencies have referred.

[23] The serving of a PIN can be effective in preventing low level harassment progressing to a course of conduct amounting to an offence under the Protection from Harassment Act 1997. It is intended for use following a first incident of harassment.

Adam was never identified as a victim of abuse by Oxford Health and so there is no evidence of not identifying and sharing that there was a risk from Tracy on Adam.

7.2.5 Wycombe Women's Aid – IDVA

WWA had no direct connection with Adam. The interactions with Tracy were limited by the fact that the caseworker had never managed to meet with Tracy, despite many attempts. It is therefore concluded that there were no issues about not sharing information in respect to the possible harm to Tracy.

7.2.6 SMART

SMART acknowledges through its IMR that there were issues around the quality of the case notes for Adam. However, the IMR also assures that clear referrals had been made to partner agencies and domestic abuse services and that there were no missed opportunities to share information. It is also worthy of note that this type of service is often reliant on self-disclosure and in the case of Adam, SMART had no information until the service started to engage with Tracy as a client in her own right, that she was a victim of domestic abuse with Adam being the perpetrator.

7.2.7 Connection – Floating Support

With such limited links to the review it would not be expected that Connections would have been failing to share information with partner agencies in respect of domestic abuse.

7.2.8 South Central Ambulance Service (SCAS)

SCAS were in regular contact with the police and often attended incidents where there were already police in attendance. There were several occasions when it was considered appropriate that a safeguarding referral should have been made for both Adam and Tracy but these were not carried out and are subject to a recommendation about improving the understanding and practice of attending crews.

7.2.9 GP

The GP for Tracy provided information which was considered by the GP to be relevant to the review. A request was sent to Tracy to seek permission for her records to be shared but she did not provide that permission. Adam did not have a permanent Dr but the surgery he referred to as his surgery and where he was seen as a temporary patient on several occasions, provided the review with the limited information they had available. Without being able to see the full patient records it is not possible to recognise if there is evidence of the GPs missing any opportunities to identify that there was a risk of serious harm to either Adam or Tracy or that the GP failed to share information with other agencies.

7.2.10 L&Q Housing

L&Q shared and sought advice continuously from Thames Valley Police, indeed they had regular meetings and discussions with the local officer.

7.2.11 National Probation Services, Connections

There are no issues for these services

7.2.12 Domestic Homicide Review Panel

The Panel considers that, whilst there is no real evidence of agencies not sharing information, there is still a need to recognise that agencies can call multi-agency meetings to discuss clients they are dealing with

who are or may be working with other agencies. This joint way of working is often very beneficial not only for the clients but also the services, enabling a far better and coordinated response to be given.

Panel Recommendation 4

Any agency can arrange a professionals' meeting when there is a need for a collaborative response.

7.3 Was information available that might have identified that there was a serious risk of harm to either the victim or perpetrator that was not shared with other agencies?

7.3.1 Thames Valley Police

The main area of information sharing in this review was in the MARAC. The actions set were focused on information gathering and sharing which is a core element of the MARAC process. The Victim Safety Plan had already been implemented immediately after the incident so there was little in terms of practical actions for the MARAC to generate. The one action for Thames Valley Police was to confirm where Adam was living. This was not completed until 24/06/15. This delay was acknowledged as not being best practice but explained in the context of a heavy workload in a particularly demanding role. It has been acknowledged that there is a fairly lengthy process to search MODUS for any actions allocated to officers which in this case led to a delay in the allocated officer being aware of the action. A recommendation has been made in this area.

7.3.2 STARS

There is evidence that following STARS attendance at the MARAC in May there is no records of the outcome of this meeting. This is an issue addressed in the recommendations.

In addition, there is no evidence of follow up through MARAC or with Women's Aid relating to concerns expressed by Tracy on 25th June and 2nd July.

The keyworker had identified there were safeguarding issues for Tracy but had not recorded any actions against this information, although at the time the worker did note that all 3 of Tracy's children were adopted. There is no evidence that the keyworker responded to the change of circumstances when Tracy's eldest son stayed with her for a period when he did not want to live with his father. This has been addressed in the recommendations.

