

# **Forest of Dean Community Safety Partnership**

**DOMESTIC VIOLENCE HOMICIDE REVIEW**

**OVERVIEW REPORT**

**Into the death of Bob M (pseudonym) in August 2015**

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Independent Domestic Homicide Review Chair**

**Report Completed: 18th May 2016**

## Contents

Family Tribute to Bob M	3
1. Preface	4
2. Review Panel Members	5
3. Introduction	6
4. Parallel Reviews	9
5. Timescales	9
6. Confidentiality	10
7. Dissemination	10
8. Terms of reference	11
9. Schedule of Meetings	13
10. Methodology	13
11. Contributors to the Review	13
12. The Chronology	14
13. Key Issues	21
14. Analysis	28
15. Effective Practice & Lessons Learnt	45
16. Conclusions	51
17. Recommendations & Action Plan	53
<b>Appendices</b>	
<i>Appendix A:</i> Glossary of Terms	66
<i>Appendix B:</i> Bibliography	67
<i>Appendix C:</i> “A Countywide Housing Protocol in responding to Domestic Abuse” Gloucestershire County Homelessness Implementation Group 2015	69
<i>Appendix D:</i> Victim’s Family history provided by his mother.	79

## Family Tribute to Bob M.

He was a loveable rogue who lived for the moment with a happy-go-lucky nature. Despite being subject to maternal abuse before being adopted, he grew up to be a polite and well-mannered man, with childlike qualities.

He was very popular, as hundreds attended his funeral, and was a well-respected footballer. Football was his life.

Bob M worshipped his mother and had a brother and sister who he adored.

There was another side to Bob M that has not been touched upon within the legal process.

We feel to a certain extent Bob M has been a victim twice. First when he was killed and the second how he was portrayed during the criminal proceedings.

As a family, we fully understand mental health and domestic abuse and we empathise with those who have suffered from them. However, taking the life of another is not justifiable.

Men can also be victims of domestic abuse but don't speak up about it. There are two sides to a relationship.

Whatever sentence given will never be enough for taking the life of our much loved son, brother and nephew. There are no winners in this case. Nothing good ever comes from a toxic relationship.

## 1. Preface

1.1. Domestic Homicide Reviews (DHRs) came into force on the 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be 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 person to whom he was related or with whom he was or had been in an intimate personal relationship or a member of the same household as himself; held with a view to identifying the lessons to be learnt from the death.

1.2. Throughout the report the term “domestic abuse” is used in preference to “domestic violence” (other than when quoting from official documents), as this term has been adopted by the Forest of Dean Community Safety Partnership.

1.3. The purpose of a DHR is to:

Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

Apply these lessons to service responses, including changes to policies and procedures as appropriate; and identify what needs to change in order to reduce the risk of such tragedies happening in the future, to prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

1.4. This Domestic Homicide Review (DHR) which examines the circumstances surrounding the death of Bob M (pseudonym) in August 2015 was initiated by the Chair of the Forest of Dean Community Safety Partnership in compliance with legislation. The Review process follows the Home Office Statutory Guidance.

1.5. The Independent Chair, Report writer and the DHR Panel members offer their deepest sympathy to all who have been affected by the death of Bob M and thank them, together with the others who have contributed to the deliberations of the Review, for their time, patience and co-operation.

1.6. The Review Chair thanks the Panel for the professional manner in which they have conducted the Review and the Individual Management Review authors for their thoroughness, honesty and transparency in reviewing the conduct of their individual agencies. He is joined by the Panel members in thanking Tess Tremlett and Alison Tomlin for their excellent administration of the Review and minute taking.

## **2. Review Panel**

Tess Tremlett, Forest of Dean Community Safety Partnership Lead

Sue Pangbourne, Forest of Dean District Council

Nicola McLean, Forest of Dean Community Safety Partnership Co-ordinator

Malcom Vine, Forest of Dean District Council Strategic Housing

Helen Chrystal, Gloucestershire Clinical Commissioning Group (CCG)

Sarah Jasper, Gloucestershire County Council Adults Safeguarding

Carol Wood, Gloucestershire County Council Adult Social Care

Vicki Butler, Gloucestershire County Council Children's Services

Simon Atkinson, Gloucestershire Constabulary

John Lynch-Warden, Gloucestershire Constabulary

Jude Marshall, Gloucestershire Domestic Abuse Support Service

Jon French, Gloucestershire Fire and Rescue Service

Jon Burford, Gloucestershire Hospitals NHS Foundation Trust

Stephen Smith, National Probation Service (also representing Bristol, Gloucestershire, Somerset and Wiltshire Community Rehabilitation Company)

Gordon Benson, 2gether NHS Foundation Trust

Stuart Fadden, Turning Point

Rachel Smith, Two Rivers Housing

Pamela Jones, Wyedean Housing

David Warren QPM, Home Office Accredited Independent Chair

### **Review Administrator:**

Tess Tremlett, Forest of Dean District Council

### **Review Panel Minute Taker:**

Alison Tomlin, Forest of Dean District Council

### 3. Introduction

3.1. This Overview Report of the Forest of Dean Domestic Homicide Review examines agency responses and support given to the deceased Bob M (pseudonym), an adult resident of [REDACTED] in the Forest of Dean and their contacts with Jane, Bob M's ex-partner (pseudonym) and with any dependent children, prior to Bob M's death.

3.1.1. Bob M, aged 43 at the time of his death, had been in an "on-off" relationship of four years, with Jane who was 51 years of age at the time of the incident. Bob M lived in rented accommodation in [REDACTED] in the Forest of Dean District of Gloucestershire. Jane lived approximately sixteen miles away, in rented accommodation in [REDACTED].

3.2. [REDACTED]

### 3.3. Incident Summary:

There had been a history of domestic abuse between Bob M and Jane over a number of years and a non-molestation order had been taken out by Jane in June 2015. On a night in August 2015, the police received a 999 call from Jane. She told the police that she had stabbed her partner and that the knife was still in his chest. An officer attended the scene and found Bob M with the knife in his hand. Officers unsuccessfully attempted first aid and CPR but Bob M was declared deceased at 11.50pm. Jane was arrested and told officers that she had moved house because of violence from Bob M, against whom she had a non-molestation order, he had found her and broken into her home. He had told her to take her clothes off and she thought he was going to rape her, so she took a knife from the kitchen and stabbed him through the heart. She was later charged with Bob M's murder but a plea of guilty to manslaughter by diminished responsibility was accepted and she was sentenced to nine years imprisonment reduced to seven years three months to reflect an early guilty plea.

3.4. The Pathologist's report gave the cause of death as being due to a single penetrating incised wound to the chest passing through the front of the right side of the heart and back of the left side of the heart. The toxicology examination found that Bob M had used cannabis, cocaine and heroin at some point prior to his death. There was no evidence that he had consumed alcohol.

3.5. The key purpose for undertaking this Domestic Homicide Review (DHR) is to enable lessons to be learned from Bob M's death. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened and most importantly, what needs to change in order to reduce the risk of such a tragedy happening in the future.

3.6. The Review considers all contact/involvement agencies had with Bob M, Jane or their dependent children during the period from 1<sup>st</sup> January 2005 and the death of Bob M on [REDACTED] August 2015, as well as all events prior to that period which could be relevant to domestic abuse, violence, drugs, alcohol or mental health issues.

3.7. The DHR Panel consisted of senior officers, from the statutory and non-statutory agencies, listed in section 2 of this report, who are able to identify lessons learnt and to commit their organisations to setting and implementing action plans to address those lessons. None of the members of the panel, nor any of the Independent Management Report (IMR) Authors have had any relevant contact with Bob M or Jane. (Pamela Jones of Wye-dean Housing declared that one of the housing officers she supervised had been responsible for providing Bob M with a single occupancy accommodation. She had no knowledge of the details of the housing application. Stephen Smith of the National Probation Service declared that he had indirect historic knowledge of the victim but not in relation to domestic abuse or his connection with Jane).

3.8. Expert advice regarding domestic abuse service delivery in Gloucestershire has been provided to the Panel by Gloucestershire Domestic Abuse Support Service (GDASS) which provides the commissioned Independent Domestic Violence Adviser (IDVA) Service in Gloucestershire. Specialist advice relating to illegal drug use has been provided by Turning Point. Specialist advice relating to mental health issues was provided by 2gether NHS Foundation Trust.

3.9. The Chair of the Panel is an accredited Independent Domestic Homicide Review Chair. He has an in-depth knowledge of domestic abuse legislation, policy and practice at national, regional and local levels. He has passed the Home Office approved Domestic Homicide Review Chair's courses and possesses the qualifications and experience required in section 5.10 of the Home Office Multi-Agency Statutory Guidance. He is totally independent and has no association with any of the agencies involved in the Review nor has he had any dealings with either Bob M or Jane.

3.10. The agencies participating in this Domestic Homicide Review are:

- Army (Provost Marshal)
- [REDACTED] Surgery
- Bristol, Gloucestershire, Somerset, Wiltshire Rehabilitation Service (BGSW RS)
- [REDACTED] Town Council
- Civica – Revenues and Benefits
- [REDACTED] Town Council
- Crown Prosecution Service South West
- Forestry Commission
- Forest of Dean Citizens Advice Bureau
- Forest of Dean Community Safety Partnership
- Forest of Dean District Council Environmental Services
- Forest of Dean District Council Housing
- Gloucestershire Care Service
- Gloucestershire Clinical Commissioning Group
- Gloucestershire Constabulary
- Gloucestershire County Council Children Service
- Gloucestershire County Council Adult Social Care
- Gloucestershire Domestic Abuse Support Service

- Gloucestershire Fire and Rescue
- Gloucestershire Hospitals NHS Foundation Trust
- Gloucestershire Multi Agency Risk Assessment Conference (MARAC)
- Green Square Housing
- HM Courts and Tribunal Service
- Independence Trust
- Info Buzz
- [REDACTED] Town Council
- National Probation Trust
- NHS England
- [REDACTED] Doctors Practice
- [REDACTED] Town Council
- 2gether NHS Foundation Trust
- Two Rivers Housing
- South West Ambulance Service NHS Trust
- Turning Point
- Wyedean Housing Association

3.11. Both Bob M's mother and Jane's solicitor were contacted at the commencement of the Review. Bob M's mother was provided with details of Advocacy After Fatal Domestic Abuse (AAFDA) and it was explained to her what help the family could receive from the Charity. She responded that she was already receiving close support from the Victim Support Homicide Service and from the Police Family liaison Officers.

3.12. Bob M's mother confirmed that she had spoken to the police about his relationship with Jane on a number of occasions and that there were no barriers inhibiting her or her son from reporting domestic abuse incidents in the past.

3.13. Jane had no contact with her family for a number of years, but she confirmed through her Probation Officer that she and her neighbours had reported incidents of domestic abuse to both the police and to her key worker at the Gloucestershire Domestic Abuse Support Service on a number of occasions and she did not believe that there were any barriers stopping her from doing so.

3.14. At the conclusion of Review, Bob M's mother read the Overview Report prior to the Panel meeting on 18th May 2016. She said; "I want to say thank you to the Review Panel. It is the first time I have felt my son has been portrayed fairly. I know what he could be like, but he was the victim in this murder and that seemed to have previously been forgotten. The Report however is balanced and reflects fairly what happened and that has helped me a great deal. I want to take the opportunity to point out that the one person who worked hard for Bob M was the Hospital Epilepsy worker, she constantly provided an amazing service and I would like her to know we as a family appreciated the care and support she provided to Bob M. Finally I noticed there is nothing in the lessons learnt section of the report, regarding Bob M's mental health issues. His epilepsy and the traumas he suffered, as a baby and later through head injuries, could temporarily adversely influence his behaviour and his ability to think rationally. At such times he needed professional help, but he would not seek it voluntarily and there is no way under the Mental Health Act to coerce someone with such temporary mental health problems to obtain treatment. In Bob M's case nothing was therefore done for him". She declined the invitation to attend the Panel meeting on 18th May 2016. The issues raised by Bob M's mother have now been addressed in the lessons learnt and recommendations sections of this Review.)

3.15. Jane's solicitor was contacted by letter and by telephone. She agreed to speak to her client about the Review and to ask her for a pseudonym and for her consent for the Review to access his medical records. She said she expected her client to ask the Review to consider the lack of police action with regard to the non-molestation order against Bob M. Later she said her client was not in the right place mentally to consider anything. She agreed that Jane was a suitable pseudonym for her client. The solicitor was contacted after the conclusion of the criminal proceedings, but said she no longer had any contact with Jane. Jane's Probation Officer on visiting Jane in prison, explained about the purpose of the DHR and asked if she would like to meet with the DHR Chair. She declined the offer, but signed a consent form to allow the DHR access to her medical records and she agreed that the name Jane could be used as a pseudonym for her. She did not wish to have any further contact regarding the DHR as she just wanted to serve her sentence and get her life back.

#### **4. Parallel Reviews**

4.1. Criminal Proceedings. Jane was charged with Bob M's murder but later a plea of guilty to a charge of manslaughter by diminished responsibility was accepted and she was sentenced to nine years imprisonment reduced to seven years three months due to an early guilty plea.

4.2. The DHR was provided with copies of all of the court papers including statements from witnesses.

#### **5. Timescales**

5.1. A decision to undertake a Domestic Homicide Review was taken by the Chair of the Forest of Dean Community Safety Partnership on 8th September 2015 and the Home Office was informed the same day. The Independent DHR Chair was appointed on 1st December 2015 and the first meeting of the DHR Panel was held at the earliest opportunity on 6th January 2016.

5.2. The Home Office Statutory Guidance advises, where practically possible the DHR should be completed within 6 months of the decision made to proceed with the review. This is the first Domestic Homicide Review instigated by the Forest of Dean Community Safety Partnership and time was taken in appointing an experienced Independent Chair as a request had been made by the Police Senior Investigating Officer (SIO) supported by the defence legal team that the Domestic Homicide Review should be delayed after the completion of the criminal proceedings which was expected to focus on domestic abuse by both the perpetrator and victim. Consequently a number of witnesses were listed who would also be involved in the DHR. After the appointment of the DHR Chair, with the agreement of the Community Safety Partnership Chair and the SIO a decision was taken that the DHR should be opened and agencies instructed to secure all documentation relating to their contacts with either the victim or perpetrator and that any obvious lessons to be learnt should be addressed expeditiously. The Home Office was notified on 4th December 2015 and agreed with this approach.

## **6. Confidentiality**

6.1. The findings of this Review are restricted to only participating officers/professionals, their line managers and the family of the deceased until after the Review has been approved for publication by the Home Office Quality Assurance Panel.

6.2. As recommended within the “Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews” to protect the identity of the deceased and her family, the following pseudonyms have been used throughout this report.

6.3. The name Bob M is used as a pseudonym for the deceased, it was chosen by his mother who also signed a consent form allowing the Review to have access to Bob M’s medical records. Initially the perpetrator’s solicitor selected the pseudonym Jane for Bob M’s partner. This was agreed with the perpetrator after her trial, when she also signed the consent form permitting the DHR to obtain her medical records.

6.4. The Executive Summary of this report has been carefully redacted. To enable the Home Office Quality Assurance Panel to have access to the detail of the Review, other than the use of pseudonyms and the exclusion of the names and addresses of involved individuals, the overview report and chronology have not been redacted. Both documents will be fully redacted prior to publication by the Forest of Dean Community Safety Partnership. (Note: This Overview Report and the Executive Summary have been fully redacted as per Home Office Guidance).

6.5. The Review Panel has obtained the deceased’s confidential information, (including police and medical records) after his mother gave her written consent. Jane’s medical records were initially disclosed through the public interest exception in S.29 of the Data Protection Act but she later signed a consent form allowing the Review access to her records.

## **7. Dissemination**

7.1. Each of the Panel members (see list at beginning of report), the IMR authors, and Chair and members of the Forest of Dean Community Safety Partnership have received copies of this report.

7.2. Bob M’s mother took the opportunity to read the Overview Report at length, prior to the final meeting of the Review. She declined the invitation to attend the final meeting on 18th May 2016 as she felt she and her family would find it too traumatic.

7.3. The perpetrator was seen in prison by her Offender Manager on behalf of the DHR but she declined the offer to read the report.

7.4. Copies of the Overview Report and Executive Summary have been forwarded to the Gloucestershire Police and Crime Commissioner.

## 8. The Terms of Reference

8.1. The Review will consider:

8.1.1. Each agency's involvement with Bob M, 43 years of age at the time of his death in August 2015 or with his estranged partner Jane (Pseudonym) aged 51 at that time or with any dependent children. Agencies involvement should include any contacts between 1 January 2005 and the date of the date of Bob M's death in August 2015; and any contacts relevant to domestic abuse, violence, drugs, alcohol or mental health issues prior to that period.

8.1.2. Whether there was any previous history of abusive behaviour towards or by the deceased or to any previous partner, or dependent children or relative of Jane or Bob M and whether these incidents were known to any agencies or multi agency forum?

8.1.3. Whether either Bob M or Jane had any previous history of dependency on any legal or illegal substance including alcohol and whether either had or were receiving support or treatment from any specialist drug or alcohol support or treatment service.

8.1.4. Whether family, friends, work colleagues or neighbours want to participate in the review. If so, ascertain whether they were aware of any abusive behaviour to or by the victim or any concerns relating to drug or alcohol abuse, prior to Bob M death.

8.1.5. Whether, in relation to the family members friends, neighbours or work colleagues; were there any barriers experienced in reporting domestic abuse?

8.1.6. Could improvement in any of the following have led to a different outcome for Bob M and Jane

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

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

- a) Professional standards.
- b) Domestic Abuse policy, procedures and protocols.
- c) Drug/alcohol abuse policy, procedures, protocols or treatment.

8.1.8. The response of the relevant agencies to any referrals relating to Bob M or Jane concerning drug/alcohol abuse, domestic abuse or other significant harm from either Bob M or Jane or to any other incident relevant to drug/alcohol abuse, violence or domestic abuse prior to that date. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:

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

8.15.9. Whether organisational thresholds for levels of intervention were set appropriately and/or applied correctly in this case.

8.1.10. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective family members and whether any specialist needs on the part of the subjects were explored, shared appropriately and recorded.

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

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

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

## **9. The schedule of the Domestic Homicide Review is:**

9.1. Death of Bob M in August 2015

9.2. Decision of Forest of Dean Community Safety Partnership to hold a Domestic Homicide Review was made on 8th September 2015 and the Home office were notified the same day.

9.3. Independent Chair appointed on 1st December 2015

9.6. 5th December 2015 pre-meeting Lead Officials Forest of Dean Community Safety Partnership, SIO and DHR Chair at Forest of Dean Council Offices in Coleford

9.7. DHR Panel meeting: 6th January 2016, 0930 -1230 Forest of Dean Council Offices in Coleford

9.8. DHR Panel meeting: 8th April 2016, 0900 -1330 Forest of Dean Council Offices in Coleford

9.8. DHR Panel meeting: 18th May 2016 0930 -1230 Forest of Dean Council Offices in Coleford

## **10. Methodology**

10.1 This report is an anthology of information and facts gathered from:

- The Individual Management Reviews (IMRs) and Reports of participating agencies;
- The Pathologist
- The Police case file
- Psychiatrists' reports
- Members of the deceased's family
- The perpetrator
- Discussions during Review Panel meetings.

## **11. Contributors to the Review**

11.1 Whilst there is a statutory duty that bodies including, the police, local authority, probation trusts and health bodies must participate in a DHR; in this case thirty-five organisations have contributed to the review (listed in Para. 3.10). Seventeen have completed Individual Management Reviews (IMRs) or reports. The deceased's mother and the perpetrator have also provided information to the DHR.

11.2 Individual Management Review Authors:

Dr. Lawrence Fielder, [REDACTED] Surgery

Malcom Vine, Forest of Dean District Council Housing

Alison Bradshaw, Gloucestershire Care Services NHS Trust

Christopher Maughan, Gloucestershire County Council Adult Social Care

Andy Christopher, Gloucestershire Risk Assessment Conference (MARAC)

Jonathon Williams, Gloucestershire Constabulary

Julie Miles, Gloucestershire County Council Children's Services

Sally Morrissey, Gloucestershire Domestic Abuse Support Service

Jeanette Welsh, Gloucestershire Hospitals NHS Foundation Trust

Clare Woodhouse, Green Square Housing Support

Ted Yates, National Probation Service

Dr Jasmine Dargan, [REDACTED] Doctors' Practice

Simon Hester, South Western Ambulance Service NHS Trust

Caroline Andrews, 2gether NHS Foundation Trust

James Osborne, Two Rivers Housing Association

Neil Pascoe, Wyedean Housing Association

**NB.** Whilst neither Jane nor Bob M had any recorded contact with Turning Point, Stuart Fadden of Turning Point has provided a report with lessons learnt and recommendations.

## 12. The Chronology

12.1. Bob M was adopted as a baby, his birth mother was well known to the police and Social Services, his father was unknown and his mother's new partner rejected him as he was of mixed race. His new parents were an Army family who later also adopted a baby girl and subsequently had a son of their own. Bob M was brought up in a loving environment, although his adopted father spent long periods away on Army duties and was killed in a plane crash when Bob M was in his teens. As Bob M went through his childhood, he increasingly displayed behavioural problems, including self-harming and was referred to a child psychiatrist before being sent to a school for children with behavioural issues. As a teenager he came to the attention of the Police on a number of occasions and was given cautions for anti-social behaviour.

12.2. Bob M's mother told the Review that just after Bob M's 18th birthday he joined the Army and spent some months in Northern Ireland. He boxed for his regiment which resulted in him suffering several head injuries. Whilst he was in the Army he fathered a baby daughter but had little contact with her or her mother. He got into trouble (not relevant to domestic abuse or violence) with the Army and spent some time in military prison prior to being dishonourably discharged.

12.3. Jane, one of nine children, was brought up by her mother until the age of 11. She described that period of her life as extremely difficult, with a complex pattern of physical,

psychological and sexual abuse (by her elder brother) and by marked neglect from her mother.

12.4. Jane was taken into care and moved through two children's homes. By the age of thirteen she said she was a heavy drinker and she ran away regularly, spending time on the streets. She left care at sixteen years of age without any educational qualifications and went home to stay with her mother. She said, her mother was abusive and told her to "F... off" and that she never wanted to see her again. She lived rough on the streets of [REDACTED], used drugs and continued drinking heavily until at the age of 17, she met her first husband.

12.5. She described this relationship as "the best thing that ever happened to me." They moved to North Wales and she had two children (both now in their early 30s). She said her husband was a good man and there was never any domestic abuse, however she eventually found life dull, being at home with her young sons and she started drinking again. When her sons were nine and ten, she left home and returned to living on the streets until she met a group of travellers and went with them travelling around the country.

