



*THE CONTENT OF THIS REPORT IS RESTRICTED*

**DOMESTIC HOMICIDE REVIEW OVERVIEW REPORT:**

**MR A**

**Report Author:**

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## **Preface**

This report of a domestic homicide review (DHR) examines agency responses and support given to Mr A, a resident of Newcastle upon Tyne prior to the point of his death at the end of 2012. While the exact date of death remains unknown, the review will cover the period from 1 July 2010 to 1 December 2012, the date when Mr A's body was discovered. The exact date of death was unknown due to his body being in a state of some decay having been stored in a freezer for an unknown period of time, possibly some weeks.

Mr A's ex-partner, Miss B and another male, Mr C, were convicted of his murder and sentenced on 25 July 2013 to life imprisonment with minimum terms of 25 and 23 years respectively. It has been difficult to gain a clear picture of the nature of the relationship between Mr A and Miss B. As far as we can surmise, Mr A and Miss B only lived together for a few weeks in early 2012 and there was no contact between them between 5 March 2012 and the time of the murder.

We would like to express our profound sympathy for family members of the victim and assure them that in undertaking this review we are seeking to learn lessons from this tragedy and to improve the response of organisations in cases of domestic violence.

This is the second Domestic Homicide Review to be carried out in Newcastle upon Tyne. Some changes in agency policy and practice have been implemented as a result of recommendations of the first review but the implementation post-dates the timeframe for this review.

We would like to thank all those who have given their time and co-operation through this review process as review panel members, Individual Management Review (IMR) authors and those staff members of participating organisations who were interviewed as part of the preparation of IMRs. We would also like to express gratitude to the Safe Newcastle Unit for administration support for the review process.

## **Introduction**

### **1.1 Domestic Homicide Review Process**

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 13th April 2011.

It states that a Domestic Homicide Review will be undertaken following:

- The death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:
- A person to whom he was related or with whom he was or had been in an intimate personal relationship, or
- A member of the same household as himself, held with a view to identifying the lessons to be learned from the death.

The purpose of the review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result
- Apply these lessons to service responses including changes to policies and procedures as appropriate and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for coroners and criminal courts, respectively, to determine as appropriate.

DHRs are not specifically part of any disciplinary enquiry or process. Where information emerges in the course of a DHR indicating that disciplinary action should be initiated, the established agency disciplinary procedures should be

undertaken separate to the DHR process. Alternatively, some DHRs may be conducted concurrently with, but separate to, disciplinary action.

As far as is possible, the review has been conducted in such a way that the process is seen as an opportunity to learn and for service development and not as a way of apportioning blame.

The rationale for the review process is to ensure agencies are responding appropriately to victims of domestic violence 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.

The review will also assess whether agencies have sufficient and robust procedures and protocols in place, which were understood and adhered to by their staff.

## **1.2 Involvement of the victim's family**

The Panel members agreed at the beginning of the review process that contact with family members would be guided by, and in conjunction with, Northumbria Police's Family Liaison Officer (FLO). Such contact led to the identification of four primary family members, Mr A's mother, brother and his two sons, who for the purpose of this report will be referred to as Mr X and Mr Z. It was also identified that the wife of Mr X was involved significantly as a family contact point.

Initial contact was made with the family members by the Family Liaison Officer and through a written letter from the Chair. At the initial stage of contact Mr A's mother and brother wrote to the Chair to inform her that they did not wish to take part in the review or to receive any further contact or updates. This wish was respected and adhered to by the Panel and Chair.

As the review progressed Mr A's two sons, Mr X and Mr Z, continued to be sent written updates regarding the process of the review as both lived outside the local area. Following the murder trial, the Family Liaison Officer confirmed with the Chair that she had spoken to Mr X and Mr Z and they were happy for direct contact to be made.

On 29 August 2013 the Chair spoke via telephone with Mr and Mrs X to advise them of the progress of the review and answer any questions they may have. They identified that they did not feel they had anything they wished to contribute to the review process but that they would like to have sight of the review once it was completed. The Chair agreed to contact them once more following completion of the Overview Report to arrange a meeting to present this. Mrs X also stated that

she felt Mr Z would like to be involved but due to the fact he lived abroad felt it would be best to contact him via email.