The STARS IMR states that staff followed best practice in respect of case management processes. However, an area of learning for STARS was in respect to the communication with GPs. Existing pathways of care requires services to communicate when clients are prescribed methadone. In the case of Tracy, it has been identified that communication with the GP would have been beneficial, despite Tracy not being on methadone as this would have enabled a more robust approach to managing Tracy's access to benzodiazepines and anti-depressants. This communication would enable both services to understand and manage issues relating to polypharmacy of prescribed and non-prescribed medicines. This is addressed in the recommendations although not identified as a causal or contributory factor.

7.3.3 Frimley Health NHS Foundation Trust

Whilst there are no significant issues identified through the review, it is acknowledged that there were a couple of occasions when Adam presented with physical and behavioural signs which may have indicated that he was a victim of abuse and in accordance with good practice should have been asked about abuse. The review is cognisant that the victim in this review was male and so are concerned that this is a gender based issue and that in hindsight, had the victim been female, she may have been questioned about the possibility of abuse when presenting with such injuries or behaviour. There are a couple of recommendations for Frimley Health NHS Foundation Trust to improve this area, including an update of the Domestic Violence Policy and raising awareness with staff of the Emergency Department Domestic Violence Flow chart.

7.3.4 Oxford Health NHS Foundation Trust

Adam was never identified as a victim of abuse by Oxford Health and so there is no evidence of not identifying and sharing that there was a risk from Tracy on Adam.

7.3.5 Panel Observation

During the period of this review the DHR Panel had several discussions about the lack of patient information being shared between hospitals and health care professionals. At present, it appears there is limited information available to hospitals and other health professionals about the patients they see and so will not know if they have been a patient at another hospital. The Panel was concerned that there may be a degree of 'hospital shopping' if a patient is not keen for there to be a clear picture to be seen about injuries of illnesses which they may have suffered and been treated for at another hospital. Indeed, the concern is further stretched that a perpetrator may take a victim to different hospitals to avoid questions being asked and to run the risk of being identified as having attended a hospital emergency department in the past and so possibly avoid awkward questions being asked. At present, there is limited information available that can be accessed by health professionals and is contained on the Summary Care Records if a patient is registered with a GP practice in England.[24] The Panel feel for patient protection and to enable the best care to be offered to patients, there ought to be a national/central database where information can be accessed regarding hospital attendances and treatments. This is equally as relevant for any patient and not just those who may have suffered or experienced abuse.

Panel Recommendation 2

Department of Health to consider a central database for hospitals to access accurate and timely information about treatments and medications a patient has received when attending either their GP or another hospital.

7.3.6 Wycombe Women's Aid – IDVA

The IMR for WWA identified that it may have been useful, when the caseworker spoke with the DVU, to have spoken about the unborn child mentioned in the referral and whether they knew if Tracy was linked in with midwife. It may also have been useful to ask if the abuser was aware of the pregnancy because of potential escalation of the risk. It could have been beneficial to have had a discussion with DVU about the 'medium' risk level on referral and whether this needed to be reconsidered in light of pregnancy and Adam's previous history.

Before closing the file, it may have been useful to check in with the Key Worker at Oasis (STARS) to find out if Tracy was engaging with her.
There are recommendations for the service regarding these concerns.

7.3.7 SMART

The SMART IMR shows that referrals were made to partner agencies and domestic violence services wherever need has been identified. THE IMR review did not identify any missed opportunities to share information and that any information was shared in accordance with the Bucks Partnership Information sharing protocol and the requirements of MARAC.

[24] Summary Care Records - http://www.nhs.uk/NHSEngland/thenhs/records/healthrecords/Pages/overview.aspx

7.3.8 South Central Ambulance Service (SCAS)

The referrals that were made to other services in respect to the incidents attended by SCAS were undertaken appropriately and effectively. There were several occasions where safeguarding referrals should have been made and these did not taken place.

7.3.9 L&Q Housing

The only identified service issue in respect to the sharing of information was that L&Q did not attend MARAC meetings. This will be dealt with by way of recommendation to ensure a designated officer checks monthly to see if there are relevant cases for L&Q to be present for.

7.3.10 National Probation Services, Connection Floating Support

There are no issues for these services.

7.4 Did any of the agencies or professionals involved consider that their concerns were not taken sufficiently seriously or not acted upon appropriately by other agencies?

