# FINAL REPORT

# DOMESTIC HOMICIDE REVIEW:

## INDEPENDENT OVERVIEW REPORT
## INTO THE DEATH OF
## 'Janice'

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## PART 1:  DOMESTIC HOMICIDE REVIEW, BACKGROUND AND PROCESS

### 1.1 Purpose of 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. In order 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 in order to reduce the risk of such tragedies happening in the future.

### 1.2 Who the report is about:

This DHR is about *'Janice'* [1], who was 46 when she died as a result of domestic violence perpetrated by her partner '*Ian*'. The following description of Janice's background is based mainly on information provided by her family members in the course of police enquiries following the homicide. The family were unable to provide precise dates for some periods of Janice's life, much of which was spent abroad in the USA and in parts of Europe.

Janice was born in Blackburn and had 2 sisters. Both of her parents were alcohol dependent and died a number of years ago. Having spent her formative years in Blackburn, in her late teens Janice travelled through Europe working as a Nanny.

Whilst in her 20's Janice moved to the USA, where she met her first husband, with whom she had a son (born 1994) and a daughter (born 1997) This is reported to have been a happy marriage whilst the children were young. However, Janice's family report that she drank excessively and that this became more problematic after she started working in a local bar. Ultimately the marriage broke down and Janice's son and daughter remained in the care of their father.

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[1] For reasons of confidentiality, pseudonyms of 'Janice' and 'Ian' (homicide victim and perpetrator, respectively) are used throughout the report. Other pseudonyms are used for family members, ex-partners, etc.

Following the breakdown of her first marriage, Janice married another USA citizen. Janice's family described her second husband as having had alcohol and drug problems, leading to a further increase in Janice's excessive use of alcohol. Janice was arrested for being drunk and disorderly, at which point it was discovered by USA authorities that she did not have citizenship to stay in the country. She remained in prison in the USA for 18 months before being deported back to the UK. Whilst she was in prison, her second husband died.

On her return to the UK in 2008, Janice lived with her sister in Blackburn and commenced work at a local hotel where she organised events. Janice's sister described her as being very good company when she had her drinking under control, but also recalled that Janice could be short tempered and volatile for no apparent reason.

After a period of time Janice moved out of her sister's house to live with a friend in the Blackburn area. At some point after that she was prosecuted for drink driving, following which she moved to Spain.

Whilst in Spain Janice formed a new relationship with a man whose details are not known. Neither had jobs and they lived a nomadic lifestyle, moving from hostel to hostel. The family describe the relationship as a volatile one during which Janice suffered domestic abuse. She would often ask her sisters for money and on 2 occasions they funded flights back to the UK as they were concerned about this abuse.

In Autumn 2014 Janice flew back from Spain to the UK, on a flight paid for by one of her sisters. It appears that she spent some weeks with a male friend in London before travelling to Leicester to stay with a female friend whom she had previously met in Spain. This friend has since advised that Janice's behaviour became aggressive as a result of excessive alcohol consumption and after a period of about 2 weeks she wanted Janice to leave. Janice presented to

Leicester's Homelessness Prevention and Support Service, and was accommodated at the Dawn Centre (temporary homeless accommodation) in November 2014. At this stage, Janice disclosed that she had recently been violently assaulted by a male friend in London, resulting in an injury to her finger.

Janice informed clinicians at GP Practice 1[2] that she had a history of mental health problems, including a bi-polar disorder. As this reported history was when she was living abroad, it is uncertain whether or not there had been a confirmed or reliable medical diagnosis of a bi-polar condition. GP Practice 1 clinicians did not identify symptoms of a bi-polar disorder or any other type of psychosis, but Janice was prescribed medication for anxiety.

Janice had serious problems of alcohol misuse, including particularly episodes of excessive consumption (binge drinking), when it seems that her behaviour could become out of control. She appeared not to have had a serious physical addiction to alcohol, or any other substances. When sober, she presented as having a socially confident and bright personality, with no reason to question her mental capacity to make decisions about her life and life-style.

**November 14 – May 2015:**

Part 2 of the report provides more detailed description and analyses of events during this last period of Janice's life. The following is a brief outline:

Janice had 2 stays at the Dawn Centre:

- Around 4 weeks in November / December 2014
- One night in January 2015

Janice left the Dawn Centre voluntarily in December 2014, when she went to stay with her sister in Blackburn for a short period, before being re-admitted to the

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[2] This GP Practice is a Community Interest Company. It specialises in working with people who are homeless or in temporary accommodation.

Dawn Centre around 3 weeks later. After 1 night Janice was asked to leave as she was suspected of supplying illicit substances to another resident.
After leaving the Dawn Centre until the homicide (around 15 weeks later) Janice had no secure or stable accommodation. On occasions, she stayed at Ian's address, where there were a number of reported domestic violence incidents. Some of these incidents resulted in the involvement of the police, emergency medical services and other agencies, as detailed in part 2 of this report.

**1.3 Perpetrator background:**

At the time of the homicide Ian was 44 years old. He was born in the Republic of Ireland and moved to Leicester around 1998, following an incident in Ireland that resulted in one of his family members being stabbed. In 1998 (aged 27 years) he formed a relationship with *'Karen'* [3] who was then 16 years old. The following year the couple moved from Leicester to Dublin, where their first child was born. Ian and Karen went on to have 2 more children born in 2002 and 2004. The family unit returned to live in Leicester in 2004. It was reported that Ian had decided to leave Ireland after a violent incident with a man who Ian believed had assaulted his brother[4]. The relationship between Ian and Karen was volatile with reported incidents of violence, threats and abuse resulting in the involvement of Leicestershire Police (see table below for further detail). Excessive use of alcohol by Ian was a common factor in all of the reported incidents. It is understood that the couple separated at some point during 2005.

Following this, it appears that Ian had a number of short term relationships with women. Some of these relationships also featured police involvement following reports of violent or aggressive behaviour by Ian when under the influence of alcohol. During this period, he was well known to Leicester's Homeless Outreach

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[3] Karen is a pseudonym used for reasons of confidentiality

[4] This reported incident was outside UK police jurisdiction and the full details of what took place remain unclear.

Team as a person with a history of rough sleeping and street drinking behaviours.

Ian's last relationship (prior to meeting Janice) was with '*Linda*'[5]. The couple had lived together, but the relationship ended as a result of Ian's excessive and problematic use of alcohol. There is no reported history of violence in this relationship. In November 2014 Ian referred himself again to homelessness services in Leicester. With support, he secured a privately rented flat in Leicester. This flat was the location of the homicide.

Ian has 8 previous convictions which involve the commission of 12 offences. The majority of these convictions involve alcohol abuse and violent behaviour. The following is a summary of the history of police involvement with Ian, prior to the start of his relationship with Janice:

| **Summary of incidents** | **Outcome** |
|---|---|
| **April 2005 (Following Ian's separation from Karen)** Karen reported a burglary. The offender had broken in through a glass panel in a back door, consumed a large quantity of alcohol and food, then boarded the door back up. Ian was arrested and charged with an offence of criminal damage | Charge withdrawn: Insufficient evidence |
| **May 2005** Ian attempted to force entry to Karen's house and threatened to throw a wheelie bin through the window | Ian was arrested and charged with using violence to secure entry to premises. Released on bail with conditions. |

[5] Linda is a pseudonym used for reasons of confidentiality

| | |
|---|---|
| **June 2005** Ian gained entry to Karen's house around 6am, when Karen was in bed. She heard loud music downstairs and found Ian, who initially refused and shouted at her, before eventually leaving. As a consequence of this incident Karen and her children moved to a women's refuge for a period, as she feared for her safety. | **Criminal conviction:** Ian was being sought by the police for this and the previous offence. He was arrested about a week a later and after period remanded in custody, he was fined for these offences |
| **Nov 2005** Police records show that Ian had been in a new relationship with *'Jane[6]'* since July 2005. In Nov 2005 it was reported that Jane was approached by Ian in Leicester city centre (around 11am), when he verbally abused her and made threats to injure her. She walked to the police station with Ian following her. After she left the police station it was reported that:<br><br>• Ian grabbed her and dragged her across the road, causing injuries to her knee.<br>• Took a carrier bag from her, which contained 4 cans of lager.<br><br>Later on the same day it was reported that Ian again approached | Police investigation failed to identify any independent witnesses. In early December Jane was seen by officers but she refused to give any further statement or to assist with the investigation, describing the incidents as 'inconsequential'. It appeared she was still in a relationship with Ian at this time. No further police action was taken against Ian in relation to these alleged incidents. |

[6] Jane is a pseudonym used for reasons of confidentiality

| | |
|---|---|
| Jane in the street, when it was alleged that:<br>• He was verbally abusive<br>• He grabbed Jane from behind<br>• He subjected Jane to a sustained assault, head-butting her several times and striking her head against a wall.<br><br>At this stage police officers attended the scene and arrested Ian. In addition to Jane's injuries it was noted that Ian had grazing to his hands and a bruised cheekbone. | |
| **October 2006:** Jane (now resident at Dawn Centre) reported that Ian had assaulted her. Dawn Centre staff confirmed that Jane had facial injuries | Ian was interviewed by the police on the same day and denied the allegation of assault. As there was no independent witness, no further action was taken in respect of this allegation |
| **December 2006:** Police were called to hostel in Leicester after a report that Jane had been assaulted. She was seen to have severe bruising and swelling to her face. | **Criminal conviction / 3-month prison sentence:** A number of witnesses at the hostel were identified. Ian was interviewed and claimed that Jane had instigated the violent incident and he had retaliated with a 'slap'. He said he then blacked out and had no recollection of what followed. He was remanded in custody before pleading guilty to assault occasioning actual bodily harm (ABH) and received a 3-month prison sentence. |

| **April 2008:** Metropolitan Police officers attended a flat in Stoke Newington (London). At this time Ian was in a relationship with a different partner, *'Beryl'.* Beryl stated that Ian had placed his hands round her throat and tried to strangle her. She was recorded as being in a very distressed state and told officers that there had been a gradual escalation of violence towards her by Ian, in the preceding few months. | **Criminal conviction / 3-month prison sentence:** Ian was arrested and admitted the assault. He was convicted for common assault and received a 3-month prison sentence. |
|---|---|
| **June 2011:** Karen reported to the police that Ian had gone to her home address and banged on the door. Demanding to see one her children. | No police action followed as no offences were reported. |

From 2008 until the commencement of his relationship with Janice, there is no further record of police involvement with Ian. There were several more police incidents involving Ian and Janice in the period from Jan 2015 until the homicide in May 2015. These incidents are described in Part 2 of this report.

**1.4 Janice and Ian's relationship**

Janice and Ian's relationship commenced at some time between late November 2014 and early January 2015. Agency IMRs indicate that none of the services involved with Janice or Ian had knowledge of the relationship until January 2015.

At this time, Ian was already well known to the services based in the Dawn Centre building, including the hostel itself and GP Practice 1 which provides primary health care services to hostel residents and other people in the locality

affected by homelessness and complex needs. Ian had recently moved into his privately rented flat, with support from homelessness services and the Anchor Centre (city centre day service for street drinkers).

The collective evidence from agency IMRs suggests that a significant feature of the relationship was mutual binge drinking followed by verbal conflict, escalating to physical violence. When violent incidents were reported (to the police or other services) it often proved difficult to reliably ascertain whether Ian or Janice had been the primary instigator.

Throughout the period of the relationship, Ian was resident as the sole tenant of his privately rented flat. Janice's first presentation as being homeless in Leicester was in November 2014. She was resident at the Dawn Centre for 2 relatively short periods (as detailed at 1.2 above) but apart from this she had no secure accommodation. She may on occasions have slept rough or stayed with other people, but this detail is unknown.

For some periods Janice stayed overnight in Ian's flat, but she would then leave - or be ejected by Ian – often following an alcohol fuelled conflict. During daytime periods Ian and Janice sometimes attended the Anchor Centre, either together or separately.

In summary:

- When the homicide happened Janice and Ian had known each other for around 6 months.
- It had been a highly volatile relationship between 2 people who each had a long history of alcohol misuse, street drinking and periods of homelessness.
- Ian had a history in previous relationships as a perpetrator of domestic violence, including some serious assaults resulting in prison sentences. This pattern of behaviour continued in his relationship with Janice.

- Janice had a history in previous relationships as a victim of domestic violence.

**1.5 Outline summary of the homicide incident:**

At around 7.30 am on a Saturday morning, Leicestershire Police received an anonymous telephone call stating that a woman had been murdered at Ian's address, which was a flat (situated in a block of flats) in Leicester. The male caller rang off before any further detail could be obtained. Police officers attended at 7:50pm but were unable to gain entry to the block. The supervisory officer present concluded that the available information / intelligence did not justify the use of force to enter the flats and the incident was closed.