On the advice of Mrs X and the Family Liaison Officer contact was made with Mr Z via email updating him regarding the review and suggesting that should he wish to be involved further at this stage a time convenient to him could be arranged for the chair to contact him. No response was received so further email contact was made, but once again no reply as received. Mr Z was therefore contacted in writing to confirm the completion of the review and to provide him once again with contact details of the Chair should he wish to have sight of the report or discuss the outcomes of the review further.

Consideration was also given as to whether there were any friends or acquaintances of Mr A that should be contacted as part of the review, however none were identified.

### **1.3 Focus of the review**

The circumstances of this review have been unusual in that the focus has primarily been on the contact that agencies have had with one of the perpetrators in this case, Miss B. Within this contact she was mostly presenting as a victim of domestic violence, both historically and in the timescale of the review. Therefore, much of the focus of the review has been on the responses of interventions to her rather than on interventions with the perpetrator with whom agencies had limited contact.

### **1.4 Participants in the Review Process**

#### **1.4.1 Independent Chair and Overview Report Writer**

Kath Albiston – Director, i-to-i Training and Consultancy Ltd. (Independent Review Panel Chair)

Peter Grant – Associate trainer/consultant, i-to-i Training and Consultancy Ltd. (Overview report author)

The DHR process has been chaired by Kath Albiston, a qualified Probation Officer, who prior to leaving the Probation Service worked within a joint Police and Probation unit acting as Chair for Multi-Agency Public Protection (MAPP) meetings. Working independently as a consultant and trainer for eight years she has undertaken a variety of roles within the domestic violence and Safeguarding arena, working with statutory and voluntary sector agencies around the writing of risk assessment tools, policy and procedure, and the training and clinical supervision of staff. She has also undertaken service reviews, scoping exercises and audits in relation to provision of domestic violence services. Alongside her current

involvement with a number of Domestic Homicide Reviews, she also currently acts as an 'expert witness', writing domestic abuse risk and vulnerability assessments for public and private law cases.

Peter Grant has worked as an associate consultant with i-to-i on a number of projects in the area of domestic violence since 2008. He has a background of working since 1995 as a practitioner, consultant and trainer in the field of domestic violence, with a primary focus on work with male perpetrators and risk assessment. He has undertaken specialist risk assessments for Child Protection and private and public law family proceedings. He was previously a member of the Executive Committee of Respect, the UK membership association for domestic violence perpetrator programmes and associated support services for women and children. He is currently part of a team responsible for assessing domestic violence projects against the Respect Accreditation Standard and is an accredited Respect trainer.

#### 1.4.2 DHR Panel members

The review was initiated by Safe Newcastle and the DHR panel consisted of members of all organisations relevant to the case. None of the Review Panel members have had any direct involvement with the case and all are of senior standing within their respective organisations. The panel members are:

Lesley Storey - Community Safety Specialist, Safe Newcastle Unit, Newcastle City Council

Robyn Thomas – Head of Community Safety, Safe Newcastle Unit, Newcastle City Council

Steve Barron – Detective Chief Inspector, Northumbria Police

Linda Gray – Acting Safeguarding Adults Co-ordinator, Newcastle Safeguarding Adults

Sheila Breslin – Director of Corporate Services and Assistant Chief Executive, Your Homes Newcastle

Lesley Thirlwell – Named Professional for Safeguarding Vulnerable Groups, North East Ambulance Service

Anthony Deery – Nurse Director, Northumberland Tyne and Wear (NTW) NHS Foundation Trust

Angela Fail – Caldicott, Police and Court Liaison Lead, NTW NHS Foundation Trust

Liz Harris – Head of Nursing RVI, Newcastle upon Tyne Hospitals

Dr Stephen Blades, GP Lead for Safeguarding Adults

Liz Jarvis – Divisional Manager Northumbria, Victim Support

### 1.4.3 Individual Management Reviews (IMRs)

IMR reports were produced by all organisations represented on the Review Panel, with the exception of North East Ambulance Service and Victim Support, who had no direct involvement with either the victim or perpetrators in this case. IMR reports were based on a review of all records, both paper and electronic, relating to the victim and the perpetrators, as well as interviews, where possible, with staff members who had contact with either the victim or the perpetrators within the period of time covered by the review. The production of the IMRs was undertaken by staff in the following posts:

**Northumbria Police** – Major Crime Review Advisor

**Newcastle City Council Adult Services** – jointly undertaken by the Acting Coordinator and Service Development Lead, Safeguarding Adults

**Your Homes Newcastle** – Investment Delivery Manager

**NTW NHS Foundation Trust** – Head of Safeguarding Children and Domestic Abuse

**Newcastle upon Tyne Hospitals NHS** – Matron working in Women’s Services

**Newcastle North and East and Newcastle West Clinical Commissioning Groups**  
– GP Lead for Safeguarding Adults

None of the IMR authors had any prior knowledge of either the victim or perpetrators in this case, ensuring that they could take an independent stance in reviewing practice within their respective organisation. All reports were reviewed and approved internally within the agency by a senior member of staff for quality assurance.

The nature of agency involvement and sources of information (records, interviews and relevant policies and procedures) contributing to the production of the IMRs are detailed below:

#### **Northumbria Police**

Northumbria Police serves a population of 1.5 million people and covers an area of more than 2,000 square miles in the North East of England, from the Scottish border down to County Durham and from the Pennines across to the North East coast. The force is split into six geographical area commands and supported by 13 specialist departments.

Northumbria Police has a clear policy regarding domestic violence – this is outlined in Appendix 2 of this report. This is set out on the force intranet and is available to all officers and staff. The procedure clearly defines the responsibilities of all officers and staff when dealing with cases of domestic abuse. During the period of this

review Northumbria Police followed the Multi Agency Risk Assessment Conference (MARAC) risk assessment model, however this has been upgraded to the Domestic Abuse, Stalking and Harassment (DASH) model in 2013. These are nationally accredited models, which have been effectively used by professionals for a number of years.

During a previous Domestic Homicide Review carried out by Northumbria Police in late 2012/early 2013 it was recognised that there was a gap in the training received by frontline staff in respect of domestic violence. The force reviewed the domestic violence training needs for frontline staff and a training package was prepared for delivery in February and March 2013. This focused on recognising and recording risk, and investigating offences particularly when the victim is not engaging.

Northumbria Police attended six separate incidents between October 2010 and December 2012. All these incidents involved Mr A and Miss B. The IMR was prepared on the basis of the following information:

- Force incident logs;
- Intelligence records;
- Custody records;
- Address histories; and
- Home Office Large Major Enquiry System (HOLMES).

No police staff members were interviewed for the preparation of the IMR due to them all being witnesses in the criminal proceedings.

In addition to the information presented in the IMR, the Overview Report Writer interviewed the Senior Investigating Officer in the murder trial and had access to the Police Report.

### **Newcastle City Council Adult Services**

Adult Services are responsible within Newcastle City Council for the completion of initial assessments, coordinating safeguarding adult alerts, and safeguarding adult protection plans.

Adult Services had long-term involvement with Miss B from 1998, primarily in undertaking Social Care assessments, focused on meeting practical needs. The following staff members were interviewed:

- SW1 – Social Care Assessment Officer: involved as a reviewing officer from 21 October 2011 – 9 March 2012;

- SW2 – Social Worker: involved in role as duty social worker / care manager from 9 March 2012 – 8 May 2012; and
- SW6 – Social Care Assessment Officer: involved as a duty assessing officer from 3 April 2012 – 10 April 2012.

It was not possible to interview one member of staff who was on maternity leave at the time of the IMR being produced. That member of staff's involvement in the case was minor and staff members that worked alongside her were interviewed.

The following documents were accessed:

- Adult Social Care Record for Miss B;
- Newcastle Safeguarding Adults Board Adults Policy and Procedure;
- Newcastle City Council Domestic Violence Policy; and
- MARAC Domestic Abuse Risk Assessment Check List June 2011.

### **Your Homes Newcastle**

Your Homes Newcastle (YHN) is an Arms Length Management Organisation (ALMO) responsible for managing council homes on behalf of Newcastle City Council. YHN was set up in 2004 to manage council properties, to improve housing in order to meet the Government's Decent Homes standard, and to provide a range of support services for Newcastle City Council.