After reviewing all the IMRs for this review the Panel is satisfied that there were no concerns shared that were not taken seriously or acted upon appropriately by any agency that information was shared with.

7.5 Did the MARAC deal effectively with both victim and perpetrator in this case?

The MARAC referral for Tracy was appropriately made following an incident where Adam threatened to break Tracy's jaw and was smashing the house up. He then threatened to kill himself with a large knife and then a meat cleaver. Following this incident Tracy was assessed as being at high risk of serious harm from Adam. There was a gap of about 6 weeks after this incident before the meeting took place on 7th May 2015. This delay would not have meant that safety planning and engagement with the IDVA and TVP did not take place, indeed there was joint work on a Victim Safety Plan.

The meeting on 27th May was attended by TVP, Health, Mental Health, STARS and the IDVA. There wasn't a representative from Housing. This has been highlighted as a concern in the report and a recommendation for L&Q has been made which will ensure that if a relevant case is being heard, L&Q will be aware and send appropriate representation.

An issue with ensuring that the DV champions who attend the MARAC meeting are aware of their actions has also been identified and as a result a recommendation has been made which will require the MARAC coordinators send out the actions following the meeting.

At the meeting, there was consideration given to both the victim (Tracy) and the perpetrator (Adam) with actions relating to both. The case did not get referred back to the MARAC before Adam was murdered.

SCAS identified in their IMR that the service has tried at their board level meetings to be part of the MARAC process but that this is proving to be complicated. The subject has also been brought up at local safeguarding boards. The SCAS report contains a recommendation to implement a process to engage with MARAC.

There has been a concern identified by the Panel about agencies not making repeat referrals or failing to refer if they think that another agency has already made a referral. This is an issue which needs to be

addressed by all agencies who come into contact with those who are experiencing abuse. If there is a concern or evidence of abuse; all agencies should make a referral as each agency may hold slightly different information and so may help complete the jigsaw.

Panel Recommendation 5

Individual Agencies are responsible for submitting MARAC referrals regardless of whether other agencies have referred.

7.6 What services did the victim have contact with. If no known connections, is there a need to promote/raise awareness of local provision?

Because of the complex needs and chaotic lifestyles of both Adam and Tracy, they came into contact with many different agencies.

Both had frequent engagement with Thames Valley Police both as victims and as perpetrators. The Police made referrals to Adult Social Care in respect to Adam's mental health and the Liaison and Diversion Service and a referral to the mental health team. A referral was also made to BCC Childrens' Services when it was suspected that Tracy was pregnant. TVP was aware of the on off support that was being received by both Adam and Tracy from SMART and STARS, along with the support from the IDVA.

Both Adam and Tracy were involved with health through visits to GPs and by attending Emergency Departments. In addition, Tracy whilst not meeting with the IDVA, did have contact with the service via text and phone calls.

L&Q had frequent engagement with Tracy, and were aware of Adam but were not involved with him.

Adam was known to Connections and was seen once by them when he was rough sleeping.

Tracy was not known to Probation and Adam's only connection to the service was that Probation was required to carry out a Pre-Sentence report but never met with Adam and he failed to appear at court, resulting in a warrant for his arrest being issued by the Magistrates Court.

The Panel is satisfied that relevant services were engaged or attempting to engage with both Adam and Tracy and that there is no need to raise awareness of local provision, other than a reminder to services that despite the IDVA being managed through Women's Aid, the service can also take referrals for male victims. It is listed on the DOM5 form which would have been given to both Adam and Tracy at various times during the last year.

7.7 Does the homicide appear to have any implications or reputational issues for any of the agencies or professionals?

None of the IMRs received give any indication that there might be any implications or reputational issues for any agencies for professionals.

7.8 Does the homicide suggest that national or local procedures or protocols may need to be changed or are not adequately followed or understood?

The Panel is satisfied that there are no national procedures or protocols that need changing. Locally it has been identified that several local procedures and policies need reviewing and updating. Where these have been identified, relevant recommendations have been made for the agencies and services

concerned. None of the changes needed would have impacted adversely on this case but will in the long term improve the response that services give to victims of DV and improve working practices.