The following day (Sunday) , the incident was reviewed and further intelligence checks were completed. That process identified previous incidents involving Ian and Janice at this address. Entry was forced into the flat at 12:23pm when Janice's body was discovered.

A forensic pathologist's report was unable to specify the cause of death, but a guilty plea to manslaughter was accepted by the prosecution. Ian had admitted placing Janet in a choke hold, during an alcohol fuelled row. The Court were informed that he did not intend to kill his victim.

**1.6 Police Professional Standards investigation**

The initial police response to the anonymous phone call was referred to the Independent Police Complaints Commission (IPCC) who decided the matter could be investigated locally by the Leicestershire Police Professional Standards Department (PSD).

The PSD investigation concluded that the failure to force entry to the flat on the Saturday would not have saved Janice's life as it is believed she had been dead for approximately 12 hours prior to the telephone call. However, in light of the available intelligence and information regarding domestic incidents at the address, the investigation found that the supervisory officer should have taken greater steps to

identify the actual premises. It was recommended that management advice should be given to that officer.

### 1.7 Decision to carry out a DHR

The statutory Home Office Guidance [7] on the conduct of DHRs states:

*"Domestic Homicide Review means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—*

*(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or*

*(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.*

*Where the definition set out in this paragraph has been met, then a Domestic Homicide Review must be undertaken."*

In this case, the presenting evidence was that the couple had been in an intimate relationship (but not formally co-habiting) for a period of several months leading up to the homicide incident. On this basis, Leicester CSP confirmed that a DHR would be undertaken, in line with their statutory responsibilities.

### 1.8 Review timescales:

Home Office guidance suggests a target period of 6 months for the completion of DHRs. This DHR has taken nearly 12 months from outset to completion. This has been due to a number of factors, including the need to wait for completion of the criminal process so that DHR enquiries would not unduly interfere with the criminal case which concluded in autumn 2015.

### 1.9 Confidentiality:

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[7] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised version, August 2013. Home Office

Pending Home Office approval for publication of the report, the DHR panel and Leicester CSP have managed all information about this case as highly confidential. Information sharing has been restricted to members of the DHR Panel, their line managers and senior managers of services which provided Individual Management Reviews.

**1.10 DHR Panel**

There was no Adult Services involvement in this case, allowing Adult Services Directorate senior managers to chair meetings with professional independence. The Panel Chairs were:

- Mr. Paul Kitney, Head of Service Adult Safeguarding, Leicester City Council (first 2 meetings).[8]
- Ms. Ruth Lake, Director Adult Social Care & Safeguarding Leicester City Council (subsequent meetings).

Independent Consultant Richard Corkhill[9] was appointed as Overview Report Author. Mr. Corkhill has been a self-employed consultant since 2004. His professional background includes practitioner and senior manager roles in the social care and supported housing sectors. In the last 4 years, he has worked as a DHR Chair / Author for a number of different Community Safety Partnerships. He has never been employed by any of the organisations which had involvement in this case.

In addition to the Chair and Report Author, the Panel included representation from the following organisations:

- Action Homeless
- Anchor Centre

[8] Mr. Kitney left his employment with Leicester City Council during the course of the DHR and was replaced as DHR Panel Chair by Ms. Lake.

[9] Further information about the report author can be found at: www.richardcorkhill.org.uk

- GP Practice 1
- Leicester City Clinical Commissioning Group
- Leicester City Council Domestic Violence Coordinator
- Leicester City Council Housing Options & Homelessness Services
- Leicestershire Partnership NHS Trust
- Leicestershire Police
- Living Without Abuse
- Nottingham City Council Domestic Violence service
- Nottingham University Hospitals NHS Trust
- SAFE (Non-statutory domestic violence service)
- University Hospitals of Leicester NHS Trust

Administrative support was provided by Leicester City Council.

**1.10 Terms of reference**

Each of the agencies which had been identified as having significant and relevant involvement with Janice and / or Ian carried out an Individual Management Review (IMR) of that agency's involvement. The terms of reference required IMRs and this overview report to address the following questions, covering the period from September 2014 until Janice's death.

**DHR TERMS OF REFERENCE AS AGREED BY SAFER LEICESTER**

1. To review whether practitioners involved with Ian and Janice were knowledgeable about potential indicators of domestic violence and aware of how to act on concerns about a victim or perpetrators

2. To establish how professionals and agencies carried out risk assessments, (including assessment of the victim's mental capacity to make decisions relating to risks) including:
   i) whether the risk management plans were reasonable response to these assessments.
   ii) whether police DV risk assessments and management plans of Ian took account of his early forensic /criminal history, and assessments of risk made during this period.
   iii) whether there were any warning signs of serious risk leading

up to the incident in which the victim died that could reasonably have been identified, shared and acted upon by professionals

iv) whether risk assessments considered risk to individuals when services were withdrawn

3. To identify whether services involved with Janice and/or Ian were aware of the circumstances of Janice presence in the home and agencies involved with them. Whether connections were made and information shared between these services in order to establish a full picture of the vulnerability and risks arising from the relationship.

4. Did agencies involved make routine enquiry about domestic violence when working with these adults and if so were any opportunities missed.

5. To establish whether agencies responded to alcohol and drug dependence and offered appropriate services and support to Ian and Janice.

6. At each point of contact with services for assaults, self-harm and injuries –were enquiries made about Domestic Violence and procedures followed?

7. To establish whether mental health needs of the adults subject to this review were supported and managed appropriately by local agencies.

8. To establish if any agency or professionals considered any concerns were not taken seriously or acted upon by others.

9. To establish if there were any barriers experienced by Ian, Janice or family / friends that prevented them from accessing help to manage domestic violence; including how their wishes and feelings were ascertained and considered.

10. To identify whether more could be done locally to raise awareness of services available to victims of domestic abuse.

11. To establish whether agency DV risk assessments and response to risk followed agreed local multi-agency procedures.

12. To establish how referrals into MARAC were responded to, whether these responses were in line with local multi-agency procedures and whether they were appropriate, in the light of information about risk

which was available at the time of referral.

13. To establish whether vulnerable adult / adult safeguarding concerns were recognised by agencies and were appropriate multi-agency procedures followed.

14. To consider how issues of diversity and equality were considered in assessing and providing services to Ian, Janice (protected characteristics under the Equality Act 2010 age; disability; race; religion or belief; sex; gender reassignment; pregnancy and maternity; marriage or civil partnership)

15. How effective were local assessments on Ian & Janice's housing needs? Was appropriate housing support offered? How well did Leicester and Nottingham Housing agencies work together in safeguarding Janice?

16. To establish how effectively Leicester / Nottingham agencies and professionals worked together to safeguard Janice.

17. To establish whether domestic violence policies, protocols and procedures (including risk assessment tools) that were in place during the period of review, were applied and whether they were fit for purpose.

### 1.11 Chronologies and Individual Management Reviews

Chronologies and IMRs were provided by the following organisations:

| Organisation | Primary reason for contact<br>With perpetrator (and/or) victim |
|---|---|
| Leicestershire Police | Call outs to domestic incidents (P&V) & homicide response |
| Leicester City Council Homeless Prevention & Support Service | Periods of accommodation at Dawn Centre hostel (P&V separately) |
| Leicester City Council Housing Options Service | Housing applications (P&V separately) |
| SAFE Project | Domestic violence helpline contacts |

| | |
|---|---|
| | (V) |
| GP Practice 1 | G.P. and other primary healthcare services (V & P) |
| University Hospitals of Leicester NHS Trust | Treatment at Emergency Department, Leicester Royal Infirmary (V) |
| George Eliot Hospitals NHS Trust[10] | Treatment at Urgent Care Centre, Leicester Royal Infirmary (V) |
| Anchor Centre | 'Wet' day centre for street drinkers (V&P) |
| Nottingham University Hospitals NHS Trust | Treatment at Emergency Department, Queens Medical Centre (V) |
| Leicestershire Partnership NHS Trust | Community mental health services |

**1.12 Involvement of family members and friends:**

Janice's sister in Blackburn was invited to contribute to the DHR and it was hoped that she may also facilitate communication with Janice's (now adult) children who remain resident in the USA. This invitation was declined.

The female friend that Janice met in Spain and stayed with for a short period in Leicester was also contacted, but she also chose not to take any part in the DHR.

**1.13 Meeting with perpetrator**

The perpetrator accepted an invitation to contribute to the DHR and was visited in prison by the report author and Leicester City Council's Domestic Violence Coordinator. His prison based Offender Supervisor was also in attendance.

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[10] At the time these events occurred the Urgent Care Centre was managed by George Eliot Hospitals NHS Trust whilst the Emergency Department (on the same hospital site) was managed by UHL. The Urgent Care Centre has since been taken over by the UHL Trust. Separate IMRs were provided, in relation to events at Emergency Department and the Urgent Care Centre.

Contents and learning points from this meeting are summarised in part 3 of this report.

**PART 2: CHRONOLOGY OF AGENCY INVOLVEMENT:**

**ANALYSIS AND KEY LEARNING**

**Introduction**

This section of the report provides a chronological overview of the most significant incidents and agency contacts with Janice and Ian during the critical period from Janice's first arrival at the Dawn Centre , until the homicide around 5 months later.

It also includes sections of analysis and key learning, set out as follows:

| **Analysis & key learning**<br>Where events and agency responses have resulted in important points of key learning, this is highlighted and placed within boxes.<br><br>The purpose of this format is to ensure separation between factual accounts of what took place and analytical content. |
|---|

**November 14:** Janice made a homeless declaration to Leicester City Council's Housing Options service, as the friend she had been staying with was no longer willing to allow this arrangement to continue. From the information, available it appears that Janice and Ian's relationship had not commenced at this point in time. In her homelessness assessment Janice stated that she was fleeing from a domestic violence incident which had occurred in London. (The precise date of this incident is not known, but it appears to have been 2-3 weeks earlier). Janice was offered and accepted temporary accommodation at the Dawn Centre. The Housing options IMR notes that the Janice was assessed as vulnerable (i.e. the legal definition of vulnerable under homeless legislation) due to her reported bi-polar disorder and being at risk of rough sleeping.

Following advice from a Leicester GP practice[11], Janice presented at the Leicester Royal Infirmary (LRI) Emergency Department, (part of UHL NHS Trust) with an injury to her finger, which she said had been inflicted in the domestic violence incident in London, some 3 weeks earlier. She had already given the GP practice the same information about the cause of this injury.

The UHL IMR clarifies that this was a ‘mallet injury', which is common minor injury to the finger usually associated with accidental trauma and not commonly seen as a result of violent assault.

Janice was provided with appropriate treatment for her injury. A nurse arranged a follow up appointment for 1 week later and recorded: "*discuss DV in view of 3 week delayed presentation".*

**December 2014:** Janice attended the follow up appointment at LRI and was seen by a doctor at the fracture clinic who took the opportunity to discuss the incident which caused the injury. It was recorded by the doctor that *'call was not counted as domestic violence, according to her, as it happened on the street.'*

No formalised or recorded domestic violence risk assessment was undertaken by any of the services (i.e. homeless service, GP practice, Emergency Department or the fracture clinic) in relation to this disclosure of domestic abuse.

**December 2014**:Janice registered with the Anchor Centre. (At this time, Ian had been a long-standing client of the Anchor Centre.) At her initial registration with the Anchor Centre she disclosed that she had a history of depression in the past, when she had been victim of domestic violence.

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Care Centre has since been taken over by the UHL Trust. Separate IMRs were provided, in relation to events at Emergency Department and the Urgent Care Centre.

**December 2014**:Janice registered with GP Practice 1. (Specialist primary healthcare service for people who are homeless or vulnerably housed). **On the following day** Janice attended an initial GP appointment and advised she was waiting for emergency dental treatment for a cracked molar, after being beaten up by an ex-partner. This appears to have been related to the same incident in London when she sustained the injury to her finger, although records are not entirely clear on this point. There was no suggestion that she had any ongoing contact from the person who had beaten her up or that this person presented an ongoing threat. Janice was referred to the Homeless Mental Health Service. There is no record of any further discussion at this appointment in relation to domestic violence. On the next day, Janice was seen again at GP Practice 1 for a physical health check, when it was noted that her alcohol consumption was very high. Referral to a specialist alcohol service was discussed, but Janice felt she would get support with this at the Dawn Centre and declined a referral. Domestic violence issues were not discussed.

