

**CHORLEY AND SOUTH RIBBLE COMMUNITY  
SAFETY PARTNERSHIP**

**DOMESTIC HOMICIDE REVIEW IN THE CASE  
OF 'DAVID'.**

**REVIEW PERIOD**

**JANUARY 2011 – AUGUST 2015**

**OVERVIEW REPORT**

**(Final draft approved by the Panel January 2017 and amended in  
February 2018)**

**Independent Chair of the Panel: Maureen Noble  
Independent Author: John Doyle**

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## 1. Introduction

The Review Panel offers condolences to the family and friends of David and would like to extend thanks to them for their contributions to this review.

### 1.1 Purpose and conduct of the review

Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). This provision came into force on the 13<sup>th</sup> of April 2011. This Act makes it a statutory responsibility for Community Safety Partnerships (CSPs) to complete a Domestic Homicide Review (DHR) when a case meets the criteria set out in the guidance.

Following the publication of the associated Home Office Action Plan in March 2012 (particularly Action 74, which gave a commitment to “review the effectiveness of the statutory guidance on Domestic Homicide Reviews”), guidance on the conduct and completion of DHRs has been updated. It is under this guidance that Chorley and South Ribble Community Safety Partnership commissioned this DHR.

This Review has been completed in accordance with the regulations set out by the Act referred to above, and in line with the revised guidance issued by the Home Office to support the implementation of the Act.

### 1.2 Significant people in this case

David’s family were consulted with regard to an appropriate pseudonym, they requested that David’s own name be used in the final report. The panel chose a pseudonym for the perpetrator and it was agreed that all children should be referred to numerically.

<b>Pseudonym for this report</b>	<b>Ethnicity of the subject</b>	<b>Relationship between the subjects of the review</b>	<b>Age at the time of the incident</b>	<b>Address at the time of the incident</b>
David (own name)	White and British	Victim	51	Address 1
Alex	White and British	Perpetrator	42	Address 1
Child 1	White and British	Oldest Child of ‘Alex’	>18 year	Unknown
Child 2	White and British	Second Child of ‘Alex’	>18 years	Unknown
Child 3	White and British	Child of Alex – Step child of David	<18 years	Address 1
Child 4	White and British	Child of Alex – Step child of David	<18years	Address 1
Child 5	White and British	Child of David and Fran	<18 years	Address 2
Fran	White and British	Ex-Partner of David – Mother of Child 5		Address 2

### **1.3 Incident leading to the DHR**

On a Sunday evening in August 2015 the Lancashire Constabulary received a call from the North West Ambulance Service (NWAS) who were in attendance at Address 1 in Chorley. NWAS attended the address following a report of a deceased male (David) with a wound to his chest. Also present at the scene was Alex, the wife of the deceased, who had called the ambulance. Lancashire Constabulary was directed to an upstairs bedroom where David's body was found on the bed. David was pronounced deceased by the paramedic attending the scene.

A kitchen knife was recovered from the scene. Alex made comments to the Constabulary officers who attended that indicated that she was responsible for David's injuries. Alex was subsequently arrested on suspicion of murder and taken into custody. A Home Office Post Mortem was authorised at which the cause of David's death was established. David died as a result of a stab wound to the heart. Alex was charged with the murder of David and a trial ensued. Alex was found guilty of murder and was sentenced to life imprisonment (see 1.9.1).<sup>1</sup>

### **1.4 Period under Review**

The panel agreed the timeframe of the DHR should cover the period from the 1<sup>st</sup> of January 2011 to the date of the murder in August 2015. This timeframe included some years prior to David and Alex forming their relationship and marrying. The panel judged it was important to understand both David's and Alex's background prior to their relationship.

As is usual in DHRs, authors of reports were also encouraged to submit information that they considered to be important, even if it was out-with the formal scope of the DHR.

### **1.5 Statement of Confidentiality**

The members of the Panel were cognisant of the protocol concerning confidentiality. The submissions made by all participating agencies were confidential and were not for circulation to other agencies or professional's outwith the DHR process.

### **1.6 The conduct of the review and methodology**

The Chorley and South Ribble Community Safety Partnership (CSP) has commissioned this Domestic Homicide Review. The Review has been completed in accordance with the regulations set out by the Act, referred to above, and with the revised guidance issued by the Home Office to support the implementation of the Act.

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<sup>1</sup> Alex sought leave to appeal against her conviction on two occasions. Once in May 2016, which the Court of Appeal refused in November 2016 and again in December 2016, which the Court of Appeal refused in December 2017.

## 1.7 The DHR Panel

Following notification of David's death, the Chorley and South Ribble Community Safety Partnership (CSP) agreed to undertake a Domestic Homicide Review.

A DHR Review Panel was established by the CSP and met on six occasions to oversee the process. The Panel received reports from agencies and dealt with any associated matters such as family engagement, media management and liaison with the Coroner's Office.

The CSP appointed an independent Chair, Maureen Noble, to oversee and direct the Review, in accordance with the Home Office Guidance. The Independent Chair has extensive experience in the field of public protection and community safety and significant experience in conducting Domestic Homicide Reviews and Serious Case Reviews. The Chair had no prior contact with the subjects of this case and had no professional or personal contact with any of the agencies involved in the Review prior to the incident occurring.

In turn, an independent author, John Doyle was appointed to write the overview report. The independent author has extensive experience in public health, health protection and NHS management had no connection with the case or with the agencies involved in the review.

Panel members were appointed based on their seniority within relevant agencies and their ability to direct resources to the review and to oversee implementation of review findings and recommendations. Officers with specialist knowledge in relation to domestic abuse and the needs of vulnerable people were invited to serve on the panel.

<b>Designation</b>	<b>Name</b>	<b>Agency</b>
Chair of the Panel	Maureen Noble	An independent consultant with experience of chairing DHRs and other serious case reviews, multi-agency working groups, and other public protection proceedings.
Head of Early Intervention and Support	Louise Elo	Chorley Borough Council
Service Manager – Independent Domestic and Sexual Violence Manager	Bridget Cheyne	Lancashire West Citizens Advice Bureau and Independent Domestic and Sexual Violence Service
Public Health Specialist	Andrea Smith	Lancashire County Council – Health Equity, Welfare & Partnerships
Associate Director of Nursing (Safeguarding Adults). (Deputy: Specialist Safeguarding Practitioner)	Bridgett Welch (Deputised by Kirsty Byrne)	Lancashire Care NHS Foundation Trust (LCFT)
Review Officer	Garry Fishwick	Lancashire Constabulary

Designated Lead Nurse (Safeguarding Children)	Louise Burton	Chorley & South Ribble Clinical Commissioning Group
General Practitioner and GP Lead for Safeguarding	Dr Linda Whitworth	Chorley & South Ribble Clinical Commissioning Group
Team Manager, Assessment and Safeguarding	Simie Abbott	Lancashire Children's Social Care (CSC) Service
Practice Manager	Barbara Baron	Lancashire Children's Social Care (CSC) Service
Associate Director, Patient Safety and Governance. (Deputies: Safeguarding Adults Specialists – Adults)	Julie Seed (deputised by Vivien Barns and Deborah Sangster)	Lancashire Teaching Hospital NHS Trust
Safeguarding Practitioner and Prevent Training Lead	Andrea Edmondson	North West Ambulance NHS Trust
Community Safety Officer	Heather Corson	South Ribble Borough Council
Chairman	Mark Brooks	ManKind
<b>In attendance</b>		
Author of the report	John Doyle	Independent Practitioner with experience of writing Domestic Homicide Reviews.
Secretarial and Corporate Support Assistant	Alison Stringfellow	Chorley Borough Council

The panel sought representation from a specialist third sector agency specialising in the provision of services and support to men experiencing domestic abuse and violence. The Chair of ManKind joined the Panel and submitted a presentation outlining the issues concerning male victims of domestic and partner abuse and submitted his advice and perspective on this specific case.

There were no conflicts of interest recorded during the Review. The authors of Management Reports and Short Reports were not directly connected to the subjects of the case.

## 1.8 Contributors to the Review

Agency	Nature of the contribution	Completed and submitted by:
Lancashire Constabulary	IMR	The author is a Review Officer with the Lancashire Constabulary. The author has no prior involvement with the subjects concerned and is not the line manager of the staff involved in the investigation, the

		<p>decision making or in the management of the case.</p> <p>The IMR was quality assured and approved by a Detective Chief Inspector in the Lancashire Constabulary.</p>
<b>General Practitioners (Chorley and South Ribble Clinical Commissioning Group)</b>	IMR	<p>The author is a local GP as well as working for the Clinical Commissioning Group (CCG) as GP Lead for Safeguarding. The author is entirely independent of the case and independent of the management of the decision making within the case.</p>
<b>Lancashire Teaching Hospital NHS Trust</b>	IMR	<p>The author of the IMR is a Safeguarding Practitioner based within the Safeguarding Team. The author had no direct involvement with any of the subjects of the Review.</p>
<b>Lancashire Care NHS Foundation Trust</b>	IMR	<p>There were 2 co-authors for LCFT. A Team Leader for Children and Families Service (CFHS) and the Deputy Manager, Crisis Resolution and Home Treatment Team. They had no clinical contact or line management responsibility for the case.</p>
<b>North West Ambulance Service</b>	IMR	<p>The author is a member of staff within the Trust's Quality Directorate and is accountable to the Safeguarding Practice Manager.</p> <p>The author is a State Registered Paramedic, who has worked for the Trust for fifteen years, and had no contact with the subjects of the case.</p>
<b>Lancashire County Council Children's Social Care (CSC)</b>	IMR	<p>The author is a Team Manager within CSC at Lancashire County Council. The author had no direct involvement with the subjects of the case. The IMR was quality assured and approved by a Senior Manager within the Division.</p>
<b>Bolton NHS Foundation Trust</b>	IMR	<p>The author of the IMR is the lead Nurse for Safeguarding within the Trust and had no contact with the subjects of the case.</p>
<b>Gillibrand Primary School</b>	Short report	<p>The Author of the report is the Head-teacher of the School.</p>

<b>NSPCC</b>	Short report	The author of the report is a senior officer from the NSPCC responsible for completing safeguarding, serious case review and domestic homicide review reports to independent Panels.
<b>Lancashire CAB and IDVA service</b>	Advisory	The CAB had no contact with any subject of this case but did provide advice and support in the analysis of submissions.
<b>Salford Royal Hospital NHS Foundation Trust</b>	Short Report	The author of the short report is a member of staff at Salford Royal NHS Trust and is a Named Nurse for Safeguarding. The author had no contact with the subjects of this case.

### 1.8.1 Other sources of information

The review panel invited authors to present their Individual Management Review Reports at a panel meeting held in April 2016. This enabled further questioning and clarification of the information provided. Following this process, a number of agencies submitted revised IMRs.

The panel requested a copy of the judge's summing up in the murder trial. The Panel received this in August 2016 and elements from the summing up have been used to supplement the background information and context for this report.

The panel also received advice and support from ManKind, which is an independent organisation that provides support to men who experience domestic violence and abuse from an intimate partner. An abridged version of the submission made to the panel by ManKind can be found in **Appendix 3**

## 1.9 Parallel Processes

Setting aside the court proceedings, there were no pertinent parallel processes necessary for the Panel to consider.

### 1.9.1 Criminal and Coronial Matters

Alex was arrested and charged with David's murder. Alex denied the charge of murder and submitted a plea of not guilty. Consequently, a trial took place and Alex was found guilty of murder. Alex received a custodial sentence of life imprisonment, to serve no less than 20 years.

The trial was conducted during the proposed timeline of the DHR process; hence the proceedings of the Panel were suspended until the trial was concluded in March 2016. The DHR Panel then resumed its statutory duty but remained cognisant of the process and outcome concerning the leave to

appeal. Alex sought leave to appeal against her conviction on two occasions. Once in May 2016, which the Court of Appeal refused in November 2016 and again in December 2016, which the Court of Appeal refused in December 2017. These processes unavoidably delayed the completion of this overview report. On each occasion that a leave to appeal was made by Alex, the commissioning organisation contacted the Home Office in order to appraise them of the circumstances. The Home Office acknowledged the situation and advised the panel to resume as soon as the appeal process concluded.

## **1.10 The Purpose of a Domestic Homicide Review**

The over-arching purpose of a Domestic Homicide Review (DHR) is to:

- Establish what lessons are to be learned from a domestic homicide, particularly regarding the way in which 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;
- Prevent domestic violence, abuse and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity; and
- Contribute to a better understanding of the nature of domestic violence and abuse; and highlight good practice.

The rationale for the review process is to ensure agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence.

### **1.10.1 The Terms of Reference**

The over-arching purpose of a Domestic Homicide Review (DHR) is to:

- Establish what lessons are to be learned from a domestic homicide, particularly regarding the way in which 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

- Prevent domestic violence, abuse and homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

The Home Office definition of domestic abuse and homicide is employed in this case and this definition is attached to this Report at **Appendix 2**.

### **1.10.2 Specific terms of reference and key lines of enquiry for the DHR in the case of David**

- To establish the circumstances surrounding the homicide of David. Agencies were invited to provide chronological information regarding contacts with David and Alex from January 2011 to the date of the incident in August 2015
- To establish whether David was known as being at risk of domestic abuse by any statutory agency, non-government organisation (including the third sector) or any other individuals
- To establish what actions were taken to safeguard David and whether these were robust and effective
- To establish whether the perpetrator was known and what actions were taken to reduce the risks presented to David and/or others
- To establish whether organisations have appropriate policies and procedures in place to identify, refer and escalate concerns to appropriate safeguarding pathways
- To establish whether there are any lessons to be learned from the case about the way in which professionals and organisations carried out their duties and responsibilities and worked together to safeguard David and manage risks posed by the perpetrator
- To identify clearly what those lessons are, how (and within what timescales) they will be acted upon and what is expected to change as a result through the production of a multi-agency action plan
- To recommend to organisations any appropriate changes to such policies and procedures as may be considered appropriate in the light of this review.

### **1.10.3 Key Lines of Enquiry for the Domestic Homicide Review**

The DHR Panel agreed 8 key lines of enquiry. These are set out, along with the responses, at **Section 4** of this report. A key aspect of the review was to enquire and draw conclusions as to whether agencies recognise and respond appropriately to male victims of domestic abuse.

## 1.11 Equality and Diversity

The review panel were committed to the ethos of equality, openness, and transparency. There was no suspicion of concealment and all factors were thoroughly considered with an objective, open-minded, impartial and independent view. Due regard was paid to confidentiality and the balance of individual rights and the public interest. The review panel sought to involve family, friends and employers to participate in the review and approached this with sensitivity, and respect.

The review panel gave appropriate consideration to any equality and diversity issues in line with the Equality Act 2010 that appeared pertinent to the victim, perpetrator and family members.

David and Alex were not formally categorised (in accordance with the Lancashire County Council Adult Safeguarding Policy) by any agency involved in this Review as a 'vulnerable adult'. However, it was noted by the Panel that whilst subjects may not be 'vulnerable' they could experience 'vulnerability' and it was noted that the Lancashire Constabulary submitted a significant number of PVPs concerning Alex and her immediate family.

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

As a consequence of some reflection – following the consideration of the information shared by Mankind<sup>2</sup> – the Panel considered the possibility that, whilst domestic abuse is a crime primarily committed against women, the public perception of domestic abuse may have made it difficult for David to be easily recognised as a victim of abuse.

## 1.12 Submission and dissemination of the Overview Report

The DHR commenced in October 2015 following the appointment of an independent Chair and independent Author to manage the process of the Review and to compile the report to be approved by the Panel. The initial meeting, which occurred a number of weeks after the death of David, discussed the requirements concerning the establishment of a DHR Panel and then the meeting was adjourned until the full Panel was established.