12.6. After two years, she met a man in Oxfordshire and during what she described as a casual relationship they had two children. She described the children's father as often being violent, having terrible mood swings and would "smash her house up on a regular basis".

12.7. In 1993 Jane moved to Gloucestershire and later her GP referred her to the [REDACTED] Addiction Treatment Unit (ATU) for assessment in respect of a ten year history of drug and alcohol misuse plus depression. Jane did not attend appointments and was discharged from the service.

12.8. In 1994 Jane was in a relationship with another man with whom she had a child. She had a period of stability with him until she was into her mid-forties when they then split up. She was drinking heavily at this time and the children spent some time in care prior to going to live with their father. Later there were a number of incidents when both Jane and her ex-partner reported incidents of domestic abuse to the police,

12.9. In 1994 Bob M was living with his girlfriend in the Forest of Dean area when his second child was born. Bob M's mother claimed the first occasion he was violent to his girlfriend was after a night of drinking he woke to find her in bed with his best friend. Bob M assaulted them and received a prison sentence.

12.10. In 1997 Bob M was referred to the Addiction Treatment Unit for a detoxification from substances, including heroin, but on discharge from hospital he failed to attend any community follow-up and was discharged from services in September 1998.

12.11. In 2006 Jane reported an assault by her ex-partner, but due to delays in the police interviewing him, the case was eventually closed. In May 2007 in the presence of their children, Jane's ex-partner grabbed her by the throat until she became unconscious. The ex-partner was arrested and later charged. Conditions were imposed for him not to enter the Forest of Dean and not to contact Jane, however Jane withdrew her support for the prosecution and the case was dismissed.

12.12. In 2006 and 2007 there were a number of incidents when the police were called by Bob M's partner after he had assaulted her. He was arrested and on one occasion he was

given a caution, on another, his partner failed to give a statement and the case was discontinued. In November 2007 Bob M was arrested for assault and false imprisonment. His partner provided evidence and Bob M was charged with two counts of common assault and bailed with conditions not to contact her or go to her home address. He later pleaded guilty and was given a twelve month conditional discharge.

12.13. During August and October 2008, Jane was taken to hospital after having taken overdoses; on the second occasion she said she wanted to be "sectioned to get peace and quiet". She was seen by the Gloucester Crisis Team and following their assessment of the situation, they took her home. Her children were being looked after by their father.

12.14. During October and November 2008 Bob M's partner contacted the police complaining about abuse from Bob M. She asked the police to make him leave the house, but they explained that as there had been no offences, they had no grounds to do so. Offers of a Refuge placement was refused by his partner. Bob M was later arrested following further offence on 10th November 2008. He was interviewed and admitted criminal damage and assaults during incidents on 4th and 5th November, but denied the offence on 10th November. Bob M was bailed pending further evidence from his partner which she refused to give, the Crown Prosecution Service therefore decided that no further action should be taken.

12.15. On 24th December 2008 the police received a call from Bob M's partner complaining of an assault by Bob M while the children were present. He was arrested, a DV/1 (domestic abuse risk assessment form) was completed and referrals made to the domestic abuse support service. Bob M admitted the offence and was charged and bailed to court with conditions to live in Gloucester, not to enter [REDACTED] and not to contact his partner. At Court he received an eighteen month community order, costs, supervision requirement and programme requirement.

12.16. On 8th June 2009 the police received a complaint from Bob M's ex-partner that Bob M was outside her address, throwing stones at the windows. A window was broken and Bob M made off when the police attended. A DV/1 was submitted but his ex-partner declined a personal attack alarm and domestic abuse support. Bob M was arrested three days later, charged with criminal damage and bailed to court with conditions not to enter the street where his ex-partner lived. At Court he pleaded guilty and was sentenced to fifty hours unpaid work, compensation/costs and a twelve month community order. However at 3.15 am on 6th April 2010 Bob M was again arrested at his ex-partner's address after being aggressive and damaging the front door. He was charged with criminal damage and was sentenced to a twelve month community order, a six month alcohol treatment order and supervision requirement.

12.17. When Jane and Bob M met some time in early 2011, he was not working, being on long term disability benefits on the grounds of epilepsy. At first they got on well but about six months into their relationship, Bob M assaulted Jane so badly an ambulance was called.

12.18. In May 2011 Jane was taken to the [REDACTED] Hospital Accident and Emergency Department reporting an overdose of paracetamol and having suicidal thoughts which she stated she would act on if sent home. She reported a history of depression and that she had discontinued her antidepressants. A risk assessment indicated moderate-high risk to self. It was deemed she was safe to discharge having started an al-

ternative antidepressant. Her medical records noted in 1993 that she drunk excessively but there was not further record of alcohol abuse after this time.

12.19. On 7th July 2011 there was a Child Protection Case Conference with regard to Jane and her youngest children. Since 2008 there had been five referrals to Social Care, involving domestic violence, alcohol misuse and concerns for the children's welfare due to inappropriate parenting and concerns regarding Jane's mental health. Investigations revealed that there were two men staying at Jane's property, one of whom was used for baby-sitting the children and the other, Bob M, was in a relationship with Jane. Both were known to the police for domestic violence and alcohol misuse. The children also expressed worries about the situation at home saying that they are scared. There were a number of incidents when the children's school had expressed concerns about their welfare and social workers visiting the address had found Jane drinking and unsteady on her feet. Additionally, on the 26th of June 2011 the Police attended the property and removed the children to the care of their father, because of Jane's drug and alcohol misuse. Other men were reported to be at the property including Bob M. There were also reports that the children were becoming distressed by Jane's behaviour as she was making comments to them that they were going to be taken into care.

12.20. On 13th February 2012 Jane called the police reporting an assault by Bob M and that he was refusing to leave her home. Jane had her two children with her. Police attended and found Jane hiding with the children in an alley-way. Bob M was arrested and a DASH form completed as medium risk. Both Bob M and Jane appeared drunk. The case was later discontinued due to retraction from Jane and inconsistencies in her account. Her medical records indicate that she received treatment on 16th February 2012 at her GP Practice and on 22nd February 2012 at Accident and Emergency for two broken ribs after an assault caused by her ex-partner.

12.21. On 4th April 2012 the police received a call from Jane stating that she could no longer cope with her two children, stating "I am going to kill my kids". Police attended and found Jane drunk and aggressive. The children were located in the area and arrangements were made for their father to collect them from [REDACTED] Police station.

12.22. On 8th May 2012 Police were engaged dealing with a house fire, when two of Jane's children were found near the scene in distress. Police found Jane asleep in her home with Bob M, both with no knowledge that the children were out. Jane claimed that they were supposed to be staying with a neighbour, when the neighbour denied this, both Bob M and Jane were arrested for child neglect. As Bob M was not involved in the care of the children no further action was taken in relation to him. Jane denied neglecting her children and no charges were made against her with the matter being left with Social Care to follow up regarding long term care.

12.23. On 14th November 2012 the police received a call from Jane. There were sounds of disorder in the background. On police arrival they found that Bob M had left. Jane disclosed verbal arguments with Bob M over drug use. Whilst communication was difficult due to Jane's level of intoxication a standard DASH was raised and the door lock was changed. The same day, Jane's GP records show she attended "after being punched in the head by her boyfriend".

12.24. Jane's circumstances were referred to the MARAC and on 30th November 2012. Jane told the Independent Domestic Violence Advisor (IDVA) that her relationship with Bob M had ended. Jane said she had support from friends with whom she had re-

established contact with since Bob M's departure. Jane also said Wyedean Housing had changed her locks and she felt safe. It was agreed that she would make contact should she want further support. On 4th December 2012 the MARAC closed the case as Jane did not want any further support.

12.25. On 25th March 2013 Jane made a 999 call to the police, crying "Help Me". Bob M was heard to say "You tried to kill me". Police attended and Jane displayed a superficial puncture wound and stated that she has fallen over. Bob M was arrested but Jane made a statement denying it was a stab wound and she refused medical treatment. A high risk DASH was submitted. Bob M claimed that Jane had initially assaulted him with a glass, he had thrown the broken glass and it had accidentally hit her leg. The case was discontinued due to the inconsistencies in Jane's account.

12.26. On 14th April 2013 Jane reported to the police that Bob M was being aggressive. A second call was then received from Bob M reporting Jane had damaged his flat. Police attended and were told it had been a verbal argument and that the damage was the emptying of the bin on to the floor. A standard DASH form was submitted and Jane left to stay at a friend's house.

12.27. On 30th July 2013 the police received a 999 call from Jane. Jane was heard screaming and Bob M shouting and swearing. The operator could hear Bob M hitting Jane and shouting he would "do time" for this. Bob M was arrested for a wounding on Jane with a knife. Jane claimed Bob M had held her head under water, slashed her arm and hit her. Bob M stated he was not responsible as Jane had done it herself. The injury on Jane's arm was consistent with self-harm and the police decided to discontinue case as this undermined the other elements of the alleged assault. Jane declined to provide DASH details, nevertheless a skeleton DASH was submitted as medium risk and the incident was referred to the MARAC.

12.28. Later Jane contacted the IDVA stating that Bob M had been attempting to drown her and she would make a statement as she could take no more. She also stated she had received a text message from Bob M after he had been released from custody bragging that nothing was going to be done. Jane had black eyes and other injuries and stated that she had harmed herself as a cry for help as she believed Bob M would kill her. The IDVA arranged to contact the National Centre for Domestic Violence and the Police on Jane's behalf. A six month non-molestation order was subsequently granted on 5th August 2013.

12.29. On 15th August 2013 Jane requested a house move as she was afraid of Bob M, who was the subject of a non-molestation order. As she no longer had her children living with her it was agreed that she should be rehoused. A new house was later found for her in another town, [REDACTED].

12.30. On 17th September 2013 the police received an anonymous call reporting an argument between Jane and Bob M. Police attended but there were no allegations from either party. Bob M however did complain that he wanted Jane away from his address. Jane acknowledged that the non-molestation order was ineffective as it had been her who had visited Bob M.

12.31. On 15th October 2013 a third party telephoned the police to report that Bob M was hitting Jane. Police attended and Bob M claimed that Jane was with him causing him to breach his injunction. Jane made no complaint of assault, she refused to give any details

for a DASH and a decision was taken not to enforce the non-molestation order as Jane had caused the breach.

12.32. On 18th April 2014 Jane called the police to ask for Bob M to be removed from her address. Police attended and Bob M was taken back to his home address. No allegations were made and a standard risk DASH was submitted.

12.33. On 4th June 2014 Jane again telephoned the police stating that Bob M was refusing to leave her home. Police attended and were informed by Jane that Bob M had been staying for a few days but had overstayed his welcome, due to his drug taking. Bob M was taken to his home address and a standard risk DASH was submitted.

12.34. During the early hours of 25th June 2014 the ambulance service received a call that Bob M had been stabbed in the stomach. Having initially said he had been stabbed in town, en route to hospital, he said he had been angry with his girlfriend and had stabbed himself with a steak knife. Although Bob M was drunk and uncooperative, a one cm stab wound to right side of his abdomen was treated. He was admitted overnight an X-ray was obtained and it was recorded that no surgical repair was necessary; he was given a tetanus booster and discharged home. The police found evidence to suggest that Bob M's injury occurred in Jane's address and Jane was arrested. Whilst in custody she was given a mental health assessment. She was fully orientated to place, date, and person, and understood the nature of the allegation made against her. Bob M told the police that Jane had not been responsible, claiming that he did it to himself. Jane was interviewed and also stated Bob M did it to himself after an argument. Jane was released from custody with no further action and a standard risk DASH was submitted.

12.35. The police received several calls to minor disputes between Bob M and Jane during the following months, but on 23rd November 2014 Jane contacted the police stating Bob M was hitting her. Police attended and found Bob M had caused damage in the flat and Jane was hiding in the bathroom. She alleged that Bob M had gained entry and had tried to force his penis into her mouth. Bob M was arrested and a DASH form submitted as high risk. The sexual offence was denied by Bob M and he was bailed with conditions not to have contact with Jane, while further enquiries were being made. Although Jane had told the IDVA that she would support a prosecution, no further action taken due to discrepancies in her account. This incident was discussed at MARAC and a personal attack alarm was fitted at Jane's address.

12.36. On 6th January 2015 the alarm was activated, Bob M had entered Jane's property, in breach of his bail conditions. Jane said he had broken into the premises and assaulted her. Jane needed hospital treatment but whilst in the ambulance, she became aggressive to the paramedics and they allowed her to leave the ambulance. Jane telephoned the IDVA while the police were present, she said Bob M had followed her home from the Post Office and had come into her flat. She stated that he had stolen her money and had knocked her unconscious. Bob M was arrested, interviewed and denied the offence. He stated that he had been living with Jane, despite the panic alarm having been installed. He was bailed with conditions, for further enquiries and a DASH form completed as high risk. The Crown Prosecution Service discontinued the case for evidential reasons, i.e. inconsistencies in Jane's account. Subsequently Jane contacted the IDVA to tell her that Bob M had been seen in the town [REDACTED] and she felt unsafe and wanted to move again. This was organised and in March 2015 Jane moved to another town, [REDACTED]

12.37. On 6th June 2015 the police received calls from three of Jane's neighbours, reporting anti-social behaviour relating to a drunk male and female in the street. The female was on the floor, but it was not clear if she had been hit or fell. Police attended but the male, Bob M had already left. A window had been smashed. No allegations were made by Jane and she refused to provide full DASH details, but a standard risk DASH was created. She said Bob M had been staying with her and he had locked her out. Bob M was spoken to away from address and warned to stay away.

12.38. The following day Jane contacted the police and reported she has come home and found Bob M in her flat. Bob M left during the call, but later returned and accused Jane of stealing money. He assaulted her and made off. Police attended and Bob M was found and arrested. A DASH form was completed as high risk and a personal attack alarm was fitted following a request from the IDVA. Jane made a statement with regards to both the assault and the criminal damage of the previous day. Bob M was released with bail conditions not to go to Jane's address. The Crown Prosecution Service was consulted and the case was discontinued, as it was revealed that Jane had lied in her witness statement about the criminal damage on the 6th June 2015.

12.39. On 10th June 2015 the IDVA visited Jane and saw she had bruising on her face and was very shaken. She said she had moved to [REDACTED] to make a fresh start and was very upset and frightened that Bob M had tracked her down. Jane admitted she had not told the police the truth when she had been interviewed, as she was terrified of reprisals. The IDVA submitted a DASH to the MARAC and asked Two Rivers Housing Association to repair the broken window and change the locks as a spare key was missing. (Bob M later claimed to the police that Jane had in fact asked him to help her move into the new address.) On 15th June 2015 the IDVA arranged an application for a non-molestation order and on 24th June 2015 the MARAC met and set out a series of actions for completion.

12.40. On 19th July 2015 Jane called the police and passed the telephone to a 15 year old child, who was staying at her address. The child stated that Bob M had hit Jane over the head and stolen her bag. Officers attended but Bob M was not there, the verbal allegation was confirmed but Jane refused to make a formal statement. There were child protection concerns raised over the fifteen year old child and a DASH form was submitted as high risk. The child refused to give a statement, nevertheless attempts were made to trace and arrest Bob M. This was reviewed by a police supervisor who without consideration of the non-molestation order nor the breach of the conditional police bail conditions which were still in place, recommended that the case be discontinued.

12.41. On 24th July 2015 the IDVA received the following text from Jane: "No I'm not 2 good I'm 2 scared 2 go out on my own I feel like a prisoner again I'm really scared of him I think he's lost the plot." The MARAC Chair was informed but decided not to consider this at the MARAC as he was of the view the situation had not changed from the previous month and Jane was being supported by the IDVA.

12.42. In the early hours of 7th August 2015, Jane called 999 to report that Bob M was in her house and that she needed the police. Shortly after, there was a second call from Jane to say that Bob M was still in her property and she was outside. Police attended and found Bob M in bed. He explained he had been living there and that he and Jane had been drinking together during the evening. A decision was made not to arrest for breach of the non-molestation, due to belief that Jane was abusing the order. Bob M was taken to his home address. Jane had left the area and was not seen at that time, although she was

seen later when a standard DASH was completed. This was reviewed and changed to medium risk by a supervisor.

12.43. At 4.11pm on [REDACTED] August 2015 Gloucestershire Children's Services reported to the police that a 15 year old child was missing. It was believed the child was camping in the Gloucester area or that the child could be with Bob M and Jane. Various enquiries were made initially in the Gloucester area but just after 9 pm, police in the Forest of Dean area were asked to check for the child at Jane's address in [REDACTED]. At 9.50 pm an officer went to Jane's address in relation to the missing person enquiry but could get no reply at the premises.

12.44. At 9.34pm the same evening the police received a complaint that a female and mixed race male had swapped an empty wheelie bin for a full one. The complainant did not know the couple but said they appeared to be arguing. The call was recorded as anti-social behaviour initially but then upgraded as possibly a domestic in the street. At 10.15pm two officers attended, but found no one in the street. While the officers were trying to identify the address the couple came from, a 999 call was received from Jane that she had stabbed Bob M.

12.45. Details of the fatal incident are set out in para 3.3. of this Report.

12.46. Whilst in custody after Bob M's murder Jane was seen by the mental health services after she had made threats to kill herself at the earliest opportunity. During the assessment she described her life before and during her relationship with Bob M, including the violence and traumas she was suffered. It was noted that she "presented in a warm and friendly manner, although she is clearly upset by the events of the last 24 hours,...She did not exhibit any adverse behaviour, and her presentation in every aspect from her actions, body language and speech, including content of remorse was all in context of her current situation. ....Jane is suffering from anxiety and depression and her current situation is only going to increase those symptoms. She appeared in shock at times, and still not quite believing the events that had occurred.....She is not suffering from psychosis; thought insertion, command hallucinations etc. Jane understands the reason for her arrest and has capacity as defined under The MCA 2005."

### **13. Key issues arising from the review**

13.1. The Review Panel, having had the opportunity to analyse the information obtained from agencies and from Bob M's mother consider the key issues in this Review to be;

- 1) Persistent abuse of alcohol and regular misuse of substances by both Bob M and Jane during their relationship.
- 2) Mental health (both parties)
- 3) History of domestic abuse (both parties).
- 4) MARAC involvement
- 5) Non Enforcement of Court Orders and bail Conditions.

#### **13.2. Persistent abuse of alcohol and regular misuse of substances by both Bob M and Jane during their relationship.**

13.2.1. Both Bob M and Jane had long histories of regular excessive drinking and periods of using a variety of illegal substances, including heroin and cannabis.

13.2.2. Jane claims she had been a heavy drinker and had used drugs from the age of thirteen. She stated that whilst she had stopped drinking during the early part of her first marriage, due to boredom she had started drinking again and that destroyed her marriage to a "good man". She continued to drink excessively and her later relationships were defined by alcohol related mutual violence. Research suggests that victims of abuse who like Jane have problematic alcohol use, more vulnerable to domestic abuse and they are less likely to be able to protect themselves when incapacitated by drink or drugs.<sup>1</sup> With this background of alcohol and drug misuse it is not surprising that Jane took refuge in drinking and using drugs with she was in her abusive relationships. It is noted that women who experience domestic violence are 15 times more likely to use alcohol and 9 times more likely to use drugs than women that have not been abused. There is evidence that women who are being abused often use alcohol to self-medicate to dull the effects of physical abuse and/or emotional pain.<sup>2</sup>

13.2.3. Bob M started to self-harm and drink in excess when he was seventeen after the death of his adopted father. His mother told the Review he was deeply traumatised by the accident. The loss of a loved one, dealing with stress or as a means of escape to forget about problems have been identified in a number of psychological studies as being among the most common reasons why adolescents self-harm or start to use alcohol or drugs.<sup>3</sup> Bob M had "detox treatment" for heroin addiction during his twenties but he continued to use drugs. Traces of cannabis, cocaine and heroin were found in the toxicology examination after his death.

13.2.4. At the time of their relationship, both Bob M and Jane were drinking heavily and there were numerous accounts by neighbours, friends and agencies that they were regularly intoxicated. The Police, Social Services and Housing Associations received a number of complaints that when drunk Jane and Bob M would regularly argue and behave inappropriately. The police also found evidence of drunkenness in the reported incidents of assaults by Bob M on Jane and her damage to his property. There were three incidents reported to the police in 2008, 2011 and the beginning of 2012 when Jane was intoxicated with her youngest children present. Although she was never prosecuted for neglecting her young children whilst inebriated, her behaviour caused officers concern for the safety of the children and subsequently they were the subject of Child Protection Procedures and went to live with their father.

13.2.5. After a driving incident on 24th May 2009 Bob M was convicted of a drink driving offence whilst accompanied by a child.

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<sup>1</sup>Spouse abuse, Stark E, Flitcraft AH. in Rosenberg M, Mersy J eds. Violence in America: a public health approach. cited in Domestic violence: a health care issue? British Medical Association.

<sup>2</sup> Domestic Violence & Substance Misuse, Overlapping issues in separate services. Humphreys C, Thiara R, Regan L. (2005)

<sup>3</sup> "Adolescent self-harm" by Ann Hagell summarised in AYPH Research Summary No 13, March 2013; Canadian Centre for Addiction Journal 2016; 9 Reasons Why People Use Drugs and Alcohol Sharon Blair (The Jennifer Act 2012 USA), ACMD (2006) Pathways to problems: Hazardous use of tobacco, alcohol and other drugs by young people in the UK and its implications for policy.

13.2.6. Both Bob M and Jane admitted to frequently smoking cannabis during their relationship. On one occasion Jane claimed to have been given an injection of heroin whilst drunk, on another occasion her children's social worker was refused entry to Jane's house because Jane and her friends were using drugs, but the matter was never reported to the police.

13.2.7. Bob M's and Jane's drug and alcohol use appeared to affect their ability to make rational decisions/responses within their relationship. The Psychiatrist who assessed her at the 2gether Trust stated : "Although drugs or alcohol are not the cause of domestic abuse, they can be a trigger and can also heighten responses. Drug and alcohol abuse can sometimes be used as coping strategies for victims to block out the abuse and Jane's responses would appear to indicate this was her way of managing her anxieties cause by the abuse she was receiving".

13.2.8. On the day Bob M was killed, Jane was known to have been drinking throughout the day and Bob M had used cannabis, cocaine and heroin at some point prior to his death.

13.2.9. The Review Panel highlighted that although agencies were aware of the significance of alcohol and substance abuse within the context of Bob M and Jane's mutual domestic abuse, they were not referred to Turning Point, which provides specialist substance abuse support services within the Forest of Dean area. The MARAC however did try to refer Bob M but were unable to do so without his consent.