2 days later Janice was seen again at GP Practice 1, for a New Patient Check with the Practice Nurse. This included use of 'Alcohol Use Disorders Identification Test (AUDIT) for which she scored 19[12]. Domestic violence was discussed at this appointment and Janice disclosed that she had a history as a victim of domestic violence in previous relationships over a period of 15 years. Janice was offered a referral to SAFE (voluntary sector domestic violence service) but she declined, stating that she was no longer in an abusive relationship. A week later she had another appointment at GP Practice 1 for routine medical tests. Domestic violence issues not discussed**.** 2 days after this GP appointment, Janice vacated the Dawn Centre hostel and advised that she was going to stay with her sister in Blackburn.

For the following 2 – 3 weeks, there is no record of Janice having contact with Leicester based services.

[12] Score of 19 in this standardised test indicates '*higher risk and nearing possible dependence'*

**Analysis / key learning**

All of the evidence from this period shows that Janice was willing to openly share information (i.e. with homelessness services, primary and secondary healthcare services and the Anchor Centre) about her recent and longer term history as a domestic abuse victim. Notwithstanding her history as a victim of domestic violence, she was generally perceived by these services as having a socially confident personality, rather than as someone with obvious vulnerabilities.

The IMR produced by UHL NHS Trust confirms that Emergency Department procedures for domestic abuse were not followed at the initial contact. Under these procedures staff should complete a CAADA-DASH RIC whenever a patient discloses that they have suffered domestic abuse. Depending on the level of risk identified, specific pathways should then be followed. That this did not happen in this case was a missed opportunity, not only to assess levels of risk, but also to open a dialogue with Janice about the issue of domestic abuse and possible strategies to reduce risk.

Risk assessments could also have been (but were not) completed when Janice made her homeless declaration and when she attended her GP practice, both of which were prior to going to the Emergency Department. In the case of her homeless declaration, the absence of a domestic violence risk assessment was contrary to Housing Option's procedures.

It is acknowledged that, had there been a risk assessment (by any of the services involved at this stage), it is probable that risks would have been assessed as being at a standard level (and thus would not have resulted in a MARAC referral) given that the alleged perpetrator was in London, there was no suggestion that he posed an ongoing risk to Janice and no evidence that Janice had entered another abusive relationship.

**Key learning point 1:**

**There were breaches of operational procedure at the LRI Emergency Department and Housing Options which resulted in missed opportunities to assess potential domestic violence risks. There had also been a missed opportunity to carry out a risk assessment (or refer to a specialist domestic violence service for assessment) at the GP practice. This highlights the importance of ensuring that staff awareness and understanding of domestic violence policy, procedure and good practice is promoted through training, supervision and management processes.**

At the follow-up appointment a week later, the doctor did ask Janice about the circumstances of her injury and this was good practice. The IMR author for the Trust advises that it is not possible to determine how (or whether) Janice's view that the incident 'did not count as domestic violence as it happened on the street' influenced the doctor's actions.

**Key learning point 2:**

**There is a potential misconception – possibly shared by some professionals as well as members of the public – that 'domestic abuse' can only take place within the confines of a domestic dwelling. This may result in homeless victims of abuse being effectively excluded from multi-agency domestic abuse procedures.**

**There is evidence that homeless people are likely to be at higher risk from domestic violence compared to the general population, as is illustrated by this case and other recent DHRs[13]. It is therefore essential that all services which work with homeless people should ensure that staff understand that any abuse within the context of an intimate relationship – *regardless of the***

[13] For example: DHR SW01 published June 16 by Safer South Warwickshire CSP: apps.warwickshire.gov.uk/api/documents/WCCC-671-101

***physical location of incidents* – should be recognised as domestic abuse and responded to accordingly, within local multi-agency policy, procedure and good practice guidance.**

Although the above learning points follow events at LRI, it should be recognised that Janice had already disclosed the recent domestic violence incident (and her longer-term history of abusive relationships) to other professionals, including the homelessness service and a GP practice, and they also did not pro-actively explore this issue with Janice. It would therefore be unfair to single out LRI for criticism, when responsibility was shared between a number of services.

At subsequent appointments GP Practice, there were more missed opportunities to open dialogue with Janice about her experience as a victim of domestic violence.

At the following GP Practice Nurse appointment, there was discussion about domestic violence, when Janice talked about her longstanding pattern of entering relationships with domestic abuse perpetrators. At this appointment, Janice was offered referral to a specialist domestic violence service (SAFE). This was good practice, as SAFE may have been able to help Janice to develop strategies to try and break the pattern of entering relationships with abusive men. Unfortunately, Janice declined a referral to SAFE.

There appears to have been a common judgement (by each of the services Janice had contact with in November / December 2014) that current domestic violence risks were low, not least because she had removed herself from the perpetrator who was understood to still be in London. Other factors appear to have been the delay in Janice seeking medical attention, the minor nature of her physical injuries and her general presentation as a bright and socially confident individual.

On the basis of the evidence available at the time, it seems probable that a CAADA-DASH assessment at any point during this period would have supported a

view that Janice was currently at standard risk (i.e. the lowest level of risk category in the CAADA-DASH assessment model) as she appeared not to be in a current relationship and the last reported incident was in London. However, it would at least have been an opportunity to open a dialogue with her about her history as a domestic violence victim and potential strategies for reducing risks in the future.

As none of the agencies involved at this stage had any knowledge of a relationship with Ian (either because the relationship had not commenced or Janice chose not to disclose it – it is not entirely clear which of these was the actual position) it seems unlikely that a risk assessment during November and December 2014 would have led to specific actions which could have directly prevented the homicide some months later.

**January 15 (Late morning / lunch time):**
**Street incident witnessed by Anchor Centre staff**[14]
Janice had been asked to leave the Anchor Centre after a dispute with another female service user. A staff member subsequently saw Janice in the street (near the Anchor Centre) when she was congregated in a group of around 8 other people. There was then a confrontation between Janice and the same female service user, who had also been required to leave the centre around 10-15 minutes after Janice. The staff member phoned the police (non-emergency line) and was told the situation was being monitored on CCTV. Following this Janice was seen by another Anchor Centre staff member in a physical confrontation with Ian, on the same street. In this confrontation, Janice was observed by the Anchor staff member to be the primary aggressor, with Ian repeatedly trying to push her away. The police were phoned again by an Anchor Centre member of staff, this time using the 999 system. It was confirmed again that the situation was being monitored on CCTV.[15]

**January 2015:** Janice failed to attend an appointment with the Mental Health Nurse from the Homeless Mental Health Service. She had been referred to this service by GP Practice 1. This was the third appointment she had missed with this service.

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[14] This incident was not referred to directly in the Anchor Centre IMR, but has been described by the Anchor Centre manager (who was one of the witnesses to the incident) in the course of DHR enquiries.
[15] DHR enquiries have confirmed that Leicestershire Police did receive these calls and there was a police presence after the second call, but no offences recorded. However, there was no record of either Janice or Ian being identified by name. Consequently, these incidents would not be included in either party's police record and are not referenced in the police chronology or IMR.

**January 2015, Police incident 1:**

At 7.47pm Janice called the police to report she had been assaulted by Ian at his flat in Leicester. The call taker noted that Janice sounded intoxicated.

At the time of her call Janice was on her way to the Dawn Centre (and arrived there before the call ended) and was no longer with Ian. As she was not in immediate danger it was agreed she would attend the police station the following day, to formally report the incident.

Janice attended the police station on the following day as agreed and reported the following:

- She visited Ian at his flat after he had texted her, inviting her for a drink.
- 3 other people were present when she arrived.
- Ian was heavily intoxicated and asked Janice to remove a hat she was wearing, which she declined to do.
- When Janice went to the toilet Ian followed and started shouting at her about the hat, before removing it and punching her several times on the top of the head.
- He then pulled her away from the toilet and pinned her down on the floor with her legs over her head.
- Janice managed to break free and ran away from the flat, she then made the telephone call to the police

Janice was unable to complete a statement whilst at the police station due to a pre-arranged appointment with the local housing department, however the officer completed a Domestic Abuse, Stalking and Honour Based Violence (DASH) risk assessment and the risk was graded as ‘standard’.

Subsequently, this incident was followed up by a local beat officer, who met with Janice. Police records show that her recall was confused. Following this, further efforts by the police to engage Janice in the matter were unsuccessful. When she

was contacted by the police in telephone calls she was recorded to have been verbally abusive, refusing to answer questions or to have another meeting with the officer.

Although efforts were made to arrest Ian, these were not successful. Ultimately, a decision was taken for no further police action, primarily due to Janice's non-cooperation.

**Analysis / key learning**

The Police IMR and follow up enquiries from the DHR Panel have not been able to establish whether or not Leicestershire Police domestic violence risk assessments (following this and all subsequent police incidents) were informed by reference to Ian's history as a domestic violence perpetrator in previous relationships. As detailed in Part 1 of this report, this history included a significant number of reported incidents and 2 convictions for acts of domestic violence, each resulting in custodial sentences. The last recorded police incident had been in 2008, but officers should have considered the fact that most domestic violence incidents are not reported to the police. Another factor in this case was that for some of this period Ian was believed to have been resident in the Republic of Ireland and any records of police incidents or convictions whilst outside of UK police jurisdiction would not be recorded on UK police systems.

**Key learning point 3**

**When conducting domestic violence risk assessments, police officers should review local and national police records relating to the perpetrator. Where these records confirm a history in previous relationships of serious domestic violence (including in this case criminal convictions resulting in custodial sentences) this is a strong indicator of higher risks in the current relationship. The time period which may have elapsed since the last recorded police incident should not unduly influence officers towards a**

**lower risk score, as it is entirely possible that the abusive behaviour has continued but has not been reported to the police.**

The police decision for no further action against Ian was due primarily to Janice being apparently unwilling to engage with police enquiries following the incident. It is acknowledged that the chances of a successful prosecution would have been greatly undermined by Janice's non-cooperation. However, it is also noted that there were (according to Janice) 3 other potential witnesses present, who were not interviewed by the police. It is arguable that these witnesses should have been followed up, but as they were reported to have been in a different room from the alleged assault and may well have been intoxicated it is unclear whether they could have been useful witnesses.

**January 2015: Janice accommodated at Dawn Centre**

Immediately following Police incident 1, Janice attended the Dawn Centre and self-referred, stating that she was fleeing domestic violence. The Dawn Centre record of her self-referral includes the observation that she was *'in a bad way'*. She was allocated a place at the Dawn Centre for one night pending interview with the Housing Options Service the following morning. That evening (around 10.50 pm) Janice presented at **Urgent Care Centre**, where she described the assault she had already reported to the Police and to staff at the Dawn Centre. She initially said that her assailant had tried to strangle her, had punched her twice in mouth. She was subsequently seen by a locum GP at the UCC when she said she had been on the floor, stamped on around the chest, strangled and repeatedly punched in the face and chest. Her injuries were recorded, including:

- Faint bruising around her neck
- Large bruise to right chest just above breast
- Bruise to right forehead
- Mild soft tissue swelling

There was no indication of bone fractures, lacerations or other serious injuries. Janice was prescribed pain killers and discharged.

**Analysis / key learning**

There appears to have been a degree of inconsistency in Janice's description of the incident, but the nature of the injuries observed at the UCC indicates that she did suffer a significantly violent assault and that Dawn Centre's record of her being *'in a bad way'* was accurate, if not very descriptive.

The UCC IMR has identified a pattern (relating to each of her 4 attendances over the period under review) whereby Janice's injuries have been medically treated appropriately, but there has not been proactive enquiry into the background to the assault, or consideration of the need to refer for specialist domestic violence support, or to flag her on UCC systems as being at risk from domestic violence. A key factor in this has been the understanding of UCC staff that the matter had already been reported to the police and that there was therefore no requirement for further action. The IMR for the UCC notes that:

*"UCC does triage for ED (Emergency Department) so if a patient is being transferred to ED then treatment/referral is done in ED usually. However, this could be better communicated. In none of the consultations there is any documented evidence of offering any help/referral for domestic violence. Again, this could be due to the fact that it was assumed that if the police were aware then a referral was not warranted. On 2 occasions when she was discharged home there was no documentation of mental health assessment or offer of referral to Mental Health. It seems there is also a pattern of assumption that if police are aware then a safeguarding referral is not warranted."*

**Key learning point 4**

**There was a pattern of assumption on the part of UCC staff that responsibility for addressing concerns about domestic violence risks to Janice lay with the police and other services she was in contact with.**

**As a minimum, UCC staff should have discussed ongoing domestic violence risks with Janice, with a view to referring her for specialist support. Additionally, concerns about domestic violence should have been flagged on UCC records and discussed with her GP and other relevant services. (The UCC DHR Action Plan addresses these issues in more detail.)**

**In fairness, it must be acknowledged that a number of other services (such as housing, homelessness and primary healthcare services) appear to have followed a similar pattern of assuming that 'somebody else' would be leading in relation to domestic violence concerns, so this learning point is relevant not just to UCC.**

**Housing Options**

Having been accommodated overnight at the Dawn Centre, Janice presented at Housing Options the following morning, as had been agreed. Housing Options did not find proof of homelessness, but Janice was offered another night at the Dawn Centre, in dormitory accommodation.