It became clear that it was unlikely that the process would be completed within the six months timeframe suggested by the Home Office. This was due to the duration of the trial and the subsequent pausing of the DHR process, the complexity of the enquiries that needed to be made with the family and the employer of David and the necessity to engage with a specialist service dedicated to providing support to male victims of domestic abuse.

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<sup>2</sup> ManKind is an independent charity providing, amongst other things, advice and support to male victims of domestic abuse, and attended the Panel to offer advice and support.

Additionally, there was some delay as the Panel sought clarification concerning the impact of Alex submitting an appeal against conviction. The lead officer from Chorley Borough Council notified the Home Office that the Overview Report would be delayed and a revised timetable was agreed with the Panel.

The views and conclusions contained within this overview report are based on findings from both documentary evidence and interview transcripts and have been formed to the best of the Review Panel's knowledge and belief.

## **2. Background information**

David was a respected professional, an active supporter of his local football club and a well-liked member of his local community.

David had been in a relationship and lived with Fran for a number of years and they had a child (Child 5). Fran was clear that David was never violent or abusive to her.

David and Alex made an initial contact via social media, they then met and began to form a relationship. This occurred between April and August 2014. In August 2014 the Lancashire Constabulary reported that Alex had attended the home of Fran and an allegation of damage to the property of Fran by Alex was made and the Constabulary attended to assess the allegation.

In September 2014, David attended his GP reporting that he had pain in one shoulder. David stated that his 'girlfriend had pulled his shoulder'. There was no clear disclosure of domestic violence in the GP notes.

As their relationship developed, there were frequent assaults on David by Alex, although David did not disclose them as such. A neighbour recorded a number of incidents when Alex, after consuming alcohol, was shouting at and berating David. A work colleague who had worked with David for 25 years met Alex in October 2014 and recalled that Alex had threatened staff at the office where David worked, leading the employer to install CCTV.

Work colleagues, who were interviewed by the Constabulary during the investigation, stated that they had, on certain occasions, noticed injuries to David and they recorded that they had noticed some deterioration in his appearance. However, they all recalled that David, after being asked, denied being a victim of abuse. A senior partner in the firm where David worked described an incident when David attended a Child 2tmas party with work colleagues; that David spoke to a woman at the party and, subsequently, Alex assaulted David and poured a drink on him. Despite this, David continued to deny being a victim of abuse.

Colleagues recalled that both prior to and after the wedding of David and Alex (the wedding occurred in June 2015), David appeared with a black eye and "fresh looking injuries".

David told a work colleague that Alex would kill him if he left her and disclosed that Alex had stabbed him and at one point (when David had his arm in a sling from an existing injury) he told a colleague that Alex had pushed him down the stairs and that Alex had hit him on the head with a coffee table

A client of David's – at a meeting in March 2015 – reported that David disclosed that Alex had caused scratches to his face. The client lent his phone to David so that he could call Alex and overheard Alex abusing David. The client expressed concern that Alex may harm David and David replied: "yes, she probably will".

During 2015, David's demeanour and functioning declined to the point where he could not complete his work and in August 2015 (the 4<sup>th</sup>) he was told not to come into work, and issued with a notice that his employment would be terminated. This cessation of employment actually came into effect from the 4<sup>th</sup> of September 2015, less than two weeks after David's death.

David visited his parents with Alex on two occasions prior to the fatal incident occurring. David's parents reported that during one visit, Alex lost her temper and left to return home to Lancashire. David's parents asked him to reconsider the marriage but David stated that he had "made his bed and had to lay in it".

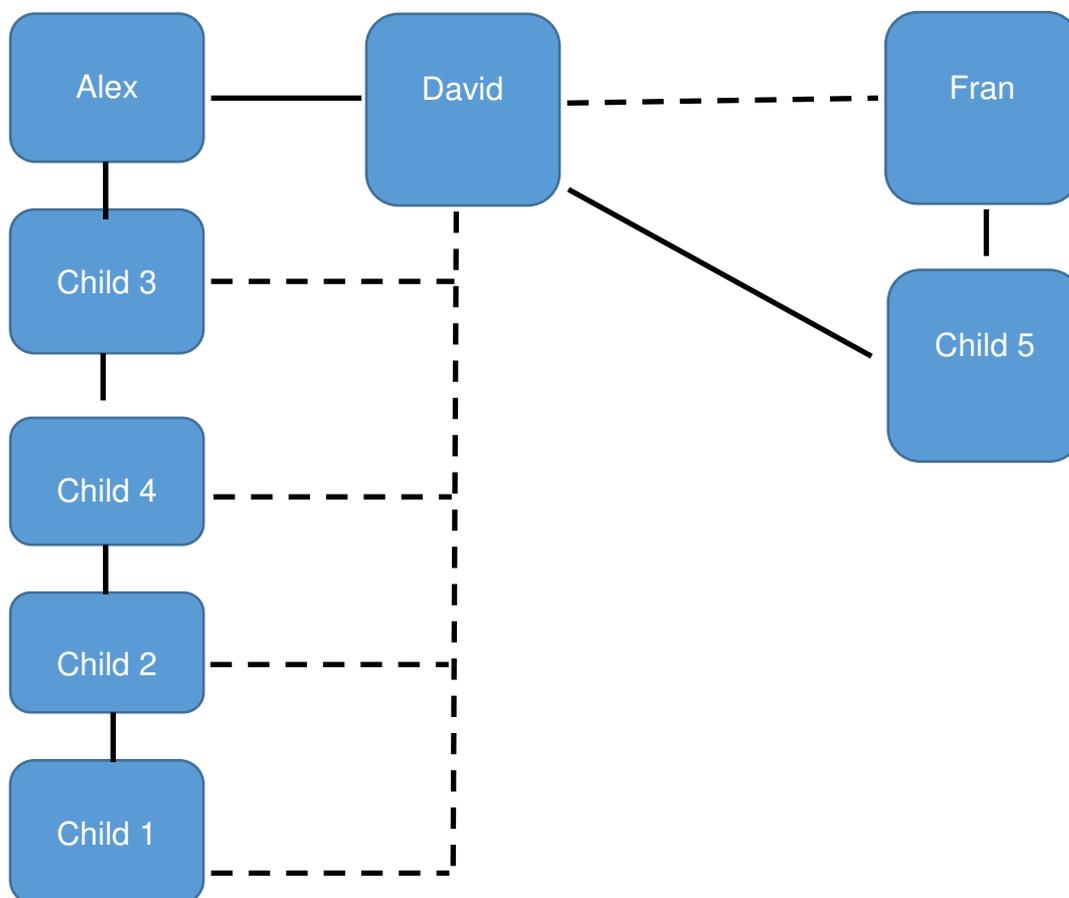
Child 5 stated to Fran that they had seen Alex hit David. Fran regularly collected Child 5 from Address 1 and on one occasion had seen injuries on David and then decided to stop Child 5 from seeing David. Fran said that in a 'phone call prior to the incident occurring, David had been crying, said that his life was hell and that Alex would not allow him to meet Fran and Child 5. Fran said that on one occasion, during a 'phone call, David sounded terrified.

One week prior to the incident, David and Alex had been on holiday. A fellow tourist – who had been staying in the same hotel as David and Alex but was not known to them – returned to the UK and noticed the reports concerning the death of David. They contacted the Constabulary and reported that they had heard shouting and arguing in the hotel between David and Alex. They also reported that Alex threw a drink over David and publicly ridiculed him.

David and Alex visited a public house during the evening prior to the day that the murder took place. The landlord of the public house stated that they saw blood trickling down David's neck and that he had damage to his shin. The injuries were corroborated by a customer in the pub. The landlord noted that Alex was being aggressive but that David declined any assistance. When they left the public house, the landlord noted that David and Alex were arguing and the Constabulary arrived and took them home. It was noted by the Constabulary officers that David had a head injury (as noted by the witness in the public house) but David did not describe how he received the injury.

## 2.1 Family genogram

Set out below is a genogram that describes the relationship between David, Alex, Fran and their respective children.



## 2.2 Involvement of David's family

David's family and the accounts contained within the summing up of the Judge at Alex's trial have provided an insight into David's relationship with Alex and raised a number of key issues that have been considered and summarised by the review panel. David's family and colleagues had met Alex and knew that David was in a relationship with her.

The DHR Panel is particularly indebted to David's parents, whose comments and perspectives are included throughout this report and are set out in detail at Section 2.6

The Review Panel discussed at length whether the children of Alex, David and Fran should be invited to participate in the Review process. Three of the children – Child 5, Child 3 and Child 4 – were below the age of 18 at the time of the incident and two – Child 1 and Child 2 – were over the age of 18 years. David was the biological Father of one of the children, who was of primary school age at the time of the murder. The Panel formed the view that it would not be in the best interests of Child 5 to be interviewed as a part of the DHR

process. The Panel also considered the value of interviewing the children of Alex, taking account of the information submitted by the Constabulary concerning their involvement with the children of Alex both in the period leading up to the incident and their involvement as a part of the investigation. As a result of these considerations the Panel decided that there would be limited value gained from involving the children.

### **2.3 Involvement of the perpetrator**

During the early stages of the Review the Offender Manager overseeing Alex's case was contacted by the commissioning lead for this DHR in order to organise a mutually convenient time to meet the Chair of the Panel. The chair of the panel made contact with the Offender Manager but Alex did not engage with the review process. Alex then sought leave to appeal and the review panel did not interview her.

### **2.4 The perspective of David's parents**

The Panel, noting the advice received from the Lancashire Constabulary, took the decision to contact the parents of David when the trial had finished. Initial contact was made with David's parents via a family liaison officer and David's parents agreed to participate in May 2016. The Independent Author visited David's Parents to receive their views and perspectives on the Review and then engaged in correspondence with them in order to approve the transcription of the meeting. Set out below is the information shared with the Panel that, in turn, helped the Panel to form a fuller picture of David's life, his interests, his work and experiences:

- David was the elder of two sons
- David studied law. Following his graduation and whilst completing his articles of law, David joined the legal department at a local Council and assumed responsibility for a significant proportion of court related work for the Council. David was keen on this element to his work and enjoyed the experience of court procedure.
- David enjoyed criminal litigation in court and became well known and respected by the local Magistracy and by many people living in the town where he practiced law.
- David was approached by a local legal firm and left the Council and commenced work for the local firm as an Assistant Solicitor. In the fullness of time, David became a partner in the firm. In 2014, the firm where David worked was taken over by another law firm. The nature of David's work tended to alter from that time.
- David's relationship with Fran began to breakdown in late 2013/early 2014.

- The relationship with Alex began in the Spring/Summer of 2014. David's parents said that David was besotted by Alex.
- David's parents met Alex perhaps four times and only very briefly. On one occasion, David visited with Alex whilst in the process of purchasing an engagement ring and a wedding ring. David's parents specifically recall advising David not to marry Alex. Their recollection was clear because to take the time to offer such advice was unique for them – they had never before offered such relationship advice to David. David's parents also recall a former colleague at the firm where David worked advising him not to marry Alex.
- David married Alex whilst on holiday in June 2015. David and Alex also had a civil ceremony in the UK. David's parents did not attend the wedding and could not recall being informed that a civil ceremony was being conducted and so did not attend. They could not recall seeing either Alex or David following their marriage in June 2015.
- They knew that Alex and David argued with one another – arguments occurred when they were visiting David's parents. It seemed apparent that Alex could not relate to David's parents. They did not visit David in Chorley from the point when Alex moved into the family home with her children.
- They had no clear idea of precisely what was going on in the latter stages of the relationship between Alex and David – but they did know that something was wrong because they were aware of the incident whereby one of Alex's children called the Constabulary and David denied that any abuse was going on and that his injuries were caused by an accident.
- In the later stages of their relationship, David admitted to his father that there was abuse occurring and that Alex had hit him. David's father was of the view that David, by telling the Police that he had accidentally injured himself, would, in effect, be shielding Alex from the Police.
- David's parents had also heard from Fran that David had been abused by Alex.
- In their words, they never, ever thought that the abuse would reach the point whereby Alex would murder their son.

The chair of the panel also contacted David's brother by letter in order to invite him to participate in the review and offer his perspective on the case but the chair did not receive a reply.

## **2.5 The perspective of Fran**

The Panel, cognisant of the advice received from the Lancashire Constabulary, took the decision to contact Fran when the trial had finished.

The Chair of the Panel invited Fran to participate in the Review in June 2016 and visited her in August 2016. The Chair contacted Fran to confirm that the contents of the transcribed conversation was fair and accurate. The view and perspective of Fran is set out below:

- Fran felt that David was afraid of Alex and that is why he tolerated her abuse and stayed with her. He told Fran on more than one occasion that Alex would kill him if he tried to leave her. Fran was of the view that David was going to leave Alex and that he had told her this. He had become more withdrawn over the 12 months or-so prior to the incident occurring and had begun to drink more heavily. He had always been a bit of a drinker when they were in a relationship but this was often related to the stress of his job. He did socialise quite a lot and this also involved drinking. However, he was never violent or aggressive when he'd had a drink. When he was drinking he did have some falls and injured himself. However, more latterly, he appeared several times with injuries that were definitely not the result of falling over.
- Fran said that David would not be violent towards a woman. He had been well brought up and he still had a very close relationship with his mother whom he would ring often. Fran felt that David's mother knew about the difficulties in his relationship although perhaps not the extent of the violence.
- Fran said that David had once said that he would not be seeing Child 5 again as he loved Alex more than Child 5. Fran said that this was completely out of character as he 'worshipped' their child. Fran spoke to him about this later, she suspected that Alex threatened him in relation to Child 5 but that was never confirmed. Fran had become concerned about their child's wellbeing when Child 5 said that she had seen Alex hitting David and that she had panicked and sent a message to Fran as she didn't know what to do.
- David and Fran had quite a lot of contact in relation to Child 5 so Fran was able to see how David changed over the time that he knew Alex. David told Fran that Alex had made threats to him if he ever thought about leaving her. Alex also made threats to people that he worked with. Fran said Alex was unafraid of being violent and aggressive in front of other people, although Fran did make it clear to Alex that she was not afraid of her.
- Fran had told David that she was not going to let him see Child 5 because of Alex's aggression. She had phoned the NSPCC who had advised her to go to Social Services to protect the child. Social Services informed her that she did not need any sort of court proceedings to keep the child safe and that she had parental responsibility. Fran felt that the NSPCC had provided good advice. Fran didn't have much contact with Social Services after that.

- David had phoned Fran a few weeks before his death saying that he really wanted to see Child 5 and that he was missing them. He said that he wanted to leave Alex but that he was scared she would kill him. Fran said that she wished she had just got him away from Alex but recognised that it wasn't that easy. She said her advice to anyone who was in the same situation as David would be to contact someone, possibly the Police to let them know that they are in danger; or to get help from another agency. Fran felt it was because David was frightened of what Alex would do to him, that he stayed with her. He probably did love her at first but Fran felt that he was desperately unhappy. He told her that he was living in hell.

## **2.6 The perspective of David's Employer**

The DHR Panel invited David's employer to contribute to the Review. A letter was sent to the Head Office of the organisation informing them of the Domestic Homicide Review and inviting the organisation to participate. A representative of the employer contacted the commissioning officer at Chorley Council and declined the invitation to participate in the review. Following a positive conversation, the employer asked for further communication with the Chair and the Chair had a telephone conversation with the employer in June 2016. This conversation concerned the reasons for the completion of the DHR. The employer contacted the commissioning officer in July 2016 and indicated that they had considered participating in the Review but did not wish to be involved. They said that they had participated in the trial and were satisfied that they had discharged their duty to David. They expressed the view that the death of David had affected all of their staff and that they needed to 'move-on'. The Panel acknowledged the Employer's wish not to participate in the Review.