### 13.3. Mental health (both parties)

#### 13.3.1. Re Jane

13.3.1.1. As Jane did not seek help in respect of her anxieties and self-harming until 2008, it is not clear how long she had suffered from depression. It is however noted that she had been seriously abused as a child and childhood abuse has been associated with a plethora of psychological and somatic symptoms, as well as psychiatric and medical diagnoses including depression, anxiety disorders.<sup>4</sup>

13.3.1.2. Similarly, other than during her first marriage, Jane's relationships with men had all been characterised by violence and research evidence clearly shows a direct link between women's experiences of domestic violence and heightened rates of depression, trauma symptoms, and self-harm.<sup>5</sup>

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<sup>4</sup> Childhood family violence and adult recurrent depression. Kessler RC, Magee WJ Health Soc Behav. 1994 Mar; 35(1):13-27. and Childhood sexual abuse as a risk factor for depression in women: psychosocial and neurobiological correlates. Weiss EL, Longhurst JG, Mazure CM

*Am J Psychiatry.* 1999 Jun; 156(6):816-28

<sup>5</sup> e.g. Violence, Alcohol, and Completed Suicide: A Case-Control Study Kenneth R. Conner, Psy.D., Christopher Cox, Ph.D., Paul R. Duberstein, Ph.D., Lili Tian, M.A., Paul A. Nisbet, Ph.D., and Yeates Conwell, M.D.

13.3.1.3. The first recorded indication that Jane had mental health problems was in August 2008 when she was taken to hospital after deliberately self-harming. It is perhaps significant that after March 2009 when she and her then partner separated after a violent argument, she appeared to have had a period of comparative stability. There were no further reports of domestic incidents or of her seeing medical services for depression or anxieties until after she had met Bob M in early 2011. In May 2011 Jane was taken to hospital, she reported feeling suicidal for the last couple of days and depressed for several months. During this time Jane had been prescribed anti-depressants by her GP. She told the hospital doctor that she had taken these initially and then stopped, due to feeling unwell. She said two days previously she had taken an overdose of 8 paracetamol tablets and 12 phenylephrine tablets. It was during this time that Bob M was having acute problems in relation to his severe form of epilepsy.

13.3.1.4. Over the following years, Jane was prescribed antidepressants and she given regular support from a health visitor, who demonstrated an awareness that Jane's depression was linked not only to her excessive alcohol consumption and drug misuse but also to the domestic abuse she suffered. There were many incidents when the health visitor went beyond her role requirements, helping Jane with her housing and financial needs and also organised food parcels for her.

### 13.3.2. Re Bob M.

13.3.2.1. Bob M had a long history of psychological problems. His mother recognised that he had behavioural issues from an early age. She told the Review: "By the time Bob M was two, he had become destructive, tearing up his own drawings, pulling his toys apart, taking things from children at play school, ..... By the time he went to school it had already become difficult to know how to deal with his behaviour, all the usual things just didn't work..... During this period Bob M had been referred to the army child psychologist, for behaviour issues. We were advised to make a number of changes to the way we dealt with him." However she reported the changes and medication he was given made no difference to his behaviour.

13.3.2.2. When the family returned to the UK from Germany, (Bob M's adopted father was a serving soldier), Bob M was referred by his school to a child psychologist and was subsequently sent to a boarding school for children with behavioural problems. When he was 16 years of age the Gloucester Child Guidance Panel made a referral to mental health services, without his mother's knowledge and when she learnt of it, she stated that they did not want help. A brief initial assessment was completed at home and he was discharged. A few months later, his adopted father died in a plane crash and Bob M reacted badly, starting to self-harm by cutting his wrists, using drugs and getting into trouble with the police.

13.3.2.3. He joined the Army when he was 19 years of age and having taken up boxing and representing his Regiment in boxing tournaments he suffered a number of head injuries. After approximately 18 months Bob M was dishonourably discharged from the Army and he returned home. He was later diagnosed with a severe form of epilepsy (status epilepticus).

13.3.2.4. In November 2010, Bob M was referred to [REDACTED] community mental health team for an assessment, due to his inability to adjust to life with epilepsy.

The referral was discussed at the multidisciplinary team meeting, however, Bob M was not diagnosed with a severe and enduring mental illness.

13.3.2.5. In December 2011, Bob M was assessed in the Primary Mental Health Clinic at the GP practice. Again, no signs of acute mental illness were noted in the assessment, however psychological and emotional issues were present but appeared to relate more to his head injury, including “possible frontal lobe damage and epilepsy”; concern regarding possible capacity issues was also documented.

13.3.2.6. Bob M received regular support from an occupational therapist from the Safeguarding Adults Team to help him towards independent living.

13.3.2.7. In 2013 after a referral from the epilepsy team, a review by a hospital brain injury team identified that “Bob M had sustained a number of head injuries due to past assaults and boxing; his history of drug and alcohol abuse was also considered to be a factor”. On assessment he was found to have impaired immediate and delayed verbal memory and recommendations were made to reduce demands placed on him at any one time. Due to the severity of his epilepsy he had several periods of inpatient treatment in hospital but he primarily received support through regular outpatient appointments and intensive home visits from an epilepsy specialist nurse due to the severity of his epileptic seizures.

13.3.2.8. The epilepsy nurse when assessing the control of his epilepsy, noted that his personality had changed to having more erratic moods and his temper was quick to flare. This was however not to suggest that his violent behaviour was directly related to his epilepsy. The Review Panel noted research which found that epilepsy was not associated with an increased risk of violent crime.<sup>6</sup> In contrast Bob M’s known assaults on Jane and his previous partner occurred when he was intoxicated. The epilepsy nurse made referrals to mental health and alcohol teams for Bob M and mentioned that she thought he was taking drugs as well as alcohol.

13.3.2.9. Whilst the mental health advisers to the DHR Panel were of the opinion that Bob M’s epilepsy and frontal lobe brain damage would have had some effect on his behaviour, this would have been primarily evident in his ability to assimilate information slowly. This was noted by both the hospital epilepsy team and by his Specialist Epilepsy Nurse in 2013.

13.2.3.10. In 2012 as a result of a MARAC meeting action, health care organisations and social services placed an alert on Bob M’s file warning of his domestic abuse and potential for violence, however none of the medical professionals or social workers working with him experienced or witnessed any violence behaviour by him. In 2014 during a social work assessment his social worker and occupational therapist stated they had no concerns about Bob M’s behaviour during their contacts with him and his mother. Bob M was always polite and both Bob M and his mother were helpful and appropriate. The assessment concluded “The social worker therefore did not have any reason to consider any Safeguarding issues or Section 42 enquiries. Neither did the Social Worker feel that a warning on the electronic records was warranted”.

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<sup>6</sup> Risk of Violent Crime in Individuals with Epilepsy and Traumatic Brain Injury: A 35-Year Swedish Population Study. Seena Fazel, Paul Lichtenstein, Martin Grann, Niklas Långström. Published: December 27, 2011. <http://dx.doi.org/10.1371/journal.pmed.1001150>

13.3.2.11. The hospital trust IMR Author also stated “The greatest danger to Bob M appeared to be from himself, due to erratic taking of medication, alcohol and drugs”.

13.3.3. The Review Panel was satisfied that agencies in their dealings with Jane and Bob M, generally showed sensitivity to their vulnerabilities as a result of their psychological disorders.

#### **13.4. History of domestic abuse (both parties).**

13.4.1. There were fifty-four incidents of domestic abuse involving Bob M and/or Jane recorded by the Gloucestershire Constabulary from 2006.

13.4.2. The Review leaves no doubt that Bob M was a serial perpetrator of domestic abuse. He had a recorded history of domestic abuse as a perpetrator with previous partners from 2006. He was regularly arrested and on several occasions was dealt with at Court. He had periods under the supervision of probation officers, but due to his epilepsy and inability to work in group environments he was never considered suitable for a perpetrator programme to address his perpetrating behaviour. The Review Panel was informed that the Department of Justice validated programme used in Gloucestershire is based on group work and there was no suitable one to one type programme available.

13.4.3. The Review Panel has considered Bob M’s mental health, particularly his epilepsy and brain injury, his alcohol and drug misuse as possible causes of his abusive behaviour within relationships. They have taken note of the reports from his social workers, GP and other medical professionals that when they had contact with him he was consistently personable and polite. The DHR Panel felt his mother’s following assessment was particularly relevant, “That Bob M found it difficult to come to terms with his epilepsy, and although he could no longer work he refused to change his lifestyle and continued to drink heavily”. She described him as having a Jekyll and Hyde type personality. He could be loving and kind but when he drank too much which he regularly did, he was not able to control his moods and he could react aggressively to anything he considered to be a provocation.

13.4.4. Jane, experienced a particularly traumatic childhood (summarised in the Chronology section of this report), followed by abusive relationships over a twenty five years period (according to Jane from “before 1993”). Yet It was many years before she used violence herself. At first it was violence against herself. In 2006 she lost confidence in the police after her ex-partner was never prosecuted for a serious violent assault on her because of the length of delays in the investigation. From that date there were signs of her loss of self-esteem, she saw her GP for depression and for self-inflicted injuries. A comment she later made during an assessment in custody after Bob M’s death was telling “Being told you are a piece of shit every day is draining and exhausting”. The first recorded time she was violent to another person was in November 2008 when she assaulted her ex-partner. This partner had in the past assaulted her violently on a number of occasions resulting in her requiring hospital treat, as detailed in the chronology. The police then felt that those occasions when she was the perpetrator of domestic abuse made it difficult for them to take appropriate interventions.

13.4.5. The DHR Panel considered if there were any characteristics that might be common to women who use violence. They noted that research indicates that rates of childhood trauma and abuse are high amongst women who use violence. Amongst a sample of women who used intimate partner violence, 60% had experienced emotional abuse and neglect, 58% had been sexually abused, 52% were physically abused, and 41% were

physically neglected. High rates of childhood abuse were also found in studies of women in court-mandated treatment for domestic violence.<sup>7</sup>

13.4.6. The Review considered two studies into mutual intimate partner violence which appeared to have some relevance to Bob M and Jane's situation. One examined the relationship between being a victim and being a perpetrator and three psychosocial variables (depression, self-esteem and substance abuse). The results indicated an association between substance abuse and self-esteem and partner violence perpetration, but depression was associated with both victimisation and perpetration. Associations between mutual violence and depression and substance abuse was found to be greater among women than men, supporting the position that gender symmetry in reported violence perpetration does not imply symmetry in outcomes.<sup>8</sup> The second study indicated the prevalence of alcohol related problems in mutual intimate partner violence.<sup>9</sup>

### 13.5. MARAC involvement

13.5.1. Bob M and Jane had been known to the MARAC since November 2012. The first MARAC meeting in December 2012 was after six incidents; two of which were recorded as standard risk by the police (one of which being recorded as high risk by the Hospital Accident Department) and one a medium risk. The other three incidents were considered not to be domestic abuse as they related to drink related verbal arguments and no DASH assessments had been submitted.

13.5.2. After the first MARAC meeting, between April 2013 and August 2015 there were four further MARAC meetings and six Reviews conducted in relation to sixteen incidents of domestic abuse between Bob M and Jane. In three of those incidents, Bob M was recorded as being the victim. Nevertheless Bob M was considered to be a high risk perpetrator and the IDVA managed the support of Jane, encouraging contact and engagement with other support agencies.

13.5.3. There were comprehensive action plans recorded, however it was noted that due to the volume of referrals, the MARAC did not have the capacity to review the outcome of those actions. Nevertheless, the MARAC Chair has highlighted that the MARAC was not able to refer Bob M as the perpetrator, to either Turning Point, the substance misuse support service or to the Splitz "Turnaround Men's Group" voluntary programme for perpetrators without his consent.

13.5.4. The Gloucestershire MARAC is currently undergoing a comprehensive review of working practices which includes capacity issues, membership, co-ordination and monitoring of action plans.

### 13.6. Non Enforcement of Court Orders and Bail conditions

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<sup>7</sup> A Review of Research on Women's Use of Violence With Male Intimate Partners  
Suzanne C. Swan, PhD, Laura J. Gambone, MA, Jennifer E. Caldwell, MA, Tami P. Sullivan, PhD, and David L. Snow, PhD 2008

<sup>8</sup>Perpetrator or Victim? Relationships Between Intimate Partner Violence and Well-Being  
Kristin L. Anderson 2002

<sup>9</sup>Alcohol-Related Problems and Intimate Partner Violence Among White, Black, and Hispanic Couples in the U.S. 2011 Carol Cunardi, Raul Caetano, Catherine Clark, John Schafer

13.5.1. At the instigation of the IDVA and with MARAC involvement, two non-molestation orders were obtained on behalf of Jane against Bob M for periods between 5th August 2013 to 5th February 2014 and again on 18th June 2015 (which was due to expire on 18th June 2016). There were also occasions, (detailed in this Report), when Bob M was granted police bail with conditions not to contact Jane.

13.6.2. There were two occasions in 2013 and three in 2015 when officers knew of the existence of the court order and/or the bail condition yet did not implement them, because Jane had either instigated the contact by going to Bob M's home or had agreed to him being at her address despite knowing of the court order.

13.6.3. Gloucestershire Constabulary, whilst acknowledging the reasons the officers used their discretion not to arrest Bob M for these breaches of the non-molestation order and bail conditions, has taken positive disciplinary action in relation to individual officers. The Force has also introduced policy and training to ensure that officers and control room staff are now aware that breaches of Court Orders or bail conditions should be the subject of positive action and it should be left to the Crown Prosecution Service or Court to decide on any mitigating factors.

## **14. Analysis**

14.1. Agencies completing IMRs and Reports were asked to provide chronological accounts of their contact with Bob M, Jane or their dependent children prior to Bob M's death. Where there was no involvement or insignificant involvement, agencies advised accordingly. In line with the Terms of Reference, the Review focuses on the contacts of agencies from 1<sup>st</sup> January 2005 and the death of Bob M in August 2015, together with relevant information prior to that time. The recommendations to address lessons learnt are listed within the action plans in section 17 of this report.

14.2. The Review Panel has checked that the key agencies taking part in this Review have domestic abuse policies and is satisfied that those of the statutory and specialist domestic abuse organisations are fit for purpose. The need for other organisations to introduce domestic abuse policies is addressed in the recommendations and action plans.

### **14.3. Equality and Diversity.**

14.3.1. The Panel and Individual Management Review (IMR) Authors have been committed, within the spirit of the Equality Act 2010, to an ethos of eliminating discrimination, fairness, equality, openness, and transparency, and have ensured that the Review has been conducted in line with the Terms of Reference. IMR Authors confirmed that their organisations have appropriate policies and practices that are sensitive to Equality Act Protected Characteristics and Codes of Practice.

14.3.2. In particular the Review considered specific equality and diversity issues.

14.3.2.1. Whilst agencies were aware that Bob M was of mixed race (Black/White British heritage) there has been no evidence found by IMR authors that his ethnicity adversely affected the manner in which he was dealt with by agencies. His mother was asked if she considered that Bob M's ethnicity was ever an issue in the way he was treated by service provider. She responded that the only occasion when his mixed heritage was ever com-

mented upon was when she and her husband were trying to adopt him. Social Workers understandably questioned them at length on how they as white people would be able to ensure he learnt of his black background. She stated that other than his love of Bob Marley music BoB M was never interested in learning about his real father's cultural background.

14.3.2.2. With regard to Bob M's gender, the police recognised that on occasions Bob M was the victim of mutual domestic abuse, However it was noted by the National Probation IMR Author that there was one occasion when Bob M's probation officer did not believe him when Bob M challenged information that he had assaulted Jane, by claiming to be the victim instead. However the probation officer stated the reason for not believing him was the evidence from Jane, supported by the number of times Bob M had been the perpetrator, rather that because of Bob M being male.

14.3.2.3. Whilst Bob M was repeatedly violent to his two female partners, he behaved well with other women he came into contact with; his female social worker and occupational therapist going as far as challenging the alert warning for violence on his social services record as they always found his behaviour appropriate and polite.

14.3.2.4. The DHR Panel was satisfied that the medical services, housing providers the police and Probation recognised Bob M's and Jane's vulnerabilities because of their respective disabilities and depression and dealt with them with appropriate sensitivity in line with the Diversity and Equality legislation. (See para 13.3.)

14.4. Thirty-five agencies/multi-agency partnerships were contacted about this review. One, the Army (Provost Marshal) has confirmed historical information relating to Bob M's service in the Gloucester Regiment, a second the Crown Prosecution Service was contacted for opinion relating to Bob M's breaches of bail conditions and the non-molestation orders. Seventeen have responded as having had no relevant contact with either Bob M or Jane.

They are:

- Bristol, Gloucestershire, Somerset, Wiltshire Rehabilitation Company (BGSW CRC)
- [REDACTED] Town Council
- Civica – Revenues and Benefits
- [REDACTED] Town Council
- Forestry Commission
- Forest of Dean Citizens Advice Bureau
- Forest of Dean Community Safety Partnership
- Forest of Dean District Council Environmental Services
- Gloucestershire Clinical Commissioning Group
- Gloucestershire Fire and Rescue
- HM Courts and Tribunal Service
- Independence Trust
- Info Buzz
- [REDACTED] Town Council
- [REDACTED] Town Council
- NHS England

- Turning Point<sup>10</sup>

14.5. Sixteen organisations have provided Individual Management Reviews and Reports relating to contacts with either Jane or Bob. The Review Panel has considered them carefully from the view point of Bob M, Jane and their dependent children to ascertain if each of the agencies' interventions were appropriate and whether they acted in accordance with their set procedures and guidelines. Where they have not done so, the Panel has deliberated if all of the lessons have been identified and are being properly addressed.

14.6. The Panel is satisfied that the authors of the IMRs and Reports have followed the Review's Terms of Reference carefully and addressed each of the points within it where relevant to their organisations. The Panel is also satisfied that each author has been honest, thorough and transparent in completing their reviews and reports. The following are the analyses of each report together with the Review Panel's opinion on the appropriateness of the agency's interventions.

#### 14.7. ██████ Surgery

14.7.1. The IMR author has focused on those GP contacts Bob M had which related to his mental health, epilepsy, substance abuse, anger management, violence and known domestic abuse of partners.

14.7.2. It was noted that Bob M complained of anxieties and depression but he would not attend mental health services as he did not believe he had mental health problems. A GP in-house review arranged for him to be assessed by a Community Psychiatric Nurse (CPN) who concluded he was not suffering from any acute mental illness although issues were identified around emotional and psychological problems relating to his epilepsy and frontal lobe damage. In 2013 after referral from epilepsy team, a review by the Brain Injury team identified that Bob M had sustained a number of head injuries due to past assaults and boxing; his history of drug and alcohol abuse was also considered to be a factor. On assessment he was found to have impaired immediate and delayed verbal memory and recommendations were made to reduce demands placed on him at any one time.

14.7.3. The IMR author noted that Bob M was known to have used illegal and legal drugs (heroin, cannabis, methadone and alcohol) but it was believed that he had successful treatment in Gloucester during the 1990's for his significant drug abuse. He had abnormal liver function due to his excessive alcohol intake.

14.7.4. The surgery was aware of Bob M's violence to his partners from MARAC meetings. The IMR author believed that this should have been made clearer on his notes, so that any clinician involved in his care would have been aware of any potential abuse issues and to then cascade any concerns to the adult/child safeguarding lead.

**14.7.5. The Review Panel is satisfied that the key lesson has been identified and will be addressed by the recommendations made.**

#### 14.8. Forest of Dean District Council Housing

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<sup>10</sup> Although Turning Point had no contact with either Bob M or Jane, it was clear that they should have been referred and Turning Point has therefore taken the opportunity to identify lessons and to make recommendations to address them.

14.8.1. The IMR Author explained that the Forest of Dean District Council Housing Options team, manage the housing waiting list through the Gloucestershire Homeseeker system and the Council's homelessness responsibilities.

14.8.2. The Housing Team had involvement both with Bob M and Jane over a number of years. Bob M first registered for housing in January 2009 as potentially homeless due to a bail condition that he was not allowed to go to the family home after an incident of domestic abuse. He managed to secure himself a privately rented property. In November 2009 he received notice on this property and was subsequently accepted as homeless by the Council as he suffered from epilepsy and was given priority for accommodation. In March 2010 he accepted the tenancy of a one bedroomed property in [REDACTED]

14.8.3. The Council assisted Jane with house moves on two occasions. Jane applied for rehousing in February 2011. When it was confirmed that Jane's children were no longer living with her, she was given high priority for a move as she was downsizing. She took up a new tenancy in [REDACTED] in October 2013.

14.8.4. From November 2014 there were a number of requests for housing information by the MARAC. In March 2015 the team registered an application for housing for Jane and on receipt of information regarding domestic abuse, she was given high priority for a move. Under the "autobid" system she was matched to a property in [REDACTED] and the tenancy commenced on 16<sup>th</sup> March 2015. In May 2015 Jane made a further application to move closer to her children in [REDACTED], communications were ongoing with the MARAC at the time of Bob M's death.

**14.8.5. The Panel is satisfied that the IMR author has identified the need for the Forest of Dean District Council to adopt the Gloucestershire Domestic Abuse Housing Protocol.**

#### **14.9. Gloucestershire Care Services NHS Trust**

14.9.1. Gloucestershire Care Services had over 50 contacts with Bob M directly and via his mother with regard to accommodation issues. It was only during the final tele-care contact from his mother on 7th June 2015 that the Care Services became aware that he was living with an unnamed "girlfriend" and that his mother was having little contact with him.

14.9.2. The Care Service had no knowledge of Bob M's relationship with Jane nor any indication of domestic abuse. The Service does have a domestic abuse policy but is taking this opportunity to review their domestic abuse policy and to ensure all staff receive appropriate level domestic abuse awareness training.

**14.9.3. The Review Panel is satisfied that the Gloucestershire Care Services had no reason to consider domestic abuse whilst working on behalf of Bob M and welcomes the fact that the Service is taking the opportunity to review their domestic abuse policy and training.**

#### **14.10. Gloucestershire Constabulary**

14.10.1. The IMR Author found that the majority of the fifty-four contacts the police had with Bob M and Jane were dealt with in accordance with policy current at the time. Positive action was taken by call takers, attending officers and investigating officers.

14.10.2. There are eleven incidents the IMR author has singled out due to the possibilities of opportunities lost, failure to follow policy, lack of supervision, or poor practice.