At her Housing Options appointment, Janice divulged the violent incident on the previous evening, but asserted that she was not at risk of domestic violence because Ian had no reason to look for her. The record does not clarify whether or not Janice was in a relationship with Ian at this point. No risk assessment for domestic violence was conducted by Housing Options.

**Janice evicted from Dawn Centre**

On the same day, Janice was required to leave the Dawn Centre. The reasons for this decision were that she was suspected of supplying an unknown substance to another Dawn Centre service user and her behaviour towards staff when challenged about this.

**Analysis / key learning**

Janice informed Housing Options of the violent incident on preceding evening, but no CAADA-DASH assessment was carried out. This was a **missed opportunity** to more closely examine the background to the violent assault on the previous evening and to assess the risks of further such incidents occurring. Even though the decision of whether or not Janice was in fact a homeless person (i.e. in line with homelessness legislation) was pending, it was very clear that domestic violence was a primary factor in her presentation to the Housing Options service.

**Key learning point 5**

**There is a need to ensure consistency of practice in the use of CAADA-DASH assessments where people present as homeless and there is evidence that that domestic violence is a factor in this presentation. The risk assessment should be conducted at the time of the homelessness presentation and not delayed until a decision is made regarding the person's statutory homeless status, which may be up to 33 working days later. As is clearly shown by Janice's experiences, if the individual is fleeing a violent relationship this period of 33 working days may well be a particularly high risk period.**

Following her eviction from Dawn Centre Janice was homeless. Janice's homelessness would have added significantly to her vulnerability to domestic abuse, because she appears to have had very limited (if any) choice but to spend periods staying in Ian's flat, even when the relationship subsequently became increasingly volatile and violent.

The circumstances leading to Janice's eviction have been more closely reviewed by the IMR author for Homeless Service. The local policy on suspected supply of illicit substances on or near to the Dawn Centre premises states that:

*"As a minimum a written warning to be issued, this can vary up to immediate eviction depending on specific circumstances".*

It is understood that immediate eviction was judged appropriate in this case, as a result of behaviour Janice displayed when approached about the alleged supply of substances and behaviour she had presented at her previous stay at the Dawn Centre.

In reaching this decision Dawn Centre staff would have faced the difficult challenge of balancing concerns about potential risks to Janice (if evicted) with the wider needs of a population of more than 40 other vulnerable residents.

Following closer review of all of the circumstances, the IMR author has concluded that, even taking account of the needs of the wider resident population, a written warning would have been a more appropriate response to this particular allegation regarding supply of substances. The DHR panel supports this conclusion, whilst acknowledging that the decision to evict did not have the benefit of hindsight concerning the events which followed.

Having reached the decision to evict Janice from the Dawn Centre, there was no further assessment of needs or risks **(see previous learning point)** and no strategies put in place to meet her accommodation needs or manage ongoing risks. This was despite the fact that it was known that her admission on the previous evening had followed a domestic violence incident resulting in significant physical injuries. In these circumstances, it should have been apparent that the decision to evict would significantly increase the possibility of her returning to stay with the perpetrator, as possibly her only option other than rough sleeping.

**Key learning point 6**
**Even if Janice's eviction from the Dawn Centre had been unavoidable due to concerns about other vulnerable service users, there should have been careful consideration of her ongoing vulnerability as a domestic violence victim. Attempts should have been made at finding more suitable alternative accommodation or at the very least signposting to specialist support services.**

**January 2015, Police Incident 2**

Janice telephoned the police (10.47 am) advising that she was on her way to the police station to report an assault by Ian. Officers then met her, when she reported that she had gone to Ian's flat to collect belongings, when an argument ensued and Ian had pushed her and had hurt her arm. The officers observed that Janice appeared to be heavily intoxicated and confused about the exact details of the incident. They also recorded that there was no visible sign of injury. Janice stated an intention to return to stay with her family in Blackburn and was given a lift to Leicester Railway station. It subsequently transpired that she did not leave Leicester.

A DASH risk assessment was completed and found the risk level to be standard. There were subsequent attempts by officers to follow up and take a formal statement, which had not been possible at the time, due to Janice's apparent intoxication and confusion. However, these attempts were unsuccessful and a decision was then taken that there would be no further police action in relation to this reported incident.

**January 2015 Police incident 3**

Janice telephoned the police (at 23.02) stating that Ian had attacked her. Officers attended and found Janice in the street with a member of the public. Janice

appeared to be extremely intoxicated and was very difficult to communicate with. She was taken to the police station where she reported the following:

- She had called at Ian's flat during the evening but he was not there so decided to wait for him to return and went to a friend's flat.
- When Ian arrived at that flat he appeared drunk. An argument began regarding the purchase of more alcohol so Janice left and went to Ian's flat alone before returning to her friend's flat around 15 minutes later.
- The argument with Ian continued and resulted in him pushing Janice against a wall whereupon he grabbed her around her neck.
- Janice managed to escape from the flat but she asked for her belongings to be returned to her and, in frustration, kicked the flat door. She then left the flat complex and contacted the police.

A DASH risk assessment was completed by officers and the risk level at this stage was assessed as medium. Due to Janice's responses to the standard DASH assessment, a DASH stalking form was also completed, and also resulted in a risk level of medium. As in her previous contact with the police Janice was still stating that she planned to return to Blackburn, but she did not do so.

**January 2015, Police Domestic Abuse Review**

As a result of the three previous incidents a review was completed by Leicestershire Police's Domestic Abuse Investigation Unit (DAIU) to establish if there were any clear and obvious underlying problems that were identifiable.
The review highlighted the abuse of alcohol, the frequenting of similar locations to consume alcohol and the lack of a fixed address for Janice as key factors for the continuing incidents. In line with that assessment a number of actions were drawn up and included referrals to support agencies with Janice and Ian's consent. The actions were allocated to a local officer to complete.

| **Analysis / key learning** |
| --- |

A pattern was emerging of Janice and Ian drinking excessively in his flat then having arguments which developed into physical fights. The increase in assessed risks to medium is an indication that officers were considering cumulative evidence across the 3 incidents which had so far taken place and this can be identified as good practice. It was also good practice to carry out a separate assessment for risk of stalking behaviours when the standard assessment indicated that this may be an issue of concern.

The DAIU review on shows that the police were attempting to proactively identify and manage risks and the planned referrals to support agencies (subject to consent on the part of Janice and Ian) is further evidence that the police were trying to find solutions and reduce risks.

However, even at the DAIU review, it is still not clear whether officers had accessed police records, or had any knowledge of Ian's history as a domestic violence perpetrator. **(See key learning point 3).**

If the DAIU review taken account of Ian's history of domestic violence related incidents and convictions, this could have resulted in an application of professional judgement, leading to an increase of assessed risks from medium to high and escalation into the MARAC process. That this did not happen at this stage was a **missed opportunity**.

**February 2015, Police incident 4**

At 11.35pm Janice contacted police to report she had been assaulted by Ian at his flat. Police attended and found Janice sitting in the doorway of a wine shop. Police records show she was intoxicated. Janice stated that Ian had held a knife to her throat and assaulted her. She did not explain the circumstances as to how the incident had developed and ultimately refused to engage with the officers. It was noted that there was no apparent injury to her neck but there was a small amount of bruising and a lump on her head.

The attending officer erroneously believed no domestic incident had taken place and did not complete a DASH risk assessment. The oversight was quickly identified and a DASH was completed with the risk graded as ‘standard’.

Despite the investigating officer’s continued efforts, it took nearly three weeks to contact Janice by which time she had changed her stance and stated she did not require any further police involvement, she had sorted things out with Ian and had left him. Janice stated that she was in the process of arranging permanent accommodation of her own and was unwilling to assist the police any further. A supervisory officer reviewed the incident marking it ‘no further action’.

**Analysis / key learning**

The previous DASH assessment in January reached a conclusion of medium risk. However, 10 days later (after another reported incident which for the first time included an allegation of a threat of violence using a lethal weapon) the DASH outcome was standard risk. In the interim the DAIU had identified actions needed to reduce risks from an assessed medium level, but (due to extreme difficulty in contacting or establishing effective engagement with either Janice or Ian) none of the actions had been completed.

This indicates that the officer(s) who carried out the latest risk assessment were doing so purely on the basis of the current incident, with no reference to the recent history of reported domestic violence incidents or risk assessments. If these recent

police records were not consulted, it is very unlikely that there was any reference to Ian's longer term police record as a domestic violence perpetrator.

**Key learning point 7**
**When carrying out DASH risk assessments officers should consider cumulative risk, especially when there has been a succession of similar incidents within a short space of time. A risk assessment which fails to consider such recent events and evidence of escalation is likely to be unreliable.** (**See also key learning point 3.)**

**February 2015, Consultation with Consultant Nurse at GP Practice 1**

This was one of number of contacts which Janice had with GP Practice 1 outreach services, during the period following her eviction from the Dawn Centre. The following points of significance were recorded at this appointment:

- Janice said she was currently 'sofa surfing' and still in a relationship with her abusive partner, but she was planning to end the relationship.
- She said that, because she is from a different area, the council cannot house her and she cannot get a place in a refuge, but can seek private rented housing, using a rent deposit scheme.
- She disclosed that (4 days previously) Ian had punched her hard on the chest, causing her to fall back against a wall.
- Examination confirmed that Janice had extensive bruising to her left shoulder and bruising to her thigh. Bruising was also noted under her right eye, which she said was an older injury.

**February 2015, Consultation with GP Practice 1 Homeless Mental Health Service CPN.**

Following on from the above consultation Janice was referred directly for further support from the CPN who was present in same building. (Homeless Mental Health Service, Leicestershire Partnership NHS Trust).

Janice explained to the CPN that she was currently staying with her abusive partner (as a sofa surfer). As she has nowhere else to go she planned to go back to stay at his flat, even though she really wanted to end the relationship. She confirmed that she had been offered assistance through the LCC rent deposit scheme and would like to gain stable housing so she could 'sort herself out' and then have regular contact with her children in the USA.

Following discussion between CPN, the Consultant Nurse and an Outreach Worker, CPN records state that a verbal referral was made to the SAFE domestic violence service who agreed to contact with Janice and offer her support to find alternative accommodation.

**Alcohol Outreach Worker arranges 3 nights B&B accommodation for Janice:**

Immediately following the CPN appointment (on a Friday), the Alcohol Outreach Worker approached One Roof Leicester who arranged for Janice to stay in B&B accommodation for 3 nights (Friday – Sunday). On the same day, the Outreach Worker emailed Housing Options and advised that on Monday Janice would have no accommodation and would therefore be either rough sleeping or (more probably) return to the abusive relationship, which was known to be her usual pattern. He further asked if they could assist her with something, even a refuge and asked them to re look at her case given the change in her situation and ongoing domestic violence incidents.

On the following day (Saturday) the Alcohol Outreach Worker saw Janice and advised her to attend Housing Options on the Monday morning as early as possible and to consider a refuge place if one was available, regardless of where it might be. He advised her that he had written to the Housing Options Service and they would be expecting her.

**Monday: Janice did not attend Housing Options**

| **Analysis / key learning** |
| --- |

The intervention of the Alcohol Outreach Worker in securing 3 nights B&B accommodation provided Janice with a short period of relative safety and security. The outreach worker's email to Housing Options shows that they recognised (and most importantly communicated clearly) that Janice would be at a serious ongoing risk of domestic violence, unless suitable accommodation could be secured immediately. These practical interventions from the Outreach Worker are recognised as **examples of good practice.**

Janice did not follow the Outreach Worker's advice to attend Housing Options on the Monday , which was obviously very unhelpful to her prospects of being assisted in accessing any type of accommodation. This was part of a continuing pattern of agencies finding that Janice was a difficult person to help.

However, there is no record to show that Housing Options workers made pro-active attempts to follow up Janice's non-attendance, for example by contacting the Alcohol Outreach Worker and asking them try and locate Janice and get her to an urgent appointment. This was a **missed opportunity**.

**Key learning point 8**
**It should be recognised that people with multiple and complex needs such homelessness, alcohol problems and domestic violence (i.e. those in the most critical and urgent need of help) are very frequently the most difficult people for services to meaningfully engage with and effect positive change. However, there could have been more concerted and proactive attempts at getting Janice to attend Housing Options with a view to finding her somewhere safe to stay. This did not happen and the outcome was that Janice remained dependent on her violent partner for accommodation, which was apparently her only option other than rough sleeping.**

**March 2015**, **Anchor Centre**

An incident was observed at the Anchor Centre when Janice kicked Ian. He did not react. Janice was asked to leave the centre.