It is not known if the employer has, or had at the time of the homicide, a specific Domestic Abuse Policy for employees and customers or whether this policy was followed by the employer, or any employee working at the company at the time.

The decision of the employer not to participate in the Review encouraged the Panel to consider what support could be offered to employers – of victims and perpetrators – to enable staff to engage at some level with the DHR process. This issue is pursued in more depth later in this report.

## **2.7 Record of Alex's Trial**

The Chair requested a copy of the record of the summing up of the trial to ensure that information regarding David's presentation in the workplace, where many of the injuries and concerns regarding them were raised, was fully represented in the review.

### **3. Abridged chronology of agency contacts and key events**

#### **Events prior to 2011**

According to the summing up of the Trial, Alex first encountered David in his professional capacity. This was a single event some 15 years before the homicide occurred. They met again in 2011, again in a professional capacity.

The panel learned that between 1990 and 2002, David's GP received a number of letters concerning attendances at local A&E services. The Panel were made aware that David was a keen sports fan and was assured that these attendances were very often for sports related injuries and did not pertain to domestic abuse or violence.

In January 2004, there was concern that Alex had been intoxicated whilst in charge of her children. The Father of one of the children informed the Lancashire Constabulary that Alex had threatened one of the children. In June 2004, a child protection conference was held concerning the children of Alex and a child protection plan was implemented and then ceased in October 2004.

In October 2005, the Lancashire Children's Social Care service (referred to in this report as Lancashire CSC) implemented a Child in Need (CiN) plan concerning the children of Alex. This CiN plan ceased in February 2007.

Between 1997 and 2010, the Lancashire Constabulary reported contact with Alex on 15 occasions. These incidents ranged from Alex being warned under the provisions of the Harassment Act<sup>3</sup>, being arrested for common assault and more frequently, Alex being the victim of assault and being threatened by one of her children.

#### **Events in 2011**

In January, Alex was attending regular sessions with a benzodiazepine reduction counsellor, and Alex was recorded as 'vulnerable' by the counsellor but not by the GP.

In February it was recorded that David had an appointment at the fracture clinic at Salford Royal Hospital. This appointment was for a review by the orthopaedic service concerning an operation that had occurred in 2010 to attend to a fracture. The review panel received no information or intelligence to suggest that this fracture was caused by an incident of domestic abuse and the record from the Hospital stated that David had suffered the injury whilst playing football.

In February, Alex was removed from her GP list and attended another GP. At this point the Benzodiazepine counselling service ceased. Alex's alcohol consumption was recorded as 'high'. The Panel noted that this might have

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<sup>3</sup> Protection from Harassment Act 1997

<https://www.legislation.gov.uk/ukpga/1997/40/contents>

been a missed opportunity to undertake a more comprehensive assessment of Alex's health and social care status.

In May, Alex was arrested and charged with common assault when she assaulted Child 3 by pulling their hair, hitting them in the face and grabbing them by the throat. Child 3 was placed with Grand-parents as a safeguarding measure. Alex was convicted of common assault in September 2011 and received a 12 months conditional discharge. The Constabulary submitted a vulnerable child referral concerning the children of Alex and this was shared with Lancashire CSC. Alex's GP recorded that Alex hit her child. Alex's GP referred her to the mental health team. The mental health team saw Alex once and Alex then failed to attend further appointments and was discharged. There was, consequently, no record of any assessment being undertaken to assess the level of Alex's risk to self or others. This was an opportunity to construct a fuller picture of Alex and her family that was missed. Additionally, at this time, there was no record of Alex's GP being invited to Child Protection meetings.

In August, the Constabulary responded to a disturbance at Alex's home address. The Constabulary reported that Alex had taken an overdose and that the North West Ambulance Service (NWS) had transported Alex to hospital.

The children were removed to a place of safety (the home of a relative).

Following a number of missed appointments, in August Alex was discharged from the mental health NHS Trust. The assessment undertaken by the Trust at the initial appointment did not indicate a significant mental health issue but did record difficulties related to alcohol. A discharge plan of care was produced for Alex. This involved Alex contacting the Primary Care Mental Health services for an appointment and a letter was sent to Alex's GP to review her medication and to consider an organic cause for her presentation.

In September, Alex contacted Lancashire Constabulary and reported that there was an on-going domestic incident between one of her children and their partner at the home of Alex. Lancashire Constabulary arrived at the home of Alex and took action to safeguard the children by removing them to the home of a relative. The officers submitted a Protecting Vulnerable People (PVP) Domestic Abuse referral graded as Medium Risk. The information concerning this incident was shared with the Lancashire CSC.

Lancashire CSC received the referral from the Lancashire Constabulary in relation to the incident between Alex's child and their partner. An initial assessment<sup>4</sup> was undertaken and following this, a core assessment was undertaken in October. A strategy discussion was completed on the 12<sup>th</sup> of October 2011 and a Section-47 enquiry on the 17<sup>th</sup> October 2011, which recommended a child protection conference.

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<sup>4</sup> As set out in Working Together to Safeguard Children (2010)

The category under which the children were made subject to a child protection plan was 'emotional abuse'. Information within the chronology submitted by the Lancashire CSC reported that at core group meetings, no safeguarding concerns were raised. It was reported within these meetings that Alex was engaging with professionals and at the 'Review Child Protection Conference' in January 2012, no further incidents had been reported concerning alcohol use, there had been an improvement in Alex's working relationship with professionals and it was a unanimous decision for the child protection plan to cease and to de-escalate to a Child in Need Plan.

The children remained subject to a Child In Need Plan from January 2012 until the case was closed to Children's Social Care in July 2012. It was concluded that positive progress had been made and that there was no requirement for the continued involvement of the Local Authority's Children's Social Care service.

In October it was reported that Alex had assaulted her neighbour. The Constabulary issued a summons to Alex for an offence of common assault.

In December Alex attended an appointment with her GP. Alex said she had experienced anxiety and depression since her teenage years. Alex's GP recorded some concern about Alex's alcohol consumption, which was considered to be in excess of recognised safe limits.

One week before Child 2, David attended a local Emergency Department and reported that he had slipped on ice. It was recorded that he suffered an abrasion to his forehead and a fracture of his nose. There was no record of any disclosure or inquiry to suggest if the injury had been caused by an act of violence or abuse.

### **Events in 2012**

In January 2012, Child 1 (one of Alex's children) went to the home of Alex in breach of their bail conditions. Child 1 punched Alex three times in the face. Child 1 was arrested in a nearby street. Officers from the Constabulary completed the CAADA DASH Risk Identification Checklist Assessment<sup>5</sup>, and submitted a Domestic Abuse referral and graded the incident as High Risk. The Citizens Advice Bureau/Independent Domestic Violence Advocate (CAB/IDVA – a commissioned and combined service) recorded a domestic abuse incident with Alex as the victim and Child 1 as the perpetrator. The case was heard at the Multi Agency Risk Assessment Conference (MARAC).

The panel learned that the mental health service recorded that Alex was not engaging with the mental health services, despite the incidents involving the Constabulary and despite the Lancashire CSC reporting at the MARAC that Alex was exhibiting chaotic and risky behaviour.

In February, Lancashire Constabulary received a telephone call from Child 1 alleging that Alex had attended their house and kicked the door down before

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<sup>5</sup> A tool used to assess risk to victims of domestic abuse

assaulting them by grabbing them around the neck whilst kicking and screaming. Alex was arrested for Common Assault. Constabulary officers completed a Domestic Abuse referral with Child 1 as the victim and Alex as the perpetrator. The referral was graded at Medium Risk. This incident was recorded by the CAB/IDVA service with Child 1 as the victim and Alex as the perpetrator.

In June, following a consultation, Alex's GP made an urgent referral to the mental health team. The referral was categorised as 'urgent' due to the high level of distress expressed by Alex and the GP had concerns regarding self-harm. Alex agreed to another referral to the mental health team. However, due to an administrative error, this was amended to a 'routine response'. When the appointment was made with the community mental health team a couple of weeks following the referral, Alex did not attend but Alex then made contact with the service in July. When Alex attended this appointment, the outcome was that no specific mental health diagnosis was made. Excessive alcohol consumption was noted but Alex declined referral to the alcohol team. Alex subsequently attended one session of counselling and made no further use of the service.

The panel learned that, in July, Child 4 attended the local A&E service with bruising/swelling to the face (specifically, the left eyebrow). Alex attended A&E with Child 4 and the record of the examination stated that the reported cause of the injury was that Child 4 had walked into a lamp-post. There were no safeguarding concerns recorded and nothing in Child 4's record to indicate that any further referrals were made following this attendance.

The GP records submitted to the panel showed that Alex reported drinking 1-2 bottles of wine per day due to the loneliness experienced when her children were away. Whilst it may be considered that this represented an opportunity to escalate concerns about the welfare of Alex and her children, it is important to note that Alex was very specific with regard to the reporting of her consumption of alcohol – Alex clearly stated to her GP that she drank heavily only when her children were away and the Lancashire CSC later reported that Alex would suggest that her seemingly drunken behaviour was a result of her medication and not her alcohol consumption (see reports from 2013 as an example). This contradiction was not at this time clarified by the agencies involved.

Later in July, Alex was referred to the Lancashire Care Foundation NHS Trust (LCFT) RESTART service. Community RESTART works in partnership with people who access the services offered by the LCFT, (including carers), to provide opportunities and community connections for individuals to improve their health and wellbeing. These connections can include: mental health specialists, employment providers, housing services, third sector agencies, sports and arts communities, education providers and environmental agencies. The referral stated that Alex lacked purposeful activity and this affected her mood. Alex had stated that she felt far more positive when she worked. There is a record of some communication between RESTART and the Primary Care Mental Health Team (PCMHT) regarding the recent referral

for Alex that indicates that Alex had been unclear as to what RESTART offered and that contact with her was proving difficult. An opt-in letter was sent and it was reported that if Alex did not engage then she would be discharged from the service. Alex did not contact the RESTART service.

It was noted by the PCMHT that there may have been a repeated pattern of non-engagement by Alex. However, it was noted that Alex called the service in times of crisis and when under the influence of alcohol.

### **Events in 2013**

In March, Lancashire CSC completed an assessment on all of the children living with Alex. The CSC recorded that Alex had said that she did not consume alcohol and it was her medication that affected her speech. It is important to note that Alex's GP had not been consulted by the CSC at this time but the GP held information that would have contradicted the account given by Alex and if the GP had been asked about this matter, they would have confirmed that this was not the case.

In August, Child 1 was due for release from prison following a sentence for an assault on their partner. Probation reports regarded Child 1 as a significant risk to others including their Mother, Alex. An intelligence entry was placed onto the Lancashire Constabulary system along with a PVP file in accordance with Constabulary procedures.

The panel learned that in October, Alex attended an appointment with her GP and had a frank conversation "concerning the frustration with the situation" she was in, i.e. presenting at times of crisis but repeatedly not engaging with services that have been arranged to attempt to help her. The GP made a further referral to the PCMHT and this referral was categorised as routine. The referral alluded to the 'frank conversation' that occurred during the consultation and referred to severe anxiety and depression, panic attacks, a history of overdoses and non-engagement with services. This referral was a routine referral because, in the clinical view of the GP, the risk of harm was not imminent.

Later in October Alex was discharged from the primary community mental health team as she failed to attend any appointments. Consequently, there was no routine assessment of Alex and there was no clinical communication with the referring GP regarding Alex's condition. Whilst it was acknowledged that the referral was routine because the risk of harm was no imminent, LCFT did suggest in their submission that 'low mood' or 'feeling low' may suggest that some follow-up may be required.

In November, Fran attended an appointment with her GP reporting that she was experiencing 'low mood' and that she had suffered 'mental' abuse by her husband and so had moved out of the home.

In December, Lancashire Constabulary attended an incident where Child 1, in breach of their restraining order, had visited the property of Alex. Officers

submitted a PVP referral and completed a DASH risk assessment and this was graded as standard.

### **Events in 2014**

In January the local Multi-Agency Safeguarding Hub (MASH) contacted the school nurse regarding a standard risk PVP being submitted to them by the Lancashire Constabulary (following the incident recorded in December 2013). Following an assessment of the details of the case, no role was identified for the School Nurse at this time. This was, in part, due to the PVP being categorised as 'standard'.

In February, the information concerning the incident in December 2013 (where a PVP and DASH risk assessment were completed) shared with the School Health Service (which is a part of the Lancashire Care Foundation NHS Trust) encouraged the service to contact the Lancashire CSC. The CSC reported that the case concerning the children of Alex was closed to them and that the CSC were not aware of the incident that had occurred in December 2013.

In April, Alex contacted Lancashire Constabulary stating that she was worried about one of her children attending her address. The Constabulary visited Alex to offer re-assurance and submitted a medium risk PVP.

### **It is from April 2014 that David and Alex first made contact with one another via 'social media' and then began to form a relationship**

According to the summing up of the Trial:

“...the relationship really began in the early summer of 2014, apparently, according to Alex, because David sent her a friend request on Facebook, she took it up, there was messaging going on and they finally agreed to meet on the 28th June and David went to the home of Alex and their relationship began there. Very quickly a full relationship developed, which was described by Alex at the Trial as: 'very passionate, very intense and very loving'....”.

In August, Alex went to Fran's home and Fran made an allegation of damage to her property by Alex. Officers from the Lancashire Constabulary attended to look into the allegation. No charges were brought to the case.

In September, David attended his GP with pain in one shoulder stating his 'girlfriend pulled the shoulder'. David did not make any disclosure of domestic abuse but it was clear from the submission made to the panel that the GP did not make any direct enquiries about domestic abuse or domestic violence.

In October David attended the A&E service at Lancashire Teaching Hospitals NHS Trust. David told staff that he had fallen down the stairs. It was found that David had sustained a broken clavicle. The panel were not made aware of any record of any enquiry being made concerning domestic abuse.

In November, David attended Lancashire Teaching Hospital fracture clinic to assess the existing injury to his shoulder and rib. A referral was made to the shoulder clinic and then to the spinal team to investigate a possible hernia of a spinal disc, i.e. to check if the disc was pressing against the spinal cord. The assessment of David's shoulder and rib is recorded in the GP notes but there was no GP record of a disc hernia.

In December, David attended an emergency appointment at the GP Practice and saw the Practice Nurse. David was accompanied by Alex. Alex told the Practice Nurse that David was crying a lot and drinking too much. David was noted as being calm. It is recorded that when Alex left the room David said to the Practice Nurse: "are you surprised why?" Thorough notes of the conversation were kept and the Practice Nurse recommended to David that he re-visit the Practice to see the GP. However, David did not make a follow up appointment.

### **Events in 2015**

Early in January, Alex contacted Lancashire Constabulary to say that one of her children, (Child 2) had assaulted her. The Constabulary attended the address and Child 3 was present and was recorded as being highly agitated stating that they saw Alex bite David and that it was Child 3 who had telephoned Child 2 and asked them to attend the address and pick them up because they were frightened. Alex stated that nothing had happened and that it was Child 2 who had called the Lancashire Constabulary. No allegations were made by any of the parties in the house. Both parties admitted they had been arguing. The officers agreed to transport Child 3 and Child 2 to the address of a close relative, where Child 2 was living at the time of this incident. No injuries were noted and the Lancashire Constabulary made no domestic abuse referral.

Also in early January, Fran contacted the NSPCC National Helpline and engaged in a lengthy consultation with an advisor, primarily about Child 5. Fran stated that she was concerned about the welfare of Child 5 when they stayed with David and Alex. Fran had been to Address 1 to discuss the matter but was verbally abused by Alex. Fran was advised that the Helpline would send the details to the Lancashire CSC and that an assessment would be requested but also stated that the CSC may decide that the issue was a legal matter. The referral to CSC was made as Priority 3 (on-going low level concerns and no current risk identified).