Three relevant staff members were interviewed who had contact with Miss B and Mr C, who were both tenants of YHN. There was no contact with the victim Mr A or Mr D.

- Housing Services Officers 1, 2 and 3.

A YHN Financial Inclusion Officer had contact with Miss B but could not be interviewed as they had left YHN.

An examination was made of all documents in the house files for each of the properties held by Miss B and Mr C.

### **Northumberland Tyne and Wear NHS Foundation Trust (NTW)**

Northumberland, Tyne and Wear NHS Foundation Trust is one of the largest mental health and disability Trusts in England employing more than 6,000 staff, serving a population of approximately 1.4 million, providing services across an area totalling 2,200 square miles.

NTW works from over 100 sites across Northumberland, Newcastle, North Tyneside, Gateshead, South Tyneside, Sunderland and North Easington. They also have a number of regional and national specialist services.

The victim, Mr A, had one contact with psychiatric services on 3 March 2012 following an intentional overdose. The perpetrator, Miss B, had contact with psychiatric services intermittently from 1989 and on 2 occasions within the period being considered in this review. Seven sets of paper records dating from 1998 in relation to Miss B were reviewed. Electronic health record activity relating to Mr A and Miss B was also reviewed.

The Senior Nurse for MARAC and Domestic Abuse was interviewed as an expert in NTW domestic abuse policy and procedures. No clinical staff were interviewed.

### **Newcastle upon Tyne Hospitals NHS Foundation Trust**

Newcastle Hospitals provide healthcare to communities in the North East of England and beyond. They are one of the largest NHS trusts in the UK, offering a wider range of specialist services. They deliver healthcare services from six hospitals in Newcastle.

Seven sets of medical notes relating to the victim, Mr A and perpetrators, Miss B and Mr C were reviewed. Mr D had no contact with the Trust.

Mr A had a number of attendances at Newcastle Hospitals between 29 July 2010 and 11 October 2012 but none of these were related to the DHR; therefore confidential medical information has not been included.

Miss B had a number of attendances between 21 July 2010 and 31 January 2102 for medical treatment and investigations. Only 2 of these were relevant to the DHR and have been included in this report.

Mr C had a number of attendances between 29 July 2010 and 21 April 2011 but none of these were related to the DHR; therefore confidential medical information has not been included.

No staff members were interviewed. The IMR author met with the Safeguarding Trainer, KD, to discuss expectations of staff working within the organisation.

## **Newcastle North and East and Newcastle West Clinical Commissioning Groups**

Newcastle North and East Clinical Commissioning Group (CCG) is a group of seventeen GP practices serving a population of 155,000 people in the north and east of Newcastle-upon-Tyne. Similarly, Newcastle West CCG is a group of GP practices in the West of the city. The coming together of these GP practices is a result of the NHS reforms as described in the Health and Social Care Act 2012 which saw clinical commissioning groups take control of the planning, purchasing and delivery of the NHS services from April 2013.

The medical records of the victim, Mr A and the perpetrators, Miss B, Mr C and Mr D were examined. The only relevant records were in relation to Mr A and Miss B. The following staff were interviewed:

- General Practitioners Drs B, F, G, J and L; and
- The practice nurse, Nurse K, who last saw the victim was also briefly interviewed.

### **1.4.4 Interview with the perpetrator, Miss B**

Miss B was interviewed in prison by the Panel Chair and another panel member, the Community Safety Specialist from Safe Newcastle Unit. A summary of information from this interview is included within the analysis section of the report.

## **1.5 Details of parallel reviews/processes**

There have been no parallel reviews undertaken in relation to this case within any participating organisations, nor within other multi-agency arrangements.

## **1.6 DHR process and timescales for this review**

Following initial investigation of the murder, Northumbria Police notified the Chair of Safe Newcastle, Cllr Linda Hobson for the case to be considered for a Domestic Homicide Review. The Chair confirmed with the Home Office that this case met the criteria set to establish a domestic homicide review, as outlined at the start of this report.

Following the decision to hold a review, Kath Albiston and Peter Grant, both from i-to-i Training and Consultancy, were appointed as Independent Panel Chair and Overview Report Author.