**March 2015, Police incident 5**

The police were called to Ian's flat by a third party. Both Ian and Janice had minor facial injuries, but both claimed these had been caused in a separate assault earlier in the day. They were making no complaints against each other. Although their explanation was not believed by officers, Ian and Janice refused to answer questions and the matter was recorded as a verbal argument only.

**March 2015, SAFE response to referral:**

Following some inter-agency confusion in the interim period, it was confirmed on that SAFE had received the referral made by the CPN around 1 week earlier and had made several calls to Janice's mobile number, but had received no response. SAFE policy was not to leave voice mail messages due to the risk that an abusive partner may pick them up. Janice was given SAFE's number by the Homeless Outreach Service and by the Anchor Centre, with advice to contact them if she wanted support or access to the women's refuge.

**March 2015, Anchor Centre:**

The manager at the Anchor Centre spoke to Ian and raised concerns about his visible injuries and those of Janice. Ian stated that it was Janice who started fights and when they are drunk it escalates. He said he was concerned he may lose his tenancy.

**Analysis / key learning**

Whilst it was good practice on the part of the Anchor Centre manager to engage with Ian about his injuries, there appears not to have been any discussion with either Ian or Janice about possible sources of support to help to reduce domestic violence risks. This was a **missed opportunity.**

**March 2015, Police incident 6**

The Police were contacted by East Midlands Ambulance Service, reporting that they were en-route to Queens Medical Centre Nottingham with Janice who had a puncture wound to her thigh and a burn mark on her left hand. Officers attended QMC and Janice described the incident as follows:

- Ian had been increasingly angry due to problems with his welfare benefits
- That evening she had been at his flat with another female friend trying to calm him down.
- Without warning Ian picked up a kettle and poured the contents over her head
- Janice ran to the bathroom and Ian followed and held a knife to her throat, before slamming the bathroom door onto her hand.
- Janice stayed in the bathroom for 15 minutes until Ian assured her that he had calmed down.
- She then came out of the bathroom and switched on the kettle to make a drink. When the kettle switched itself off Ian grabbed it and poured boiling water over her head. He then hit on the back of the head 2 or 3 times and stabbed her once in thigh with the knife he had had earlier.
- Janice then managed to escape the flat and went to a local hostel, who called the ambulance.

On the following morning, Ian was arrested. He confirmed that they had been drinking in his flat together with the other female friend, but his account of the incident was very different:

- At some stage in the evening Janice had picked up a kitchen knife and lunged towards him. He managed to take the knife from her, but she continued to be aggressive towards him.
- Later he boiled the kettle for a drink. About 10 minutes after it had boiled they had an argument about the water and were both pulling at the kettle,

resulting in hot water spilling over both of them. At this point, Ian asked Janice to leave.

The female friend was also interviewed by the police. According to her account:

- All three of them had been drinking very heavily.
- Janice had picked up the knife, had held it to her own throat, before stabbing herself in the thigh.
- As this was happening the female friend and Janice were shouting at each other and Ian was sitting on the bed.
- The friend took the knife from Janice and Ian took it from her.

The outcome of the police investigation was that no further action would be taken against Ian.
A domestic violence risk assessment was completed by police officers and the risk was graded as medium.

**Decision not to charge Ian with any offences:**
Janice's description events, if accurate, would represent an extremely violent and dangerous domestic violence incident. However, the police's decision not to charge Ian with any offence appears to have been reasonable, given the lack of evidence to corroborate Janice's allegations. Specifically:

- The IMR in respect of QMC describes redness to the skin on the back of Janice's neck and that she was medically fit for discharge on the morning after her admission. On this basis, it was reasonable for officers to conclude that Janice's injuries were not consistent with having had a kettle of boiling water poured over her head.
- The stab wound to her thigh was relatively minor (QMC described a 1-inch stab wound) and appeared to officers to be more likely to have been self-inflicted, as described by the other witness present in the flat.
- The other witness's statement generally supported Ian's account of what took place and in no way supported Janice's.

**Police risk assessment**

The police risk assessment judged ongoing domestic violence risks to be medium, which may well have been influenced in part by the fact that Janice's account of the incident was judged to be unreliable, as outlined above.

However, it is important to make a distinction between evidence to support a criminal charge against Ian (which was not a realistic prospect) and evidence of risk of repeat incidents of serious domestic violence. In assessing these risks the following factors should have been considered:

- This was the 6th reported domestic violence incident in just over 2 months.
- A weapon (a knife) had been used, even if the stab wound was believed to have been self-inflicted.
- All parties to this incident were reported to have been very heavily under the influence of alcohol.
- The reported fight involving a kettle of hot (probably not boiling) water between people heavily under the influence of alcohol was an additional risk factor
- Janice's homeless status meant that she was likely to return to stay at Ian's flat because she had little other option, apart from sleeping rough.

As with all of the previous risk assessments, it is not clear whether Ian's police records were accessed. However, if his history as a domestic abuse perpetrator had been considered, along with the other risk factors outlined above, this should have resulted in a risk assessment finding of high risk, resulting in a MARAC referral. That this did not happen was a significant **missed opportunity.**

**Clarifying victim / perpetrator roles and risk profiles**

It is evident that Janice was not always an entirely a *passive* victim of abuse,

as her behaviour towards Ian and others had been observed (for example at the Anchor Centre) as having been aggressive at times, even though the outcomes were usually that she sustained significant injuries and Ian was relatively unharmed. The reality was that the risks to Janice were probably increased significantly *because* she tended not to accept a passive role in the relationship. It should be acknowledged that in relationships of this nature victim / perpetrator roles may become very difficult to define and this creates real challenges for the police and other services in trying to accurately assess and effectively manage risks. Clearly, risk assessments should not make *automatic* assumptions based on gender *(i.e. 'male = perpetrator / female = victim'*) even though it is clearly true that male violence on female partners is much more common than the reverse.

Having said this, there were known factors in this case, which could and should have helped agencies more clearly assess the relative **power** and **risk** factors in the relationship between Ian and Janice. If these factors (as summarised in learning point 9, below) had been taken into account, this would have helped to ensure an appropriate challenge to any 'victim blaming' responses from the agencies involved.

| **Key learning point 9:<br>Clarifying victim / perpetrator roles and identifying risks** | |
|---|---|
| **Ian** | **Janice** |
| Confirmed history / criminal convictions as perpetrator of domestic abuse and serious physical assaults in previous relationships. | **Risk factor:** Self-reported history as victim of domestic abuse and physical assault in previous relationships |
| Recent and repeated history of assaulting Janice, causing significant injuries requiring hospital treatment | **Risk factor:** Observed on occasions to be physically aggressive and towards Ian, not known to have caused him serious injuries, but has |

| | |
|---|---|
| | received serious injuries in these conflicts. |
| Securely housed | **Disempowered:** Homeless, largely dependent on staying at Ian's as alternative to rough sleeping |
| Serious problems with binge drinking | **Risk factor:** Serious problems with binge drinking.<br>**Risk factor:** History of mental health problems. |

**Queens Medical Centre following police incident 6**

Janice was taken to QMC (Nottingham) by ambulance as this was the closest treatment centre with access to specialist treatments for burns. She arrived at 23.24. On examination she was found to have:

- Redness to skin on the back of her head
- 1-inch stab wound to thigh
- Injury to right index finger

Janice was then transferred to a short stay unit attached to the Emergency Department (ED) for further review and due to concerns about potential domestic abuse. By the following morning, she was deemed medically fit for discharge, but she was not discharged due to continuing concerns about domestic violence risks. A domestic violence risk assessment (DASH RIC) was completed and resulted in a finding of high risk. A MARAC referral was generated and sent to the MARAC office which is managed by Leicestershire Police. This MARAC referral was subsequently rejected, on the basis that Janice's statement to the police about the incident on had been judged by officers as being inconsistent with the presenting evidence.

Janice remained an in-patient at QMC for 5 nights.. During this period QMC records show that staff attempted to secure suitable accommodation and support for her, contacting a number of services including Nottingham Women's Aid, Nottingham Street Outreach service, Leicester EDT[16] and SAFE.

**(Sunday) Telephone call from SAFE helpline to Janice**

3 days after her admission SAFE telephoned Janice (still in-patient at QMC), in response to a police referral received following the incident. (Previous attempts made by QMC ward staff to contact the SAFE helpline had been unsuccessful) A risk assessment was conducted over the telephone, which resulted in a score of 12 (medium risk). However, the assessing worker also noted additional risk factors concerning Janice's mental health and recorded that there was a need for assessment by a senior IDVA, in relation to a MARAC referral.

Over the following 2 days there were a series of telephone contacts and conversations between SAFE and QMC and various other services, including:

- Refuge and domestic violence services in Nottingham and Leicester
- Dawn Centre
- Homelessness and Housing services in Nottingham and Leicester

The inter-agency communications at this stage were protracted and complex, but the outcomes can be summarised as follows:

- The clear advice from the SAFE project was that Janice should not return to Leicester as she would continue to be at risk from Ian. On this basis, a referral was made to Shine, a Nottingham based domestic violence support service.

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[16] The EDT service in Leicester does not have any record of this contact.

- The Dawn Centre told QMC that they had no vacancies, but that she would not be allowed to return anyway, due to the events leading to her eviction in January.

  The information regarding Janice's eviction from the Dawn Centre was reportedly passed on from a member of QMC's nursing staff to Womens Aid Integrated Services (WAIS) in Nottingham. On this basis, WAIS advised that the background to her eviction from the Dawn Centre may present a barrier to her being accepted at the Nottingham refuge, due to potential concerns about the safety and wellbeing of other women and children resident there. WAIS attempted to make further enquiries directly with the Dawn Centre about this, but were advised that the Dawn Centre could not disclose any information, without written consent from Janice.

- QMC staff recorded that, following a number of phone calls (including to Leicester Emergency Duty Team and the Dawn Centre) no vacancies could be found in hostels in Leicester.

- Janice was discharged from QMC and went to Nottingham Housing Aid. During the course of an interview lasting about 15 minutes, Janice gave some information about her background and the incident leading to her admission to QMC. The Housing Officer enquired into her safety and she stated that she was safe. She also made it clear that she wished to return to Leicester. With public transport fares paid by Nottingham Housing Aid, Janice returned to Leicester.

**Analysis / key learning**

Although Janice's injuries were not serious, QMC staff recognised that there were significant ongoing risks and did not immediately discharge Janice back into a dangerous situation. This decision to allow her to remain in hospital

whilst attempts were made to secure appropriate support and safe accommodation was an example of very **good practice.**

Similarly, the decision to carry out a domestic violence risk assessment and the resulting MARAC referral due to the finding of high risk was also a **good practice** example.

It was very unfortunate that the multi-agency attempts over the following days to find Janice suitable accommodation and support proved unsuccessful, despite very considerable efforts made by QMC staff.

Janice's discharge from hospital back into precisely the same set of circumstances and risks has to be recognised as **a missed opportunity.** Although Nottingham Housing Aid records show that Janice made it clear that she wanted to return to Leicester, the reality was that she had not been offered any viable alternative. This resulted partly from weaknesses in communications between different agencies in Leicester and Nottingham.

It is concerning that staff at the Dawn Centre reportedly refused to share information with WAIS, without written consent. In a situation of urgent need, information should have been shared, subject to verbal consent which Janice could have provided over the telephone. In any event, there appears to have been an element of inconsistency, as information about the circumstances of Dawn's eviction had apparently already been shared with a member of the QMC nursing staff.

**Key learning point 10**
**In an urgent situation where a person is fleeing domestic abuse and potentially seeking a refuge placement, the requirement for written consent before sharing information with the refuge service may create an unnecessary barrier to them being able to access the service. Where the**

**person is willing and able to confirm verbal consent over the telephone (provided their identity can be verified with reasonable certainty) this should be a sufficient basis for sharing information.**

**MARAC referral**

DHR enquiries have established that a decision was taken by a non-supervisory officer within the MARAC process that the referral generated by QMC would not be discussed at MARAC. The primary basis for this decision appears to be that the allegations made by Janice that she had been violently attacked by Ian were believed by the police to be seriously undermined by the presenting evidence.