14.10.3. On 10th September 2006 Jane called police to report an assault by her ex-partner (not Bob M). Initially policy was followed, positive action was taken, a statement was obtained and a crime report raised. The investigation was allocated to a local officer on the 13th September 2006 but in spite of numerous reminders, it took over six months before Jane's ex-partner was interviewed, by which time it was too late to prosecute him. It is noted that the ex-partner denied the offence and Jane said she no longer wanted him arrested.

14.10.4. On 13th October 2008 a neighbour of Jane reported hearing Jane screaming at her children "I'm going to kill myself. I'll stab myself with a knife". Police arrive a short time later and after gaining entry found that Jane had set up the living room as though in preparation to hang herself. Jane was detained under the Mental Health Act and the children were passed into the care of their father. The decision was made that Jane was drunk rather than being in need of medical help and she was released with no further action. No consideration was given to offences against the children although a referral was made to the police child protection unit, who later referred it onto social services.

14.10.5. On 6th April 2010 Bob M's previous partner called the police to report Bob M had been at her address in [REDACTED], had got drunk and had caused damage. Officers attended, Bob M was arrested and later that day charged with criminal damage and bailed to attend court on 4th May 2010. No DV/1 risk assessment was completed to identify the level of risk and no bail conditions were imposed in order to reduce the risk of harm to the ex-partner. Bob M was arrested outside her address again on 23rd April 2010 and he was charged with harassment and remanded in custody. He was released at court and given conditions forbidding him from contacting his ex-partner or going to her address. Bob M appeared to have abided by this restriction. At court he was handed a restraining order as part of his sentencing and there were no further contacts reported.

14.10.6. On 25th June 2011 The Police received a call that Bob M was being aggressive and had his 3 year old child with him. Police attended and found Bob M, Jane and the caller at an address in [REDACTED], all were very drunk. It was established that there had been an argument between Jane and Bob M, but no offences had been committed between them. Officers recognised that Bob M was not in a fit state to care for the 3 year old child and they arranged for Bob M's mother to take the child. However Bob M was not arrested for the offences relating to drunken charge of a child or neglect and no rationale was recorded for not doing this. Police left the address, but were called back a short time later following a call that Jane had assaulted her own children at the address. Police were unaware on their first visit that Jane's children were present. Jane was found a short distance away walking home and the children were spoken to. One of Jane's children said Jane had not hit them but only pulled them out of the house as they had not wanted to leave. There showed no sign of injury. Jane was highly intoxicated and alternative arrangements were made for the children. Again no rationale was given for not arresting Jane for offences relating to the care of the children.

14.10.7. On 4th April 2012 Jane called Police and told the call handler that if police did not attend she would kill her children or kill herself. The call handlers recognised that the children were on the child protection register and this was noted on incident. On arrival the police found Jane intoxicated. Her children were not present, but found to have gone to a

neighbouring address. A child protection order was discussed with the duty Inspector and the decision was made to allow the children to go into their father's care and a referral made to children's services. No rationale was given for not considering Jane for child abuse offences.

14.10.8. On 17th September 2013 police received an anonymous call regarding a domestic incident at Bob M's address. The control room operators identified the likely identities of those at the address and the fact that Bob M had a live non molestation order, which included a non-contact condition between Bob M and Jane. On arrival police found Jane in the street with her belongings. She had been drinking but was not considered drunk. She said she had argued with Bob M but there had been no assault. Jane was asked why she was at the address despite there being an order in place to forbid Bob M from being near her. She said it was her fault that Bob M was in breach. The attending officers including the local supervisor were aware of the order and it was decided that due to the fact that Jane had attended Bob M's address it was not appropriate to arrest Bob M for the breach. Instead Jane was taken the five miles back to her address. It was recorded that a standard DASH risk assessment was to be completed, but no form was ever logged as received within the central referral unit (CRU).

14.10.9. On 15th October 2013 Bob M's neighbour reported seeing Bob M punch Jane. Upon police arrival neither Bob M nor Jane were present. Shortly afterwards Bob M called the police to report that Jane was causing him to be in breach of a non-molestation order. It was Bob M himself who told the officers about the non-molestation order when they arrived. As it was Jane who had gone to Bob M's address, the officer did not arrest Bob M for breaching the order. No complaints or crime allegations were forthcoming from either Jane or Bob M, however it is not recorded if the original witness actually saw an assault and it would appear this witness was not followed up. Policy was not followed with regard to submission of a DASH risk assessment as neither party wished to fill one out, but the expectation would have been to submit a "skeleton" DASH so further assessment could be made.

14.10.10. Two incidents of assault were committed by Bob M against Jane at her home address on 23rd November 2014 and on 6th January 2015. On both occasions positive action was taken by officers attending and Bob M was arrested. However due to evidential difficulties Bob M was released on both occasions with pre charge bail conditions. Both cases were assessed as high risk on DASH completion. Nothing was recorded to say why a Domestic Violence Prevention Notice/Order (DVPN/O) was not considered for issue. Despite the provision of conditions and orders previously Jane continued to seek out Bob M and allowed him to stay at her address. The IMR Author highlighted that a DVPN/O would have allowed police to take enforcement action without the support of Jane in order to try and keep the couple apart for their own safety.

14.10.11. On 19th July 2015 Jane made a 999 call stating Bob M was breaching his non-molestation order, however when officers attended, Jane refused to engage with them, despite being visited three times and she was consistently verbally abusive towards them. On this basis the officers felt there was insufficient cause to arrest Bob M without any further corroborative evidence.

14.10.12. In the early hours of 7th August 2015 Jane called to report Bob M in her house and that she wanted the Police to attend. Before the police arrived she made a second call to report that Bob M was still in property and she was outside. Police attended at 4.34am and found Bob M in bed. He explained he had been living there and that he and Jane had

been drinking together during the evening. No offences were disclosed and a decision was made not to arrest Bob M for breach of the non-molestation order due to the belief that Jane was abusing the order. Bob M was taken to his home address. Jane had left the area and was not seen until 6pm when a standard DASH was completed, This was later reviewed and changed to medium risk by a supervisor.

14.10.13. The IMR author highlighted that Gloucestershire Constabulary voluntarily referred the incidents on 19th July 2015 and 7th August 2015 to the Independent Police Complaints Commission (IPCC), who responded that the matter was suitable for investigation into the actions of the officers. Three officers were identified as having a case to answer for not arresting Bob M for the non-molestation order. The decision to deal with them by way of management advice reflected the fact that Jane had initiated the contact with Bob M and the officers had made decisions with good intentions but that the Order should have been enforced. Nevertheless it is clear that if Bob M had been arrested on either of those occasions, he would not have been in custody on [REDACTED] August 2015.<sup>11</sup>

14.10.14. The IMR author has highlighted that the Force is currently introducing "VIST" (Vulnerability Indication Screening Tool) to operational officer's mobile devices. This is an intuitive electronic form which amalgamates the following areas of vulnerability: domestic abuse, child abuse, adults at risk and the other variables within these areas such as CSE, FGM, HBV, internet abuse, stalking and harassment). This combined form negates the need to carry a variety of paper documents. It allows officers to record all the relevant information at the scene, so it can be supervised and referred to the CRU for any further work through MARAC.

**14.10.15. The Review Panel thanks the IMR Author for a thorough and open review. They note that many of the issues identified as lessons to be learnt have already been addressed following HMIC inspections of the Force and individual failures have been the subject of internal police disciplinary action. The Panel is satisfied that none of the lessons identified by the IMR Author would have changed the outcome of the events of the [REDACTED] August 2015.**

#### **14.11. Gloucestershire County Council Children's Service**

14.11.1. The IMR Author found that the Department had only limited involvement with Bob M. He was known through his relationship with Jane as there had been involvement with her children due to their volatile relationship.

14.11.2. There were flags/markers against his name which were used to alert those accessing his files to the fact that he was known for violence and to be a risk to children. The risk to children flag was added to his record on 1st August 2013 following confirmation by the Police that Bob M had received a conviction for being drunk in charge of a child. A hazard flag was added to his record on 9th December 2014 as he was considered to be a high risk perpetrator of domestic abuse following a MARAC meeting. The reported victim at that time was Jane.

14.11.3. One of Bob M's children was made the subject of a Child Protection Plan due to concerns about the level of violence the child was exposed to whilst the parents remained

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<sup>11</sup> This paragraph will be redacted prior to publication.

in a relationship. Once the relationship ended and there was no on-going contact between Bob and his child the Children's Services' involvement ended.

14.11.4. The Department had significant involvement with Jane and her children. They had been subject to Child Protection Plans following an Investigation which started on 26th May 2011 following a strategy meeting, convened under Section 47 of the Children Act 1989. This was due to the level of violence reported in the home but also due to Bob M driving his car in 2009 whilst under the influence of alcohol with a child in the car.

14.11.5. Jane's family has been known to Children's Social Care since 2008 and in that time there were five referrals. The referrals involved domestic violence, alcohol misuse and concerns for the children's welfare due to inappropriate parenting. There were also concerns raised regarding Jane's mental health. This was due to a report from an ambulance crew that Jane may have taken an overdose and there were also similar concerns of alcohol misuse. Further investigations revealed that there were two men staying at the property one of whom was used for babysitting the children and the other, Bob M, was in a relationship with Jane and staying at the home. Both these men were known to the police for domestic violence and alcohol misuse. The children also expressed concerns about the situation at home saying that they felt scared. Consequently a Child Protection Case Conference was convened. On the 27th June 2011, due to the continuing incidents of domestic abuse and alcohol misuse, the children were made subject to child protection plans, under the category of emotional abuse. Despite the seriousness of the situation Jane and Bob M continued with the same type of lifestyle. On the 24th of June 2011 the social worker attended the property and found Jane had been drinking during the day and unstable on her feet. On the 26th of June 2011 the Police attended the property and removed the children to the care of a family member. This was again due to Jane's drug and alcohol misuse, other men were reported to be at the property, including Bob M.

14.11.6. The child protection plan continued as further incidents were reported and on the 9th May 2012 the children were placed voluntarily (Under S20 Children Act 1989) in the care of the local authority before moving permanently to the care of their father on the 25th August 2012. They have remained in the care of their father since this date and there have been no further concerns raised with Children's Services about their care. The Child Protection plans were ended on the 11th September 2012.

14.11.7. The IMR Author was satisfied that the appropriate actions were taken at the time to safeguard and protect the children and she had no concerns about the appropriateness of multi-agency information sharing at that time.

14.11.8. Children's Services were notified by the police of continuing domestic abuse between Jane and Bob M, these incidents were logged accordingly but no action taken, as the children were not in their care. The IMR author was satisfied that the decisions made by Children's Social Care practitioners in relation to these contacts were appropriate.

14.11.9. The IMR author highlighted that a young person, known to Children's Services, was in Jane's property at the time of Bob M's death. The allocated social worker confirmed that all necessary action was taken and support offered, which remains on-going at this time.

**14.11.10. The Panel is satisfied that the IMR author has completed a thorough Review and that practice was in compliance with accepted policy and practice. The**

**Panel agrees with the one lesson relating to the review of MARAC decisions which has also been highlighted by the MARAC Chair.**

#### **14.12. Gloucestershire County Council Adult Social Care.**

14.12.1. The IMR Author considered all aspects of the DHR's Terms of Reference whilst reviewing the Department's involvement with Bob M. (Jane was not known to the Adult Social work team). He was satisfied that whilst the Safeguarding Adults Team had ensured that the occupational therapist working with Bob M and his mother to help him towards independent living was made aware on 20th December 2012 that Bob was 'potentially violent and aggressive, that all involved should be aware of this and he had a history of drug use and domestic violence'.

14.12.2. The Social Worker involved with Bob M was informed of the 2013 MARAC after her initial visit to Bob in 2014. She understood that the relevance of this notification was to consider the safety of staff more than any request to take action. Neither the social worker nor her occupational therapist colleague had any concerns about Bob M's behaviour during their contacts with him and his mother. Bob M was always polite and the social worker found both Bob M and his mother appropriate. The social worker therefore did not have any reason to consider any Safeguarding issues or Section 42 enquiries. Neither did the Social Worker feel that a warning on the electronic records was warranted. They had no contact with Jane who lived in another town.

14.12.3. The IMR Author, used the Health and Care Professions' Council, Standards of Conduct, performance and ethics as the template for considering the involvement of the Social Work staff concerned. He was satisfied that the social worker undertook all appropriate communications, internally and externally, that were required to undertake her professional duties towards Bob M's community care needs.

**14.12.4. The Panel is satisfied that all contacts carried out by Adult Social Care personnel was in accordance with policy and procedures. The issues highlighted re the MARAC are addressed in this Report.**

#### **14.13. Gloucestershire Hospitals NHS Foundation Trust**

14.13.1. The IMR author found that the Hospital Trust had frequent contact with Bob M as he had epilepsy as a result of a head injury and drug and alcohol misuse. The contact was mostly specialist outpatient appointments, but there were also some inpatient admissions related to having severe fits that did not stop of their own accord (known as status epilepticus), requiring Intensive Care admission. There was no mention of Jane by name in Bob M's health record.

14.13.2. There was clear evidence in Bob M's medical notes that he had abused both drugs and alcohol in the past and been referred to the appropriate agencies for help with this.

14.13.3. There was no mention in Bob M's records of any domestic abuse with a partner, although he was noted as a domestic abuse perpetrator on the Safeguarding Log. Alerts are not placed on the records of domestic abuse perpetrators, unless they have also been violent to public sector workers or are known to carry weapons that could be used on staff.

14.13.4. There was a considerable amount of communication and information sharing between services about Bob M and many efforts were made to follow up non-engagement and non-attendance. The greatest danger to Bob M appeared to be from himself, due to erratic taking of medication, alcohol and drugs.

14.13.5. The epilepsy specialist nurse made referrals to mental health and alcohol teams for Bob M and mentioned that she thought Bob M was taking drugs as well as alcohol. In February 2013 the epilepsy nurse wrote that his seizures were finally coming under control but that the amount of medication required to achieve this slowed down his thought processes and was likely to affect his short-term memory. She also noted that his personality had changed to having more erratic moods and his temper was quick to flare. She felt that he had probably reached the maximum likely progress.

14.13.6. Jane's contact with the Hospital was initially related to overdoses and later due to assaults by Bob M. There was no record of any ongoing diagnosis or treatment for any condition.

14.13.7. Jane's notes all indicated that she was known to MARAC from December 2012 as a high risk domestic abuse victim of Bob M. All staff were alerted to this on either accessing her "Patient First" record or her medical notes. There were explicit instructions of what actions were to be taken in regard to domestic abuse, should she present. At the last contact with Jane in January 2015 this alert was not acknowledged or actioned. Hospital records included copies of six DASH forms completed by police in 2015 prior to the death of Bob M.

14.13.8. There was no evidence in Jane's notes that the Hospital were aware of any drug abuse or of her having any contact with specialist drug or alcohol support services. It was noted that she consumed excess alcohol at times.

14.13.9. Within Jane's health record there were three documented occasions of physical domestic abuse towards her by Bob M. On one of these occasions police and the ambulance service were called by her young sons. Jane was conveyed to hospital and although it was not recorded that on this occasion she made any allegation of domestic abuse at the hospital, hospital alerts were in place indicating that she was a high risk victim of domestic abuse.

14.13.10. There was limited communication and information sharing within Jane's health record. This was restricted to handover notes and summary communications with her GP. There was evidence of escalating domestic abuse via information sharing from the MARAC on the hospital Safeguarding Log, but this was not accessed on the one occasion that Jane presented to hospital after this information was received.

14.13.11. No risk assessments were required to be undertaken on Bob M by the hospital. However there was a failure to complete a safeguarding risk assessment and DASH form on the last contact with Jane on 6th January 2015.

**14.13.12. The Panel is satisfied that the IMR Author has carried out a thorough and open review, identifying key lessons and making appropriate recommendations.**

**14.14. Gloucestershire Domestic Abuse Support Services**

14.14.1. After reviewing case notes and discussing with the support staff who worked with Jane, the IMR author was satisfied responses were appropriate as Jane was supported with all her practical needs and staff worked to try and ensure her physical safety. They challenged other agencies in an appropriate way to try and ensure their client felt safe.

14.14.2. The IMR author identified a few procedural issues that need to be tightened up internally and these are already being addressed as part of the service working to obtain Leading Lights status from Safe Lives.

14.14.3. While there were occasions when Jane was difficult to meet with, overall Jane's engagement with GDASS was good. Jane did start the Freedom Programme and managed attendance with help from a support worker.

14.14.4. Due to the number of house moves Jane had, there was no settled base for her to feel safe and GDASS staff spent a lot of time dealing with the practicalities of each house move. Having to prioritise Jane's safety and housing issues meant it was more difficult to have time to address fully her other support needs.

14.14.5. The IMR Author commented that Jane perceived the GDASS workers as being the only people who believed what was happening to her and that this led her to not following through with supporting the prosecution of Bob M as she did not feel that the outcome would be beneficial or safe for her.

**14.14.6. The Panel wishes to highlight the exceptional level of support GDASS and in particular the IDVA provided to Jane over a significant length of time. The Panel is satisfied that the recommendations made will fully address the lessons identified by the IMR Author.**

#### **14.15. Gloucestershire Multi Agency Risk Assessment Conference (MARAC)**

14.15.1. The MARAC Chair provided a report to the Review under a Memorandum of Agreement. He explained the Gloucestershire MARAC process.

14.15.2. The Gloucestershire MARAC is staffed by one Part Time MARAC Administrator who is employed for 22 hours per week. Over the past year there have been, on average, 72 MARAC cases each month. This equates to a total of 873 High Risk DASH forms.

14.15.3. The Gloucestershire MARAC does not convene a meeting for every High Risk DASH form received. All however, are considered as MARAC cases and are shared with relevant partners and information collated to allow a more detailed understanding. Irrespective of whether a meeting is held all victims are entitled to all support a MARAC may offer.

14.15.4. The process is as follows:

- High Risk DASH received (Police or Agency)
- DASH circulated to partner agencies and information sought around any involvement. Agencies are also asked whether they would like to or be able to add benefit from attendance at a meeting.
- Incident placed into MASH and research conducted by MASH partners
- Incident reviewed by MARAC Chair with benefit of MASH and MARAC partner information available. ( normally about 2-4 days from incident)

- Decision made as to any additional action required with an option being a meeting. Decision circulated to all partner agencies with an opportunity to challenge or request a meeting if not convened.

14.15.5. There is a midday time slot allocated every week day for MARAC and meetings are held on an as required basis. A Daily meeting will consist of appropriate MASH partners with an open invite to any other agency with an interest. Most regular attendees are allocated Social Workers or Housing providers. A bespoke meeting is usually a week ahead and efforts are made to secure attendance of wider agency representatives such as Probation or Mental Health services.

14.15.6. It is the view of Gloucestershire MARAC that this allows a detailed consideration of each incident and a more bespoke consideration of the issues rather than holding a generic meeting. Challenge is encouraged and if an agency or any professional considers a meeting is necessary this is convened. All high risk cases result in a High Risk Marker being attached to the perpetrator on police systems and a tag attached to the victims address to notify police should an incident be created for that address, known locally as an OPI. There is no capacity to monitor and track all actions and no capacity to allocate a coordinator for each case.

14.15.7. He highlighted that Bob M and Jane had been known to the MARAC from November 2012. The first MARAC meeting to discuss them in December 2012 was after six incidents; two of which were recorded as standard risk by the police (one of which was recorded as high risk by the Hospital Accident Department) and one a medium risk. The other three incidents were considered, not to be domestic abuse, by the police officers who attended, as they related to drink related verbal arguments and no DASH assessments were submitted.

14.15.8. After the first MARAC meeting, between April 2013 and August 2015 there were four further MARAC meetings and six MARAC reviews conducted in relation to sixteen incidents of domestic abuse between Bob M and Jane. In three of the incidents, Bob M had been recorded as being the victim. Bob M was, nevertheless, considered to be a high risk perpetrator and Jane, who was perceived as the victim, was provided with IDVA support.

14.15.9. The MARAC Chair informed the DHR that information was shared appropriately with relevant agencies although he highlighted that the MARAC was restricted with regard to interventions and support for Bob M as his consent was required to refer him to Turning Point, the substance misuse support service or to the Splitz "Turnaround Men's Group" voluntary programme for perpetrators.

14.15.10. As a result of MARAC involvement non-molestation orders were put in place between 5th August 2013 to 5th February 2014 and again on 18th June 2015 which was due to expire on 18th June 2016.

14.15.11. The MARAC Chair informed the DHR that the MARAC has identified that there are a number of repeat high risk victims and perpetrators where there is a significant chaotic or alcoholic lifestyle which is the main cause of the abusive behaviour. GDASS review these on receipt and refer for a bespoke MARAC to ensure the right agencies are invited to consider ways of engagement and intervention in these very difficult scenarios.

**14.15.12. The Panel thanks the MARAC Chair for his report and notes that there is an ongoing review of the MARAC by the MARAC Steering Group which includes resource issues relating to the high volume of cases being referred to the MARAC.**

#### **14.16. Green Square Housing Support**

14.16.1. Bob M was referred to Green Square but after an initial meeting with him and his mother, it was clear that Green Square's services were not suitable for his needs. During the assessment there was no indication of domestic abuse, although there was mention of his head injury and possible mood swings. He was given details of other service providers that could provide the type of help he required to live independently from his mother. It was not known to Green Square which, if any of those services he decided to contact.

14.16.2. The IMR Author was of the opinion that Green Square's contact with Bob M and his mother was in accordance with policy and procedure. Green Square has a fit for purpose Domestic Abuse policy.

**14.16.3. The Panel is satisfied that Green Square's contact with Bob M was minimal and that there were no lessons to learn nor recommendations to make.**

#### **14.17. National Probation Service**

14.17.1. The IMR author found no contacts with Jane, but Bob M came under Probation supervision on five occasions between January 2009 and September 2011. The first four were community orders for offences including assault, criminal damage, being drunk in charge of a child under seven and harassment. For an offence of racially or religiously aggravated common assault he received a suspended sentence order of eighteen months.

14.17.2. Bob M maintained a good level of contact with his probation officer and enforcement occurred on the occasions he did miss appointments.

14.17.3. The IMR author found that whilst contact logs gave brief recorded accounts of what Bob M told his probation officer, there was no evidence of any degree of analysis or questioning.

14.17.4. On 14th February 2012 Bob M's probation officer was informed by a social worker that Bob M had been to Jane's house and assaulted her, possibly breaking her rib. On 16th February 2012 Bob told his probation officer that it was in fact he who had been attacked. There was no evidence in the case record that the probation officer questioned this to establish who was the victim in this incident. The IMR author acknowledged that it could have been because Bob M had a history of inflicting domestic violence that he was not viewed as a possible victim of domestic violence. Nevertheless even after this incident Bob M's statements to the probation officer about not having a relationship with Jane or not drinking were taken at face value, in spite of them being found together in bed in May 2012.