Later in January the primary school attended by Child 5 (the child of David and Fran) received a telephone call from Lancashire CSC concerning Child 5. A call had been received by Lancashire CSC from Fran stating that they were concerned for the welfare of Child 5 (following contact with the NSPCC). The School ensured that both teaching and non-teaching staff who had contact with Child 5 were aware of the situation and could monitor Child 5's attendance and behaviour. No reports of concern regarding Child 5's attendance, concentration or behaviour have been made.

Towards the end of January, Child 3 contacted Lancashire Constabulary stating that Alex and David were arguing, that Alex was hitting David in the face. Child 3 said that they had locked themselves in the bathroom. The Constabulary attended the property and noted injuries to David. He told the Officers that he had "fallen into a door". David denied that anything happened despite Child 3 urging David to say something to the Officers. In the presence of the Officers, Child 3 said to David:

*"Just tell him the truth. She punched you, she wants me out of the house, I know it".*

In February 2015, Alex contacted the Lancashire Constabulary alleging abuse by David and stated that David was keeping her locked in the house. Alex stated that David did this because he was jealous of her past. Alex stated that David had never been violent to her. Alex requested that the Constabulary did not need to attend the address and she had only reported this incident for a log number. However, as reported by the Lancashire Constabulary, this would be a breach of Constabulary protocol and so the Constabulary did attend the address and submitted a PVP. The CAB/IDVA service recorded the receipt of a PVP stating Alex as the victim and David as the perpetrator. LCFT also received a copy of the PVP and noted that this was the 7<sup>th</sup> PVP from the Lancashire Constabulary. This PVP is recorded as medium risk.

According to the summing up of the Trial, on the evening of 20<sup>th</sup> March, David and Alex went to a concert in a town in Greater Manchester. Following an altercation outside a shop about buying alcohol – Alex stated that David wished to buy alcohol and she didn't – Alex stated that she left David drunk, but completely uninjured. It was a half an hour walk back, in the opposite direction to that in which she had just come, in order to get to a taxi rank. Alex stated that when she got there, she borrowed a telephone from a stranger to call David to see what was going on and the phone was answered by somebody, who identified themselves as a paramedic, who told her that David had fallen down, so Alex went back. Alex was argumentative at first, but then went in the ambulance to the hospital, with David.

The paramedic who attended arrived at the scene at about 3.50 AM and the Paramedic stated that David was drunk, and he had a lot of injuries. He had scratches on the back of his neck, he had abrasions on the palms of his hands and on his elbows and knees, he had abrasions on his nose, on his right cheek and his left forehead, which was also swollen and he had bruising behind one of his ears, he also had some old injuries to the back of his head. David was asked by the Paramedic how he sustained the injuries. The Paramedic recorded in their report that David was: "unsure how injuries have occurred". The Paramedic was treating David and then Alex arrived (so far as the paramedic was concerned, a wholly unexpected arrival). The Paramedic reported that Alex was drunk and became verbally aggressive and was asked to leave and when Alex left the ambulance David told the Paramedic, "You see what I have to put up with, see what she's like, she's done this to me", but he immediately said he was joking and, when questioned further, said he did not want to elaborate.

David was transported to the A & E service in Bolton, and when being attended to at the A&E service, David told both the triage nurse and the doctor, whom he saw, that his injuries were due to domestic violence, but he declined any Police involvement and, the panel learned that when he saw one of his professional colleagues the next week, who obviously could see he was injured, he said, "I've hit my head on a cash machine", though, when asked further questions, David was rather vague as to how he had done this.

When David disclosed to the Paramedic staff that he had been subjected to domestic violence, they passed this information to the A&E staff when David was transferred to their care. David stated to the A&E staff that he did not wish the Police to be involved. Nevertheless, David's details were passed on to the local Victim Support service in Bolton. This was in accordance with the protocol of the A&E service.

David did not contact the Victim Support Service, despite the referral, and so the Victim Support service could take no further action.

Following this incident, the Safeguarding Team at LCFT contacted the school health service to advise that, with regard to the domestic violence incident that was reported at the A&E service in Bolton, the Named Nurse for Safeguarding at Bolton Hospital had apparently made a referral to Lancashire Children's Social Care Service to ensure that they were informed of the incident. However, following a review of the CSC information system, no contact record, case note or referral information could be found. The safeguarding nurse at Bolton had, however, contacted the safeguarding nurse at LCFT to share the information with them.

According to the summing up at the Trial, there was a significant body of evidence that, over the early spring and summer months of 2015, there was a gradual deterioration in David's condition and he had visible injuries on him

In April, Alex contacted Lancashire Constabulary to report a domestic incident. The Constabulary record stated that the report from Alex was confused. Alex reported mental abuse by her fiancé, David. She stated that she was being bullied by David to make a complaint about a particular officer. An appointment was made for Alex to see a Constabulary Inspector concerning the complaint. Alex stated that she wished to disclose to the Inspector issues of mental abuse by David against her. Alex stated that she couldn't take it anymore and wished to make a formal DV complaint. She confirmed that she was not at risk of physical harm. It was noted on the incident log that officers should attend double crewed and preferably with a body camera as Alex had previously made allegations against Constabulary officers. Alex later re-contacted the Constabulary and stated that she did not want the Constabulary to attend and did not wish to make a formal complaint. A number of telephone calls and text messages were made to Alex to contact Lancashire Constabulary on "101" to arrange a suitable time for an officer to visit, but Alex did not respond to the contact messages and therefore no visit was made.

In May, Alex was arrested for being drunk and disorderly outside a Public House. A woman made an allegation to staff that she had been assaulted by Alex. A Constabulary Officer attended and as the officer was making enquiries into the incident, Alex became abusive and threatening towards the officer. The officer arrested Alex and had to call for assistance as the officer was alone and was struggling to detain Alex, who was resisting arrest. David was present throughout the incident, and remained passive, not intervening in any way.

In June, a domestic abuse incident was reported at the address of Alex. It was reported that a loud disturbance had been heard and a woman was heard to be crying and stating there had been a family incident. The report submitted by the Constabulary stated that the woman no longer needed the Constabulary to attend and the call was then abandoned. Nevertheless, the Constabulary attended the address. David was present and left the address of his own accord and no allegations were made. Later the same day, Alex re-contacted the Constabulary stating that David had returned to the address and was being threatening. When officers attended, David was sat in a chair drinking alcohol and refused to leave. Consequently, the attending officers took the decision to arrest David so that he could be removed from the situation and in so doing, prevent a Breach of the Peace.

In June 2015 Child 3 made a call to the Lancashire Constabulary and stated that Alex and David were both very drunk and were arguing. The Constabulary attended the property and removed the children to the home of a relative. In this case a PVP was submitted and was graded as medium risk.

Lancashire Children's Social Care Service received a referral from the Constabulary concerning this incident and within this referral there was reference made to the adults arguing in the family home and also that Alex had reported that David had kept her locked in the house.

Fran made contact with the NSPCC national helpline and reported that, prior to flying to Las Vegas to be married, Alex had assaulted David and David had contacted Fran to say that he could not have Child 5 to stay with him. Fran said that during this 'phone call, David was drunk. Fran visited David and stated during her interview with the Chair of the Panel, that he had scratch marks on his face, neck and ear and a black eye. Fran stated that she contacted the parents of David who said: "has she attacked him again?" Fran realised at this point that Alex was the cause of David's injuries.

Fran stated that later in June, in the late evening, Alex attended the home of Fran and began banging on the door and shouting. Fran told her to go away, or the Constabulary would be called.

Later in June, Lancashire CSC received a referral concerning Alex due to concerns about domestic abuse and alcohol use. This referral originated from contact made with the NSPCC, following the conversation the NSPCC had with Fran.

It was not very long afterwards that David and Alex took a trip to Las Vegas. According to the summing up of the trial:

*“On that trip David undoubtedly suffered an injury, first to his eye and then to his face or lip. According to Alex, he got a black eye because he hit himself with the telephone handset by mistake and he split his lip because he fell out of bed and hit himself on a bedside table”.*

In July, Fran made another call to the NSPCC national helpline saying that she had concerns for her child and that she had rung before. She said that her ex-husband (David) had re-married and she was concerned that Alex was violent towards David. Fran expressed concern from what she had heard following a visit made by Child 5 to her father (David) at the address where he lived with Alex (address 1). David and Alex had recently married. Fran expressed concern about David and Alex’s alcohol consumption stating that David was alcoholic and that there was domestic violence occurring in the home and that Alex had assaulted David. Fran stated that she had witnessed scratch marks and bruising on David’s neck and that in mid-June David had sustained two black eyes. Fran reported that David had denied that his injuries were a result of domestic violence.

Fran stated that David’s Mother told Fran that Alex had assaulted David. Fran stated that she had stopped Child 5 from visiting David. Fran also stated that she was concerned about Alex’s younger child (Child 4) who was living at the address with Alex and David.

Later in July a report was made to the School Nurse concerning the incident in June. There is no record that the School Nurse followed this up. It was not entirely clear from the records held by the service whether this was as a result of poor record keeping or deciding, at the time, that the incident did not need to be followed up. According to the submission by LCFT, this should have triggered a follow-up response within 24-hours of receipt but this did not happen. Practice has been reviewed and amended since the time of the homicide and steps have already been taken to ensure that the response following receipt of a PVP is standardised and responded to in a timely manner.

Later in the same month, Lancashire Constabulary received a telephone call from the NSPCC concerning a call they (the NSPCC) had received from Fran. The concern focused upon alcohol consumption and violence. The Constabulary discussed the call with the NSPCC advisor and suggested that the next step would be for the NSPCC to contact the Lancashire CSC. In the view of the Panel, this raises a point concerning how to ensure that information from what may be referred to as “third party agencies”, such as the NSPCC in this case, reaches the Multi-Agency Safeguarding Hub (MASH).

In the second half of July, Fran reported this information to the Head-teacher of the Primary School attended by Child 5 and that she had seen David and that he had been beaten up and the perpetrator was Alex. The school did not

notify any outside agency of this report but relied upon the agencies outside of the School (the CSC, the Constabulary and others) to maintain contact with them (which they did) and managed this incident alongside other notifications they had received. The staff in the school maintained their oversight of Child 5 and were prepared to report any concerns to the Head-teacher.

Following a call to the NSPCC, Fran informed the School that the Constabulary were investigating the issue, particularly with regard to the safety of Child 5 and that the Lancashire CSC had been informed. The Head-teacher of the School asked Fran if she would inform the Constabulary and the CSC to contact the School if they had any concerns or wished to School to take any action. Following a conversation between the DHR Author and the Head-teacher in early July 2016, it was reported by the Head-teacher that no contact was made prior to the School closing for the summer break in July 2015.

At the end of July, David attended the A&E service at Chorley Hospital with a cut to his nose and ear. The record stated that David had been bitten on the nose and ear. There was no record of whether David was asked about how the injuries occurred.

According to the summing up of the trial, Alex said that this visit to the hospital occurred as a result of an injury that David had suffered when he had gone out for a walk:

“.....he came back, having gone out uninjured, with an injury and said he had fallen on a broken bottle. However, the submissions made by the Hospital attended by David stated that David had two separate injuries when he went to the hospital, one was fresh, described as a laceration to his ear and one was an older injury, described by the doctor as a deep bite. David told the doctor that this had been inflicted when he intervened in a fight. What was seen by the medical professionals was the result of two separate events, separated by days”.

The Panel considered that not recording how David acquired these injuries when he attended the A&E service was a missed opportunity.

David had not been in work for some time and in August David's employer decided to contact him to ascertain his circumstances. The employer spoke to Alex who was abusive and obstructive. A colleague of David then called the Police due to their concern for his welfare. The Lancashire Constabulary attended Address 1 and spoke to Alex who informed officers that David could be found at his previous address (a property retained by David for rental purposes). Officers visited this address and found David and he invited the officers into the property. The officers noticed he had a bruise to his right eye. When asked about this, David stated it occurred following an accident when he opened the garage door onto his face. When asked if Alex had caused this injury he denied it and he signed the officers note book to that effect. David said that both he and Alex had gone to David's rented home simply to check on it and that whilst there they had an argument and Alex had left David at the house.

The CAB/IDVA service recorded the receipt of a PVP stating David as the victim and Alex as the perpetrator. The PVP was recorded as a standard risk.

In mid-August LCFT received a PVP concerning David. This was the 4<sup>th</sup> since the beginning of January 2015 and as already noted, it was graded as a standard risk.

David and Alex went on holiday in the middle of August, together with Alex's children. Within 48 hours of returning from holiday, the homicide occurred. Lancashire Constabulary were contacted by NWAS who were in attendance at Address 1. Constabulary officers attended the scene. Alex was present at the address and was arrested on suspicion of murder and the scene was preserved.

#### **4. Overview of service responses to key lines of enquiry and analysis by the panel**

##### **Hindsight bias**

The Panel was acutely aware that hindsight bias can lead to over-estimating how obvious the correct action or decision would have looked at the time and how easy it would have been for an individual to do the “right thing”. It would be unwise not to recognise that a DHR will undoubtedly lend itself to the application of hindsight and that looking back to identify lessons often benefits from such practice. That said, the Panel made every effort to avoid hindsight bias and has viewed the case and its circumstances as it would have been seen by the individuals at the time.

All of the agencies involved in this review provided candid accounts of their involvement in order to identify lessons. The Panel analysed each agency’s involvement on a separate basis. The involvement of each agency covered different periods of time and some of the contacts contained in the IMRs appear to hold more significance than others. This section is constructed in light of this fact.

##### **Responses to the Key Lines of Enquiry**

It is important to note that the responses set out below are determined by the agencies that specifically responded to the line of enquiry described. If an agency (listed elsewhere in this report) had no pertinent or germane comment to make, then no response is offered in this section.

##### **4.1 *Did your agency have information to indicate that David might be a victim of domestic abuse? How did your agency respond to this information?***

###### **Lancashire Constabulary**

Lancashire Constabulary attended a significant number of incidents involving Alex and members of Alex’s family and from June 2015 they had numerous contacts, concerning domestic abuse, with Alex and David.

At an incident in August 2015, when officers found David with facial injuries, a bruise under David’s left eye and a lump at the side of his forehead. When asked about the injuries David said:

“You won’t believe me officer, but I’ve hit myself in the head with the garage door, as I swung the door up it hit me in the head”.

The officer recorded the comment in their pocket note-book. David denied that the injuries had been caused by Alex and stated that the Constabulary would be the first people to call if Alex had assaulted him.

At another incident, when David denied that his injuries had been caused by Alex, the attending officer asked David to sign his notebook to that effect, which David did. The Constabulary attempted, on one occasion, to complete

a DASH Risk Identification Checklist (RIC) with David but he refused to answer the questions in the RIC.

### **Salford Royal NHS Foundation Trust (SRFT)**

The panel sought clarification concerning the nature of David's attendance at the Trust (some years before meeting Alex) and the clinical assessment corresponded accurately with the account offered by David. Consequently, the panel concluded that David had no relevant contact with the Trust that was pertinent to the terms of the reference of the review.

### **North West Ambulance Service (NWAS)**

Within the time-frame of the review, the North West Ambulance Service (NWAS) had one disclosure of domestic abuse during the first contact they had with David. NWAS received a call from a member of the public who had found David on the floor in a public place. David was conscious but had a head injury and once David was on the ambulance and prior to being transported to Hospital he was asked how he had sustained the injuries. David stated that his partner had done it. Alex arrived into the company of the ambulance crew and the crew were subjected to verbally aggressive behaviour from Alex. The ambulance crew did try to further explore the disclosure by asking David to repeat what he had said, simply for the purposes of clarity. David then made light of the comment and stated that he had only been joking. It should be pointed out that this further exploration was undertaken away from Alex but David did not repeat his initial statement. The paramedic in this case did not adhere to the usual protocol and escalate the matter internally (through the NWAS safeguarding structure) because David would not repeat any of the details of his initial statement. Instead, the paramedic informed the staff at A&E that David had alluded to being the victim of abuse.