However, Leicestershire MARAC protocol and procedures do not give any authority for such screening and rejection of referrals received into the MARAC process. Once QMC had assessed Janice as being at high risk from domestic violence and referred to MARAC, this should have resulted in this case going to MARAC for multi-agency discussion and planning. That this did not happen was a very significant **missed opportunity.**

**Key learning point 11**

**The MARAC referral should not have been screened out of the MARAC process, regardless of any doubts that police officers or others may have regarding the reliability of an alleged victim's statement. That there was insufficient evidence to bring criminal charges should not have resulted in any assumptions about levels of domestic violence risks.**

**To screen and reject MARAC referrals on such a basis completely undermines a key principle: MARACs should consider risk assessments and risk management strategies from a *shared and multi-agency* perspective.**

**There is a need to ensure that the above points are made completely clear in the local MARAC Protocol.**

**March 2015 Urgent Care Centre & Leicester Royal Infirmary:**
Janice presented herself to UCC (approx. 8pm) with head and facial injuries. She said she had been drinking all day and that she had been assaulted by her boyfriend – *'punched to floor and possibly kicked to the left side of face'.* She informed the Triage Nurse she had reported this to the police. (The police have no record of an incident being reported) Janice also referred to the previous incident. The Nurse noted that Janice had small grazes and swelling to the top of her head and under her left eye. The Nurse cleaned Janice's face and sent her to the Emergency Department at LRI.

Further examination at ED noted that Janice had superficial facial bruising, a bump to her head and bruising to her shoulder blade, the middle of her back and her buttock. Janice told ED staff that she had been subjected to a 30-minute assault by Ian and that the police were aware of this allegation. Although Janice was judged not to require any further medical care or treatment she remained in the ED overnight as a place of safety before being discharged the following morning, to attend GP Practice 1.

The IMR prepared by UHL in respect of the Emergency Department states that, as a result of this attendance:

*"there is evidence that staff appropriately completed a CAADA-DASH Risk Identification Checklist (RIC) and this prompted a referral to MARAC. The RIC score was recorded as 12, which is below the standard score for referral to MARAC, however the nurse indicated additional risk factors to justify the referral in this case (it was recorded that there had been 3 or more incidents reported to Police between Jan-Feb 2015 and that the nurse was using her professional judgement.*

DHR enquiries have established that the MARAC office can find no record to show that this referral was received. Consequently, no MARAC process followed.

**Analysis / key learning**

The decision by ED staff to keep Janice in hospital overnight as a place of safety before discharging to an appointment with Inclusion Health Care is an example of **good practice.**

**Missing MARAC referral**

The completion of a risk assessment and the application of professional judgement to make a MARAC referral (as reported in UHL's IMR) were **good practice**.

Follow up DHR enquires with UHL confirm they retained a copy of the referral documentation in Janice's records. Whilst the MARAC referral is recorded by UHL as having been sent by email, UHL have been unable to locate any email history to confirm that is was sent to the correct MARAC email address. It is understood that this is due to weaknesses in UHL's electronic communications systems, which have since been addressed.

Due to the absence of reliable records, the DHR Panel has not been able to ascertain precisely what happened, but the outcome was that no MARAC process followed.

**Key learning point 12**

**When agencies refer to MARAC they must ensure that they retain a clear record of the risk assessment and the MARAC referral and request and receive a confirmation that the referral has been received. They should also be notified when the case will be discussed at MARAC and invited to attend the MARAC meeting.**

If this second MARAC referral was not received by the MARAC office this would have significantly compounded the issue of the first MARAC referral having been screened out. Had the second referral been received, this might have further highlighted cause for concern, as 2 different agencies had each assessed Janice as being at sufficiently high risk to warrant a MARAC referral. This represents another significant **missed opportunity.**

**March 2015,GP Practice 1**

Following her discharge from ED, Janice attended the appointment with at GP Practice 1, as arranged. At this consultation, recent domestic violence incidents and hospital admissions were discussed. It was recorded that the police were aware of the recent incidents and *'has been in touch with MARAC'.* Janice said she was planning to go back and stay with Ian, as she would otherwise be homeless. Janice also reported that SAFE had contacted refuge services but there were no vacancies.

**Analysis / key learning**

The record of this consultation shows that the GP was making real efforts to engage with Janice about increasing domestic violence concerns, whilst recognising and recording the fact that she seemed to have no immediate choice but to stay with her violent partner. This GP's obvious concern and level of individual engagement with Janice on domestic violence issues at this consultation was **good practice.**

Janice's recorded reference to MARAC in this consultation appears to confirm that a MARAC referral had been discussed with her at ED on the previous evening. The GP's note *'has been in touch with MARAC'* does not provide any clear record of what (if anything) was expected to happen next in terms of a MARAC process. It also suggests a possible misunderstanding of what MARAC is (i.e. a multi-agency process rather than a service which Janice

could have been in contact with). There was also a risk that the reference to MARAC may have resulted in an assumption (which with the benefit of hindsight was incorrect) that the matter was now being dealt with through this multi-disciplinary process.

*Ideally* the GP would have followed up the reference to MARAC and asked a practice administrator to contact the MARAC Coordinator to clarify whether or not there had been a MARAC referral. In fairness, such proactive engagement with MARAC from primary healthcare services is (unfortunately) very unusual. This is probably due to issues of time and resources as well as gaps in knowledge and awareness of the MARAC process.

**Key learning point 13**
**It is important that GPs and other primary healthcare professionals have a good knowledge and awareness of domestic violence issues in general and of the MARAC process in particular. If there is any doubt about whether there is a current MARAC referral or MARAC coordinated risk management plan, this should be checked with the MARAC Coordinator.**
Had the GP been able to ascertain that there was no current MARAC involvement an option would have been for the GP practice to carry out a CAADA-DASH assessment, with a view to generating a new MARAC referral. An alternative course would have been referral to the specialist domestic violence service for assessment. That neither of these courses of action were followed represents a **missed opportunity.**

**April 2015**

Janice had a further appointment at GP Practice 1, where she was seen by a Consultant Nurse. At this appointment she said she was no longer living with Ian, though it is not clear where she was living at this stage, or if she was sleeping rough.

**April 2015**

12 later, Janice was seen by a GP at GP Practice 1. This consultation was for medical issues not directly related to domestic violence. There was no discussion in this consultation about domestic violence concerns, or about where Janice was staying or whether she was sleeping rough. On the same day, Janice was seen at the Anchor Centre, where staff were assisting her with an appeal letter in relation to her exclusion from the Dawn Centre, although there is no record of such a letter having been received by Housing Options.

**Analysis and key learning**

It is notable that during April there were no further recorded incidents of domestic violence, the last one having been police incident 6 in March. It is unknown whether this was because no incidents occurred or because incidents were not reported by Janice.

During this period there is little evidence of ongoing actions to try and resolve Janice's ongoing homeless status, apart from the Anchor Centre assisting her to challenge the Dawn Centre exclusion. The Anchor Centre deserve some credit for trying to assist in this way, though some more proactive advocacy directly with Housing Options might have been of more immediate assistance.

The apparent lack of action from housing and homelessness services may well have been due largely to Janice being in less frequent contact with services and the absence of new reports of domestic violence.

**March 2015**

Following an anonymous phone call, police forced entry to Ian's flat, where they discovered Janice, deceased.

**Perpetrator perspective:**

Ian accepted an invitation to meet with the overview review author and another DHR Panel member. The following is a summary of key points from this meeting which are of particular relevance to DHR learning:

- Ian felt that his and Janice's excessive and uncontrolled alcohol use was a major cause of violence in the relationship and ultimately to the homicide itself.
- Ian stated that at times he had felt used and jealous on occasions when Janice would come to stay with him, before 'disappearing' for a number of days.
- He felt that Janice's homelessness was a major issue, which meant she was often reliant on him for somewhere to stay. He did not feel that local services had offered Janice adequate help with her housing needs.
- Ian acknowledged that the police and Anchor Centre staff had spoken to him about the relationship and warned him that it was very high risk. He observed that both he and Janice had ignored these warnings, thinking that they 'knew better'.
- Ian recalled that that he had previously attended intervention programmes to address alcohol issues, but could not recall being offered any interventions which specially addressed issues of domestic violence.
- Ian felt that he was a victim of violence in the relationship as much as Janice was, but that local services did not recognise this. He believes local services viewed him as 'alpha male' and therefore assumed that he could not be a victim of violence from a female partner.

**Analysis key learning**

Ian's observations about the very significant impacts of his and Janice's alcohol misuse and of Janice's unmet housing needs are valid and have already been discussed in some detail.

There is evidence which supports Ian's assertion that Janice was at times violent towards him and she may well have been the instigator of some conflicts. However, it is also clear that Ian had a previous history as a domestic abuse perpetrator and was the person with most of the power and control in this relationship. (See learning point 9) The outcomes were that Janice sustained some very significant injuries in a series of incidents, before ultimately losing her life. The DHR has not seen evidence to indicate that Ian was at high risk, or needed specialist support as a male victim of domestic violence.

Probably the most significant learning arising from Ian's contribution to the DHR is that he cannot recall ever being offered attendance (or required to attend as part of a criminal order) any interventions to specifically target what was clearly a pattern of abusive and violent behaviour towards female partners.

**Key learning point 14**

**This report has appropriately focussed very much on the availability and effectiveness of services to support and protect Janice. However, it is equally important to acknowledge the potential benefits of targeted interventions with repeat domestic violence perpetrators, which may ultimately change this behaviour pattern and protect other women from future abusive relationships. This also highlights the need to increase knowledge and awareness of local services which can offer such interventions.**

## PART 3:

## SUMMARY OVERVIEW OF FINDINGS AND KEY LEARNING POINTS

This section of the overview report returns to the topics set out in the DHR terms of reference to summarise findings and learning points. Evidence bases for these are detailed in Part 2 of the full report.

**1. To review whether practitioners involved with Ian and Janice were knowledgeable about potential indicators of domestic violence and aware of how to act on concerns about a victim or perpetrators**

There is evidence that some practitioners were knowledgeable about indicators and how to act. For example, the responses by staff at Queens Medical Centre in assessing risks and then taking actions aimed reducing future risks have been identified as good practice. Similarly, the Outreach Alcohol Support Worker demonstrated a good understanding of the risks Janice was facing and acted appropriately. There are several other examples of good practice highlighted in Part 2 of the report.

There is also some evidence of lack of understanding of risk factors in some agencies, either at individual practice levels or at policy and procedure levels Examples include:

- Awareness of impact of homelessness as a DV risk factor.
- Closely associated with homelessness - isolation from informal social support apart from local street drinking networks.
- Awareness of significance of Ian's past history as a perpetrator in previous relationships as a risk factor in current relationship.
- Possible 'downgrading' of perceived risks and need for strategic multi-agency actions, where violence is believed to be mutual – failure to recognise that mutual violence may actually indicate *higher* risks.
- Insufficient recognition of power balance in the relationship.

**2. To establish how professionals and agencies carried out risk assessments, (including assessment of the victim's mental capacity to make decisions relating to risks) including**

**i) whether the risk management plans were reasonable response to these assessments.**

**ii) whether police DV risk assessments and management plans of Ian took account of his early forensic /criminal history, and assessments of risk made during this period.**

**iii) whether there were any warning signs of serious risk leading up to the incident in which the victim died that could reasonably have been identified, shared and acted upon by professionals**

**iv Whether risk assessments considered risk to individuals when services were withdrawn**

**Warning signs:**

- There were clear and repeated warning signs. This included 6 police incidents in the months leading up to the homicide and 2 CAADA-DASH risk assessments which found Janice to be at high risk.

**Risk assessments:**

- There is clear evidence that police DV risk assessments did not take sufficient (if any) account of Ian's early forensic and criminal history.
- Risk assessments also did not sufficiently take into account a number of other factors, including those associated with Janice being homeless.
- There was no assessment of the increased domestic violence risks to Janice, when a decision was taken to evict her from the Dawn Centre hostel accommodation.
- There were many missed opportunities by housing, homeless, primary healthcare and alcohol services, when incidents of domestic violence were disclosed, but no formal risk assessment was carried out and no pro-active

attempt made to engage Janice with specialist support. This appears to have been primarily due to a lack of staff training and awareness in relation to domestic violence risk assessment processes and local multi-agency policies and procedures, including the MARAC protocol.

**Risk management plans:**

- Although two different agencies completed MARAC referrals (only one of which has been confirmed as received by the MARAC office) Janice's situation was not discussed at MARAC, due to a breach MARAC policy / procedure. As a result of this there was never any clear multi-agency risk management plan. This has been identified as a very significant missed opportunity.

**Mental capacity:**

- It is very probable that when heavily under the influence of alcohol Janice's ability to recognise risks and make informed decisions about possible DV risks posed by Ian was temporarily impaired. However, there is no evidence to suggest Janice's mental capacity was impaired or that there would have been any grounds to formally assess her mental capacity to make decisions about her relationship or about whether or not to drink excessively.

**Information sharing:**

- There was some sharing of information by some of the agencies involved and there were significant (but unsuccessful) attempts to support and encourage Janice to effectively engage with specialist DV services.
- On one occasion staff at the Dawn Centre refused to share information with Nottingham Womens Aid, without Janice's written consent. The DHR has concluded that, given the urgency of the situation (i.e. potential placement in a women's refuge) seeking verbal consent via a telephone call to the hospital where Janice was an in-patient would have sufficiently addressed concerns about confidentiality.