14.17.5. The IMR author highlighted that Bob M was possibly obscuring the true nature of his relationship with Jane to his probation officer i.e. about both the level of contact with her and his alcohol consumption and because this was not questioned the opportunity to increase the frequency of contact or to consider additional interventions was missed. It was however acknowledged that Bob M had known memory loss and an inability to en-

gage in group work, which may have inhibited him from being considered for a perpetrator programme.

**14.17.6. The Review Panel is satisfied that whilst Probation contact with Bob M was historic, the IMR Author has conducted a searching review, identifying the relevant lessons and setting appropriate recommendations to address them.**

#### 14.18. [REDACTED] Doctors Practice

14.18.1. The IMR Author, a doctor at this surgery where Jane had been registered for a few months, reviewed all of Jane's medical records. The IMR author had had no relevant previous contact with Jane or Bob M.

14.18.2. Jane's early medical records showed that since childhood she had a history of depression and anxiety likely related to a history of physical and possibly sexual abuse by her father and brothers. Her mother did not give her any support when it was reported to her. According to her notes she presented to primary care whenever she was in distress but did not engage long term. This pattern of seeking help, medication being started, then not continuing to attend was seen many times. The IMR author was satisfied that the care she was provided was appropriate, however she pointed out that by seeing different GPs each time Jane could not develop a rapport with a clinician. If Jane had a named GP she may have engaged better and perhaps the non-attendance would have been followed up.

**14.18.3. The Panel thanks the IMR author for reviewing all of Jane's medical history. The Panel is satisfied that key lessons have been identified and that the recommendations are appropriate.**

#### 14.19. South Western Ambulance Service NHS Trust (SWASfT)

14.19.1. Prior to attending the death of Bob M, the ambulance service had just one direct contact with Bob M in 2011, attending to treat a seizure. This incident was dealt with according to set procedure.

14.19.2. The Service attended seven separate 999 calls relating to Jane, between 2010 and 2015. Six of the seven attendances featured physical injury and five featured police involvement. A recurring feature was Jane's reported reluctance to receive further assistance. All contacts except one appeared to demonstrate an acceptable level of service delivery. In relation to that one incident, on the 8<sup>th</sup> November 2011, the IMR author was not able to locate a record of any safeguarding referral having been made to external agencies, however this may have been due to the organisational change in 2013 whereby the former Great Western Ambulance Service (GWAS), which covered Avon, Gloucestershire and Wiltshire, was acquired by SWASfT. The records from GWAS were transferred across but the safeguarding referrals from GWAS were not properly indexed.

14.19.3. Other than that isolated Information Governance issue, contacts had been of a good standard. The frequent co-involvement of the police has meant that SWASfT have not had to carry out any significant reporting activity. Cooperative working between police and ambulance staff on-scene at incidents of domestic abuse is an effective way to share concerns between our agencies.

14.19.4. The safeguarding referral process currently employed by SWASfT bears no resemblance to the referral system used in GWAS in 2011. The SWASfT system utilises

online referral forms, secure email transmission and data tracking and is managed by a team of staff dedicated to this process alone. An audit and governance system ensures that the referral records are stored and retained in accordance with Trust policies for Information Governance.

**14.19.5. The Panel is satisfied that the current South Western Ambulance Service NHS Trust has no lessons to learnt from this Review nor recommendations to make.**

#### **14.20. Turning Point**

14.20.1. Although Bob M and Jane had long histories of alcohol and drug abuse, they were never referred to Turning Point which is the main substance misuse support service in Gloucestershire. Turning Point has therefore identified lessons relating to communication with other agencies and the public regarding the availability of substance misuse specialist services in Gloucestershire in general and the Forest of Dean in particular. Turning Point has also taken the opportunity to identify the need for a review of its Domestic Abuse policy, staff domestic abuse awareness training and for risk assessments to include domestic abuse.

**14.20.2. The Panel welcomes the fact that Turning Point having had no contact with either the victim or perpetrator has taken the opportunity to identify lessons and to make appropriate recommendations.**

#### **14.21. 2gether NHS Foundation Trust**

14.21.1. In 1988 Bob M was first referred to the Child and Family Mental Health Services aged 16 for a mental health assessment due to his aggressive behaviour. He had a forensic history dating from 1986 and was attending Cam House School. His mother was unhappy that the Gloucester Child Guidance Panel had made the referral to mental health services without her knowledge and she stated that did not want help. A brief initial assessment was completed at home and he was discharged.

14.21.2. In 1993 Jane was referred by her GP to the Addiction Treatment Unit (ATU) for assessment. She presented with a ten year history of drug and alcohol misuse plus depression. She had returned to live in Gloucestershire, leaving her two children (then aged 9 and 10yrs) with their father in Wales. Jane did not attend community appointments and was discharged from services.

14.21.3. In 1995 Jane was referred to the [REDACTED] Community Mental Health Team by her GP for an assessment and was in the service periodically for three years. Jane disclosed a long history of physical and sexual abuse, and alcohol and drug dependence. She described a traumatic childhood where her brother sexually abused her and she was taken into care. She was in a difficult relationship (domestic abuse was hinted at but not confirmed) with her then partner and the father of her third child. Jane's treatment plan included seeing a member of the team specialising in sexual abuse and a consultant psychiatrist, who reviewed her mental health regularly. Child Safeguarding was a concern and risks were documented. Her use of substances remained a significant problem throughout 1997 and Jane was seen again by the ATU. She was admitted to [REDACTED] Ward in [REDACTED] [REDACTED] Hospital for a six day detoxification from drugs and alcohol after losing custody of her three year old son and becoming homeless. Jane disengaged with services after this time. Psychiatric reports were completed for the Courts in 1998. The IMR Author was satisfied

that the care provided by the team was of a good standard and inclusive of other agencies, including Jane's GP and Health Visitor. The Consultant letters and treatment plans were comprehensive and provided good quality records.

14.21.4. In 1997 Bob M was referred to the Addiction Treatment Unit (ATU) for a detoxification from substances including heroin; he was assessed and placed on the waiting list for five months (routine at this time) and he was offered community support in the interim, which he did not attend. In July 1998, his GP requested a further assessment for detoxification from drugs and alcohol and Bob M received a twelve day inpatient detox programme in ██████████ Hospital in August 1998. On discharge from hospital he failed to attend any community follow-up and was subsequently discharged from services in September 1998.

14.21.5. In November 2010, Bob M was referred to ██████████ Community Mental Health Team by his GP for an assessment due to his inability to adjust to life with epilepsy. The referral was discussed at the multidisciplinary team meeting (MDT), however, Bob M did not have a severe and enduring mental illness and it was suggested to the GP that a referral to a specialist at a Health Psychology Unit would be more suitable. The IMR author pointed out that it can be difficult to determine what service to refer to for treatment when a patient has multiple and/or complex needs and the team's suggestion for Bob M to receive psychological treatment, via Health Psychology at GRH, to help him better manage his epilepsy appeared appropriate.

14.21.6. In May 2011, Jane was admitted to hospital feeling suicidal after taking an overdose of eight Paracetamol and alcohol. Jane was seen and assessed by the Mental Health Liaison Team, a nurse and a consultant psychiatrist the following day. She had a mental health assessment, including risk, and her medication was reviewed and changed. Jane recognised that the alcohol she had consumed had 'tipped her over the edge'. She was discharged as medically fit and a letter outlining Jane's admission and treatment plan was sent to her GP on the same day.

14.21.7. In October 2011, Jane was seen and assessed by the Community Specialist Substance Misuse Service (CSSMs) and agreed to work towards a plan to reduce her dangerous drinking pattern (approx. 90 units on pay day), whilst waiting for an inpatient detox admission in December 2011. A full assessment took place and was documented, including her mental and physical health, family history and social circumstances. Risks were assessed and a recent incident was recorded; Jane was at a known drug den and was injected with heroin whilst unconscious. In the assessment Jane spoke about a friend called Bob M; this is the first time his name is recorded in association with Jane in the mental health records.

14.21.8. Jane attended one community appointment in November 2011 and then informed the team that she would be unable to complete an inpatient detox as her children were back in her care after her ex-partner said he could no longer look after them. In the limited Care Notes (recording system used at that time) that are available, the IMR author found no evidence recorded that concerns for the safety of her children were raised when they went back into Jane's care. Trust staff have a duty to safeguard and promote the welfare of children by sharing information with other services, or escalating their concerns to the Trusts Safeguarding Team or via the Children's and Families Helpdesk, as per the Trust Safeguarding Children Policy. Jane disengaged with the service before receiving treatment and this resulted in her discharge.

14.21.9. In December 2011, Bob M was assessed in the Primary Mental Health Clinic at the GP practice. No signs of acute mental illness were noted in the assessment, however psychological and emotional issues were present but appeared to relate more to his head injury, including possible frontal lobe damage and epilepsy; concern regarding possible capacity issues was also documented. Bob M denied any current intoxicants, he stated he was currently clean and sober and claimed he had not had a drink since June 2011. Previous drug and alcohol abuse was noted, plus a forensic history. A risk assessment was completed and risk of violence/aggression/abuse to the general population was recorded. The risk summary stated, "none of the risks assessed appear to be current and he is well supported in the community. However, his risk substantially increases should his social network deteriorate".

14.21.10. In January 2014 Jane was referred by her GP and was seen in the Primary Mental Health Clinic. The assessment included Jane's presenting situation/current problems, mental state exam and a risk assessment. A diagnosis of social anxiety and low mood, relating to a violent relationship that had ended the previous summer, was documented along with Gloucestershire Domestic Abuse Support Service (GDASS) involvement. A plan was agreed for Jane to receive practical support and graded exposure to help her manage her anxiety. In addition, the clinician liaised with GDASS to understand their involvement regarding the domestic abuse with the aim to work jointly together.

14.21.11. From January to April 2014, Jane received ten home visits and six telephone contacts from the support worker; a good rapport was established from the outset and additional information was obtained and documented regarding Jane's housing, finances, friends and support from other agencies. However, no information about her children was documented. The treatment plan and support worked reasonably well for approximately two months, however, by the end of March 2014, Jane started to disengage from the service. The situation at the flat became chaotic due to Jane's lifestyle choices; her ex-partner began living at the property and the Police became involved. Jane said that she had started using drugs and alcohol again after fifteen years of abstinence. It became impossible to provide any active treatment or support to Jane and after discussion with a senior colleague Jane was discharged from the service. There is no evidence that the information regarding Jane's increasing risks, her use of substances and being back with her abusive partner was shared with GDASS or with the GP in a discharge letter.

14.21.12. In June 2014, the Criminal Justice Liaison Team (CJLT) completed a mental health assessment in the Police Custody Suite. Jane had been arrested for grievous bodily harm (GBH) against her ex-partner (Bob M) who was refusing to accept that the relationship was over, she maintained that he stabbed himself after she told him that there was no opportunity for them to resume the relationship. Jane was released with no further action to be taken.

14.21.13. In January 2015, Jane was assessed in the Primary Mental Health Clinic. A brief mental health assessment was completed and documented (including risk), medication was reviewed and written information was given to Jane. The domestic abuse was discussed with Jane during the assessment and the clinician was aware that a safety plan was in place and that she was receiving support from GDASS and IDVA (for domestic abuse) and this is documented. Jane had access to the clinic and could make another appointment should she want to, but she did not. The assessment delivered by the clinician is in line with the standards for the Primary Mental Health team and the recording of information in RiO is proportionate and in line with the Trust's Assessment and Care Management Policy (2014).

**14.21.14. The Panel thanks the IMR Author for her detailed review and is satisfied that the main lessons have been identified and that the recommendations will help improve services further.**

#### **14.22. Two Rivers Housing Association**

14.22.1. The IMR author noted that Jane requested a high number of lock changes in a short period of time (5 lock changes in 10 months) while living in Two Rivers Housing properties. This was far higher than would normally be expected and should have raised concerns, particularly as four of the five occasions followed a police crime number being provided.

14.22.2. Two Rivers Housing were aware that Jane was being assisted by a health worker and an IDVA although this information was not known at the time of the tenancy sign up.

14.22.3. On 9th June 2015 a broken window was reported at Jane's address. It was identified as a tenant recharge, although it later became clear that this was as a result of a police crime number incident, where the window was broken and keys were stolen.

**14.22.4. The Panel is satisfied that the IMR Author has identified all of the key lessons that should be learnt and the recommendations made will improve services for future tenants suffering domestic abuse. The Panel notes that Two Rivers Housing Association is engaging in the Gloucestershire Domestic Abuse Housing Protocol.**

#### **14.23. Wyedean Housing Association**

14.23.1. Wyedean Housing Association was the landlord for separate tenancies for both Jane and Bob M at different times. Jane's first tenancy began in December 1994 and ended in July 1995. Her second tenancy began in June 2001 and ended in October 2013. Bob M's tenancy began in March 2010 and ended in August 2015.

14.23.2. There were a number of incidents recorded, relating to all three tenancies, in respect of breaches of the tenancy for rent arrears, domestic abuse and antisocial behaviour, a number of which had police involvement. The Housing Association's knowledge of the domestic abuse primarily came from police notification.

**14.23.3. The Review Panel accepts that Wyedean Housing Association carried out landlord responsibilities in accordance with set policies and procedures. The Panel also notes that the Association is taking the opportunity to identify lessons and to make appropriate recommendations**

#### **14.24. Family**

14.24.1. Bob M's mother was actively involved with the DHR from its commencement. She provided the pseudonym and a consent form for the Review to access his medical records. She was very conscious of how Bob M was portrayed in the press and at Jane's trial and wanted the opportunity to ensure that the DHR was aware of key parts of Bob M's life to help better understand his behaviour which she accepts could at times be aggressive.

14.24.2. Bob M's mother prepared the Tribute which is included at the start of this report and the family history which has been redacted and included in Appendix D.

14.24.3. Bob M's mother after reading the draft Overview Report pointed out that there was nothing in the lessons learnt section of the report, regarding Bob M's mental health issues. She said, his epilepsy and the traumas he suffered, as a baby and later through head injuries, could temporarily adversely influence his behaviour and his ability to think rationally. At such times he needed professional help, but he would not seek it voluntarily and there is no way under the Mental Health Act to coerce someone with such temporary mental health problems to obtain treatment. Nothing therefore could be done to treat him.

14.24.4. The Panel considered the issues Bob M's mother raised and members were of the opinion that it would not be appropriate to recommend that either the Mental Health Act Code of Practice or the Mental Capacity Act be amended to be specific regarding epilepsy, however they agreed that there is learning from this case. Nationally there are relatively few opportunities to gain experience of the neuropsychiatry of epilepsy unless clinicians and trainee psychiatrists have the opportunity to work in a specialist centre. Very few commissioners have supported the development of liaison or neuropsychiatric service in partnership with neurology. If there is to be development services capable of appreciating the significant needs of patients with peri-ictal and inter-ictal psychoses they will need people trained and experienced in this work which will require an investment that is not being made at present. It was agreed that there should be a recommendation for NHS England and the Department of Health to consider supporting further interface between neurology and liaison/neuropsychiatry and the wider provision of service and training opportunities. Nevertheless a section on Bob M and Jane's mental health has been added to the key issues part of this in the report

14.24.5. Jane has provided information included in this Review via her Offender Manager. She has no contact with other members of her family from whom she is estranged.

## **15. Effective Practice/Lessons to be learnt**

15.1. The following agencies that had contacts with Bob M and Jane have identified effective practice or lessons they have learnt during the Review.

### **15.2. Forest of Dean District Council Housing**

15.2.1. The Council's involvement in the housing of Bob M and Jane followed set procedures with requests for rehousing acted upon promptly and sensitively.

15.2.2. Following previous Domestic Homicide Reviews in Gloucestershire, the Gloucestershire District Councils together with GDASS and other partners have drawn up a county-wide Domestic Abuse Housing Protocol. This is aimed at ensuring that survivors of Domestic Abuse receive the advice and assistance they require and that there is a consistent approach across the county. (See Appendix C)

15.2.3. There were several occasions when the Forest of Dean District Council Housing team worked with partner Housing Association landlords to secure alternative housing for both Bob M and Jane. It is the practice to respect an individual's confidentiality and to only pass on information that is directly relevant to the housing needs of the individual or where there is a potential risk to the landlord's staff or the new tenant's neighbours. In this case it

is not apparent that sharing more information with the landlords involved would have resulted in another outcome but the Council will review the way that information about domestic abuse is disclosed to partners.

### **15.3. Gloucestershire Constabulary**

15.3.1. The HMIC inspected Gloucestershire Constabulary in 2013 and as a result inadequacies were identified in the way Gloucestershire Constabulary dealt with incidents of domestic violence and safeguarding of vulnerable groups. Recommendations were put in place and there was a re-inspection in June 2014 when there was improvement noted. There was and there continues to be a programme of ongoing improvement. As a result some of the areas where lessons and recommendations could have been made, have already been addressed.

15.3.2. Gloucestershire Constabulary revised its domestic abuse policy in April 2007 and in June 2013 a “how to” guide was released. This “how to guide” was updated in April 2014 and further updated in June 2015 when a new domestic abuse policy statement was released. The guide sets out clear expectations for how staff should respond to domestic abuse situations. The policy and guide are regularly reviewed in order to reflect changes in legislation, recognised practice, and is made available to all staff on the force intranet pages. This policy is reinforced through computer based training and classroom based sessions. This is an ongoing process which also reflects changes in legislation and procedure.

15.3.3. The length of time taken for the incident in 2006 between Jane and her then partner to be resolved was unacceptable. It is possible that this delay could have caused Jane to feel her reports were not taken seriously and tainted her view on reporting matters to police for the years to come.

15.3.4. To release a domestic abuse suspect from custody without bail conditions would not be expected practice in 2016.

15.3.5. DVPN/O was widely publicised when introduced, but the process to impose the notice and order was not considered or used.

15.3.6. There were several occasions over the years where a DASH form was not completed between Bob M and Jane.

15.3.7. Offences of child neglect or drunk in charge of the children were missed by officers attending three incidents in 2008, 2011 and the beginning of 2012 When Jane was intoxicated with her children.

15.3.8. The practice of using discretion over arrest when a court order is in place has in part been addressed as part of the internal investigation over the actions of officers on 7th August 2015 .

15.3.9. It was identified during the investigation that there were issues over accessibility to the conditions of the non-molestation order.

15.3.10. There was a lack of understanding of the need to record breaches of non-molestation orders as crimes.

15.3.11. Lack of investigative and supervisory oversight in respect of crime investigation.

15.3.12. Although the Gloucestershire Constabulary Domestic Abuse Policy states that a decision not to arrest can be made in exceptional circumstances, these circumstances on their own should not be normally considered exceptional, especially when there is previous history which indicates a high risk. The decision not to arrest should have been picked up by the officer's supervisor and addressed before the necessity needed to arrest had ended.

#### **15.4. Gloucestershire County Council Children Services**

15.4.1. There was evidence of good practice in relation to the children of both Bob M and Jane both historically and in the time leading up to Bob M's death.

15.4.2. There is evidence that recording procedures have been following in respect of the notifications received from the Police. It was easy to see from the Children's Social Care database that Bob M was considered to be an adult who presented a risk to children and women.

15.4.3. There was evidence of good social work practice within the Multi Agency Safeguarding Hub who followed due process to ensure that the information held in relation to Bob M and Jane having no contact with their children was correct.

15.4.4. There was evidence that the MARAC information sharing process worked well with Children's Services being appropriately notified and included in the decisions made in relation to Jane and Bob M. However there was no evidence found of decisions being reviewed through MARAC and therefore the effectiveness of the decision or planned intervention could not be measured.

#### **15.5. Gloucestershire County Adult Council Social Care**

15.5.1. It was unclear why there was not a warning put on the file in 2013 when the MARAC reported that Bob M was: '*potentially violent and aggressive, that all involved should be aware of this and he had a history of drug use and domestic violence*'. The purpose of such warnings was to alert staff about their own safety and to heighten awareness of possible difficulties.

15.5.2. Staff were not aware of any guidelines for Social Work staff around the actions that need to be considered when being notified by MARAC of a concern about an individual.

15.5.3. In enquiring whether a Section 42 enquiry should have been raised on Jane it became clear that there was some uncertainty as to whom, when and how this might have been instigated, if, as appears likely, Jane was at significant risk. Would this have been a role for MARAC, the Safeguarding team that act as a conduit for MARAC alerts, or the Social work or other agencies receiving alerts?

#### **15.6. Gloucestershire Hospitals NHS Foundation Trust**

15.6.1. There was room for a higher index of suspicion for domestic abuse as a cause when men present to the Emergency Department with a stab wound.

15.6.2. There was a need for a greater clarity of documentation, where another agency has completed a DASH whilst with a patient in the Emergency Department.

### 15.7. Gloucestershire MARAC

15.7.1. The MARAC does not have the resources to meet the high number of referrals.

15.7.2. There was no capacity to monitor and track all actions and no capacity to allocate a coordinator for each case.

### 15.8. Gloucestershire Domestic Abuse Support Services

15.8.1. There is a need for improved joint working with other professional agencies where there are multiple support needs.

15.8.2. It is apparent that additional training is needed regarding working with clients with complex support needs.

### 15.9. National Probation Service

**NB** The probation officer in this case has since left the service so the following comments are only based on the Probation Service record.

15.9.1. Bob M maintained a good level of contact with his probation officer and enforcement occurred when he missed appointments.

15.9.2. The recording of the contact log was brief, simply recording facts or what Bob had told probation officer. There was a lack of analysis or questioning. For example: Bob M maintained that he was not drinking, yet there were various proven episodes of violent behaviour towards his partners while he was drunk and there was no evidence of Bob M's claim being challenged.

15.9.3. On 14th February 2012 the probation officer was informed by a social worker (police incident number given) that Bob M had been to Jane's house and assaulted her, possibly breaking her rib. On 16th February 2012 Bob M told his probation officer that it was in fact he who had been attacked. There was no evidence in the case record that the probation officer took any further action and it was not established who may have been the victim in this incident. It could be that because he had a history of inflicting domestic violence that Bob M was not viewed as a possible victim of domestic violence.

15.9.4. Even after the above incident and in spite of them being found together in bed in May 2012, Bob M's statements to the probation officer about not having a relationship with Jane or not drinking were taken at face value.

15.9.5. Overall it would have been expected that the probation officer would have had an enquiring mind and made efforts to obtain independent verification of what Bob M was claiming.