The review panel recognised a lack of local domestic violence procedures and SLAs with local partners. However, these are under development as part of the implementation of the Complex Needs Domestic Violence Pilot Project in Buckinghamshire.

During the review, it was acknowledged that this case was when the 'toxic trio' of drugs, mental health and domestic abuse were clearly intertwined. The Review has become aware of an e-learning package offered free of charge by AVA (Against Violence and Abuse) which deal with this complex issue and so recommends that services who may come into contact with these issues are signposted to this training opportunity.

Panel Recommendation 1

Services which deal with clients who have complex needs are signposted towards the e-learning package for Complicated Matters – Domestic and Sexual Violence, Problematic Substance Misuse and Mental Ill-Health.

During the review, it was identified by the DHR Panel that the Thames Valley Safeguarding Adults Policy was out of date and required reviewing and a recommendation has been made in respect to this.

Panel Recommendation 7

Thames Valley Police to review the Thames Valley Police Safeguarding Adults Policy which is currently dated 15/10/09

8. ACTION PLAN TEMPLATE

Domestic Homicide Review – Action Plan

The Panel is responsible for ensuring that all recommendations must be SMART (specific, measureable, achievable, realistic and timely) and for the completion and implementation of the Action Plan.

The Wycombe Community Safety Partnership and the Chiltern and South Bucks Community Safety Partnership will monitor the implementation and delivery of the Action Plan.

Recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date
Theme 1 – Countywide and National				
Panel Recommendation 4 Any agency can arrange a professionals' meeting when there is a need for a collaborative response.	To disseminate through agencies via training, policies and procedures.	Chair of the D&CV Strategy Group	Professionals meetings held.	September 2016
TVP Recommendation 1 Thames Valley Police to review its capacity to	Carry out a review re capacity to manage high risk	D/Supt – Crime and PVPSU (TVP)	Result of review	March 2016

manage high risk domestic abuse victims. This should look at the recent increase in victims being assessed as high risk and the reasons behind this.	domestic abuse victims.	D/Supt – PVP Operations		
Panel Recommendation 2 Department of Health to consider a central database for hospitals to access accurate and timely information about treatments and medications a patient has received when attending either their GP or another hospital.	Write a letter to Department of Health on behalf of Wycombe CSP and Chiltern & South Bucks CSP.	Wycombe CSP Chair and Chiltern & South Bucks CSP Chair.	Central database introduced.	July 2016
Theme 2 - Gender				
Panel Recommendation 6 To undertake a review of information and advice available to men about Domestic Abuse locally and nationally.	Review services available to male victims.	Chair of the D&CV Strategy Group	Current service provision reviewed, gaps identified and improvements to service provision recommended.	December 2016
FH NHS Recommendation 5 To include men as victims of domestic abuse in the content of the organisation's domestic abuse training.	Already embedded in DV training	Frimley Health NHS Foundation Trust and Buckinghamshire Healthcare Trust.	Ongoing training both at induction and regular update sessions.	July 2016
Theme 3 – Policies and Procedure				

Panel Recommendation 7 Thames Valley Police to review the TVP Safeguarding Policy which is currently dated 15/10/2009.	Review and update the Safeguarding Policy.	TVP	Policy updated.	July 2016
L&Q Recommendation 1 L&Q Housing to maintain awareness of cases and contribute to MARAC where appropriate.	A designated officer to check the MARAC list monthly via MODUS for cases relevant to L&Q and arrange appropriate attendance and follow-up action.	L&Q	Process agr4eed and implemented	
STARS Recommendation 1 Audit and improvement plan to be carried out to ensure all reviews are carried out in line with agreed pathways of care.	To be included in and monitored through forward audit programme 2016/17.	South Staffordshire and Shropshire Healthcare Trust – STARS. Clinical Lead, Inclusion	Audit and improvement plan created, implemented and monitored.	March 2017
TVP Recommendation 2 Thames Valley Police to ensure compliance with the SOP requirement for DAIU DI's to review high risk domestic abuse cases within 72 hours.	Review high risk DA cases to establish level of compliance.	D/Supt – Crime and PVPSU (TVP) D/Supt – PVP Operations	Result of review	July 2016
TVP Recommendation 3 Thames Valley Police to provide guidance in	Create suitable guidance and deliver to relevant staff.	D/ Supt – Crime and PVPSU	Copy of the guidance	March 2016