***3.* To identify whether services that were involved with either Ian or Janice were aware of the circumstances of Janice's presence in the home and agencies involved with them. Whether connections were made and information shared between these services in order to establish a full picture of the vulnerability and risks arising from the relationship.**

Most services in regular contact with this couple were aware that Janice and Ian were in an intimate relationship; that this included occasions when Janice would stay at Ian's flat and that there were increasing concerns about violent incidents. Collectively, the agency IMRs also show that there was significant communication and information sharing between agencies. This included an intensive period of communication between GP Practice 1, CPN, Anchor, SAFE and Housing Options, in attempts to put an effective plan to reduce risk levels. Within these communications there are examples of good practice as well as some examples of communication breakdowns.

In summary, it appears that most services did recognise that there were significant domestic violence risks and attempts were made to share information, refer for specialist DV support from SAFE to establish a risk management plan. However, it is not clear that the *'full picture of vulnerability and risks arising from the relationship*' was established. A full picture would have included:

- Sharing of police records which would have highlighted Ian's past history as a serious DV perpetrator and recognition of the significance of that history in assessing current risk levels
- Wider recognition of Janice's homelessness as a major risk factor, because she stayed in Ian's flat when she had no other options.

Multi-agency weaknesses in respect of the above points was a major factor in the circumstances leading up to the homicide.

**4. Did agencies involved make routine enquiry about domestic violence when**

**working with these adults and if so were any opportunities missed.**

There is evidence that some agencies frequently engaged with both Janice and Ian about domestic violence issues. A number of agencies took opportunities to advise both Ian and Janice to end the relationship as it was widely recognised that there were significant domestic violence risks when the Janice and Ian were drinking excessively. However, there were many missed opportunities when the level of risk that Janice was under could have been more effectively and accurately assessed, followed by more proactive signposting and referral for specialist support. Advising Janice to end the relationship was a simplistic response which failed to recognise that the process of separation from an abusive relationship can often lead to a period of significantly higher risk.

**5. To establish whether agencies responded to alcohol and drug dependence and offer appropriate services and support to Ian and Janice.**

As noted above, when the couple were together and drinking excessively, this was widely recognised as a major risk factor for potential domestic violence. The couple were offered support to bring their drinking under control. Both Ian and Janice had access to support and harm reduction approaches at the Anchor Centre. Janice also had contact with an alcohol outreach worker.

In summary, the evidence is that alcohol was recognised as a highly significant issue and both Ian and Janice were actively encouraged to access relevant services. The Anchor Centre provided a ‘wet house’ which helped reduce immediate risks associated with street drinking. Unfortunately, it appears that neither Janice or Ian were able to engage with longer term treatment for alcohol dependency / misuse issues. This has highlighted the need for substance misuse services to develop more flexible and opportunistic responses to people who are homeless and have a range of complex needs.

**6. At each point of contact with emergency health services for assaults, self-**

**harm and injuries –were enquiries made about domestic violence and procedures followed?**

The level and quality of response from emergency health services was variable:

- Responses from the Urgent Care Centre tended to make assumptions that any active follow up to domestic violence concerns was the responsibility of other agencies.
- At Janice's first contact with Leicester Royal Infirmary following a reported domestic violence incident, no CAADA-DASH assessment was completed, which is breach of local policy and procedure. At her second contact an assessment was completed, resulting in a MARAC referral which according to hospital records was emailed to the MARAC office. However, there is no record of it being received by the MARAC office. Due to weaknesses (since resolved) in the hospital's email systems it is not possible to be certain whether or not the email was in fact sent to the correct email address.
- Queens Medical Centre (Nottingham) followed multi-agency policy and procedure, completed a CAADA-DASH assessment and made a MARAC referral. QMC's overall response has been identified as good practice.

**7. To establish whether mental health needs of the adults subject to this review were supported and managed appropriately by local agencies**

Although Janice spoke of having a bi-polar disorder which she said was diagnosed when she lived in the USA, the IMR from GP Practice 1 indicates no known history or medical record of such a diagnosis. It also indicates that, during the period under review, Janice's mental health was assessed by the GP service, but she was found to show no symptoms of psychosis or of risk of suicide.

However, Janice was referred to the Homeless Mental Health Service, which provided her with support from a Mental Health Nurse. Janice also had an appointment with a CPN, who made a verbal referral to the SAFE project.

In summary, it appears that Janice's mental health needs were adequately supported.

There is no evidence to indicate that Ian had significant mental health needs.

**8. To establish if any agency or professionals considered any concerns were not taken seriously or acted upon by others.**

The alcohol outreach worker raised concerns in an email in February 2015 with Housing Options about the DV risks resulting from Janice being homeless and reliant on an abusive boyfriend for overnight accommodation. It is unclear what Housing Options did with this information.

**9. To establish if there were any barriers experienced by Ian, Janice or family / friends that prevented them from accessing help to manage domestic violence; including how their wishes and feelings were ascertained and considered.**

Ian has stated that he felt he had been a DV victim as well as a perpetrator, but that as a man he experienced a barrier, because services assumed that the male partner could not be a victim. However, the DHR has not found evidence that would indicate Ian was at any significant risk of serious injury or homicide.

As a homeless person with alcohol problems, Janice experienced many barriers related to her lifestyle and flexibility of service provision. Many professionals genuinely listened to her wishes and feelings and she was offered support by specialist domestic violence services. However, as her basic need for safe and sustainable housing was not met, this undermined attempts to achieve consistent engagement with domestic violence services. Her homelessness created additional barriers for services trying to make and maintain contact. Even contact by mobile phone was unreliable, as Janice would not always be able to keep the battery charged. As a general rule, domestic violence services are reluctant to leave voice mail messages, due to fears that a perpetrator may pick up messages resulting in

higher risks to the victim.

In summary, this DHR has highlighted the need for agencies to develop more flexible, creative and responsive services, in order to reduce or remove some of the barriers which impacted negatively on Janice.

**10. To identify whether more could be done locally to raise awareness of services available to victims of domestic abuse.**

There is evidence that there was a lack of awareness within local services of the voluntary perpetrator programme, which could potentially have worked with Ian to address what was a clearly established pattern of abusive and violent behaviour in this and in previous relationships.

**11. To establish whether agency DV risk assessments and response to risk followed agreed local multi-agency procedures.**

See responses above and to question 12. There were procedural breaches.

**12. To establish how referrals into MARAC were responded to, whether these responses were in line with local multi-agency procedures and whether they were appropriate, in the light of information about risk which was available at the time of referral.**

**The first recorded MARAC referral** was generated by QMC in March 2015, after they had scored Janice as being at high risk on the CAADA Dash risk assessment. This was following the incident when Janice attended the QMC Emergency Department after the incident when she stated Ian had poured boiling water on her head and stabbed her in the thigh. The evidence reviewed by the Police (including the apparently minor nature of Janice's injuries and a third-party witness statement which contradicted Janice's account) indicated no realistic prospect of successfully prosecuting Ian with any criminal offence.

A decision was taken by the MARAC office that this would not be discussed at

MARAC. The primary basis for this decision appears to be that the allegations made by Janice that she had been violently attacked by Ian were, in the judgement of police officers, not supported by the presenting evidence.

However, the decision in this instance was contrary to local MARAC protocol and procedures and represented a very significant **missed opportunity** to establish a coordinated multi-agency approach, which could have better recognised and more effectively managed ongoing domestic violence risks. It is fundamentally important to recognise that the lack of evidence to support a criminal prosecution was *not* an indicator for low risk of further domestic violence.

**The second MARAC referral,** also in March 201*5,* was recorded as having been made by UHL's Emergency Department. This was after Janice attended ED with bruising to her face and back, and a bump to her head. Whilst the MARAC referral is recorded by UHL as having been sent by email, UHL have been unable to locate any email history to confirm that is was sent to the correct MARAC email address. It is understood that this is due to weaknesses in UHL's electronic communications systems, which have since been addressed.

Due to the absence of reliable records, the DHR has not been able to ascertain precisely what happened, but the outcome was that no MARAC process followed.

**13. To establish whether vulnerable adult / adult safeguarding concerns were recognised by agencies and were appropriate multi-agency procedures followed**.

The DHR has not found significant learning in relation to this question

**14. To consider how issues of diversity and equality were considered in assessing and providing services to Ian, Janice (protected characteristics**

**under the Equality Act 2010 age; disability; race; religion or belief; sex; gender reassignment; pregnancy and maternity; marriage or civil partnership)**

Janice's gender, mental health problems, alcohol misuse and homelessness were all highly significant factors in relation to Janice's needs as a person who was at risk from domestic violence. Learning in relation to these factors is disseminated throughout the report.

**15. How effective were local assessments on Ian & Janice's housing needs? Was appropriate housing support offered? How well did Leicester and Nottingham Housing agencies work together in safeguarding Janice?**

Janice's homelessness status (after losing her space at the Dawn centre) was a critical risk factor for domestic violence, but this appears not to have been sufficiently recognised or acted on.

Janice was evicted from the Dawn Centre in January 2015 for an alleged incident of supplying an illicit substance to another resident. An internal review of this decision by Leicester's Homeless Service has since concluded that a final warning would have been a more appropriate response. On eviction, there was no assessment of the likely impact of this decision, even though it was known that she was at risk of domestic violence and had been assaulted on the day preceding her eviction.

When she was admitted to QMC in Nottingham there were attempts to negotiate some form of suitable housing, including a refuge placement (for which there were no vacancies in the local area) homeless provision in Nottingham and a return to the Dawn centre. However, none of these were offered.

Another factor in Janice being refused services in Nottingham was her previous eviction from the Dawn Centre, so it can be seen that the earlier decision by the Dawn Centre then had significant 'knock-on' effects in further reducing the chances of her finding suitable and safe accommodation. This seems to have been compounded by the Dawn Centre then refusing to share further information with WAIS unless Janice completed a written consent form. Given the urgency of the situation when Janice was a patient at QMC, verbal consent over the telephone could have been sought.

In summary, housing and homeless services in Leicester and Nottingham did not

work effectively together to safeguard Janice from further domestic violence.

**16. To establish how effectively Leicester / Nottingham agencies and professionals worked together to safeguard Janice.**

There was very good communication from staff at QMC hospital and agencies in Leicester, but unfortunately this did not lead to any positive outcomes in relation to Janice's immediate need for safe and secure accommodation. See also response to question 15.

**17.To establish whether domestic violence policies, protocols and procedures (including risk assessment tools) that were in place during the period of review, were applied and whether they were fit for purpose.**

See responses above.

**18. Identify any areas of good practice**

This DHR has established a pattern dominated by missed opportunities, poor inter-agency communications and breaches of procedure in relation to risk assessments and the MARAC process. However, there were isolated examples of good practice, including:

- Responses by staff at Queens Medical Centre in allowing Janice to remain in hospital when medically fit for discharge, having assessed her as being at high risk from domestic violence, then attempting (unfortunately without success) to work with outside agencies in Nottingham and Leicester to establish a safe discharge arrangement.
- The Outreach Alcohol Support Worker demonstrated a good understanding of the risks Janice was facing and acted appropriately to meet her immediate needs and to try (unfortunately without success) to ensure her engagement with Housing Options services.

- There are several examples of good practice by GP Practice 1, when concerns about domestic violence were proactively explored by practitioners and referral for specialist support was offered.
- Following the first 3 police incidents, Leicestershire Police carried out a review and increased assessed risk levels from standard to medium, due to cumulative evidence of risk.
- UHL's completion of the CAADA DASH risk assessment and the application of professional judgement in deciding to generate a MARAC referral was also good practice, but it is unfortunate that did not result in implementation of the MARAC process. (See question 12)

**Key learning points:**

For ease of reference, the following is a summary of all key learning points from part 2 of the report:

**Key learning point 1:** There were breaches of operational procedure at the LRI Emergency Department and Housing Options which resulted in missed opportunities to assess potential domestic violence risks. There had also been a missed opportunity to carry out a risk assessment (or refer to a specialist domestic violence service for assessment) at the GP practice. This highlights the importance of ensuring that staff awareness and understanding of domestic violence policy, procedure and good practice is promoted through training, supervision and management processes.

**Key learning point 2:** There is a potential misconception – possibly shared by some professionals as well as members of the public – that 'domestic abuse' can only take place within the confines of a domestic dwelling. This may result in homeless victims of abuse being effectively excluded from multi-agency domestic abuse procedures.

There is evidence that homeless people are likely to be at higher risk from domestic violence compared to the general population, as is illustrated by this case and other recent DHRs[17]. It is therefore essential that all services which work with homeless people should ensure that staff understand that any abuse within the context of an intimate relationship – *regardless of the physical location of incidents* – should be recognised as domestic abuse and responded to accordingly, within local multi-agency policy, procedure and good practice guidance.