15.9.6. There was a lack of evidence in the contact log of a response within probation supervision to recorded episodes of violence. There would appear to have been a continuous and escalating level of violence in Bob M's relationship with Jane that was not met with any response by the probation service in terms of increased frequency of contact or

additional interventions. This is partially explained by his memory loss and subsequent inability to engage in group work.

15.9.7. The nature of the violence towards partners e.g. a broken rib would appear to meet the definition of serious harm. As there was evidence that he was possibly obscuring the true nature of his relationship with Jane to his probation officer i.e. about both the level of contact with the victim and his alcohol consumption the stated level of risk of causing serious harm i.e. Low would appear to be inaccurate.

#### 15.10. **Doctors' Practice**

15.10.1. Early indications of domestic abuse of Jane as a child were not fully recognised in the way they would be now.

15.10.2. The fact that Jane saw different GPs did not help her in developing a rapport with a clinician. If she had a named GP, she may have engaged better and perhaps her non-attendance would have been followed up.

15.10.3. A multi-disciplinary approach with the involvement of the primary care, the mental health trust and other agencies such as GDASS would have been useful to manage such a vulnerable patient.

#### 15.11. **Turning Point**

15.11.1. There is a need to review how other service providers and the public are informed about Turning Point and the services it provides.

15.11.2. There is a need to ensure that all staff are aware of the Turning Point Domestic Abuse Policy and know what to do if a client presents with domestic abuse problems.

15.11.3. There is a need to ensure that risk assessments include domestic abuse issues.

#### 15.12. **2gether NHS Foundation Trust**

15.12.1. Bob M and Jane were offered and completed assessments based on their presenting problems. Appropriate interventions were identified that met their needs at the point of access to 2gether services, however, Jane consistently disengaged.

15.12.2. There are three areas identified where improvements to internal documentation was required: a) Obtaining accurate information about children; b) That safeguarding concerns and outcomes are recorded; and c) That discharge letters are sent.

15.12.3. The Trust has considered Bob M's mother's observations regarding access to mental health services in relation to epilepsy, capacity and the Mental Health Act. (See Paragraph 14.24.4. above)

#### 15.13. **Two Rivers Housing Association**

15.13.1. While each individual contact was handled according to correct procedure, it was not identified how many lock changes had been completed in a relatively short period of time at the two consecutive properties where Jane was a tenant. Detailed analysis of all the contacts showed an excessively high number of lock changes which could have triggered further action.

#### **15.14. Wyedean Housing Association**

15.14.1. Incidents were noted when they arose and appropriate actions were undertaken in accordance with practices at the time.

15.14.2. External/statutory agencies, including the Police, were notified as appropriate.

15.14.3. Wyedean Housing Association currently does not have a Domestic Abuse Policy.

### **16. Conclusions**

16.1. In reaching their conclusions the Review Panel has focused on the the following questions:

**16.2. Have the agencies involved in the joint Review used the opportunity to review their contacts with Jane and Bob M in line with the Terms of Reference (ToR) of the Review and to openly identify and address lessons learnt?**

16.2.1. The Review Panel acknowledges that the Individual Management Reviews and other reports have been thorough, open and questioning from the view point of Bob M and Jane. The Panel acknowledges that a number of those organisations whose contacts with Bob M and Jane were in accordance with their established policies and practice have no lessons to learn, yet have taken the opportunity to review their practices and procedures and have made recommendations to improve their service delivery. Other organisations have used their participation in the Review to properly identify and address lessons learnt from their contacts with Bob M and Jane in line with the Terms of Reference of the Review.

**16.3. Will the actions they take improve the safety of Forest of Dean domestic abuse victims, particularly those with other complex needs including substance abuse issues in the future?**

16.3.1. The Panel is satisfied that the changes already made by some agencies, together with the implementation of the recommendations made during the Review, will address the needs identified from the lessons learnt and make life safer for Forest of Dean victims of domestic abuse including those with complex needs due to substance abuse problems and mental health issues. The two housing associations engaged in this Review together with the Forest of Dean District Council Housing have confirmed that they have each adopted the Gloucestershire Domestic Abuse Housing Protocol.

**16.4. Was Bob M's death predictable?**

16.4.1. The Review Panel, while considering the numerous incidents of domestic abuse by and to Bob M, has identified only two when he may have been subjected to serious harm.

- On 25<sup>th</sup> March 2013 Jane made a 999 call to the police asking for help. Bob M could be heard in the background saying: “You tried to kill me”. When the police attended they found Jane with a superficial puncture wound to her leg. She claimed she had fallen, denying it was a stab wound and refused medical treatment. Bob M had no visible injury, but claimed that Jane had initially assaulted him with a glass, which he had then taken from her. He said, he had thrown the glass down and broken glass had accidentally cut her leg.
- The second incident was on 25th June 2014 when the police received a call that a male had been stabbed. The police attended at Jane’s address and found Bob M with a one cm stab wound to the stomach. Bob M initially said he had been stabbed in town but later stated he was angry with his girlfriend and had stabbed himself with a steak knife. He was admitted overnight, an X-ray was obtained and it was recorded that no surgical repair was necessary, he was given a tetanus booster and discharged home.

16.4.2. Whilst significant risk factors were present it is noted that their accuracy in terms of predictions has been found to be low.<sup>12</sup> Further research claims that “In terms of predicting murder or serious harm most tend to commit the “hindsight fallacy”.”<sup>13</sup>

**16.4.3. The Panel therefore concludes that there was insufficient evidence to give any agency grounds to predict that Bob M would sustain a fatal injury.**

#### **16.5. Could Bob M’s death have been prevented?**

16.5.1. Jane told the IDVA that she had little confidence in the Police as they did not enforce the non-molestation orders against Bob M. He would contact her when he was released from police custody and boast that he was out and would see her. The Panel has therefore considered if it was this lack of confidence in the authorities that led her to take matters into her own hands when she stabbed Bob M.

16.5.2. Gloucestershire Constabulary responded to fifty four incidents involving either Jane or Bob M and most were dealt with positively, however there were occasions when officers or their supervisors made decisions not to arrest Bob M for breaches of the non-molestation orders or for bail breaches as Jane had initiated the breaches by visiting Bob M or by allowing him to stay at her address. The Constabulary acknowledge that on those occasions, Bob M should have been arrested with the decision to prosecute being left to the Crown Prosecution Service (CPS). Gloucestershire Constabulary has subsequently taken disciplinary action against officers involved and has made Force policy clear to all personnel.

16.5.3. The Review Panel, after consultations with the Chief Crown Prosecutor for the Crown Prosecution Service (CPS) South West, has accepted that if Bob M had been arrested for the previous breaches of the non-molestation order or bail conditions, the CPS after consideration of all of the circumstances would probably have recommended no further action on the grounds of the public interest test not being met. The Chief Crown Prosecutor was of the opinion that if Bob M had been charged with the breaches, he would have been found guilty, but as Jane had admitted she had initiated the contacts with Bob M a nominal penalty would have been imposed.

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<sup>12</sup> Battered Women’s Perceptions of Risk Versus Risk Factors and Instruments in Predicting Repeat Re-assault (Heckert and Gondolf 2004)

<sup>13</sup> Decontextualization of Domestic Violence. (Shaman 1992)

16.5.4. The Review Panel has carefully considered the two occasions, on 12th August 2015, when the police were called to incidents connected to Jane prior to Bob M's death.

- The first was when an officer went to Jane's address looking for a missing teenager who was known to associate with her. While Jane was in the premises with Bob M, she did not answer the door to the officer.
- The second event was when police received a call that a male and a female had switched a full wheelie bin with a neighbour's empty bin. By the time the police had attended that call and had traced the unnamed female and male to Jane's address, she had already called "999" stating she had stabbed Bob M. The officers who attended, rendered first aid until other emergency services arrived.

The Panel is consequently satisfied that on that day, police officers had no opportunity to arrest Bob M for either breaching bail conditions not to have any contact with Jane or for breach of the non-molestation order.

**16.5.5. The Panel has concluded that whilst there are many lessons to be learnt there was nothing any agency could have done that would have prevented Bob M's death on that day.**

## 17 Recommendations and Action Plans.

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and Outcome
Accurate information about children should be recorded in the clinical system following assessment.	Local	This will be reinforced via "Think Family" Training	2gether NHS Foundation Trust	90% Compliance rate for all Trust staff identified as requiring "Think Family" Training (Level 2 Child Protection Training)	30/09/2016	December 2016
Safeguarding concerns, actions and outcomes should be recorded in the clinical system.	Local	This will be reinforced via "Think Family" Training	2gether NHS Foundation Trust	90% Compliance rate for all Trust staff identified as requiring "Think Family" Training (Level 2 Child Protection Training)	30/09/2016	December 2016

Discharge letters should be sent in a timely manner and within 24hrs where possible.	Local	Discharge letters will be sent within 24 Hours, compliance will be monitored via clinical audit.	2gether NHS Foundation Trust	90% Compliance rate for clinical audit results	31/03/2017	December 2016
The Department of Health will be asked to consider supporting further interface between neurology and liaison/neuropsychiatry and the wider provision of service training opportunities	National	Letter to NHS England and department of Health	2gether NHS Foundation Trust and Gloucestershire Hospitals NHS Foundation Trust	Consideration by NHS England and Department of Health	30/07/2016	December 2016
Being more aware and Identifying patients at risk of domestic abuse and /or of being a perpetrator	Local	Use of Emis warning system to target such patients	██████████ and Surgeries - Child and adult safeguarding lead			Actioned and completed
FoDDC to adopt the Gloucestershire Domestic Abuse Protocol and ensure that all relevant staff trained by 30 <sup>th</sup> April 2016. Strategic Housing Manager	County wide	Adoption and training	F o D District Council		30th April 2016	December 2016
FoDDC Housing team to review data protection procedures surrounding the passing of information on prospective new tenants to partner landlords concerning domestic abuse. Completed 31 <sup>st</sup> May 2016. Strategic Housing Manager	Local to FoD	Discussion with housing partners	F o D District Council		31 <sup>st</sup> May 2016	December 2016

FoDDC housing team to review data protection procedures surrounding the passing of information on prospective new tenants to partner landlords domestic abuse as well as reviewing participation in MARACs to ensure that relevant information passed on and appropriate actions taken.	Local to FoD	Review of current data protection procedures and adoption of identified amendments	FoD District council		31st August 2016	30th December 2016
To review the operational policy for the notification of warnings on Client /Patient Files and to raise awareness to all staff.	Local recommendation to involve multi-disciplinary and multi-agency input	Internal and Multiagency Forum	Gloucestershire County Council - Adult Social Care		30th September 2016	December 2016
Publish or review existing guidelines for Operational Staff about actions needed on MARAC notifications and reasons why.	Local recommendation to involve multi-disciplinary and multi-agency input	Internal and Multiagency Forum	Gloucestershire County Council - Adult Social care		30th September 2016	December 2016
Review operational working practices of MARAC and Safeguarding to clarify roles and boundaries .	Local recommendation to involve Safeguarding and MARAC	Internal and Multiagency Forum	Adult Social care -Internal and Multiagency Forum		30th September 2016	December 2016

The Department recognises the information sharing benefits of being involved in MASH and management will explore ways in which this can be achieved.	Local recommendation with Multi-agency involvement	Internal and Multiagency Forum	Adult Social care -Internal and Multiagency Forum		30th September 2016	December 2016
The department to consider and review its Domestic Abuse Policy in the light of the Panel's recommendations.	Local recommendation with Multi-agency involvement	Internal and Multiagency Forum	Gloucestershire County Council - Adult Social care		30th September 2016	December 2016
Develop a clear pathway through the service for clients with multiple/complex support needs	Local	Write up procedure and disseminate to team.	Gloucestershire Domestic Abuse Support Services		Apr-16	December 2016
Improve working protocols with other support agencies.	Local	Meet with other agencies and agree a protocol.	Gloucestershire Domestic Abuse Support Services		Apr-16	December 2016
Disseminate learning from Gloucester PODS (Social Care Initiative- see Glossary)	Local	clients who are open to the children and families team will have access to support from other services.	Gloucestershire Domestic Abuse Support Services	Report on pilot from PODS to be assessed and learning points put into practice.	Sep-16	December 2016
Training for GDASS staff to be arranged on working with complex clients	Local	Training to be planned for all staff on working with clients with complex needs, joint training with 2gether Trust,	Gloucestershire Domestic Abuse Support Services		Jun-16	December 2016

Increase awareness of domestic abuse and child protection across the organisation	Local	The Trust has a Fit for Purpose Domestic Abuse Policy and staff in Unscheduled Care and Maternity have received training. There is an e-learning package available to all staff. This to be further encouraged across the organisation.	Gloucestershire Hospitals NHS Foundation Trust	Domestic Abuse Policy in place . Domestic abuse e-learning in place. Face-to-face training for Unscheduled Care and Maternity staff. Child protection policy and training already in place.	31/12/2016	Ongoing
Staff to be reminded to have a higher index of suspicion of alternative explanations when patients claim to have stabbed themselves.	Local	Remind staff of the importance of considering mechanisms of injury and causative agents in penetrative trauma	Gloucestershire Hospitals NHS Foundation Trust	Training already in place. Staff have been sent reminder.	31/12/2016	Completed
Staff to be reminded to document whether alerts have been actioned and whether other agencies have completed risk assessments whilst accompanying a patient	Local	Remind staff to document that alerts have been seen and actioned and whether other agencies have completed risk assessments whilst accompanying a patient.	Gloucestershire Hospitals NHS Foundation Trust	Training already in place. Staff have been sent reminder.	31/12/2016	Completed
Review and update the current domestic abuse policy	Local	Undertake a review of the policy in conjunction with the lead nurse for domestic abuse and to include children and adult safeguarding leads	Gloucestershire Care Services	Ratification of the policy following presentation to the clinical policy group	Aug-16	December 2016

Ensure that all staff receive appropriate domestic abuse training	Local	Scope current training provision for all staff groups across the organisation. Source appropriate training and map levels across staff groups resulting in an updated training matrix	Gloucestershire Care Services	Individual training matrix reflect level of training required and this training is available through our Training Request System. Agreed compliance levels shown through the reporting process.	Apr-17	December 2016
Review MARAC process in Gloucestershire, paying particular attention to resourcing, agency participation, accountability and governance.	Local		MARAC Chair			December 2016
Ensure lower level incidents involving previously high risk victims and perpetrators are escalated to ensure a reviewed by MARAC Chair . This will allow the history to be considered and involvement of additional agencies.	Local	Escalation as necessary	Multi Agency Risk Assessment Conference		Immediate	December 2016
To ensure that an additional level of scrutiny is introduced to allow a focussed approach to those involved in repeat incidents through chaotic lifestyles.	Local	Bespoke Meeting	GDASS/Police		Immediate	December 2016
To conduct a review into the use of DVPN/Os to ensure organisational understanding, sufficient training and operational effectiveness.	Local	Education, training and monitoring.	Gloucestershire Constabulary	TBC	1st March 2017	April 2017

To review the investigative standards associated with domestic abuse and the expectations upon supervisory officers in terms of investigative oversight.	Local	Education, training and monitoring.	Gloucestershire Constabulary	TBC	1st March 2017	April 2017
Gloucestershire Constabulary to ensure that breaches of non-molestation orders are recorded as crimes to ensure breaches are readily linked to DA subjects and to comply with national crime recording standards.	Local	Staff to be reminded of their obligations under NCRS. Control room to mark reports of breaches as in need of a crime report. Supervisors to ensure compliance.	Gloucestershire Constabulary	TBC	1st March 2017	April 2017
Gloucestershire Constabulary to review the DASH risk assessment process to ensure understanding of importance by staff and supervisors.	Local	Staff training utilising outside agencies covering DA and Police response to DA. Control room to monitor DA incidents and not allow closure of incidents until DASH submission confirmed.	Gloucestershire Constabulary	N/A	N/A	2016 - Master-class training provided by Gloucestershire University. All new staff and trainee police officers receive training upon induction which includes the importance of DASH. New VIST tool being piloted that will supersede DASH. Control room now monitor incidents to ensure DASH is submitted in each DA case.

<p>Gloucestershire Constabulary to ensure that appropriate bail conditions are imposed when there is a risk to any person upon a detainee's release.</p>	<p>Local</p>	<p>Staff training, specifically for those dealing with DA incidents and custody officers.</p>	<p>Gloucestershire Constabulary</p>	<p>N/A</p>	<p>N/A</p>	<p>2016 - Safeguarding is now an organisational priority and awareness of protective measures has risen. CPS have governance on charging decisions in relation to DA incidents and will direct suitable conditions as part of their decision making process alongside police recommendations.</p>
<p>Gloucestershire Constabulary to ensure all potential offences relating to child neglect be considered by attending and supervising officers and a rational recorded for action/inaction.</p>	<p>Local</p>	<p>Staff training, specifically for those dealing with DA incidents and custody officers.</p>	<p>Gloucestershire Constabulary</p>	<p>N/A</p>	<p>N/A</p>	<p>2016 - Safeguarding is now an organisational priority. All staff have received training on vulnerability Arrests in relation to child protection have risen. More police protection orders are being recorded. Child protection incidents are now included in MASH discussions.</p>

All Delius contact log entries should use the CRISS model – Check in – Review – Intervention – Set task – Summarise.	Glos/Wilts LDU NPS	Offender managers to be instructed	National Probation Service	immediate	immediate	December 2016
Serious/significant on going domestic violence should always be recorded as serious harm on OAsys ie the level would be medium, high or very high but not low	Glos/Wilts LDU NPS	offender managers to be instructed	National Probation Service	immediate	immediate	December 2016
Turning Point will review way its services in Forest of Dean are made known to public and other service providers	Local	Review Website. Request CSP, CCG GDASS, Police and Probation ensure all agencies working with the public in FoD area are made aware of how to signpost or refer a client for drug or alcohol support.	Turning Point, CSP, CCG,		1st August 2016	30th December 2016
Ensure all staff have completed domestic abuse awareness training in accordance with our DA Policy	Local	DA awareness Training will be provided to all personnel by an external training provider	Turning Point	Training programme review and ongoing training given to staff		on going
Ensure that risk assessments of both male and female clients include questions relating to domestic abuse, where appropriate	Local	Review risk assessment process	Turning Point		1st September 2016	30th December 2016

<p>Crime references are not currently verified by TRH. The tenant has an incentive to provide these references as it means they will not be recharged for repair work.. The Customer Services procedures will be investigated to see if validation of the crime reference number can be validated.</p>	<p>Local</p>	<p>The Tenant Recharge Procedure reviewer will work with the Customer Services manager to make sure the validation and recharge tie up.</p>	<p>Two River Housing, Customer Relationship Coordinator.</p>		<p>July-31-2016</p>	<p>August 2016</p>
<p>When a recharge case is started there may be additional follow on work which may all be rechargeable. The recharge process should capture all relevant rechargeable work. A broken window is a typical example where there will be multiple visits (to board up and make safe which may occur out-of-hours, to measure the window and order the replacement glass and then to visit again to fit the glass).</p>	<p>Local</p>		<p>Two River Housing, Customer Relationship Coordinator.</p>		<p>July-31-2016</p>	<p>August 2016</p>

<p>Crime reference numbers may be easily made-up (as stated above). A mechanism to validate them at the point they are reported into TRH should be investigated, most likely with the police themselves. This validation will feed into the recharge process as it will help to establish if an item is the tenants responsibility or TRH responsibility.</p>	Local / Multi-agency		Two River Housing, Customer Services Manager.		July-31-2016	August 2016
<p>Where crime references are provided against a reported repair the incident and reference should be passed on to the Neighbourhood Housing Team for possible follow up work or to give additional information to an existing ASB case. This should be built into scripting, tasking, workflow or process-management where possible (i.e. automated).</p>	Local		Two River Housing, Customer Services Manager.		May-31-2016	June 2016

<p>There is no policy or procedure that states when a property becomes non-secure as a result of an incident that TRH will treat the repair work as an Emergency and will complete the work out of hours if necessary. However it is the working practice to do so. The most suitable policy and/or procedure should be updated to state this is the case (suggest Tenant Handbook and Neighbourhood Repairs Guidebook).</p>	Local		Two River Housing, Customer Services Manager.		May-31-2016	August 2016
<p>The 'Nuisance and ASB Procedure' needs reviewing and updating (It is dated 2010 and I noted old office address and old tenancy enforcement officer details were included. It should reflect the fact that there may also be a small amount of investigation and initial response to a report of nuisance before an ASB case is started in process-management.) The Corporate planner / policy review schedule is to be checked to ensure this policy is listed amongst the current policies maintained by the organisation</p>	Local		Two River Housing, Neighbourhood Housing Team Leader.		July-31-2016	August 2016

Consider adopting a Domestic Abuse policy	Local	Obtain other policies from other agencies to assist.	Wyedean Housing Ass.	1	Sep-16	September 2016
Ensure that record keeping is appropriate to the nature of the issue reported	local		Wyedean Housing Ass			September 2016
Domestic abuse training such as IRIS	Primary care	IRIS training	██████ Doctors Practice			December 2016
Continuity of care/Named GP	Gloucestershire CCG area	All vulnerable patients should have a named GP for continuity of care, when such patients leave the practice, notes should be passed on the new practice as a priority	██████ Doctors Practice and Gloucestershire CCG			December 2016
Multi- disciplinary approach to manage vulnerable patients	Gloucestershire CCG area	Joint meetings	██████ Doctors Practice and Gloucestershire CCG			December 2016

## Appendix A Glossary of Terms

### Forest of Dean District Council Housing

**RSL**- Registered Social Landlord now more usually called Registered Provider or Housing Association

**GHS** - Gloucestershire Homeseeker Service – the web based Social Housing Allocation system

**Autobid** – a facility on GHS that allows available properties to be matched with applicants who are unable to use the computer system themselves.

### Gloucestershire Constabulary

**MARAC** – Multi agency risk assessment conference.

**DASH** – Domestic abuse, stalking and harassment risk assessment.

**OIC** – Officer in the case (Investigating officer).

**DV/1** – (Predecessor to the DASH form).

**PPO** – Police Protection Order.

**CRU** – Central referral unit.

**DA** – Domestic Abuse.

**DVPN** – Domestic violence protection notice. Issued by Police prior to order by the court.

**DVPO** – Domestic violence protection order. Issued by the court.

**IPCC** – Independent police complaints commission.

**IO** – Investigating officer (Investigator appointed under police conduct regulations).

**AA** – Appropriate authority (Chief Officer of police area).

**MASH** – Multi agency safeguarding hub.

**HMIC** – Her Majesty's Inspectorate of Constabulary

**CSE** – Child sexual exploitation.

**FGM** – Female Genital mutilation.

**HBV** – Honour based violence.

**UNIFI** – Gloucestershire Constabulary crime recording system.

### Gloucestershire Domestic Abuse Support Service (GDASS)

**PODS** is a social care initiative currently being piloted in Gloucester City, it is a service that brings together social workers, mental health workers, drug and alcohol workers, youth support and GDASS. All workers are based in the same office, it means clients who are open to the children and families team also now have access to support from other services. In cases where the client doesn't want to engage, then the social worker will liaise with the worker from those agencies to discuss the case and explore ways of supporting the client who may have one of those support needs.