The initial DHR panel meeting was held on 29 January 2013. From this meeting it was agreed that the first task was the preparation of chronologies of any involvement with the victim, Mr A or the perpetrators, Miss B, Mr C and Mr D. This

was to gain an overview picture of agency involvement and in order to determine which agencies should prepare IMRs to contribute to this Overview report.

The second panel meeting was held on 13 March 2013. All chronologies had been submitted but there was difficulty in amalgamating them using a Chronolator programme. There was therefore a delay in disseminating the amalgamated chronology to panel members as this had to be done manually. The decision was taken at this meeting to invite the GP lead for Safeguarding Adults onto the panel.

The six agencies required to complete IMRs were identified at this meeting and IMR authors were to be invited to the next meeting.

The third panel meeting was held on 10 May 2013. By this meeting, the amalgamated chronologies had been received and the trial date been set for 6 weeks from 3 June 2013. The completion of IMRs was set for 29 July ahead of the next panel meeting on 16 August 2013.

The Criminal Trial concluded on 25 July 2013 with Miss B and Mr C being found guilty of murder and Mr D of perverting the course of justice. Miss B and Mr C were sentenced to life imprisonment with minimum terms of 25 and 20 years respectively. Mr D was sentenced to 4 years imprisonment.

All completed IMRs were submitted for 29 July and, at the panel meeting on 16 August, a 2-month timescale was set for the completion of the first draft of the Overview Report.

The review has extended beyond the stipulated six-month timescale. This has been due to:

- delays in the amalgamation of agency chronologies
- inviting additional agencies onto the Review Panel
- seeking consent from the perpetrators for disclosure of relevant records from some organisations
- awaiting the outcome of the criminal trial
- interviewing the perpetrator Miss B in custody
- undertaking re-drafts of the overview report as agreed by the Panel

The Safe Newcastle Unit sought and were granted a period of extension for completion of the review from the Home Office.

Lessons have also been learned from the delays outlined above that will be considered within future review processes to try to ensure more timely completion of the reviews.

### **1.7 Scope and Terms of Reference for the Domestic Homicide Review**

The Domestic Homicide Review Panel agreed the following areas, which were specific to this case, for consideration within the Individual Management Reviews (IMRs):

1) A number of primary incidents (in addition to the homicide) were identified within agency chronologies as significant in the relationship between Mr A and Miss B.

In relation to these incidents consideration was to be given to any contact the agencies had with those involved around the time of the incidents, including the following questions:

- How were the incidents recorded? Were they identified as domestic violence incidents?
- Were any risk assessments undertaken? What were the conclusions? In cases where they were not, why was this decision taken?
- What plans were put in place to address any risks that were identified? In cases where no plans were identified, why this was decision taken?
- Was relevant information shared with other agencies? How? If not, why was the information not shared?
- Was any multi agency working undertaken? What did this involve? What were the results? Were there any difficulties in undertaking this?

2) Issues relating to Miss B's mental health and how this was identified and addressed.

3) Issues relating to the alcohol use of all parties, the extent to which this was identified as playing a part in the relationship between them, and how this was addressed.

4) Within the chronologies a number of references were made within agency records to 'partners' without it being made clear as to whom this referred. It was been identified that this may be one of the lessons to be learnt around clarity required in recording. This should therefore be further considered within the review.

5) Within the chronologies a gap was identified between September 2009 and March 2012 when the perpetrator, Miss B, appeared to stop accessing all services. The review was to be aware of this and seek to identify any further information available

that may indicate why this was the case, or whether Miss B accessed other services during this time that should be included within the review.

The following questions were also agreed for consideration in relation to any agency contact with the parties involved:

- Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic violence and aware of what to do if they had concerns about a victim or perpetrator?
- Was it reasonable to expect them, given their level of training and knowledge, to fulfill these expectations?
- Did the agency have policies and procedures for risk assessment and risk management for domestic violence victims or perpetrators and were those assessments correctly used in the case of this victim/perpetrator?
- Did the agency have policies and procedures in place for dealing with concerns about domestic violence?
- Were these assessment tools, procedures and policies professionally accepted as being effective?
- Did the agency comply with domestic violence protocols agreed with other agencies, including any information-sharing protocols?
- What were the key points or opportunities for assessment and decision making in this case?
- Do assessments and decisions appear to have been reached in an informed and professional way?
- Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?
- When, and in what way, were the victim's wishes and feelings ascertained and considered. Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they sign-posted to other agencies?