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[17] For example: DHR SW01 published June 16 by Safer South Warwickshire CSP: apps.warwickshire.gov.uk/api/documents/WCCC-671-101

**Key learning point 3:** When conducting domestic violence risk assessments, police officers should review local and national police records relating to the perpetrator. Where these records confirm a history in previous relationships of serious domestic violence (including in this case criminal convictions resulting in custodial sentences) this is a strong indicator of higher risks in the current relationship. The time period which may have elapsed since the last recorded police incident should not unduly influence officers towards a lower risk score, as it is entirely possible that the abusive behaviour has continued but has not been reported to the police.

**Key learning point 4:** There was a pattern of assumption on the part of UCC staff that responsibility for addressing concerns about domestic violence risks to Janice lay with the police and other services she was in contact with.

As a minimum, UCC staff should have discussed ongoing domestic violence risks with Janice, with a view to referring her for specialist support. Additionally, concerns about domestic violence should have been flagged on UCC records and discussed with her GP and other relevant services. (The UCC DHR Action Plan addresses these issues in more detail.)

In fairness, it must be acknowledged that a number of other services (such as housing, homelessness and primary healthcare services) appear to have followed a similar pattern of assuming that 'somebody else' would be leading in relation to domestic violence concerns, so this learning point is relevant not just to UCC.

**Key learning point 5:** There is a need to ensure consistency of practice in the use of CAADA-DASH assessments where people present as homeless and there is evidence that that domestic violence is a factor in this presentation. The risk assessment should be conducted at the time of the homelessness presentation and not delayed until a decision is made regarding the person's statutory homeless status, which may be up to 33 working days later. As is clearly shown

by Janice's experiences, if the individual is fleeing a violent relationship this period of 33 working days may well be a particularly high risk period.

**Key learning point 6:** Even if Janice's eviction from the Dawn Centre had been unavoidable due to concerns about other vulnerable service users, there should have been careful consideration of her ongoing vulnerability as a domestic violence victim. Attempts should have been made at finding more suitable alternative accommodation or at the very least signposting to specialist support services.

**Key learning point 7:** When carrying out DASH risk assessments officers should consider cumulative risk, especially when there has been a succession of similar incidents within a short space of time. A risk assessment which fails to consider such recent events and evidence of escalation is likely to be unreliable. (See also key learning point 3.)

**Key learning point 8:** It should be recognised that people with multiple and complex needs such homelessness, alcohol problems and domestic violence (i.e. those in the most critical and urgent need of help) are very frequently the most difficult people for services to meaningfully engage with and effect positive change. However, there could have been more concerted and proactive attempts at getting Janice to attend Housing Options with a view to finding her somewhere safe to stay. This did not happen and the outcome was that Janice remained dependent on her violent partner for accommodation, which was apparently her only option other than rough sleeping.

| **Key learning point 9:**<br>**Clarifying victim / perpetrator roles and identifying risks** | |
|---|---|
| **Ian** | **Janice** |
| Confirmed history / criminal convictions as perpetrator of | **Risk factor:** Self-reported history as victim of domestic abuse and |

| | |
|---|---|
| domestic abuse and serious physical assaults in previous relationships. | physical assault in previous relationships |
| Recent and repeated history of assaulting Janice, causing significant injuries requiring hospital treatment | **Risk factor:** Observed on occasions to be physically aggressive and towards Ian, not known to have caused him serious injuries, but has received serious injuries in these conflicts. |
| Securely housed | **Disempowered:** Homeless, largely dependent on staying at Ian's as alternative to rough sleeping |
| Serious problems with binge drinking | **Risk factor:** Serious problems with binge drinking.<br>**Risk factor:** History of mental health problems. |

**Key learning point 10:** In an urgent situation where a person is fleeing domestic abuse and potentially seeking a refuge placement, the requirement for written consent before sharing information with the refuge service may create an unnecessary barrier to them being able to access the service. Where the person is willing and able to confirm verbal consent over the telephone (provided their identity can be verified with reasonable certainty) this should be a sufficient basis for sharing information.

**Key learning point 11:** The MARAC referral should not have been screened out of the MARAC process, regardless of any doubts that police officers or others may have regarding the reliability of an alleged victim's statement. That there was insufficient evidence to bring criminal charges should not have resulted in any assumptions about levels of domestic violence risks.

To screen and reject MARAC referrals on such a basis completely undermines a key principle: MARACs should consider risk assessments and risk management strategies from a *shared and multi-agency* perspective.

There is a need to ensure that the above points are made completely clear in the local MARAC Protocol.

**Key learning point 12:** When agencies refer to MARAC they must ensure that they retain a clear record of the risk assessment and the MARAC referral and request and receive a confirmation that the referral has been received. They should also be notified when the case will be discussed at MARAC and invited to attend the MARAC meeting.

**Key learning point 13:** It is important that GPs and other primary healthcare professionals have a good knowledge and awareness of domestic violence issues in general and of the MARAC process in particular. If there is any doubt about whether there is a current MARAC referral or MARAC coordinated risk management plan, this should be checked with the MARAC Coordinator.

**Key learning point 14:** This report has appropriately focussed very much on the availability and effectiveness of services to support and protect Janice. However, it is equally important to acknowledge the potential benefits of targeted interventions with repeat domestic violence perpetrators, which may ultimately change this behaviour pattern and protect other women from future abusive relationships. This also highlights the need to increase knowledge and awareness of local services which can offer such interventions.

## PART 4: RECOMMENDATIONS

### 4.1 Recommendations reproduced from the Single Agency Action Plans attached to Individual Management Reviews:

**Leicestershire Police recommendations:**

1) It is recommended that supervisory officers are reminded of their responsibility to supervise domestic abuse investigations and the importance of fully recording the rationale for their decision making.

2) It is recommended that officers are reminded of the various support agencies that are available to persons who are alcohol dependent in order that they are signposted to the most appropriate agency to receive the required support.

3) It is recommended that officers are reminded of the need to adopt a more lateral problem solving approach to domestic abuse when faced with a victim who is reluctant / reticent to engage beyond the initial report of the abuse.

4) It is recommended that the police DASH risk assessment be amended with notes of guidance in the 'professional judgement' field, to guide decision makers regarding factors, outside of the main DASH questions, which should lead an assessor to increase the risk level. These are to include:

   - History of DV offending against other separate victims (serial perpetrator)
   - Significant increase in frequency of Standard and Medium risk incidents

This change will be marketed to all officers involved in completing DASH risk assessment and otherwise reviewing DV (DAST team)

**Leicester City Council Homeless Prevention & Support Service recommendations:**

1) Consider how services are withdrawn for victims of Domestic Abuse
2) Service Users presenting with Alcohol Issues should receive additional support to encourage access to treatment.
3) Ensure that Homelessness Services staff are fully aware of ASC responsibilities for vulnerable adults.
4) Assist One Roof to compile a referral form to highlight indicators of DV.
5) Ensure the learning from this IMR is shared amongst Homelessness Services Management Team.

**Leicester City Council Housing Options Service recommendations**

1) Provide further guidance to Officers as feedback from completing this process of lessons learnt and examples of good practice.
2) Case Management procedures reviewed.

**Safe project:**

***No recommendations***

**GP Practice 1 recommendations:**

1) A DVA lead be designated to lead on this area of work and ensure the practice remains up to date in its protocols and activity.
    a. Improve awareness of the agencies (such as UAVA) and

processes (such as MARAC) involved with supporting people experiencing Domestic Abuse within the team.

b. Improve understanding of CAADA-DASH risk assessment process
c. Ensure appropriate training for clinical and non-clinical staff
d. Guard against desensitisation to risks and optimise understanding of HIGHER risks in mutually violent relationships
e. Engage with local safeguarding and DVA organisations and systems to improve primary care involvement more generally.

2) Systems to flag both victims and perpetrators of DVA within the clinical system (IT) are sought and that routine queries and offers of support and referral take place when flags are present.

**Anchor Centre recommendations**

***No recommendations***

**Nottingham University Hospitals NHS Trust recommendations**

***No recommendations***

**Leicestershire Partnership NHS Trust recommendations**

***No recommendations***

**University Hospitals of Leicester NHS Trust Recommendations**

1) Improve staff knowledge and awareness of domestic abuse and where to seek specialist advice by incorporating domestic abuse information / training into the mandatory adult safeguarding e-learning module.

2) Revise the face to face training on domestic abuse for ED / UCC staff to incorporate the learning from this review.

3) Review and revise the Emergency Department Standard Operating Procedure for Domestic Abuse, in line with the Trust's overarching DA Policy and best practice. This should include routine enquiry where domestic abuse is disclosed or suspected.

4) Review and revise the Emergency Department Standard Operating Procedure for Safeguarding Adults, in line with the Trust's overarching SA Policy and the Care Act.

5) Increase ED / UCC staff knowledge, awareness and confidence when dealing with domestic abuse, in light of this review (by implementing the above).

6) Explore the possibility of securing additional funding to recruit a permanent IDVA to work across UHL, alongside the UHL safeguarding teams

7) Ensure that the organisation maintains a secure record of all MARAC referrals made by ED / UCC staff.

**4.2 Overview Recommendations agreed by DHR Panel**

1) Leicestershire Police should review operating procedure, guidance and training for domestic violence risk assessments using DASH, to include a requirement that checks must be made on police records (Police National Computer and Police National Database) to ascertain whether the alleged domestic violence perpetrator has a history of reported domestic violence incidents and / or criminal convictions. Where such a history exists, but the current risk score has not reached the threshold for automatic referral to MARAC, officers should

consider a MARAC referral based on professional judgement. (*Key learning point 3*)

2) There should be a multi-agency review of the MARAC procedure and domestic violence training needs, in the light of learning from this case, to include

- Systems for sending, receiving and recording MARAC referrals
- Potential need for clarification of guidance for specialist domestic violence staff, particularly around the requirement that any domestic violence victim identified as high risk in CAADA-DASH must be considered at a multi-agency MARAC meeting. *(Key learning points 11 & 12)*
- Need for wider agency training and awareness raising about domestic violence and the role of MARAC, with a specific focus on training needs in primary healthcare and housing and homelessness services, to include appropriate use of the DASH risk assessment tool in cases where there are presenting concerns relating to domestic abuse.
- Supporting and training staff responsible for assessing domestic violence risks where there are multiple and complex needs, including evidence of mutually violent behaviours. (*Key learning point 9*)
- Ensuring that service users' wishes and intentions are clearly accounted for in safety planning and that follow actions are in place; particularly when the service user is identified as being high risk.

3) There should be work to increase awareness about local services which carry out specialist and targeted work with serial domestic abuse perpetrators. Perpetrators who have a history of criminal domestic abuse offences should be prioritised for such targeted interventions, which may be on a voluntary basis or as an element of criminal court imposed sanctions. If this recommendation highlights issues of insufficient capacity to meet demand, this should be

considered by commissioners as a potential area for increased resource allocation. (*Key learning point 14*)

4) All key learning points from this DHR should be disseminated as widely as possible to local health, social care, housing, homelessness and criminal justice agencies likely to be working with people affected by domestic violence. (*All Key learning points)*

***APPENDIX 1: GLOSSARY***

| | |
|---|---|
| Anchor Centre | 'Wet' day centre service for street drinkers |
| AUDIT | Alcohol Use Disorders Identification Test |
| CAADA-DASH RIC | Coordinated Action Against Domestic Abuse<br>Domestic Abuse, Stalking and 'Honour'-Based Violence<br>Risk Assessment Checklist |
| CCG | Clinical Commissioning Group |
| CPN | Community psychiatric Nurse |
| CSP | Community Safety Partnership |
| DAIU | Domestic Abuse Investigation Unit (Police) |
| Dawn Centre | Temporary homeless accommodation service in Leicester |
| DHR | Domestic Homicide Review |
| ED | Emergency Department (Part of UHL) |
| EMAS | East Midlands Ambulance Service |
| IMR | Individual management Review |
| GP Practice 1 | Specialist primary healthcare service for homeless & vulnerably housed people |
| IPCC | Independent Police Complaints Commission |
| LPT | Leicester Partnership NHS Trust |
| LRI | Leicester Royal Infirmary |
| MARAC | Multi Agency Risk Assessment Conference |
| PSD | (Police) Professional Standards Department |
| QMC | Queens Medical Centre (Nottingham) |
| SAFE | Voluntary sector domestic violence service |
| UCC | Urgent Care Centre (Part of UHL) |
| UHL | University Hospitals Leicester NHS Trust |
| WAIS | Womens Aid Integrated Services (Nottingham) |