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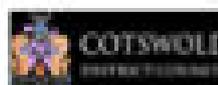
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## Appendix C

### A Countywide Housing Protocol in responding to Domestic Abuse by Gloucestershire County Homelessness Implementation Group 2015



A Countywide Housing Protocol in responding to Domestic Abuse

#### Author/Lead Officer

■ Faye Kamara

#### Position

Strategic Domestic Abuse and Sexual Violence Coordinator

#### Sponsor

County Homelessness Implementation Group

06/08/15

#### ■ 1. Introduction

■ There is a Countywide Domestic Abuse and Sexual Violence Commissioning Strategy agreed and owned by the Health and Wellbeing Board. All six districts are aware of this strategy and are signed up to assist the partnership in its implementation over the next 4 years. The district representative on the Commissioning Group is the Deputy Chief Executive for Tewkesbury Borough Council.

The vision of the strategy is that 'Individuals, families and communities who are at risk of or exposed to domestic abuse and/or sexual violence are able to access information and

support to minimise harm, and to maintain healthy relationships. Our commitment is to ensuring a zero tolerance approach’.

The purpose of this protocol is to:

- Ensure that there is a consistent approach by housing staff in homelessness and housing option teams, by providing clarity on how to respond to a domestic abuse disclosure.

## **2. Consultation Process**

*This Protocol will be subject to consultation and agreement within each district council housing option team and by:*

1. *CHOG- Countywide Homelessness Operational Group*
2. *CHIG- Countywide Homelessness Implementation Group*

*The protocol will also be considered under the Equality Analysis as per the requirements of the public sector Equality Duty (which was introduced in April 2011 under the Equality Act 2010).*

## **3. What is DA?**

The Home Office definition of DA is:

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to; the following types of abuse:

- Psychological and emotional, e.g. intimidation, isolation, verbal abuse, humiliation, degradation
- Physical, e.g. slapping, pushing, kicking, punching, stabbing
- Sexual, e.g. rape and non-consensual sex acts
- Financial, controlling of finances

Controlling behaviour: A range of acts designed to make a person subordinate and/or dependant by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour: An act or pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish or frighten their victim.

This definition includes so called ‘honour’ based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender

or ethnic group.

Gloucestershire Constabulary receive approximately 5000 calls relating to domestic abuse each year. About 500 of these are victims that have been identified as being at high risk of serious harm or homicide- for these cases they are processed through the MARAC; sharing information with partner agencies to best safeguard these individuals and their children from harm through coordinated action planning. In 2013/14 three women were killed by their partner/ex-partner and therefore three domestic homicides reviews have been undertaken. Domestic Homicide Reviews are case specific and led by district level Community Safety Partnerships. Housing Option teams/housing associations have been involved in these reviews.

The law has been strengthened in relation to domestic abuse and soon there will be 'course of conduct' offence to address the issue of coercive control which is often extremely prevalent within domestic abuse cases.

Where a victim of domestic abuse who is 16 or 17 years old presents as homeless- Housing staff will following Countywide Safeguarding Policy and Procedure and therefore will make contact with Children's Helpdesk. There is also a countywide protocol between all the districts and county Children's Services in relation to 16/17 year olds presenting as homeless.

#### **4. Our Approach to Dealing with DA**

No-one should live in fear of violence or abuse from a partner, former partner or any other member of their household. We will take all reports of DA seriously and will seek to work positively and proactively with the victim to find solutions and offer protection. Reports will be dealt with in a non-judgemental way and in confidence. We will not require survivors to take legal action or contact the Police before we provide assistance, and any action taken will be taken with the victims consent. The exception to this will be where we consider there to be a high risk of serious harm to anyone involved.

All 6 districts will work with victims of domestic abuse and support their homelessness applications. When fleeing domestic abuse these individuals have a legal right to make an application to any housing authority of their choice and will be supported in doing so. This includes making an application to their authority of residence if they choose to do so. Having taken the application the receiving Local Authority will process the application according to Homeless Legislation and determine local connection.

We are committed to tackling DA in all its forms and we will:

- Ensure that people experiencing DA have access to appropriate specialist support services as early as possible and are given advice to allow them to make choices about what to do next.
- Support survivors to rebuild their lives by working in partnership with them and other support agencies.

- Ensure victims have access to civil laws to offer maximum protection and to stop abuse reoccurring.
- Ensure that victims are supported and encouraged to report abuse to the Police.
- Follow safeguarding children and vulnerable adult's procedures.  
All complaints of DA will automatically be referred to GDASS (Gloucestershire Domestic Abuse Support Service) through an 'opt-in' process. Where there is a disclosure of domestic abuse, the housing worker will advise the client that a referral will be made to GDASS who will contact you in the next 48 hours to offer you support. The only exception is where the client refuses for this to happen.

### **How does the automatic 'opt-in' referral process work?**

1. Domestic abuse Disclosure received by housing staff
2. Housing staff worker advises the victim that an automatic referral will be made (see below as an example)

*'Thank you for being honest with me, there is help available for you and you don't have to do this alone. I am going to make a referral to the local specialist support service for you. This service is called GDASS (Gloucestershire Domestic Abuse Support Service), they can provide advice and support on a one to one basis over the phone or in person. They also coordinate the Sanctuary Scheme which enables work to be carried out on your home to make you feel safer.'*

3. Housing worker can facilitate the referral in two ways.

- If the victim appears in crisis, there are high risk factors present (eg. strangulation, separation, pregnancy) and/or you think the victim is most likely to engage there and then - call **GDASS on 01452 726561**.
- If the victim has disclosed domestic abuse but there are no immediate risks or concerns then send the following details to **GDASS email inbox: support@gdass.org.uk**

- o Full name of victim
- o DOB
- o Address
- o A brief description of the situation
- o Safe telephone number

o Safe time (is there a better time for the victim to receive a phone call)

4. Housing worker will advise the victim how they intend to refer- ie. I am going to call GDASS now for you OR GDASS will be in touch with you in the next 48 hours.

We will ensure that we:

- Place victims in contact with Gloucestershire Domestic Abuse Support Services (GDASS) at the earliest opportunity through the automatic opt in approach
- Consider referral to Sanctuary Scheme where the victim isn't and doesn't want to engage with GDASS for support and advice
- Participate in and / or request Multi-Agency Risk Assessment Conference (MARAC) when necessary.

We will ensure that we are as flexible in our approach to each individual and will work with them to arrive at an effective response to the issue. We recognise that issues of DA can be very complex and can affect individuals and families in different ways.

## **5. Support for victims of domestic abuse**

Our aim is to ensure that the victim of DA is provided with support and understanding and has access to the necessary support. We will not insist upon 'proof' of DA at any point.

### **5.1. GDASS**

GDASS is a county-wide service designed to reduce the level of domestic abuse and improve the safety of victims and their families. They operate across Gloucestershire offering a variety of support programmes for women and men over 16 years old experiencing Domestic Abuse. Support provided or facilitated through GDASS includes:

#### **5.1.1. Sanctuary Scheme**

The sanctuary scheme is an innovative approach to homelessness prevention and we will support this scheme. The scheme is operated locally by GDASS. It provides professionally installed security measures to allow those experiencing domestic violence to remain in their own accommodation where it is safe for them to do so, where it is their choice and where the perpetrator no longer lives within the accommodation.

#### **5.1.2. Independent Domestic Violence Advisors (IDVA's)**

GDASS have a number of IDVA's who have been trained to work with male and females who have been assessed as being at high risk of serious harm of domestic abuse. They specialise in assessing and reducing risk of harm to those experiencing DA. They work

with other partner agencies to create plans of support. They play a key part in the MARAC process, and can support victims in the court process.

### **5.1.3. Support Workers**

There are a number of support workers who can offer tailored support packages and provide assistance through family court if required.

### **5.1.4. Accommodation**

Short term alternative accommodation may be provided in certain circumstances, although there may be a duty on the relevant local authority under homelessness legislation.

GDASS and the districts are working together to provide 'places of safety' in each district for this client group. There are also bed spaces available at the one refuge in Gloucestershire.

Where a victim needs to flee an abusive relationship and their home and they have a pet. GDASS will work with local animal shelters and the RSPCA to find a solution to this problem on a case by case basis.

### **5.1.5 Legal action**

Sometimes legal action is needed to offer protection and GDASS will consider and support victims where this approach is appropriate. All of GDASS Support Workers have been trained to support their clients through the Family Court Systems, if needed, and act as a non-legal representative within this arena. Several of the GDASS IDVA's are also trained to work exclusively with people going through the court system.

**6. Legal protection disclosure scheme** was implemented, with two main facets;

#### **Right to Ask**

Under the scheme an individual can make an application to ask the police to check whether a new or existing partner has a violent past. This is the 'right to ask'. If records show that an individual may be at risk of domestic abuse and violence from a partner, the police will consider disclosing the information. A disclosure can be made if it is legal, proportionate and necessary to do so.

#### **Right to Know**

This enables an agency to apply for a disclosure if the agency believes that an individual is at risk of domestic violence from their partner. Again, the police can release information if it is lawful, necessary and proportionate to do so.

Housing staff can do this. A 'right to know' application can be made by:

Summarising the following in an email and sending to

[cruenquiries@gloucestershire.pnn.police.uk](mailto:cruenquiries@gloucestershire.pnn.police.uk), indicating **'Right to Know'** in the subject box.

- Names, DOBs, and addresses of the person at risk and subject of the enquiry (ie. The person they believe has a violent criminal history)
- What they know about the subject
- What their concerns are
- What professional relationship they have / had with the person at risk

- Their contact details

Domestic Violence Protection Orders (DVPO's)

DVPO's were introduced in 2014 and filled a gap in providing protection to victims by enabling the police and magistrates to put in place protection in the immediate aftermath of a domestic violence incident.

With DVPOs, a perpetrator can be banned with immediate effect from returning to a residence and from having contact with the victim for up to 28 days, allowing the victim time to consider their options and get the support they need.

Before the scheme, there was a gap in protection, because police couldn't charge the perpetrator for lack of evidence and so provide protection to a victim through bail conditions, and because the process of granting injunctions took time.

The Family Law Act 1996 created two types of injunctions relating specifically to domestic violence:

- Non-Molestation Orders, and
- Occupation Orders  
Non-Molestation Orders are to prevent further violence or harassment; Occupation Orders are to regulate the use of the home. Either type of order can be sought on its own, or both can be sought at the same time.  
It is important to remember a number of points about injunctions:
- They are not always effective – if the perpetrator of violence is not concerned about the prospect of going to prison an injunction will be ineffective against them

An applicant for an injunction is not guaranteed getting one, even where they are entitled to apply for one

- The victim of DA can be most at risk at the point when a clear signal is given that the relationship is over

The key when considering enforcement action is around the wishes and needs of the victim (s) of DA and any other person affected by it.

## **7. Data Protection - Sharing Information and Confidentiality**

Maintaining confidentiality and security is essential, and we will:

- Ensure privacy for interviews
- Be particularly careful about disclosing information about the victim' s current address
- Ensure housing records clearly show that the address must not be disclosed  
All districts will adhere to the Data Protection Act 1998 and other relevant legislation, and adopts good practice guidelines when it comes to gathering and sharing personal data.

Any information given to us will be treated in confidence. We will not discuss information given to us about DA with a third party unless those involved have agreed to this.

The exception to this will be if information needs to be shared for the purpose of reducing crime and disorder, or for the safeguarding of vulnerable adults and children. All districts should consider putting an alert on the Homeseeker applicant's record for information. If this is done it should be in accordance with the Homeseeker Policy

## **8. Safeguarding Children and Vulnerable Adults**

All districts support the safeguarding of children and vulnerable adults by alerting the statutory agencies to any concerns raised by staff. When dealing with DA cases, staff will take into account our safeguarding responsibilities, particularly when dealing with persons who are at risk of abuse, harassment and violence for example to ensure that they receive appropriate support and protection.

Housing staff are trained in how to recognise safeguarding concerns and how to report these in line with our Safeguarding Vulnerable Adults Policy and Safeguarding Children Policy.

## **9. Training**

We will ensure an appropriate level of awareness and training is provided to housing staff in these teams so that they are aware of what is expected of them when dealing with domestic abuse disclosures'.

All housing staff will have completed the free e-learning GSCB Domestic Abuse package as a minimum by August 2016. Training needs will be reviewed on an annual basis to ensure up-to-date learning.

## **10. Domestic Abuse and Sexual Violence Forums**

All district housing option teams will participate in their local domestic abuse and sexual violence forum. These forums are opportunities to share information about new initiatives/projects, plan awareness campaigns and training.

Cheltenham and Tewkesbury- Tracy Brown Cheltenham Borough Council  
([tracy.brown@cheltenham.gov.uk](mailto:tracy.brown@cheltenham.gov.uk))

Gloucester- Josie Dabbs, Gloucester City Council (Josie.Dabbs@gloucester.gov.uk),

Forest of Dean- Annie Lapington, Coleford Town Council  
([townclerk@colefordtowncouncil.gov.uk](mailto:townclerk@colefordtowncouncil.gov.uk))

Stroud and Cotswolds- TBC

## **11. Awareness**

We will ensure and promote countywide messages about the unacceptability of domestic violence through regular communication.

All six districts are committed to raising awareness, publicity and providing training for all housing option teams.

In order for staff to deal appropriately and professionally with cases of DA they need to be trained and/or provided with sufficient awareness. With awareness and training comes the confidence for staff to deal with often-complex cases and to expedite suitable outcomes. Training will consist of the e-learning package referred to above as a minimum with additional bespoke workshops delivered by GDASS when necessary.

## **12. Domestic Homicide Review (DHR)**

When someone has been killed as a result of domestic abuse and violence (domestic homicide) a review should be carried out. This is to ensure that the relevant professional agencies understand what happened in each homicide and to identify what needs to change to reduce the risk of future tragedies. The DHR will be instigated by the local Community Safety Partnership in which the victim lived and when requested and relevant District Council Housing Option teams may be asked to contribute and carry out an Individual Management Review (IMR).

The IMR's feed into an overview report that draws together overall conclusions from the analysis contained in the IMR's.

## **12.1 IMR**

The purpose of the IMR is to:

- Allow agencies to look openly and critically at individual and organisational practice and the context within which people were working to see whether the homicide indicates that changes could and should be made.
- To identify how those changes will be brought about.
- To identify examples of good practice within agencies.  
When requested a senior manager within the housing option team will make a decision on which appropriate colleague will carry out the IMR.  
The completed IMR report should be quality assured by the senior manager. The senior manager will also be responsible for ensuring that any recommendations from both the IMR and, where appropriate, the Overview Report are acted on appropriately.

## **13 Review of our Policies and Procedures**

This document is subject to review. CHIG (County Homelessness Implementation Group) will review the documents at any time if necessary, for example when new legislation may have an impact upon our work, or when there are valid requests made to review a policy area.

## Appendix D: Bob M's Family History, written by his Mother

### ██████████ – Family History (Note: dates are approximate)

**Adopted Parents** – ██████████, Occupation – at the time - A Sergeant in the Royal Pay Corps, based in Colchester with the 2<sup>nd</sup> Light Infantry. Mother – Home Maker.

██████████' **birth mother** – she had been known to social services from a very young age, a very troubled disturbed child and teenager, which continued into adulthood. Behaviour issues meant she was also known to the police, largely due to a volatile temper and control issues. Social services described her as a challenging through out the years they had been involved with her.

██████████ **Natural Father** was unknown to social services, it was suggested that ██████████'s birth Mother was not sure who his father was.

██████████ **was born** in Colchester on 11.11.1971 the 2<sup>nd</sup> child, there is a half sister.

██████████ was placed into care with the Colchester Social Services when he was approximately six and a half months old. His Mother was going into hospital to have an abortion. On her return home she decided to marry, this person was not the Father of any of the children. The intended husband refused to have ██████████ returned from social services as he was a mixed race child.

The Colchester Social Services had been asked by Adoption Resource Exchange the adoption service my husband and I were hoping to be accepted by, to complete the required investigations on there behalf. The report was ready to be sent at the time when ██████████ needed a new family. As we were, at the time the only couple they were aware of who did not have objections to any child, we were asked if we would be interested in meeting ██████████ with view to adoption after a six month foster care period. We were assured the chances of a successful adoption were very high. We would be fast tracked through there system for adoption parents, the report to Adoption Resource Exchange amended and sent on the completion of ██████████'s Adoption.

On meeting ██████████ we fell in love with him instantly, he was adorable, within a very short time ██████████ arrived in our lives! (Mid June age seven and a half months)

He settled down amazingly quickly, swapping a bottle which he apparently would not sleep without (sucking on air most of the night) from the very first night for a Teddy, and ██████████ slept all night. Within ten days he was sitting, by the age of nine months crawling, and walking at eleven months. Social workers were amazed at his progress which had gone from low for his age to high.

██████████ loved snuggling up to be read to by his Dad or to watch children's TV, was obedient and an easy child to love and care for.

### **Then, the day which changed everything!**

On the 27<sup>th</sup> December 1972, we had a surprise visit – it was ██████████ social worker, she didn't come with good news.

■■■■ birth mother had been in constant contact since before Christmas, saying she wanted ■■■■ returned to her. She claimed that her husband would be more likely to accept ■■■■ into the family if he was with them. The social worker and the case team had hoped it was just a Christmas whim, but earlier that day ■■■■ birth mother had created quite a scene, insisting she had ■■■■ re-returned to her. She wanted to have him on increasing time spans, starting from an hour up to a day, weekend and so on. At the team meeting social workers had decided this was not an option, it wouldn't be in anyone's best interests especially ■■■■ to allow that situation, also My husband and I were a forces family, and as Pay Corps could be posted to another unit without much notice! The proposed plan if allowed could have gone on for years. It was therefore agreed that if ■■■■'s birth mother still insisted on his return it has to be all or nothing!

■■■■ was taken from our care at almost fourteen months old, he left with most of his belongings including toys and cloths – in the hope it would help him in some way to make this huge change.

The following weeks defy description, it was only later, that I became aware, that I could remember very little of those six weeks!

Six weeks almost to the day, at 7.30pm the door bell rang, my husband said oh who's that! I replied ■■■■ (■■■■'s Social Worker) he replied "don't be silly" he answered the door and I heard him say "hello Mrs ■■■■"

We were then told, that there were many problems with ■■■■, they had been to see him **every day** (in the six months ■■■■ was in our care we had only had 3 visits) ■■■■'s birth mother had asked for him to be returned to us.

■■■■'s half sister would take everything from him, even his own things, he wasn't eating, sleeping, he was going downhill fast, and her husband would not acknowledge ■■■■'s presence in any positive way! The birth Mother had already agreed to sign the first of three, consent to adoption papers before ■■■■ left her care. As we had this assurance we agreed to have him returned to us.

■■■■ was returned within two days – I was horrified, by the state he was in physically and right from those few minutes the emotional trauma was evident. To put it bluntly, ■■■■ was never the same child again!

Forty plus years later, hard to know where to start, it's still so very emotional for me! So a list might be best:-

**He smelt** – unwashed, his hair smelt of sour sweets and chocolate it had not been washed or brushed, his beautiful afro hair was all stuck with food, sweets and chocolate.

**He laughed** when he saw the few big soft toys we had kept – the laugh was chilling it was like a hyena.

**As I held him** and spoke to him, asking if he wanted a bath (he used to love his bath) he nodded. Undressing him I was shocked, he was thinner, his bottom covered in what looked like brown smarts. As I cried out my neighbour came in, took one look and said she was going to call the Doctor and get an appointment.

**The suitcase** everything smelt of urine, most of it was dirty, and none of it were the cloths he had left with, there were no toys or anything clean or decent to dress him in after his bath. My husband came home then for lunch, Again that chilling laugh from [REDACTED] as he saw [REDACTED] after making a fuss of [REDACTED], [REDACTED] opened the case, stepped back at the smell, looked at me, picked the case up, said “this is going in the bin” ill get him something to wear now, ill get the afternoon of, and borrow money to get him new things tomorrow.

**The Doctors** His bottom, he had been left in wet soiled nappies, and when changed the new nappy had not been washed properly, cream to apply, the brown smarty blobs dropped off!

**Weight Loss** [REDACTED] had lost 8 pounds, extreme for a child of fifteen months.

We were told there were good signs of neglect that we could use to fight [REDACTED] being removed from us again.

**Emotional and Behaviour changes** After his bath he went to sleep on my knee wrapped in a blanket, if I moved in the slightest way he would wake cry, and clinging to me, I couldn't put him down at all! I also had to take him with me every minute of the day everywhere, even if I was coming straight back – he would scream the place down if left for a second, that went on for months!

[REDACTED] was no longer contented; he would pull all his bedding into a pile in the middle of his cot and sit on top of it. It took ages to get him of to sleep. He was now disobedient and would do what he knew he shouldn't deliberately!

Within a short time [REDACTED]'s Dad went to Northern Ireland on a four month secondment with the [REDACTED] of the Light Infantry. Returning for R&R timed to coincide with our appearance in court for the final phase of [REDACTED]'s adoption, which was granted. [REDACTED] absent so soon after [REDACTED] being returned to us I am sure didn't help [REDACTED]'s emotional state!

By the time [REDACTED] was two he had become destructive, tearing up his own drawings, pulling his toys apart, taking things from children at play school, biting holes in his bed sheets, breaking colouring pencils, tearing pages from books etc. As he got older and when out playing (very safe where we lived at that time on a small army estate in Borden Hampshire attached to [REDACTED]) not supposed to go out of sight - he would often disappear, resulting in lengthy periods of finding [REDACTED] and [REDACTED] – (if either one was missing they were always found together) by myself and [REDACTED] always found safe, and even if it had been dry for weeks, they would have found mud and be covered!

We now, had adopted a daughter who was three months old when she came to us, and a year old, when we moved to Germany; [REDACTED] was now just four years old.

A new posting took us to Germany where we spent 5 years first in Munchin Gladbach, then a few miles down the road in [REDACTED] We now had adopted a daughter who was a year old, when we moved to Germany [REDACTED] was now just four years old.