- Had the victim disclosed to anyone and if so, was the response appropriate?
- Was this information recorded and shared, where appropriate?
- Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary?
- Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?
- Are there ways of working effectively that could be passed on to other organisations or individuals?
- Were senior managers or other agencies and professionals involved at the appropriate points?
- Are there lessons to be learned from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators?
- Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?
- How accessible were the services for the victim and perpetrator?
- To what degree could the homicide have been accurately predicted and prevented?
- Consideration should also be given to whether MARAC and MAPPA processes should have been instigated, although there is no information at this time to suggest this to be the case.

The primary period covered by the review is from July 2010 when information relating to the relationship between Mr A and Miss B first came to light. However, it was also noted that agency records indicate that Miss B had presented to services with issues around mental health dating back as far as 1989. It was agreed that any information prior to the period covered by the review should be included in the IMRs if it was thought to be relevant in providing further context and analysis.

## **1.8 Coroner's Inquiry**

The Coroner's Office was notified by the Chair that a Domestic Homicide Review taking place in relation to this case. No additional investigation took place as part of the Coroner's Inquiry due to Miss B having been convicted of his murder.

## **1.9 Consent and Obtaining Confidential Information**

The Panel Chair wrote to all three identified perpetrators, via their solicitors, requesting their permission for disclosure of confidential records. No response was received within the 28 day period of time set for a reply. Therefore the agencies were asked to consider whether the public interest in maintaining the duty of confidentiality owed to the individuals was outweighed by the public interest in the use and disclosure of confidential information, records and health records for the purpose of this review. All agencies concluded that there was an overriding public interest in favour of the provision of relevant information, records and health records in order to complete Individual Management Reviews.

There was no confidential material that was relevant to the review that was withheld for legal reasons.

## **2 The Facts**

### **2.1 Details of victim and family**

The victim Mr A lived alone in Newcastle upon Tyne. He had 2 adult sons, both of whom are married, and a grandson; they all live away from the Newcastle area. Mr A was largely unknown to participating agencies prior to the period of time covered by this review. He had worked as an engineer and was retired.

The location and date of the murder remains unknown – the victim was last seen on 18 October 2012 and his body was found in the flat of perpetrator, Mr C, in Newcastle on 1 December 2012, after Miss B had alerted the Police of this. He had suffered a number of injuries. The actual circumstances of the murder remain uncertain, although the post-mortem suggests that death may have been caused by Mr A's heart stopping following gouging of his eyes. On 25 July 2013 Miss B and Mr C were convicted of murder and Mr D convicted of perverting the course of justice by aiding in concealing the victim's body for a period of around 6 weeks. The body was discovered in a flat in the Newcastle area, having been stored in a freezer, possibly for some weeks. There is evidence that the perpetrators stole money from the victim's bank account in the period following his murder.

### **2.2 Relationships between victim and perpetrators**

One of the features of this case is that it has been difficult to build up a clear picture of the nature of the relationship between Mr A and Miss B. It is uncertain when the relationship between the victim, Mr A and perpetrator, Miss B began but it first came to light to agencies participating in the DHR around July 2010.

There was one incident where Mr A was assaulted by Miss B outside a public house on 12 January 2011 but no criminal charges were pursued and Mr A declined the offer of follow-up support.

As far we are aware, there was only a short period when Mr A and Miss B lived together, from February 2012 until 3 March 2012 when Mr A took an overdose of alcohol and prescription drugs following an allegation made by Miss B that he had sexually assaulted her. There is no evidence that there was any contact between the two again until 18 October 2012, the last date that Mr A was seen – by a taxi driver who was taking Mr A to meet up with his “much younger girlfriend”. The taxi driver commented to police that Mr A was smartly dressed and appeared in a positive mood.

The majority of information in this report has come from agency involvement with Miss B. In a number of contacts she was presenting as a victim of domestic violence.