relation to what a holistic supervisory review of a high risk domestic abuse victim should include.				
TVP Recommendation 4 Thames Valley Police to ensure there is clarity for MARAC Co-ordinators and DAIU staff of the process and responsibilities for repeat referrals into MARAC.	Create suitable guidance and deliver to relevant staff.	D/Supt – Crime &PVPSU	Copy of the guidance	April 2016
TVP Recommendation 9 Thames Valley Police to support and develop consistent practice of Domestic Abuse Risk Assessors.	Develop new monitoring process.	D/Supt Crime and PVPSU (TVP) D/Supt – PVP Operations	Process agreed and Assessors using monitoring process	July 2016
FH NHS Recommendation 1 Update the Domestic Abuse Policy to reflect current legislation and guidance.	Update Domestic violence policy in Line with National Guidelines and Local Operations	Frimley Health NHS Foundation Trust and Buckinghamshire Healthcare Trust.	Policy updated	August 2016
FH NHS Recommendation 2 To raise awareness of the Emergency Department domestic abuse flowchart.	Policy under review along with posters	Frimley Health NHS Foundation Trust and Buckinghamshire Healthcare Trust.	Copies of flow chart and supporting information under review	August 2016
WWA Recommendation 1 To implement operating procedures for staff to	1. Develop a generic check list of activities 2. Monitor how well the check list is working	Manager Wycombe Women's Aid	Check list of activities created, monitored and reviewed.	End of November 2015

follow when providing services.	3. Meet to review check list and make any changes			
SCAS Recommendation 4 SCAS to implement a process to engage with MARAC.		SCAS	SCAS has the ability to flag any high risk MARAC cases just need the information to complete this	
Panel Recommendation 13 SCAS to review the Service guidance on requesting Police attendance for 999 calls where there is a concern about safety of staff or violence is possible.	Review current policy	SCAS	Review completed	September 2016
Theme 4 – Training at all levels				
Panel Recommendation 5 Individual agencies are responsible for submitting MARAC referrals regardless of whether other agencies have referred.	Include in the BCC Community Safety MARAC training package. Letter sent to all services via MARAC Chair.	BCC Community Safety Team and MARAC Chair.	Training package updated. Letter sent	September 2016
SMART Recommendation 2 Provision of domestic abuse and MARAC training to all SMART teams.	Disseminate training to all of Bucks staff	SMART – Service Manager	All training has been designed and accredited	May 2016

SMART Recommendation 6 Training on risk assessment delivered to all SMART staff within the local team meeting schedule.	Risk assessment practise standards written Team meeting workshops delivered	SMART– Service Manager	Attendance documented	June 2016
SMART Recommendation 7 All SMART staff to be aware of the local domestic abuse champions/ leads within their service and referral pathways where there are concerns or disclosure.	IDVA team attend team meetings	SMART– Service Manager	Staff now aware and using appropriate referral pathways	October 2015
STARS Recommendation 2 All staff to complete child protection training commensurate with their role.	All staff to be up to date with mandatory training in safeguarding.	South Staffordshire and Shropshire Healthcare Trust – STARS. Service Lead Inclusion Buckinghamshire	All staff fully safeguard trained.	December 2016
TVP Recommendation 5 Thames Valley Police to ensure MARAC co-ordinators include a summary of MARAC discussions and actions in the Risk Management Occurrence.	Create suitable guidance and deliver to relevant staff.	D/Supt – Crime & PVPSU	Copy of the guidance.	April 2016
TVP Recommendation 8 Domestic Abuse Risk Assessors training to include	Review current training of Risk Assessors.	D/Supt – Crime &PVPSU	Result of review	July 2016