### **Lancashire Teaching Hospitals**

David attended Chorley and District Hospital on the 30<sup>th</sup> of July 2015 with Alex. Whilst at the Hospital, Alex became agitated and was invited to leave the premises of the Hospital. The records of the Hospital do not show a cause of the injuries David attended with or whether or not any questions were asked by staff to ascertain the cause of the injuries.

There was no mention in the records of the Hospital that suggest that David was subjected to a physical assault, whether domestic or otherwise. Though there was no record, when interviewed by the Trust, the Nurse who attended to David did remember that David provided an explanation for his injuries. He said that he had been subjected to a street assault, the assailant being a client of his. The panel sought clarification concerning the clinical assessment of David's injury and his account of their cause. The Trust confirmed that the account and assessment were consistent and no enquiry concerning domestic abuse or an alert to this effect was made..

### **Bolton NHS Foundation Trust**

David attended the Royal Bolton Hospital A&E department on Saturday the 21<sup>st</sup> of March 2015. David was observed to have superficial grazes to his

face, arm and head and these injuries were of differing ages. The panel were informed that some of these grazes were 'old wounds'. Alex described the reason for attendance as a recent fall at a petrol station, whereby David injured. Alex was recorded as David's next of kin.

The panel learned that information given to the A&E staff in the handover from NWS, included a disclosure by David that he was a victim of domestic abuse and the perpetrator was David's partner, Alex. Bolton Hospital informed the panel that this issue was discussed with David when Alex was elsewhere.

After David's initial observations and examinations were deemed satisfactory, the nurse returned to discuss the injuries with David, again when David was alone. Alex had been asked to leave the A&E Department by security staff due to her becoming aggressive. David disclosed to the nurse that he experienced domestic abuse from his partner.

The panel learned that the Hospital engaged in "much discussion" about the action that David wanted to take. David did agree to a referral for support (this was in accordance with a protocol recently adopted by the Department). This referral was completed by leaving David's name and contact number on a dedicated answer machine at the Victim Support service. This is the agreed pathway for Bolton Hospital Trust to refer patients for support where there is no immediate concern for their safety and concerns are identified outside office hours. David stated to the staff at the A&E department that he did not wish the Police to be involved.

#### **Lancashire Care Foundation NHS Trust (LCFT)**

David did not have any contact with LCFT's mental health services.

The panel learned that the Children and Family Health Service (CFHS) received Protecting Vulnerable People (PVP) reports from Lancashire Constabulary that indicated domestic abuse incidents involving David and Alex. There were five PVP's received by the CFHS and documented within the records of Child 4. In two of the PVP's, David is recorded as the victim and the officers of the Constabulary attending to him noted David as having visible injuries.

The panel learned that the first of these incidents, where David was recorded as the victim, was reported to the Constabulary by Child 3 and this incident was reflected in the records of Child 4. This incident, however, was assessed as not reaching the threshold to be referred to the Multi Agency Safeguarding Hub (MASH).

The CFHS also received two PVP's where Alex was recorded as the victim. One PVP indicated that Child 4 had contacted the Constabulary and was recorded as saying to the Constabulary that they were "fed up with them arguing". This particular incident was, at the time, referred to the Early Support service. However, the panel learned that there was no evidence in the records that any communication occurred between the Early Support Team and CFHS team.

### **Lancashire Children's Social Care Service (CSC)**

The panel learned that the CSC received a domestic abuse notification from the Lancashire Constabulary on the 29<sup>th</sup> of June 2015. The referral raised concerns in respect to David and Alex who resided together and were due to marry. As a part of this referral, it was clear to the CSC that other information had been shared within the Multi-Agency Safeguarding Hub (MASH) and this information indicated that this was the third Constabulary Protecting Vulnerable Person (PVP) alert that concerned David and Alex. The other two PVP alerts noted on this information by the CSC were as follows:

- An incident on the 27 January 2015 made reference to David being the victim of domestic abuse but was reluctant to inform the Constabulary as to how a bloody nose had been sustained.
- An incident on the 3<sup>rd</sup> of February 2015, whereby Alex reported to the Constabulary that David kept her locked inside the house. The Constabulary attended the home but Alex did not want David arrested and would not speak to the Constabulary.

Lancashire Children's Social Care confirmed that there was no reference in their records (referrals or case notes) to indicate that the PVP's dated the 27<sup>th</sup> of January 2015 and the 3<sup>rd</sup> of February 2015 were reported to the CSC prior to the referral dated the 29<sup>th</sup> of June 2015. Following receipt of the June 2015 referral the CSC did commence a Child and Family Assessment.

### **General Practitioner (GP) – for David**

Within the timeframe of the review there were 5 attendances at the practice by David, all of which were in 2014 and 15. David saw 3 different GPs and a practice nurse so will not have been particularly well known to any of the practitioners involved. There was also a record of 4 separate A&E attendances between 2011 and 2015. David did not always attend the same hospital, but because GPs always receive notification of any attendance at A&E, their records include very brief clinical details of each visit.

In September 2014 David attended the practice with shoulder pain. The GP notes stated: "girlfriend pulled shoulder". The panel noted that this may have been an attempt to disclose domestic violence but there was insufficient detail in the notes to know. Three weeks later in October 2014, David attended the A+E service with a fractured clavicle stating that he had "fallen downstairs". David was seen twice in the GP surgery for pain relief shortly after these fractures and there was no challenge by either GP as to the cause of the injury.

In December 2014 David attended the surgery to see a practice nurse with Alex. This was the only time the couple were seen together at the surgery. The notes are thorough and the practice nurse describes a very difficult consultation with Alex "dominating the consultation and making demands". The practice nurse asked David to make a GP appointment to discuss matters further. However, David did not make an appointment with the practice.

David's only other attendance at the surgery was in March 2015 and concerned a medical query entirely unrelated to his previous attendances.

There were, however, two further A&E attendances: one in March (when he did disclose domestic violence to NWS staff and A&E staff) and one at the end of July 2015 at Lancashire Teaching Hospital.

There were no explicit disclosures made directly to either Practice and, consequently, any indicators of abuse that may have been present were not picked up by David's GP practice and so no response was made. The corollary is also accurate – in the view of the panel, the GP practice did not make any routine or targeted enquiries concerning domestic abuse when, given David's presentations and letters from secondary care, they should have considered doing so.

#### **4.2 *What services did your agency offer to David, and were they accessible, appropriate and sympathetic to their needs?***

##### **Lancashire Constabulary**

When the Constabulary attended a domestic incident at the family home in January 2015. Child 3 informed the call taker that Alex had assaulted David. When officers arrived at the scene David denied that he had been assaulted. The officers conducted a visual examination and could not find any injuries on David consistent with an assault. Despite Child 3 informing the call taker that they had seen Alex bite David, Child 3 denied witnessing the assault to the officers when the officers arrived.

The officers safeguarded Child 3 by taking them to another address, because they were frightened. However, the officers did not identify any risk to David from Alex. The incident appeared to be a verbal argument only. At this time Lancashire Constabulary Officers had been informed that there was no necessity to submit a PVP referral for domestic abuse because it related to a verbal argument. This is not the case at the current time, as it is within the policy of Lancashire Constabulary that all domestic incidents, including verbal arguments are subject to a PVP referral. Had a PVP risk assessment been carried out, it is likely that it would have been submitted as a Standard Risk.

Later in January 2015, Child 3 made a 999 emergency call to Lancashire Constabulary reporting that Alex was assaulting David, at their home. Two officers arrived at the scene at 2.07am and were admitted to the house by David who was bleeding from the nose, with a lump and bruising to his face. David told the officers that he had fallen in to a wall.

Child 3 informed the officers that they had witnessed Alex punching David and implored David to tell the truth to the officers that he had been assaulted. David maintained that his injuries were caused when he fell in to a wall. Alex admitted to assaulting David.

The officers arrested Alex for assault. However, neither David nor Child 3 would provide witness statements. This refusal to provide statements was detrimental to obtaining any charging authority from the Crown Prosecution Service (CPS). Due to there being no independent evidence sufficient to support a subsequent charge, the case did not meet the threshold to be

forwarded to the Crown Prosecution Service (CPS) for consideration. Therefore no further action was taken against Alex.

The officers submitted a PVP Domestic Abuse referral at Standard Risk. The DASH risk assessment checklist (RIC) was not completed as David refused to answer the questions.

### **Salford Royal Hospital NHS Foundation Trust (SRFT)**

The panel sought clarification concerning the nature of David's attendance at the Trust (some years before meeting Alex) and the clinical assessment corresponded accurately with the account offered by David. Consequently, the panel concluded that David had no relevant contact with the Trust that was pertinent to the terms of the reference of the review.

### **North West Ambulance Service NHS Trust (NWAS)**

The North West Ambulance Service NHS Trust (NWAS) provided emergency pre-hospital medical care to David following an incident in March 2015 and provided David with transport to hospital. This was the incident when David disclosed to the ambulance crew that he was being subjected to domestic abuse. The Paramedic did not act upon this disclosure in full accordance with the policy of NWAS. The Paramedic shared this information (the disclosure of abuse) with the staff in the A&E service, which was in accordance with the policy of NWAS.

### **Bolton NHS Foundation Trust**

Bolton Hospital provided diagnostic and treatment services to David, to treat the injuries he attended with, in March 2015. The diagnosis taken from observations and the medical history was of a minor head injury and superficial grazes. The discharge notes recorded by the hospital did not indicate that David was considered to be at any risk of immediate harm. The panel noted that this conclusion was drawn from the discharge notes and not from a formal domestic abuse assessment.

### **LCFT**

The Children and Family Health Service (CFHS) were aware, from the PVP reports they received from the Lancashire Constabulary, that David and Alex were using alcohol regularly and that a number of the incidents, involving David and Alex, the Constabulary attended were reported to be characterised by the use of alcohol misuse.

### **Lancashire Children's Social Care (CSC)**

The primary focus of the involvement of Children's Social Care concerned the addressing of any safeguarding concerns regarding the children of Alex. This was undertaken via either a Child Protection Plan or a Child In Need Plan. Support was also focused on Alex as a victim of domestic violence and in addressing the safeguarding risks posed to Alex and Child 3 and Child 4 by Child 1.

Following the Constabulary referral (dated the 29<sup>th</sup> of June 2015), Lancashire CSC commenced an assessment in respect of Child 4, given the concerns in

relation to the domestic abuse between David and Alex. The Social Worker reported that there was a lack of engagement from David during the assessment period due to his work commitments. There was no information recorded to describe what attempts were made to seek engagement from David within this assessment process or to establish flexibility around his work commitments. This resulted in the CSC being unable to identify any specific support needs for David.

#### **General Practitioners (GP) – for David**

David was an infrequent attender at his GP practice. His consultations dealt largely with the physical aspects of his health. On the one occasion when David presented with mental health issues the practice nurse tried to help and asked David to come back to see a GP. However David did not make an appointment.

The panel learned that David's GP did not pick up any indicators of abuse that may have been present when David attended his GP, and the GP did not make any routine or targeted enquiry concerning domestic abuse. This may have been because he was male or because David made no disclosure about domestic abuse at any time but the panel did note that there were indicators of abuse that the GP could have addressed.

#### **4.3 *What information and/or concerns did the victim's family and friends have about victimisation and domestic abuse and what did they do?***

##### **Lancashire Care Foundation NHS Trust (LCFT)**

David did not attend any mental health services provided by LCFT.

The LCFT School health records contain a number of PVP reports that indicate that on one occasion Child 3 and on another occasion Child 4 had reported concerns to the Constabulary regarding domestic abuse between David and Alex. During another incident known to LCFT, Child 3 was documented to have called the Constabulary having witnessed a significant incident where David was the victim of violence from Alex.

##### **Lancashire Children's Social Care Service (CSC)**

The CSC were aware that Child 3 and Child 4 had witnessed "domestic disputes" between David and Alex and they had been spoken to by the Constabulary and by their Social Worker.

The CSC was concerned that David was minimising what had happened. However, the CSC noted that it was difficult to progress matters because David did not wish to pursue or discuss the subject when the Constabulary raised this matter with him. It was noted by the panel that the CSC did not engage with David during their child and family assessment and whilst there may be grounds to conclude that David may well have responded in the same way as he did with the Constabulary, the panel concluded that an effort should have been made.

Direct work was undertaken with Child 4 during different stages of the CSC involvement. This work concerned Child 4's feelings regarding their witnessing domestic disputes and abuse.

Prior to the referral from the Constabulary to the CSC in June 2015, the local authority had no record concerning David or David's family reporting any episodes of victimisation or domestic abuse.

**4.4 *Did your agency have knowledge that indicated that Alex might be a perpetrator of domestic abuse? What actions/services were put in place to address domestic abuse by Alex?***

**Lancashire Constabulary**

Alex was known to the Constabulary owing to historic incidents of domestic abuse and disorder, incidents that pre-dated her relationship with David. In January 2015 – Child 3 informed officers from the Constabulary that they had witnessed Alex punching David and Child 3 implored David to tell the truth to the officers that he had been assaulted. However, David maintained that his injuries were caused when he fell in to a wall and neither David nor Child 3 would provide witness statements and no further action could be taken.

**North West Ambulance Service (NWAS)**

NWAS received a disclosure (from David) in relation to Alex being a perpetrator of domestic abuse. The ambulance crew that provided a service to David did not refer his disclosure into the safeguarding procedure that operated within NWAS at the time. Consequently, no actions could be put into place by NWAS to address the nature of this disclosure. The Paramedic did share the information (the original statement and the retraction) with A&E staff when David was transferred to the A&E service.

**Bolton NHS Foundation Trust**

David disclosed that Alex was a perpetrator of domestic abuse. David shared this information with ambulance staff and with staff in the A&E department. David gave his consent for Bolton Hospital Trust to pass his name onto the Victim Support services. David did not consent to any involvement by the Police. Bolton Hospital telephoned the Victim Support service and, because the call was made outwith usual office hours (this was the early hours of the morning) they left David's details on the Victim Support service answerphone.

**Lancashire Care Foundation NHS Trust (LCFT)**

The Trust was in receipt of a number of PVP's where Alex was recorded as the perpetrator of domestic abuse. The Children and Family Health Service (CFHS) did have knowledge that Alex had previously assaulted one of her children (in May 2011). There was also evidence within both the CFHS and Mental Health records that Alex had bitten a previous partner. Records also indicated that Alex could display aggressive behaviour. This information was reflected within the Child Protection Conference minutes and other related reports received by CFHS.

During the period of the review, CFHS did not offer any services to Alex as a perpetrator of domestic abuse or make referrals to other agencies for support in this regard. This is because it would not be the role of the School Nurse to consider referrals for Alex as a perpetrator of abuse. However, they would have a role in assessing the impact of Alex's behaviour on the children living within the family home (at any time during the scope of this review) and to consider the likelihood of harm and make referrals where appropriate to other agencies. The School Nurses offered support to the children of Alex. This was part of the child protection plan. However, the panel noted that the offer was not accepted by Alex and there was nothing within the CFHS records to indicate that this element of the plan was ever carried out.

Alex was referred on one occasion by her GP to the Single Point of Access (SPoA) and this was deemed as an urgent referral. However, the referral only received a routine response and the panel could find no information to determine how, why or who altered the referral. There was no evidence that the status of the referral was discussed with the referrer. It appears that the referral was placed onto the electronic care record system by administration staff but other sections of the documentation were not completed.

Due to the sporadic contact and the lack of engagement between Alex and mental health services, there was limited opportunity to explore and assess her behaviours, the effect these had on others and to provide further support.