By the time [REDACTED] went to school it had already become difficult to know how to deal with his behaviour, all the usual things just didn't work. [REDACTED] first two years at school were hard work for his teacher as she struggled to cope with him. Despite this she always said [REDACTED] when he was good was a delight, and even at that age very likeable.

[REDACTED]s third year was better, a male teacher, who loved sports, and channelled [REDACTED]s excess energies and controlled his outbursts by the introduction to football, rugby, and athletics, (in school and after school clubs) all of which [REDACTED] shone at, and from that young age 7/8 years it ignited a passion for sports which remained with [REDACTED] for the rest of his life.

He quickly was spotted by the Munchin Gladbach German football under ten manager, and was soon playing for them in the under ten league.

Whilst the sports didn't completely stop [REDACTED]s challenging behaviour it did make him more manageable at school.

By now I was working part time in the evenings and Saturday afternoon at the NAFFI restocking shelves, also some Sundays when stock taking. My wages saved for when we bought our first house, and it gave me a much needed break from dealing with [REDACTED]. [REDACTED] was now at the main Pay Corps Office for the forces on the Rhine, so didn't go of on exercises or to Ireland. He cared for the children while I was at work.

During this period [REDACTED] had been referred to the army child psychologist, for behaviour issues. We were advised to make a number of changes to the way we dealt with [REDACTED] Mainly he was to be sent to his room for miss behaving (removing anything he could cause damage with) the longer he shouted for the longer he had to be quite for, on a sliding scale, before he was allowed to come downstairs. If he started making a fuss any time during the "quite time" the quiet time was reset to the beginning again. If we were going out instead of not going as [REDACTED] had been difficult (punishing us all) we were to tell him he would go to his room when we returned. This needed to be done firmly, taking him physically to his room and saying "You will stay here until I say you can come downstairs" if [REDACTED] attempted to come down before you said he could the time would start over again. [REDACTED] also had to apologise with sincerity, (had to look sorry) if he didn't he was to be taken back upstairs.

During this period he was also put onto medication to calm during the day and help him sleep longer at night.

Did all that help! Not sure it did make much difference, perhaps helped by 20% overall. The putting him in his room was fine while I was physically able to do this! By the time [REDACTED] was ten I could no longer manage to do this!

We moved back to the UK in 1981 [REDACTED] would have been ten later that year! [REDACTED] had been promoted and posted to [REDACTED] Two Para's in Aldershot in charge of his own pay team. This caused friction between us! [REDACTED] had now a male teacher, who used sport as a way to get the best from [REDACTED], and this approach was more successful, [REDACTED] was doing much better. A second year with this teacher I felt would be very beneficial for [REDACTED] but my husband would not even consider ask-

ing for a year extension, which would I came to believe would have been granted. That was when I found the Army and my husband's career came well before the needs of his family.

I refused to live in married quarters in Aldershot (standard of housing and behaviour of Infantry Soldiers were along with Catterick were at an all time low, well known to be, the two worst postings you could get!)

I believed it was the worst possible environment for [REDACTED] to be taken to!

We had always said when the children were at senior school age we would buy our own home, the children and I would remain there with the children, while [REDACTED] went to wherever he was posted. It was a year early, but that is what we did, as far as I was concerned it was the only other option!

We bought a house in the Forest of Dean as my Mother, Sister and Brothers had moved into this area. Our house was on the outskirts of [REDACTED] Mum lived in [REDACTED] close enough for the support I knew I would need. I and the children stayed with my Mum for the time it took us to months move in.

[REDACTED] was being weaned of the medication the Army Psychologists had put him on. Our GP was horrified that a child as young as [REDACTED] was on the medication mix [REDACTED] was on, saying it was potentially dangerous, and it was having little effect anyway. The medication I had been put on was also slowly being reduced, and then stopped.

At School both [REDACTED] and [REDACTED] were finding it difficult to settle down. They were both doing work that they had done the previous year in Germany. There were no after school clubs to occupy them, not even any school sports teams! [REDACTED]'s behaviour was harder and harder to control, enrolling him in Cubs/Scouts was not enough to keep him from getting into trouble.

School referred [REDACTED] to Child Psychology, which was next to useless!

After meetings with school authorities the decision was made to send [REDACTED] to [REDACTED] School (for children with behaviour issues), I was really struggling with [REDACTED], during this period, [REDACTED] was on his way or in the Falkland Islands with 2 Para at the time and still doing 4 month tours of Northern Ireland during this period support from him was minimal to say the least.

[REDACTED] only got home for the weekend if he behaved, which meant he didn't get home often. Despite this I called him most days and went to visit him twice a week until he left the school.

Once again with hindsight [REDACTED] School did him no favours, he learnt from older children and it was not good things he learnt! His first weekend home resulted in a police caution; he did a "moony" at someone (classified as indecent behaviour at the age of 10/11!)

Educationally it was not a good either; despite being very bright [REDACTED] left school with no qualifications at all.

In July 1981 I gave birth to [REDACTED], [REDACTED] had returned from the Falklands just a few days before.

In 1985ish, [REDACTED] was again promoted and posted to Northern Ireland for his last posting before completing his 21 years service. Our marriage by now was in a poor state, the constant struggle

with [REDACTED], the pressures of living separate lives, I was now working part time to put food on the table as forces wages hit an all time low, rising interests rates meant if I didn't work I would have to move to married quarters in Ireland. Once again it seemed if I put the children's education first ([REDACTED] now in Secondary School) I had no option) I was lucky to have a good neighbour who adored [REDACTED] and loved having him when I needed help. So I was effectively a single Mum, (in name only) working part time, struggling to keep the house, pay the bills, cleaning, cooking etc. Visiting [REDACTED] twice a week, and trying to cope when he was home, and cope generally.

In November we moved from a small three bed to a bigger three bed (all double rooms) home with only a very small rise in our repayment costs. I was still working, 2 of my brothers helped me for 2 days, and [REDACTED] said he couldn't get back from Ireland! By the time [REDACTED] did get home on the 23<sup>rd</sup> of December I had decorated the whole house by myself, shopped for Christmas gifts, and food. Decorations were up, gifts wrapped, [REDACTED] had been home for a week.

Our marriage was deteriorating further each year, no arguing, just a lack of connection on every level. The only thing left in common were the children!

As an Army wife you are expected, to support your husband at all time, and just get on with dealing with anything on your own, anything which might distract or interfere with your husband's career on any level!

[REDACTED] was also concerned about what the future held once he left the army and that time was approaching rapidly. I was not at all sure if I could go back to living together full time.

Back to [REDACTED] by now [REDACTED] had been known to the police, given numerous cautions. [REDACTED] did do several government training schemes, but his attendance was only ever enough to keep his funding.

I am not sure of details and can't remember if he was working when [REDACTED] returned to Ireland on the [REDACTED] 1989. Flight was [REDACTED] from London to Aldergrove which had engine failure and came down on land between the M1 and a A road just short of the East Midlands Runway, which had been cleared for an emergency landing.

[REDACTED] was asleep that evening, [REDACTED] was ready for bed in her room, [REDACTED] was out, when the 10 o'clock news announced the plane had crashed. I worked out that [REDACTED] should have caught the earlier flight. But something nagged me, and I called the emergency number that had been given on TV. I got straight through (I learnt later it took a lot of people hours to get through) By now it was just over 2 hours after the crash, I was asked [REDACTED]'s details, there was a pause, I was asked if I had anyone with me (only the children) I was advised to call someone to be with us, no definitive information either way, was told someone would be in touch. [REDACTED] came downstairs for the second time, and I said "I don't know!" [REDACTED] then came in asking if it was the plane Dad was on and started crying, I said stop we don't know, someone will be in touch! I told them to go to bed, I stayed up watching the continued news coverage until gone 2 am, I went to bed and dosed on and off until the door bell rang just before 7 am. It was the police with the news [REDACTED] had died. [REDACTED] had heard and come down stairs; I woke [REDACTED] while the police woke [REDACTED]. The police called my brothers who arrived quite quickly, before they left. By the afternoon we had the national press

camped outside the front gate, taking it in turns to ring the bell every 20 minutes. I had been put to bed by my brothers and they took care of the children. [REDACTED] had gone out with his friends. The phone rang all day, the children were crying, we were all so very shocked. [REDACTED] was now 17, [REDACTED] was 14 and [REDACTED] was 6!

It was after this [REDACTED] started self harming. (Cutting his wrists) When [REDACTED] went out without his main friend group, he would get into trouble, often being arrested for getting involved in another persons stuff, standing up for the lesser able person, this was a pattern that would more often than not be the cause of arrest.

[REDACTED] was encouraged by our Army visiting Officer to apply to join the Army, but the 1<sup>st</sup> time failed – [REDACTED] was told to come back in a year when he had “grown up” a bit more! The 2<sup>nd</sup> attempt around his 18<sup>th</sup> birthday he was accepted into the Gloucester’s. Training was at Tamworth, and he successfully passed out.

During his spell in the army [REDACTED] did a 4/6 month tour of Northern Ireland which if my memory it correct was in Belfast, the worst possible place to be! He also had taken up Boxing for the regiment, and received several head injuries. Even during his time in the Gloucester’s he would get into trouble doing time in military prison – don’t (know what for) and I now know he was dishonourably discharged after. I think [REDACTED] served about 18 months all told!

It was not until his 1<sup>st</sup> child was a few months old he knew of the child's existence! He got a Father’s Day card – on contacting his ex girlfriend’s (a fellow army girl in training) mother he discovered that [REDACTED] was to be brought up by the Grandmother, and arrangements were made to see [REDACTED]. Visits were about twice a year and reliant on me taking him up to Oldham, Manchester. When [REDACTED] was 16/17 the grandparents moved to Spain, the child followed for a while but returned to Oldham. Contact then was often difficult, [REDACTED] was always loosing her phone (Just Like [REDACTED] Dad) early adult years caused emotional stuff to surface, and contact became strained between [REDACTED] and [REDACTED]. Despite this Facebook with the occasional visit did keep the contact going.

[REDACTED] was a rubbish Dad to all 3 children, however he never forgot their birthdays, or how old they were, even if he more than often didn’t send a card or gift. He did love all three of them greatly in his own way! When he lost the right to see [REDACTED] and [REDACTED] even he knew it was his own doing, it nearly destroyed him. (See funeral tribute)

I over the years, have lost count of the number of times [REDACTED] got himself into trouble, (you will no doubt be more aware of this from police records than I am, and I have no doubt that there are bound to be things of which I am not aware off) I’ve also lost count of the number of times I have picked up the pieces, or the number of times I helped sort out somewhere to live, paying the deposit – always with the promise it will be the last time! Just when you began to think you had turned a corner with [REDACTED] he pressed his self destruct button and back to square one we went! There was something in his psychic – I never worked out what or why that self destruct triggered when everything was going ok!

After [REDACTED]'s discharge from the army, he did various jobs which lasted until his 1<sup>st</sup> pay check allowed him to embark on a drinking and social outings leading to missed days, or handing in his notice.

In 1994 [REDACTED]'s second child was born. [REDACTED] and his girlfriend [REDACTED] lived together. Their relationship came to a end when [REDACTED] was arrested, when after a drinking (both of them) [REDACTED] woke to find his best friend at the time and [REDACTED] all over each other, he lost it, the police were called and he was arrested. [REDACTED] was sent to prison for that offence, which was when he got hooked on Heroin. The next few years were bad – homeless and deathly thin he came back to live at home, now on Methadone he began abusing that until I took charge of the medication giving it when prescribed. He got into a detox program via his GP, on completing the program as far as I know [REDACTED] never injected heroin again, always saying it was the worst time and was never going back there again! He did however smoke and possibly pill popped over the years, despite denying it!

It was while in prison [REDACTED] was found to have a very high IQ, I now believe, the reason for his school behaviour may well have stemmed from being bored, he needed more than was provided. It was with this finding [REDACTED] decided to go to University and do a Sport degree in Manchester (not sure what year that was) Once again the social side of Uni took president over education, and within a year he had left.

[REDACTED] had met a hard working mother of five children, two lived with [REDACTED] and two with [REDACTED]'s mother, the eldest was lived independently. [REDACTED] moved in with [REDACTED] and the two children, he got a job in the mobile phone factory where [REDACTED] worked. They both made good money, I don't know how but [REDACTED] had a really good effect on [REDACTED] she knew how to get the best from him, she knew how to handle [REDACTED], and they married in 2007 (I think) That New Year while out celebrating with [REDACTED] he was hit over the head with a large full bottle and taken to hospital where he remained unconscious for 2 days, it was touch and go to whether he would pull through or not! Over the months that followed, [REDACTED]'s behaviour deteriorated as did his personal hygiene, the relationship became strained, eventually breaking down.

[REDACTED] came home again, and once more I helped find him somewhere to live in [REDACTED] It was around this time he meet [REDACTED] [REDACTED]t the [REDACTED] Music Festival and was not long before he had moved in with her and her two daughters. [REDACTED] was again in and out of work, (sorry it's impossible to remember all the details of employment and dates) [REDACTED] was working but lost her job (not sure why or at what point in their relationship) She fell behind with the house payments, so sold up and moved with [REDACTED] and the children into rented accommodation. They were both heavy drinkers, so when intoxicated (via smoking whatever???or and alcohol) arguments flared up and got out of hand, I would get phone calls telling me to go and get [REDACTED] or she would call the police.

It was after the severe head injury in Manchester that I noticed [REDACTED] couldn't often remember , where ever he woke up, either in a cell or at home, what had happened, how he had got to where ever he was. It was with knowing this that [REDACTED] decided to have another child with [REDACTED]! When I was told by them both that she was pregnant, that it was not a mistake, I was not happy to say the least, when I said "so that will be another grandchild I will at some point no longer see" I was told

by █████ that no matter what ever happened between her and █████ I would always be able to see the child! Three years down the line that's exactly what happened!

But before then – █████ and █████ split up in the first year of █████ being born. Again I helped him secure a flat in █████ right in town. Very soon another severe head injury (someone hit █████ from behind with a metal bar) so called friends helped him home, bleeding profusely, laid him on his bed and left him. Three days later █████ rang me, and told me what had happened, he had come to after 2 days, and was still very groggy on day three. His bedding was soaked with blood, which wouldn't wash out, so was thrown out.

Shortly after this both █████ and █████ had to appear at Cheltenham Court, (can't remember why) █████ was at a cash point; █████ was waiting by her when he had his first unconscious fit. Taken to █████ Hospital, kept in over night he was diagnosed with Head Injury Epilepsy. █████ was released with an emergency appointment to see a consultant in █████ within days. Scans showed his both his front lobes were BLACK, there were also several gray patches through out the rest of his brain.

Now on medication, █████ refused to change his life style; he continued drinking resulting in unsupervised fits in his flat, at least three while cooking when the Fire Brigade were called by other flat dwellers. Result – he was told he had to leave; it took us days to paint the flat with numerous coats of paint before handing over the keys.

Now housed by Wye Dean in a downstairs flat, once again I paid the cost of second hand furniture, new carpets and curtains etc. Much of his previous house items were beyond cleaning. Now on different medication, █████'s fits still not in control, it was three years before his unconscious fits settled down, the conscious fits – gazing into space, knock, knock is any one at home fits were always present to some degree. It took three years of tinkering with his medication to stabilise █████, although he was still drinking, he had learned the hard way (4 stays in ICU where it was touch and go 3 of those times) to limit the drinking to avoid fitting. █████'s new flat was fitted with fire and smoke detectors and panic alarms, and eventually the bath was removed, and the bathroom changed into a wet room. █████ became irrational often in these early days of Epilepsy, he would argue black was white, it was better just to say "we will talk about this tomorrow" often again he would not remember being irrational. It became a full time job to keep █████ feed, clothed and warm; he had agreed to hand over his finances to me as he couldn't control them his self. Every two weeks we went to get his Gas, Electric, pay his bills and buy food, he would then get whatever was left. I also did all his medication, putting it into daily pill boxes for two weeks at a time. I had allowed my self to become responsible for keeping █████ alive, this resulted in me having a breakdown as I tried to cope with █████

Within the 1<sup>st</sup> year in his new flat, (sorry not sure which year it was – Wyedean Housing will have the dates) that █████ met █████ who at that time lived in █████. █████ was allowed to see █████ during this time, firstly supervised visits, on a Monday. Then every other weekend I would pick up █████ on a Saturday morning and take her to █████ collecting her on Sunday and taking her back home by 4pm. Whenever I saw █████ was not in a good enough state to have █████ by his self, I brought them both to █████ where I could keep an eye on them both. There were occasions

when I cancelled [redacted]'s visit with [redacted] completely. [redacted] started having [redacted] at [redacted]'s home at the weekends, up until the weekend when the police called around, they had been called to [redacted]'s address and as they could not get hold of [redacted]'s Mum, I was asked to have both [redacted] and [redacted] to prevent [redacted] going into care for the night and [redacted] from being put in a cell, which I did, but was far from happy! [redacted] was returned to the new meeting point [redacted] had moved and didn't want us to know her new address, which was as we discovered later very near [redacted]) [redacted] her older sister had been sent to collect [redacted] which by then I knew that it was because [redacted]'s Mother was unwell from drinking the night before.) Often when returning [redacted] Home [redacted] was in bed "napping" or it was clear she had been drinking. I didn't mention there had been trouble the night before. Subsequently I was accused of leaving [redacted] with [redacted] when he was not in a fit state to care for her. A lie at 10.45 on the Saturday morning he had been fine. I believe [redacted] used that to stop [redacted] and myself from seeing [redacted] – and it worked, [redacted] was believed, and I haven't seen [redacted] or been allowed to send gifts (they were returned) since.

It was after that night when I realised how [redacted] had fooled me into believing she didn't drink and she was a responsible person. I was soon to discover directly by her behaviour how volatile she was, how she was visited by social services every few weeks, how her 2 children were on the at risk register, because of her drinking, how her house had become damaged pre [redacted] and how the children were removed from her care after that night.

I got phone calls from her about [redacted] drinking and alleged drug use, phone calls saying he was fitting badly, having to tell her to call an ambulance, then rushing over to [redacted] in the middle of the night, and following the ambulance into Gloucester. After their frequent fall outs I would get text messages or voice messages saying while [redacted] was with friends in [redacted] he was not safe as they were drug users, and how [redacted] was lying to me. I over heard her kick off on the phone to [redacted] when he was with me one day, for the smallest thing that did not suit her! (He would be back a bit later than planned)

Shortly after her move to [redacted] I refused to have anything more to do with her. In the time they were together, [redacted] trashed [redacted]'s flat twice, and it was always me who sorted it out replacing what was broken! She destroyed cloths and belongings, dumped [redacted] things outside, from where they vanished (including week old new cloths – my birthday gifts to [redacted] Bragged to friends that she had stolen [redacted]'s Money and used his bank card to withdraw cash. She would flip in a instant, raving at [redacted] until he lost his temper, [redacted] showed me on more than one occasion cuts on his head where she had thrown things at him, then she would call the police and have him arrested, dropping false allegations within 48 hours, start calling [redacted] saying "I miss you" "come over" and no matter what she had done off [redacted] went.

She nagged and nagged [redacted] about me being a signature holder on his bank account and why did I deal with his finances, saying [redacted] shouldn't allow me to do that etc until I gave in as I couldn't cope with the flare ups that resulted. I with [redacted]'s consent and impute set up a care plan with Adult Care, arranged to have his medication packs done by the chemist, had my name removed from his account and gave [redacted] back all his payment cards and bank card. [redacted] then refused to sign the care plan, saying he could manage him self, the first benefit day all was well, perhaps he

was going to be responsible at last, but that's where it ended. I believe [REDACTED] was the one driving the decision not to sign the care package.

[REDACTED] had been told by myself and many of his friends, that [REDACTED] was using him, without fail she would end their relationship within a day or two of [REDACTED] receiving his benefits' when her cupboards had been stocked with food, Gas and Electric put on her cards, and anything else she wanted bought. [REDACTED] would end up back at his flat with no food, no gas or electric, often in arrears due to the daily charges, none of his own bills paid so the landline had been cut off which meant there was no emergency help line. [REDACTED] and my self were continually picking up the fall out – [REDACTED] collecting [REDACTED] and/or his belongings and I was buying food, Gas and Electric, to find a few days later he was back with her. [REDACTED] didn't like being on his own which lead to a co-dependant relationship.

There were regular times when [REDACTED] became paranoid; "everyone was out to get him" or the opposite "Everything was great" [REDACTED] could go from the depths of despair to OTT happy in a few minutes. (See funeral tribute)

Every time [REDACTED] moved 3 times I believe, it was [REDACTED] who moved her, provided items needed and decorated if required. When we cleared [REDACTED]'s flat to hand the keys back to Wydean Housing, there were many items missing, Deep Fat fryer, Iron, Pans, Cutlery, Kitchen Utensils, Bedding, Towels, TV, Stereo, most of which I had bought, some quite recently, and cloths!

My ex husband used to say I should let [REDACTED] fend for himself, look at what happened when I eventually did. STABBED IN THE HEART by someone who I believe knew exactly what she was doing! [REDACTED] couldn't manage financially without [REDACTED]'s money; [REDACTED] didn't want bail, "Why" - in prison she doesn't have to meet any financial issues! And very likely has more access to a lot of things as well as being feed kept warm – no responsibilities etc!

[REDACTED] envied [REDACTED] for having a Mum who cared – she would often say in the early days of their relationship to me "I wish I had a Mum like you" perhaps that is a potential reason; I was always there for [REDACTED] whatever. Something she never had! She knows how to play people, I never did understand why [REDACTED] continued to disregard his own needs over her needs, why he always went back, and even he didn't know when I asked him, "what was the hold she had on him" to make him return to her!

I know I didn't always get it right as [REDACTED]'s Mum, I didn't always respond in the best way as he grew and as an adult. I did the best I could, in challenging circumstances with a very difficult emotionally traumatised child, such abandonment so young, was [REDACTED] ever going to be emotionally stable, it didn't matter how much I gave, how much he was loved, I could never erase the damage caused. I am not even sure I made much of a positive difference, but then it was always me he came to for help, he knew although I said "I give up" to him many times, I never could even at the risk of my own wellbeing – I guess that is what Unconditional love for your children means, although I know some would not agree saying the level of giving at your own expense is too much. Would I do it again – probably it's what and part of who I am!

Watched a programme about the death of Amy Winehouse last night, the psychologist mentioned a list of things which indicate the mental health condition of “A Personality Disorder” he said if you ticked 5 of the things mentioned it was a strong indication – I was able to tick more than five for [REDACTED]! Not an excuse, but it could explain a lot! Like Amy he refused to acknowledge he needed help!