the risks of gender bias and the risks associated with dual perpetrators.		D/Supt – PVP Operations		
TVP Recommendation 10 Thames Valley Police to clarify roles and responsibilities of custody officers when detaining a person pending a mental health assessment.	Review of current guidance available to Custody Staff and create guidance.	Criminal Justice Supt	Copy of the guidance	April 2016
TVP Recommendation 11 All custody officers to complete the mental health training module 'Safer detention' which relates to detainees who are suspected of suffering from mental health issues.	Review current training package and assess if fit for purpose.	Criminal Justice Supt	Training module completed by relevant staff	February 2016
Panel Recommendation 8 To review guidance for risk assessment information for Information Research Bureau (IRB) staff.	Review guidance and share learning with relevant staff.	Thames Valley Police	Staff are aware of updated guidance.	August 2016
FH NHS Recommendation 3 To complete a Trust Domestic Violence Training	Review undertaken	Frimley Health NHS Foundation Trust	Awareness training being delivered to staff including signposting to	August 2016

needs analysis			the DASH liaison person located in the ED	
FH NHS Recommendation 4 Develop a Trust Domestic Violence training strategy identifying specific levels of training required for identified staff groups/ clinical areas.	Review undertaken	Frimley Health NHS Foundation Trust	Now employed DV liaison officer and elected DV Lead in ED. All levels of staff receive training in process follow up and flagging to DV Liaison person and DV Lead.	June 2016
SCAS Recommendation 1 Ensure that all SCAS staff are trained to a level commensurate with their role in Adult Safeguarding.		SCAS	Face to face training	April 2016
Panel Recommendation 1 Services which deal with clients who have complex needs are signposted towards the e-learning package for Complicated Matters – Domestic and Sexual Violence, Problematic Substance Misuse and Mental Ill-Health.	Share the e-learning package with relevant agencies.	Countywide D&CV Strategy Group	E-learning package shared with all Bucks DV Champions.	June 2016
Theme 5 – Information sharing and record keeping				
Panel Recommendation 9	Undertake review	Oxford Health NHS	Review carried out and improved information	September 2016

Review and improve the process of information sharing between CMHT (Community Mental Health Team) and inpatient services.		Foundation Trust	sharing.	
Panel Recommendation 3 GP practices which receive correspondence about patients who are not registered with them should contact the sender to advise them of this.	Learning shared with GP practices about referrals from non-registered patients.	Safeguarding Team - Clinical Commissioning Group.	Advice sent to GP practices.	May 2016
SMART Recommendation 3 Develop Information Sharing and recording processes from MARAC meetings involving service users.	Record information from MARAC meeting correctly on ILLY	SMART– Service Manager	Illy is up to date regarding MARAC actions	May 2016
SMART Recommendation 4 SMART & STARS to develop integrated working practices over recording and sharing information about MARAC cases.	Identify a MARAC leads within Bucks	SMART & STARS	Partnership and shared working between SMART & STARS at MARAC meeting for attendance and dissemination of information	May 2016
SMART Recommendation 5 A review of record keeping practices should be undertaken across the organisation to ensure consistent quality of case notes and record storage. This is to be initially undertaken via local	This is to be initially undertaken via local case notes file audits.	SMART– Service Manager	Internal and external Audit completed	June 2016

case notes file audits				
BCC Recommendation 1 Parenting assessments on adults resulting in significant findings should be recorded and accessible when relevant.	Change to recording process	Head of Children Social Care	New process to be agreed and implemented	September 2016
WWA Recommendation 2 The IDVA Manager to ensure that notes are taken and kept of all group case management meetings.	Re-instate note taking at case management meetings	Manager WWA	Case management notes are more detailed.	2/12/15
WWA Recommendation 3 The IDVA Manager to regularly audit random case files to establish consistency and conformity of the service provided by the IDVA team.	IDVA Manager to arrange regular random audits.	Manager WWA	Spot checks completed and consistency in files achieved.	Ongoing
STARS Recommendation 3 Team leaders attending MARAC to record the MARAC discussions in the client record on ILLY and feedback information from keyworkers.	All team leaders to be reminded of need to record and share MARAC discussions on ILLY.	South Staffordshire and Shropshire Healthcare Trust – STARS. Service Lead Inclusion Buckinghamshire	ILLY up to date with MARAC information.	June 2016
STARS Recommendation 4 Inclusion services to develop processes to inform	All team leaders to be reminded of need to share risks with GP and monitor	South Staffordshire and Shropshire Healthcare Trust –	GPs informed of client's involvement with the	July 2016