### **Lancashire Children's Social Care**

The involvement of Children's Social Care (CSC) with Alex and her family began in January 2004, prior to the commencement of David's relationship with Alex. Whilst outside the time parameters of this DHR, it is relevant that violence had on occasion been a feature of Alex's relationships with former partners and family members.

In the Core Assessment completed on the 13<sup>th</sup> of October 2011, Alex denied any historic issues with alcohol and advised the CSC that it was her health and medication that had an impact on her presentation. However, her GP had already recorded that this was not the case – it was her alcohol consumption that affected her aggression and mental health needs though this was not shared with CSC at that time.

Information was also presented to the Lancashire CSC (and other agencies) in respect to Alex being both a victim and a perpetrator of domestic abuse from the relationship she had with her children. This may have caused some degree of distraction and/or confusion when agencies, including the CSC, attempted to undertake an assessment of Alex.

Direct work was part of the Child Protection Plan from October 2011 when Alex admitted that she, historically, needed to hit some of her children but not others. The work was tailored around her behaviour and the concerns surrounding her alcohol use and the impact on the children. No direct work was identified to address concerns surrounding the perpetration of domestic abuse.

### **General Practitioners (GP) – for Alex**

The combination of risk factors that often precede incidents of abuse (mental health difficulties, excess alcohol consumption and substance misuse) did not raise concerns and despite frequent descriptions of Alex's behaviour being erratic and aggressive, there were no risk assessments evident in the GP notes regarding 'safety to others'.

Alex was being seen for regular review by a specialised counsellor who saw her at the GP practice. The counsellor was helping her to reduce her long-term misuse of benzodiazepines whilst supporting her psychologically. She had reduced her diazepam use from 30mg to 17mg and was doing well. In January 2011 the counsellor asked the GP to contact Alex urgently as she was expressing suicidal thoughts. When she did not answer the phone the GP made the questionable decision to remove her from the list because there had been a past history of missing appointments. On the 24<sup>th</sup> of February 2011 Alex registered at another GP practice close by. The decision to take her off the list did not take into consideration her vulnerability. One consequence of Alex moving GP practice was that her on-going support from the benzodiazepine counsellor was lost and she relied on GP appointments from then on.

Frequent referrals were made but Alex did not engage with the mental health services. The Panel discussed at length whether it would be practical to review and revise the referral process in view of Alex's vulnerability.

There were multiple records of the GP reporting Alex's erratic and aggressive behaviour. Given the recurrent reports of violent behaviour it is surprising that there is no record at any point of any assessment being undertaken concerning a risk to others. There is no record of enquiry as to who else was resident in the house with Alex and whether they were at risk at any time. In particular, there is no documentation of any awareness of child safeguarding issues, despite the presence of a number of risk factors being present in the family home (alcohol use, mental health problems and aggressive behaviour).

Alex's GP tried on many occasions to refer to other agencies but Alex rarely, if ever, engaged with any of them. Consequently, there was little, if any, feedback from the services referred to and this left the GP in a position of being unsupported and professionally isolated.

#### ***4.5 Was your agency aware of any other safeguarding issues in relation to David or Alex?***

##### **Lancashire Constabulary**

When reports of assault were made to the Lancashire Constabulary, attending officers were aware of a 'Vulnerable' marker placed on the address. On each occasion, the Constabulary, when necessary, would remove children from the home address and take them to stay with a close relative. Officers from the Public Protection Unit would also liaise with the Social Services Duty Officer on such occasions demonstrating that agencies worked together to protect the children involved in any incident.

On the 1<sup>st</sup> of January 2012, Child 1 attended the address of Alex and assaulted Alex. The Lancashire Constabulary attended and completed the ACPO DASH Risk Assessment that was graded as High Risk. Alex stated that she felt in danger from Child 1 and believed that Child 1 could kill her in the future. The case was referred to MARAC and was heard on the 18<sup>th</sup> of January 2012.

### **North West Ambulance Service**

In May 2015 a 999 call was received from a child stating that their Mother (Alex) was 'fitting'. Upon arrival of the ambulance the crew were met by a man who described himself as the patient's fiancé (this was assumed to be David). David stated that the patient was no longer fitting and they did not want an ambulance, the ambulance crew were denied any access to the patient by David. The Panel considered this incident and interviewed the author of the NWAS IMR about the details of this visit. No further details could be ascertained simply because the Paramedics were not allowed to enter the premises and there were no other services contacted concerning this issue so no triangulation of the event could be made.

### **Lancashire Teaching Hospitals**

Following an incident of self-harm in August 2011 (the incident of attempted suicide), Alex was transported to Hospital by NWAS for assessment and treatment.

### **Bolton NHS Foundation Trust**

When any adult attends the A&E service there is a requirement for staff to make routine enquiries about children and any caring responsibilities. David disclosed he had a child (Child 5) who visited him at weekends. The name and date of birth of the child was recorded, along with the school they were attending. This routine practice supports the consideration of any safeguarding issues and to support information sharing.

The Specialist Nurse in the Safeguarding Children Team was informed about the attendance of David at the A&E service. This provided limited information to inform making a decision specifically about any potential risks to Child 5. There was no other information known about previous domestic abuse incidents and no indication that other agencies were working with the family. Consequently, due to the limited information available from one attendance at A&E, the Specialist Nurse telephoned the Safeguarding Nurse in LCFT to share information about the attendance of David. The intention was that this would generate the checking of other information held by LCFT (and other agencies) in relation to the family.

### **Lancashire Care Foundation NHS Trust**

The LCFT records concerning Child 3 indicate that the School Nurse was invited to attend a child protection conference on the 18<sup>th</sup> of October 2011. This conference was called due to Alex's alcohol use and her inability to safeguard her children. The minutes of the conference demonstrated that concerns were focussed on Alex's use of alcohol, the physical assault of Child

3 and the history of the visits by the Lancashire Constabulary to the family home. The Child protection plan was noted with no actions required for the school nurse and the plan was de-escalated to a child in need plan (in January 2012). The School Nurse did however liaise with children's social care to acquire updates on the case, which is also recognised as good practice.

The Panel also noted that the School Health questionnaire for Year 6 and Year 9 pupils includes a standard question regarding whether children "feel safe". This routine enquiry was introduced as part of the core service. These questionnaires were not in place at the time of the case conference in 2011 but the Year 6 questionnaire completed on the 18<sup>th</sup> of March 2014 by Child 5 was secured and the panel were informed that the responses from Child 5 did not indicate any concerns about their feelings of safety.

It was recognised by the Panel that, following Alex's overdose in 2011, a safeguarding assessment should have been undertaken. This was, in the view of the panel, an omission in good practice. If this had been completed, it may have supported the identification of other concerns relating to the use of alcohol, mental health issues and domestic violence in the home.

The panel noted that the primary care mental health team did complete a safeguarding assessment in July 2012 but this assessment (almost 12 months after the overdose) did not identify any concerns. It was noted that staff had asked Alex about safeguarding issues and she had denied that there were any such concerns. This self-report was accepted at face value and not assessed independently by any other practitioner. It may be the case that if a more robust assessment had been completed then this may have escalated concerns and a consideration of a referral to statutory agencies in relation to the safeguarding of children and adults within the household. However, the panel were cognisant that this possibility had to be counter-balanced with the possibility that Alex may not have engaged with any safeguarding plan that may have been put in place.

### **Lancashire Children's Social Care**

The CSC noted that there appeared to be a pattern in the behaviour exhibited by Alex. This was demonstrated by incidents occurring when Alex consumed alcohol, accompanied by a lack of remorse or understanding of the actions or the impact that these incidents had on her children.

There were two short periods of Child Protection Planning. The panel learned that neither plan appeared to have been effective in addressing the underlying issue of Alex's alcohol use and her clear understanding of the concerns raised in respect to the incidents of domestic violence and the impact on her children, despite this being part of the plans.

Children's Social Care did undertake an initial assessment and core assessment following the incident in May 2011. The Children's Social Care service was aware that Alex was subject to bail conditions (following an assault on one of her children), which prohibited her from having any

unsupervised contact with any child under the age of 16 years. By written agreement, contact was supervised by the maternal grandparents.

From a review of the information made available to the panel, it was concluded that had Children's Social Care remained involved with Alex (taking into account that contact between Alex and the CSC had been initiated some years prior to the formal review period of this DHR), there may have been a more detailed consideration of the history of the family, and of Alex's vulnerability in terms of her own emotional needs. All of which may have led to a child protection conference occurring sooner than October 2011.

The panel noted that there was reference within the Initial Child Protection Conference, of Alex having taken an overdose (this information was shared by the Lancashire Teaching Hospital), but there were few supplementary details provided to the conference. The CSC records indicated that Alex was taking prescribed medication for epilepsy and depression but there was no record or any further information in relation to the referral to other services to help manage her mental health. This was an indication that Alex had been referred to appropriate services but had not engaged with them.

In the view of the panel, the duration of the Child Protection Plans was short. The panel considered that there appeared to have been an over optimism by the professionals in attendance regarding Alex's ability to change. For example, reference is made at the review of the Child Protection Conference held on the 9<sup>th</sup> of January 2012 that there hadn't been any further incidents of Alex presenting under the influence of alcohol and there was no evidence to suggest this remained a problem. Given the numerous references made to Alex's alcohol misuse in the chronology shared with the Panel by other agencies, this suggestion appears to be unrealistic. However, the record shows that it was a unanimous decision of the conference to cease the Child Protection Plan.

#### **General Practitioners (GP) – for Alex**

The panel learned that there were no risk assessments evident in the GP record regarding the safety of Alex or others. The fact that Alex may have been a perpetrator of domestic abuse was not explored and there was no questioning as to the safety or welfare of the children in the household.

There was one episode of children's social care involvement in 2011 known about by the practice, but there was no evidence in the record shared with the panel that relevant information was shared by the GP, and this was not in accordance with safeguarding policies and procedures.

In May 2011, Alex told her GP that she had hit her child and a neighbour had called the Lancashire Constabulary. The GP did not contact the Children's Social Care service to ensure they were aware of the reported physical abuse. This is contrary to the local safeguarding children policy. The social worker called the GP in early June to say the children had been placed with a relative but there is no record of any strategy meetings, case conferences,

etc. and no record of the GP sharing any information about Alex's issues, which were almost certainly affecting her parenting capability and capacity.

The panel were of the view that it is important to note that Alex was also a victim of domestic abuse. Her circumstances meant that *at times* she fitted the definition of being vulnerable and at risk.

Alex's vulnerability was not taken into account when she was required to move GP practice in 2011 or when the GP was struggling to access other services for her. In this respect, Alex's lack of engagement with the services she was referred to may be a reflection of other factors that were having an impact on her ability to undertake the usual activities of daily living. Additionally, whilst Alex was never considered as a 'vulnerable adult', it was noted by the Panel that Alex had vulnerabilities at various points in her life and that these vulnerabilities changed over time, occasionally being acute and difficult to manage.

**4.6 *Were there issues in relation to capacity or resources in your agency that had an impact upon the ability to provide services to any of the parties or on your agency's ability to work effectively with other agencies?***

**Lancashire Care Foundation NHS Trust (LCFT)**

During the period covered by this review, there were some school nurse vacancies within the Children and Families Health Services team. However, when there were vacancies, it was noted that this was managed by the service to ensure that the workload was effectively undertaken. There was also active recruitment to posts when a vacancy occurred.

The panel learned that the child protection conference report, written by the School Nurse, did not contain an analysis of the needs of the whole family. This was not in accordance with the Assessment Triangle adopted and promoted by the Trust. The LCFT Conference Template should ensure this is completed and the LCFT Safeguarding Team are planning workshops with the teams to ensure that this occurs.

**Lancashire Children's Social Care**

Support services were made available to Alex and her family, but these were not fully utilised because Alex declined some of the support or attended services with limited commitment and motivation to engage with the service. Consequently, positive change with regard to her alcohol consumption, her understanding of domestic abuse (both as a victim and perpetrator) and the impact this had on her children could not be effected.

**4.7 *Are there any examples of effective practice arising from this case?***

**National Society for the Prevention of Cruelty to Children (NSPCC)**

The panel learned that Fran called the NSPCC helpline and within one hour, a Priority 1 call was made by telephone to Lancashire Constabulary HQ. This

was followed up by email on the afternoon of the same day. All relevant information was shared, including the information about domestic violence shared with the NSPCC by Fran concerning Alex and David. The panel were informed that this exceeded the Helpline Domestic Abuse Protocol, which indicates a priority 2 referral should have been made, i.e. on-going concerns of an elevated nature, but without immediate or current incident. The Helpline Domestic Abuse Policy indicates that a referral should be made regardless of the gender of the victim or the perpetrator. Lancashire Children's Social Care Service was also informed by email on the 6<sup>th</sup> of July 2015 of the concerns expressed in the call, with this decision prioritised at Priority 2.

#### **Lancashire Teaching Hospitals NHS Trust**

The Trust reported to the Panel the specific actions they took to make a referral to Children's Social Care service following Alex's overdose.

#### **Bolton NHS Foundation Trust**

The Trust representative who attended the Panel referred specifically to the routine enquiries and accurate recording of the details of Child 5 when David attended the A&E services in March 2015. The Trust referred to the recognition of domestic abuse of one person being a safeguarding concern for other members of the family. Additionally, the records of the Trust indicated a detailed discussion with David and the phone-call they made to Victim Support with David's consent.

#### **Lancashire Care Foundation NHS Trust**

The panel learned that, following a review of the mental health records, the Primary Care Mental Health Services went beyond standard procedures in an attempt to engage Alex in the service.

#### **Lancashire Children's Social Care**

The chronology highlights examples of effective information sharing between agencies, particularly with the Lancashire Constabulary. Professionals retained a clear focus on safeguarding the children, whilst also considering the risk to Alex.

#### **4.8 *Are there any other issues, not already covered, which the DHR Panel should consider as important learning from the circumstances leading up to this homicide?***

#### **Bolton NHS Foundation Trust**

The representative from the Trust highlighted three key issues and for these are set out below:

##### Cross Boundary issues

There are challenges in gathering information where adults and/or children attend A&E services who are not resident in the District where the hospital is based. In this case, IT systems available did not provide information about the name and contact details of the school nurse for Child 5 and any recent contact David may have had with other health services.

### Safeguarding Children referrals following adult attendances at A&E

Any decision about what action to take when adults attend A&E but children in the family are not seen remains on a case-by-case basis. Making decisions in this case was difficult because there was, understandably, limited information from a single attendance by David to the A&E service and the circumstances of the Child 5 was not known.

### The role of Victim Support

Following the referral made by the Bolton Hospitals NHS Trust, David did not make any contact with the Victim Support service. The Safeguarding Team for Bolton NHS Foundation Trust now actively follow up the referrals they make for residents outside Bolton to determine what, if any, action has been taken.

### **Lancashire Care Foundation NHS Trust**

The panel learned from LCFT that they noted some inconsistencies in the information contained within Protecting Vulnerable People reports regarding previous convictions and incidents, i.e. the reports do not always detail if children were present an/or where the child was at the time of the incident, or if the safeguarding of the children was considered. This concern has been shared with other agencies in the local MASH.

As with other reviews, the panel were mindful that engagement with clients is dependent upon the consent of the individual and their willingness to commit to appointments. Therapy cannot be forced and authority to enforce engagement with mental health services can only be applied when the individual meets the criteria under the Mental Health Act 1983. In the case of Alex, she did not require assessment under the Mental Health Act therefore her sporadic engagement was considered as being determined by choice.

LCFT was aware of evidence of domestic abuse, substance misuse, and an overdose. These factors indicated vulnerabilities within the household where Alex lived. However, staff did not fully consider the impact of these factors in a safeguarding capacity and there was no evidence of a sufficient degree of information gathering and sharing. This finding supports the need for routine and, on occasion, assertive enquiry about domestic abuse by mental health professionals.

### **General Practitioners (GP) – for Alex**

Alex appears to have been caught in a repeating pattern of anxiety and depression, benzodiazepine use, alcohol misuse and domestic abuse and aggression. This pattern appeared to have been one of a short cycle of referral by her GP into the mental health services at crisis point followed by non-engagement with services, a discharge from the service and then back to the beginning. The majority of contacts were with one GP who provided excellent continuity of care and tried their best to deal with a complex situation. Sometimes when dealing with complex patients, it can be difficult to step back and see the full picture and in these circumstances, the patient's "helplessness" can be transferred to the practitioner. The panel concluded that it may have been helpful to discuss this case with other professionals in order to plan a strategy and provide support for the GP, but this was not done.

**Lancashire CSC**

The panel learned that, in a minority of cases, when the CSC received a referral concerning Alex, they had not progressed to the point of an assessment and of those that had, the assessments did not consider the full account of the historical information held by other agencies. Had all of this historical information been considered, there may have been potential for a more robust plan to be devised with multi-agency involvement, clearer expectations and timescales.

## **5 Summary analysis and learning**

### **5.1 The recognition of men as victims of domestic abuse, intimate partner abuse and domestic homicide by others and the acknowledgment by men that they can be victims of domestic abuse and violence**

The Panel discussed the research evidence made available by ManKind that describes that victims of domestic abuse may repeatedly deny that they have been subject to an assault by their partner. The Panel also considered the number and type of injuries reported to have been inflicted upon David towards the end of his life and discussed whether the extent of his injuries, seemingly without him acknowledging he was a victim of abuse, is unique to David or unique to male victims.

The panel emphasised the point that professionals must take in to consideration that men can be victims of domestic abuse by female partners, not assume that the perpetrator is always the male party and consider all options when dealing with all perpetrators of abuse. It seems possible that in this case a professional 'mind-set' may have been fixed in a particular place, i.e. that women are victims of abuse and men aren't, and that the wider picture and wider definition of abuse may have been missed.

### **5.2 The processes and procedures concerning the recognition of and responses to vulnerability and risk**

The panel noted that during the formal review period for this DHR, Lancashire Constabulary submitted 7 PVP submissions concerning either David or Alex. The Panel discussed what may have happened if these PVP incidents had been formally connected and reviewed as each PVP was submitted. LCFT noted that a more robust analysis of the incidents they and other agencies were made aware of should have been undertaken in a multi-agency setting, such as the MASH.

The Panel considered the role of the Lancashire MASH and noted that the Lancashire MASH during the period of this review was a Constabulary only referral system. Consequently, staff from other organisations, such as LCFT, were not able to refer directly into the MASH. The Panel discussed the point that the grading of the domestic abuse incidents per se should not deter professionals from making other safeguarding referrals if they consider that a person has been exposed to a significant level of risk.

Because the MASH procedure is not an "open referral" procedure and so agencies would be required to rely upon their own internal safeguarding procedures in order to complete a robust and thorough analysis of the incidents they were aware of and had responded to. In light of this, it is likely that the vulnerabilities of all the subjects in this case were 'known' to varying degrees but was not known to everyone in contact with the family.

Additionally, taking account of the number of PVP submissions made by the Constabulary, the Panel questioned whether the grading of PVP assessments should be re-examined to take into account historic and escalating incidents of domestic abuse between partners.

Lancashire Constabulary were aware that Alex had a history of excessive alcohol consumption and aggression and they shared this intelligence with a large number of agencies. The Lancashire Constabulary conducted a DASH risk assessment pertaining to Alex and this was graded as 'high risk'. This assessment was referred to MARAC for consideration by all attending agencies. However, it appears that David was not discussed at MARAC and this, in the view of the Panel, underlined the importance of undertaking safeguarding assessments that incorporate all members of the family.

### **5.3 The processes associated with risk assessment and procedures for safeguarding adults, children and families**

The Panel discussed the issue of safeguarding procedures at considerable length and concluded that agency procedures should take account of all the members of the family and that safeguarding actions should accommodate all children and adults. In the view of the panel, it is the case that more should have been known about each member of the family and shared around the safeguarding system. In this way, when considering the position of David in the family, agencies would have been able to assess if David was a risk to the family (it is apparent that he was not) or at risk by being a member of the family (which he clearly was).

The decision to put Alex's children on a Child in Need (CiN) plan was made eight days after a high-risk domestic violence incident and three months after being on a child protection plan. This was not challenged by the attending agencies. The CSC reported that this was a unanimous decision by the members of the Child Protection Panel.

With regard to assessments, the primary care mental health team completed a safeguarding assessment in July 2012. This assessment reflected no concerns. Had an opportunity arisen to undertake a more robust assessment, then this may have escalated concerns and, in turn, the consideration of a referral to other statutory agencies in relation to the safeguarding of children and adults within the household.

The panel noted the concerns expressed by LCFT regarding inconsistencies in the information contained on PVP reports regarding previous convictions and incidents. It is recognised that the reports did not always detail where any children present in the home were at the time of the incident or if the safeguarding of the children was considered.

The panel noted that there were a number of occasions when officers from the Lancashire Constabulary attended the home of Alex and David and submitted a PVP concerning Domestic Abuse and referred this at Standard Risk. However, the panel had learned that, on occasion, there was a domestic

assault witnessed by a child, where David was taking no steps to protect either himself or the child, and therefore it would be more appropriate to set the risk level as medium. Considering this point, the panel discussed the possibility of escalating assessments to a 'high risk' that would, in turn, have triggered a referral to MARAC. However, taking into account David's history, in the view of the panel it is unlikely that David would have co-operated with the MARAC procedure.

Taking account of the details of the subjects of this case, the Panel concluded that professionals should take into consideration the needs of older children who are within households where domestic abuse is perpetrated, and they are witness to or victims of such abuse. The needs of children living in such circumstances (and when these children may appear to be adults) must be taken into account when undertaking safeguarding procedures.

#### **5.4 A lack of engagement with Alex**

Alex was referred to other agencies by her GP but she did not engage with them and this left the GP isolated in the healthcare management of Alex. Additionally, the Panel examined Alex's pattern of engagement and disengagement with the services referred to and it was apparent that further analysis and an understanding of the risks to others was not vigorously pursued. For example, the panel noted that there was no indication in the record that the GP was contacted to discuss their referral of Alex to a number of services. In the view of the Panel, the loop of communication between primary and secondary care and between primary care providers needs to be strengthened.

The panel learned that, at times, Alex minimised the concerns of professionals and demonstrated limited commitment to addressing these issues. The CSC informed the panel that Alex disguised her compliance with the plans developed by the CSC. For example, it was noted that although Alex was said to be complying with support from Discover (the local alcohol service), there remained concerns regarding her denial of alcohol use. It was apparent to the Panel that when Discover was asked if they had provided a service to Alex, they confirmed that they had no contact with Alex at any time. In this case, it seems that Alex's assertion that she was engaging and was addressing her issues was taken at face value.

#### **5.5 Sharing practice and knowledge**

LCFT had contact with Alex and with the children of Alex during the same time period that the GPs, the Lancashire Constabulary and the Lancashire CSC had contact with Alex and her children. Significant details were shared between certain agencies as incidents were reported and managed but, in the view of the Panel, the entirety of the information (both historical and contemporary) was not held by one single agency.

The Panel noted that Alex reported frequent episodes of erratic and aggressive behaviour to her GP, and within the same period of time the

Constabulary attended the address of Alex on a number of occasions to respond to incidents of assault by Alex and against Alex. During this time, the Constabulary completed a DASH risk assessment but it seems that no other agency completed an assessment of “risk to others” and consequently there was no enquiry about the safety of the children in the household.

Taking account of all the information received, the Panel discussed the possibility that a number of the agencies involved did not on each and every occasion apply locally agreed multi-agency safeguarding policies and procedures.

## **5.6 Concerted professional inquiry**

David attended a number of different Hospitals for treatment to his injuries and each Hospital has its own unique patient record system. Information can and often is shared between Trusts (as it was in this case) but it was not clear which, if any, of the Trusts David attended would have assumed responsibility for escalating any particular concern they may have had about an injury David presented with, particularly if the injury David presented with did not generate a suspicion of domestic violence, a difficulty that would be pronounced if the explanation of the injury was perfectly plausible.

On one particular occasion noted by the panel, David visited a local hospital as a result of an injury that David had suffered when he had gone out for a walk. The summing up of the trial noted that David:

“.....came back home, having gone out uninjured, with an injury and said he had fallen on a broken bottle. However, the submissions made by the Hospital attended by David stated that David had two separate injuries when he went to the hospital, one was fresh, described as a laceration to his ear and one was an older injury, described by the doctor as a deep bite. David told the doctor that this had been inflicted when he intervened in a fight. What was seen by the medical professionals was the result of two separate events, separated by days”.

The Panel considered that not recording how David acquired these injuries when he attended the A&E service was a missed opportunity. The panel considered that there was a lack of routine and targeted enquiry by the professionals involved and that this was not in accordance with the guidance contained within NICE guidance PH50<sup>6</sup>. The panel learned that the majority of the A&E letters received by general practices can be filed straight into the patient’s record with no other action necessary but in rare circumstances the GP will arrange some follow up. There are no set “rules” for when GPs arrange a follow-up appointment with a patient following the attendance of the patient at A&E. However, in the view of the panel, given the specific mention of domestic violence in the A&E letter from the attendance in March 2015 it would have been good practice to arrange an appointment to assess risks to David and others in the household. This did not happen in this case.

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<sup>6</sup> National Institute for Health and Clinical Excellence, Public Health 50 (Domestic Violence and abuse: multi-agency working); February 2014.

The panel also noted that David attended his GP for a follow up assessment concerning a shoulder injury and David stated that his “girlfriend had pulled the shoulder”. The panel were informed by the GP that there was insufficient detail in the notes to know if this was an explicit disclosure of abuse. However, guidance from the RCGP is important to consider here<sup>7</sup>, and the panel would suggest that disclosures such as this are ‘flagged’ on patient notes.

Coupled with this, the panel learned that when correspondence arrives at a GP practice, important details are extracted from the letter and “Read coded”. This means that any important information is highlighted in the patient’s summary and can be quickly and easily seen by professionals in the future. In this case the injuries to David were coded (e.g. “fractured clavicle”) but the “domestic violence” clearly stated in the A+E letter from March 2015 was not coded and so not placed on the summary record. Once the letter is filed away, this information is therefore “lost” unless someone specifically looks through all the past letters.

### **5.7 What may prevent friends, and colleagues reporting concerns about abuse?**

The Panel noted that there were a number of separate incidents of abuse and/or manifestations of violence during 2014 and 2015 that were described by family, friends and co-workers. The question discussed at length by the Panel concerned why these incidents and the individuals who described them did not express their concerns and worries to the necessary authorities in a more forthright manner. The panel did consider that with crimes other than domestic abuse, people demonstrate a reticence to “become involved” because they are afraid of, amongst other things, retribution – and there is no reason why this logic would not apply when the crime happens to be domestic abuse. Where the threshold for public intervention might be remains a point of discussion.

The Panel recognised that high risk domestic abuse can be missed if each incident is considered entirely in isolation. It is only when the cumulative incidents are pieced together that a comprehensive picture can emerge of sustained emotional and physical abuse, or at least a suspicion of it. If the violence or threat to life is not overt, the public (including friends and colleagues) may be reluctant to intervene.

### **5.8 Male victims of domestic abuse may fail to recognise abuse and/or minimise its impact**

Whether David ever genuinely acknowledged himself as a victim of domestic abuse and violence is unknown. Closer to the point of the homicide, David certainly disclosed domestic abuse to colleagues, close friends or relatives.

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<sup>7</sup> [www.rcgp.org.uk/clinical-and-research/clinical-resources/domestic-violence.aspx](http://www.rcgp.org.uk/clinical-and-research/clinical-resources/domestic-violence.aspx)

Working with ManKind, the Panel considered that when men are abusive towards a partner, consideration is given to what social and cultural views might reinforce his abusive behaviour. However, a woman's use of violence does not always receive the same type of scrutiny. The Panel wished to explore whether the reversal of the usual circumstances concerning domestic and partner abuse, presented some form of barrier for David, his friends and professional colleagues in reporting their concerns about abuse. The Panel considered whether the gender of Alex was perhaps seen as a modifying factor that obscured the judgement of others to decide whether to intervene or not or whether to intervene more vigorously than they did.

## 6. Lessons learnt

It is clear when reviewing all the information received from agencies and others that David was subjected to on-going domestic abuse by Alex. David suffered experienced numerous injuries which, although he never reported these to professionals as being inflicted by Alex, there appears to be little doubt that this was the case. There was also a significant element of coercion and control such as Alex not allowing David to have a mobile telephone and controlling access to his child from a previous relationship. The violence and coercion appeared to intensify as the relationship between David and Alex continued and more-so when David received notification that his employment was being ended.

The Panel noted Alex's use of alcohol and misuse of prescription drugs, amongst other risk factors including her presentations with mental health issues. These risk factors may have increased David's risk of being subjected to violence and abuse. David also drank excessively at times, again this appears to have been a factor in his vulnerability to abuse.

Although the review is unable to say why David did not recognise or disclose that he was a victim of domestic abuse, the Panel concludes that David's objectivity concerning his own situation was compromised. The panel received information from The ManKind Initiative illustrating that male victims of domestic abuse often have difficulty accepting that they are being abused and this has an impact on their ability to seek help and support.

The review has reached the following conclusions, which are grouped into themes, against which a number of recommendations are made.

### 6.1 Conclusion 1 – male victims of domestic abuse

Data from the British Crime Survey highlights the level of under reporting by male victims of domestic abuse, with male victims being three times more likely **not to** report domestic abuse than their female counterparts<sup>8</sup>.

The Panel recognised that the cumulative impact of high risk incidents is often not recognised if each incident is considered in isolation. It is only when the cumulative incidents are pieced together that the picture emerges of sustained abuse and increasing risk.

Whether David ever genuinely acknowledged himself as being a victim of domestic abuse is unknown. Though he certainly disclosed domestic abuse to colleagues and friends. It is known that Fran suggested that David leave the relationship with Alex for his own protection, but he refused and said he wanted to stay – suggesting, at various points, that despite wanting to stay, David was in fear of Alex.

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<sup>8</sup> British Crime Survey 2015

In addition, the information from ManKind indicated that that many men often feel embarrassed to acknowledge and disclose that they are being abused. Some suffer domestic abuse in silence because they are afraid that no one will believe them or take them seriously. Some believe that they will be mocked or ridiculed.

Traditional gender assumptions may contribute to male victims being reluctant to come forward. Generalisations such as '*men are aggressive*' and '*women are passive*' effectively undermine the complexity of gender and remain a common feature within the conventions of wider society<sup>9</sup>. When men are abusive towards a partner, we ask what societal views reinforce his beliefs and abusive behaviour. However, a woman's use of violence does not receive the same societal scrutiny<sup>10</sup>.

The Panel considered whether gender was in some way a modifying factor that may have obscured the judgement of those who knew that David was a victim of domestic abuse and had an effect on whether to intervene or not. With the number of women convicted of perpetrating domestic abuse in the UK quadrupling over recent years, David's death has highlighted the need for greater public awareness of female on male violence, the different forms of domestic abuse and the signs and symptoms of coercive control, particularly pertaining to male victims.

David was a male victim of domestic violence and homicide during a time when specialist support services for men were and proportionately still are fewer than services for women. The review learned that many agencies are only just beginning to actively recognise domestic abuse towards men (by their female partners) as a problem.