the client's GP of involvement with services.	through on-going supervision.	STARS. Service Lead Inclusion Buckinghamshire	service.	
TVP Recommendation 4 Thames Valley Police to develop a system through NICHE/MINERVA (record management system) to alert the DAIU Detective Inspectors when a high risk domestic abuse victim's review is required.	Create notification tool to alert DAIU D/Is that a high-risk DA review is due.	Performance Management Lead D/Supt – C&PVPSU D/Supt – Force Change	NICHE/ MINERVA	February 2016
TVP Recommendation 6 Thames Valley Police MARAC co-ordinators to provide a list of allocated actions following MARACs within three working days.	Create suitable guidance and deliver to relevant staff.	D/Supt – Crime & PVPSU	Copy of the guidance	April 2016
TVP Recommendation 12 Neighbourhood Policing Teams to record any actions (multiagency or otherwise) taken as part of safety planning for a Domestic Abuse victim in the victim's Risk Management Occurrence on NICHE.	Reminder to be provided to NPT.	D/Supt– C&PVPSU	NPTs advised of new requirement	April 2016
Panel Recommendation 10 To ensure follow up letters to GP practices are	Oxford Health to undertake a dip sample audit of cases to establish where and when referral letters to GPs are	Oxford Health NHS Foundation Trust	Review undertaken and actions implemented.	November 2016

sent and recorded.	sent to.			
SCAS Recommendation 2 To provide assurance that the new Electronic Patient Records system is being followed appropriately.	Via an audit.	SCAS	A quality audit was completed in February 2016 as part of a multi-agency team	Feb 2016
Panel Recommendation 11 BCC Children's Services undertakes a review of the processes for recording and indexing information received and of referrals made, to ensure that key information is recorded and acted on appropriately.	Undertake a review	BCC Childrens' Services	Review undertaken	December 2016
Theme 6 – Client Engagement				
SMART Recommendation 1 Targeted and proactive outreach work should be employed with service users identified as having multiple and complex needs.	Dedicated outreach team	SMART– Service Manager	Blue light workshop provided to all outreach staff	May 2016

WWA Recommendation 4 Wycombe Women's Aid Leadership Team to consider further ways of engaging with clients who are hard to reach.	1. Discuss at Leadership Team meeting and prepare for team meeting 2. Explore ideas in team meeting and decide on way forward. 3. Assess progress in managerial supervision/ case management sessions with IDVAs.	Manager WWA	More flexible IDVAs about where they meet clients. Skype sessions offered. IDVAs to be more informal in developing rapport and accept it may take longer to complete paperwork.	1. 19/11/15 2. 2/12/15 3. Ongoing
SCAS Recommendation 3 SCAS to review the provision of mental health expertise within the Emergency Call Centre		SCAS	SCAS has held interviews for a MH practitioner but as of this time no person has accepted the job	Ongoing

9. GLOSSARY OF TERMS

AE (A&E)	Accident and Emergency
CMHT	Community Mental Health Team
BCC	Buckinghamshire County Council
CPR	Cardio-Pulmonary Resuscitation
DAIU	Domestic Abuse Investigation Unit
DASH	Domestic Abuse, Stalking Honour Based Violence Risk Assessment form
DASH IRB	Information Research Bureau
DHR	Domestic Homicide Review
DNA	Did Not Attend
DOM5	A domestic abuse risk assessment form
DV	Domestic Violence
DVU	Domestic Violence Unit (the DAIU)
GP	General Practitioner
IDVA	Independent Domestic Violence Advocate
ILLY	A Case Management System
IMR	Individual Management Review
MARAC	Multi- Agency Risk Assessment Conference
MASH	Multi- Agency Safeguarding Hub
MODUS	Domestic violence software
NFA	No Further Action
NHS	National Health Service
NICHE	TVP's record management system
NSO	Neighbourhood Support officer
OHFT	Oxford Health Foundation Trust
PACE	Police and Criminal Evidence Act 1984
PCSO	Police Community Support Officer
PEC	Police Enquiry Centre

PIN	Police Information Notice
RAM	Risk Assessment Matrix
SCAS	South Central Ambulance Service
SLA	Service Level Agreement
SOP	Standard Operating Procedure
SPOC	Single Point of Contact
TVP	Thames Valley Police
WPH	Wexham Park Hospital
WWA	Wycombe Women's Aid