This review has identified that more could be done to raise awareness of the need for services for male victims. It would certainly be beneficial to increase public awareness of domestic abuse against men, and this awareness and education (for the public and for victims) should be coupled with the development of a 'whole system' response to encourage reporting and to encourage the development of appropriate services that are able to differentiate between the different types of abuse.

The Panel noted the figures (from the British Crime Survey, the Crime Survey for England and Wales, the Office for National Statistics and others) and the value they offer, but also noted that these figures do not take into account the extremely complex nature of domestic abuse or the context of violence and abuse within the relationship. Appropriate services should therefore be tailored to the needs of individuals, rather than generic 'domestic abuse' services.

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<sup>9</sup> Eckert & McConnell-Ginet, 2003, p.47

<sup>10</sup> A book about the Freedom Programme 'Living with a Dominator' – Pat Craven

## **6.2 Conclusion 2 – disclosure to friends, colleagues and family**

The Panel were informed, through a number of sources, that there were several separate incidents of abuse that were either witnessed by members of Alex's family, or told to friends and co-workers of David by David himself. Knowledge of this led the Panel to discuss two themes that may be common in many DHR processes: why David's family, friends and/or employers did not feel empowered or able to contact agencies or report their concerns for David and why did David deny that Alex was assaulting him?

The Panel considered the apprehensiveness of individuals to intervene or get involved in what they may have considered a private matter. There are, of course, many reasons why people do not call the Police when they witness any crime, including the belief that the incident may not warrant Police intervention, the fear of making the situation worse and the fear of repercussions by the person reporting the incident.

The Panel cannot speculate on why family, friends and particularly work colleagues did not report the incidents of abuse that either David alluded to in conversation with them or they suspected following an observation of injuries that David could not hide.

There appears to have been a belief that David would deny that any abuse had occurred if anyone engaged him in conversation about the injuries he had sustained. In this respect David appeared to be protective of Alex, though not consciously so.

When the Lancashire Constabulary interviewed friends, colleagues and others as part of the criminal investigation, some were able to clearly recall specific incidents. This might suggest that there are some barriers to reporting abuse at the time the abuse occurs.

The Panel considered whether it may be the case that if a professional (for example, a police officer, a medical professional, a social care professional) had undertaken a routine and targeted enquiry with a witness about a particular incident then the witness may have found it easier to share their concerns. The rationale for this assertion is that the witness may, for want of a better term, be given permission by the aforementioned professional to share their worries and concerns.

## **6.3 Conclusion 3 – the effect of domestic abuse on children**

There were missed opportunities by Children's Social Care Services, and by the NHS to safeguard the children in this case.

The impact of adult violence upon children was not considered until a landmark case<sup>11</sup> in 2000 provided evidence of the detrimental impact and consequences that domestic abuse can have on children. A number of

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<sup>11</sup> Re L; Re V; Re M; Re H (2002) Family Law Review 334 (Re LVMH)

studies followed which provided evidence regarding the co-occurrence of child abuse and adult domestic violence and the psychological, behavioural and emotional effects that living with domestic abuse can have on children<sup>12</sup>.

The cumulative evidence of co-occurrence was recognised in new legislation in 2001 when the impact of *seeing or hearing* domestic violence was added as an amendment to the definition of harm in Section 120 of the Children and Adoption Act 2002. ACPO Guidance published in 2005<sup>13</sup> also recommended automatic screening for domestic violence in all child abuse cases, and vice versa.

Since the implementation of the Domestic Violence, Crime and Victims Act in 2004, serious offences (for example, where children or young people are present, or where there is considerable violence, or where there is the real and continuing threat to the victim or children), can still be prosecuted by the Crown Prosecution Service (CPS) in the public interest, even if the victim says that they do not wish to press charges or ask for charges to be dropped.

The implementation of 'Working Together to Safeguard Children'<sup>14</sup> now guides Professionals to consider the impact of prolonged or regular exposure of children to domestic abuse. With children being directly abused in over 50% of known domestic violence households<sup>15</sup>, this case highlights that no agency or service provider for children should become complacent about overcoming the challenges of safeguarding children exposed to adult violence and abuse.

Although the Child Protection Information System (CP-IS, introduced in 2013-14) and the recommendations resulting from other Domestic Homicide Reviews will go some way to improving how professionals respond to the co-occurrence of domestic abuse and child abuse in the same families, the Panel noted that child protection information systems (whether CP-IS or others) is only effective for children identified as 'at risk' or subject to a child protection plan.

#### **6.4 Conclusion 4 – female perpetrators of domestic violence**

In much the same way as male victims are under-represented, the same can be said for female perpetrators who fall into a similar minority subgroup in relation to the availability of services.

It appears that Alex was not clearly identified or acknowledged as a

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<sup>12</sup> Brandon, M. and Lewis, A. (1996) 'Significant harm and children's experiences of domestic violence'; Child and Family Social Work 33-42; Hester, M., Pearson, C. and Harwin, N. (1998) Making an Impact: Children and Domestic Violence: A Reader (London: Barnardo's/Department of Health); McGee, S. (1997) 'Children's experiences of domestic violence,' Child and Family Social Work 13-23

<sup>13</sup> ACPO Guidance 2005: Identifying, Assessing and Managing Risk In the context of Policing Domestic Violence

<sup>14</sup> [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/419595/Working\\_Together\\_to\\_Safeguard\\_Children.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf)

<sup>15</sup> NSPCC (1997) found a 55% overlap; Farmer & Owen (1995) found a 52% overlap

perpetrator of domestic abuse. Therefore, she was never offered the opportunity to access specialist support, such as, for example, a perpetrator treatment programme. However, it must also be acknowledged that Alex did not engage with the services offered to her and it is also important to note that Alex was also the victim of domestic violence in a previous relationship.

Professionals need to possess the skills, knowledge and open-mindedness to clearly identify the context of female violence, and whether it is used in frustration, self-defence, or as a means of control and abuse or as a desperate act. For both male and female offenders, the context of the violence within the relationship remains crucial to how services should respond.

The Panel cannot speculate as to why Alex's notes were not flagged with a READ<sup>16</sup> code or summary sheet and brought to the attention of her GP when she changed practices. If Alex's history of violence had been more clearly identifiable in the case note summary, it is possible that her treatment plan may have differed but the Panel could not form a strong position on this point.

A summary of notes by clinicians would be more likely to pick up and highlight relevant important information. However, this would require a major investment of clinicians' time and may not be feasible due to the financial costs and the demands on clinician time.

It is clear that Alex had a long history of violence that was well documented within records retained by certain statutory agencies, particularly the Lancashire Constabulary. However, this does not translate into Alex's history of aggression '*being known*'. The information was undoubtedly available but individual professionals did not always 'make the link' with historic records and/or, in this specific case, understand the dynamics of abusive behaviour. There appears to have been a culture of responding to the presenting issue and this approach may have prevented agencies from understanding and assessing the collective risk that Alex presented to her children and her partners.

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<sup>16</sup> READ codes are a coded thesaurus of clinical terms and have been used in the NHS since 1985. READ codes are a standard vocabulary for clinicians to record patient findings and procedures across primary and secondary care.

## **7. Recommendations from the Review**

The Panel would make the following recommendations:

### **Recommendation 1**

*The Chair of the Community Safety Partnership should take local action to strengthen awareness raising opportunities for the safe disclosure, assessment and necessary interventions to protect and safeguard male victims of domestic abuse.*

### **Recommendation 2**

*The CSP should be assured that professionals across the local agencies have access to training specifically in relation to male victims of domestic abuse.*

### **Recommendation 3**

*The Community Safety Partnership should be assured that local policy and practice in relation to safeguarding children also includes the impact of hidden and overt domestic abuse*

*Associated with this recommendation, the DHR Panel would welcome a review of safeguarding procedures to ensure that the assessment processes for the safeguarding of children and of adults captures the members of the whole family.*

### **Recommendation 4**

*The Community Safety Partnership should be assured that the CCG have considered the validity of screening for and recording disclosures of domestic abuse and recording these incidents by the application of an 'Aggressive Behaviour READ Code' and a summary on the patients record. This may be achieved via the General Medical Services (GMS) Contract Quality and Outcomes Framework (QOF)*

*Additionally, the recording of domestic abuse disclosures in primary care settings should be monitored and compliance with NICE and RCGP guidance should be quality assured.*

### **Recommendation 5**

*The Community Safety Partnership should develop specific information campaigns and support services for families, friends and colleagues of male victims of domestic abuse. This should include guidance that clearly describes the signposts to relevant and appropriate services.*

### **Recommendation 6**

*The Community Safety Partnership should correspond with NHS England requesting that they review the domestic abuse risk assessment tools that are applied in A&E settings and consider adopting an abridged Risk Identification Checklist (RIC) assessment to be provided in A&E settings.*

## **APPENDIX 1**

### **Glossary of Terms**

A&E – Accident and Emergency Service  
AAFDA – Advocacy After Fatal Domestic Abuse  
CBT – Cognitive Behavioural Therapy  
CAF – Common Assessment Framework  
C&F assessment – Children and Families Assessment  
CMHT – Community Mental Health Team  
CSC – Children Social Care (Services)  
CSP – Community Safety Partnership  
DASH – Domestic Abuse, Stalking and Honour Based Violence risk identification tool  
DHR – Domestic Homicide Reviews  
GP – General Practice  
IDVA – Independent Domestic Violence Advocate  
IMRs – Individual Management Reviews  
LCFT – Lancashire Care Foundation NHS Trust  
MARAC – Multi Agency Risk Assessment Conference  
MASH – Multi-Agency Safeguarding Hub  
NWS – North West Ambulance Service  
PPU – Public Protection Unit  
PVP – Protecting Vulnerable People  
RIC – Risk Identification Checklist  
S47 – Section 47 of the Children Act 1989  
SPoA – Single Point of Access

## APPENDIX 2

### The Home Office Definition of Domestic Violence

In March 2013, the Government introduced a new cross-government definition of domestic violence and abuse, which is designed to ensure a common approach to tackling domestic violence and abuse by different agencies. The new definition states that domestic violence and abuse 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
- physical
- sexual
- financial
- emotional

“Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent 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 is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.”

This definition, which is not a legal 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.

A member of the same household is defined in Section 5 (4) of the Domestic Violence, Crime and Victims Act (2004) as:

- a. a person is to be regarded as a “member” of a particular household, even if he does not live in that household, if he visits it so often and for such periods of time that it is reasonable to regard him as a member of it;
- b. Where a victim lived in different households at different time, “the same household as the victim” refers to the household in which the victim was living at the time of the act that caused the victim’s death.

## Appendix 3

### Submission by ManKind and published research concerning male victims of domestic violence and abuse.

- National charity set up by women and men and run by women and men.
- Three staff and seven volunteers (more women than men)
- Based in Taunton providing:
  - Direct services (helpline)
  - Advocacy through training (new one day course) and presentations
  - Oak Book
  - National Conference
  - Produced #violenceisviolence video: 15m+ hits  
<https://www.youtube.com/watch?v=u3PgH86OyEM>

### Statistics

- 500,000 men are victims of partner abuse every year (one in three)
- 19 Men and 81 women were killed by (ex) partner
- 89,000 men report as victims every year to Constabulary
- In Lancashire: 4,817 (2015) and 6,003 (2014) men report
- 5,000 women are prosecuted every year for domestic abuse
- 60% of male victims do not recognise they're a victim
- Male victims tend to be younger, rent, childless and unmarried

### Who do men tell?

	Male	Female
Tell anyone	61%	88%
Personal	55%	80%
In Authority	23%	43%
Constabulary	10%	26%
Health	11%	23%
Council	0%	1%
Other Government	6%	9%

### Helpline Trends

- 90% call and need emotional support
- 66% men suffer psychological abuse
- 66% men suffer violence
- 66% of men have children
- 80% of men who call have never told anyone

- 50% of those who say would only call if anonymous

### **Male Specific Barriers**

There are four specific different barriers that men face, which are generally on the whole different to female victims

- (1) The Male Script and its impact on domestic abuse
- (2) Societal Belief Systems
- (3) Lack of Public Policy and Services
- (4) Lack of Public Voice

### **The Male Script**

The male script developed by three British leading psychologists (Seagars and Barry):

- (1) Be a fighter, be resilient and be a winner
- (2) Be a provider and a protector
- (3) Retain mastery and control

“Men will seek help and are as emotionally literate as women but they do so in different ways” (M Seagars)

Additional points from Tim Child 1uels (Who Stole My Spear):

- (4) Men like to be liked by women
- (5) They always want to improve themselves.

### **The Male Script Outcomes**

It is not in the script to be a victim:

- Do not understand or recognise they are a victim
- Shame, embarrassment and pride
- Do not have control
- Magical Male Thinking’ (If I ignore the problem it might go away)
- They are not strong, resilient and providing security
- Sign of mental/physical weakness (stigmatised for getting help)
- Will not leave children behind
- Feel alone

### **Belief Systems and Victim Outcomes**

British society’s belief system is that only women can be victims of domestic abuse, so men fear:

- They won’t be believed  
Friends, family, work colleagues, Constabulary, health service, other professionals
- Ridicule  
Male peers
- They will be the ones accused
- Stigmatised for getting help
- The only man ever to suffer this and “just a domestic”
- Must have done something to deserve it (self-blame)
- Losing contact with children
- The unknown (where to go?)

## **Belief Systems and Societal Outcomes**

British society's belief system is that only women can be victims of domestic abuse, so non-victims:

- Do not always believe men are victims
- Do believe they should be ridiculed, blamed, or must have done something to deserve it
- Are more accepting of violence against a man
- Female perpetrators have no threshold to cross
- Unresponsive policy, politicians & commissioners

Some are still actively fighting against equal recognition but things are getting far better

## **Why Stay?**

- Concerned about the children: 89%
- Marriage for life: 81%
- Love: 71%
- Never see the kids again: 68%
- Thinks she'll change: 56%
- Not enough money: 53%
- Nowhere to go: 52%
- Embarrassed: 52%
- Doesn't want to take the kids away: 46%
- She threatened to kill herself: 28%
- Fears she'll kill him/Someone else he loves: 24%

(Hines and Douglas 2012)

## **Male Victim Friendly**

Tailor domestic abuse services and communications based on:

- Are all policies, staff, training, commissioning – gender inclusive?
- Who men are and not what you want men to be (male script)
- Communications and services based on: Acknowledgement, Positive and Action (speak to men)
- Online tools and information, as well as face to face and anonymous options
- Do not worry about gender of support teams

Run the reciprocation test

Normalise the male victims in the domestic abuse conversation

The behaviour of ALEX towards David (and her children and previous relationships) appears to be consistent with elements of 'the Dominator' role, as developed by the Freedom Programme (and inspired by the Duluth Power and Control Wheel) and the

'Intimate Terrorist' research defined by Professor Johnson<sup>17</sup>. A brief description of some of these key elements of the 'Dominator' role is set out below:

<b>'The Dominator' Tactics</b>	<b>E.g. of Tactics used by 'The Dominator'</b>
<b>The Bully</b>	<i>Glares, shouts, smashes things, sulks, destroys property, threatens to use weapons, abuses pets or uses pets as weapons</i>
<b>The Jailer</b>	<i>Tells you what to wear, stops you from seeing family or friends, seduces friends, family or work colleagues. Controls your movements, uses jealousy to justify actions</i>
<b>The Headworker</b>	<i>Puts you down, calls you names, humiliates you, and says that you are too fat/thin, stupid, useless and weak. Plays mind games</i>
<b>The Persuader</b>	<i>Threatens to hurt or kill you, threatens to commit suicide, cries, says that they love you, threatens to report you or forces you to drop charges</i>
<b>The Liar</b>	<i>Minimises the abuse, lies about what happened, blames everything and everyone for their behaviour, blames drink, stress, unemployment, money, overwork and you</i>

<sup>17</sup> A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and Situational Couple Violence (North-eastern University Press, 2008)