On some occasions, these allegations were made in relation to Mr A. However, on other occasions the identity of the alleged perpetrator was either not disclosed by Miss B or not sought and recorded by professionals. A pattern of involvement with Miss B is that initial disclosures were generally not followed up by professionals, partly due to her inconsistent engagement but also due to professional's focus on other presenting issues. This has resulted in the panel not having a clear picture of the details of the relationship beyond a few specific incidents. It has therefore been difficult to gain an understanding of the dynamics of the relationship.

The interview with the SIO also reflected that there was limited information available about the nature of the relationship between Mr A and Miss B, particularly prior to the murder. Some third parties did give statements after the murder about the controlling nature of the relationship, i.e. that Miss B had behaved in a controlling manner towards Mr A, but they had been unwilling to offer this information while Mr A was still alive. Mr A was 25 years older than Miss B and is reported to have been quite isolated with few friends. The view taken in the criminal trial is that he was vulnerable to the manipulation of Miss B, who exploited him financially.

There is some evidence that the perpetrator, Miss B, was previously in a relationship with Mr C, who was jointly convicted of Mr A's murder. He is noted as her next of kin in the records of Newcastle Hospitals. Miss B was also noted as the next of kin for Mr C. However, the exact relationship between Miss B and Mr C and the time periods of this are unknown. There has been no significant information available in relation to Mr C that was felt to be relevant by agencies in relation to this review.

As mentioned above, most of the information held by organisations participating in the DHR is in relation to the perpetrator, Miss B. Much of this information, both historically and within the timescale of the DHR, is in reference to her as a victim of domestic violence and in relation to longstanding mental health problems and physical, social and emotional difficulties. The issue of allegations by Miss B that she had suffered physical, emotional and sexual abuse from Mr A was something that featured in the criminal trial. The remit of this report is not to make any judgement on the veracity of these allegations but to look at the responses of participating agencies to the victim and the perpetrators and consider whether these responses were adequate, if they were in line with agency policies and procedures in responding to allegations of domestic violence, if these policies and procedures are fit for purpose and, most importantly, if a different response could have contributed to the prevention of this tragic loss of life.

### **2.3 Historical agency involvement with Miss B**

Information in the IMRs and amalgamated chronology that was compiled through the review process indicates that Miss B has been known to agencies since 1989 when she was 20 years of age.

Miss B accessed psychiatric and psychology services on a regular basis from 1989 to 1998. There was a break of 12 years in their involvement until April 2010.

In April 1989 Miss B was referred by her GP to a Psychiatrist after a Psychologist had reported depressive symptoms and anger issues that appeared reactive to previous violent partners and an alleged rape two and a half years previously. Miss B was assessed as having a personality disorder and a depressive illness that was a reaction to previous life events. She was also referred to Social Services in relation to housing difficulties and social isolation and to a Community Psychiatric Nurse for ongoing support in relation to her mental health. She identified alcohol misuse and ongoing domestic abuse as issues in her life. This included that she was being harassed and had received threats from a previous partner. She also disclosed that she was anxious within the community and carried a knife around for her own protection. No specific individuals were identified as the reason why she carried a knife.

The observation of professionals involved in working with Miss B over a three year period from 1989-1992 was that she was difficult to engage in addressing issues related to her mental health or alcohol beyond the point of initial disclosure, rather focusing on practical needs, particularly housing. She had a number of different intimate relationships through this time.

In 1996, Miss B was again referred by her GP to a Psychiatrist regarding weight loss and a request for an assessment. She did not attend the appointment offered with the Psychiatrist and was discharged.

A year later in July 1997, Miss B's GP made an urgent referral to the Crisis Team requesting an assessment as she had recently moved house, had ideas of overdose and was acutely distressed, specifically about her housing situation. The Community Home Treatment Team provided follow-up support and made a referral to Social Services for home support and assessment for day centre provision. Within this 6-week period of intervention Miss B did not report she was in a relationship.

Five months later, in January 1998, Miss B was assessed by a Liaison Psychiatrist within the acute hospital after being admitted expressing a need for help and that she was feeling suicidal. She was assessed as having alcohol misuse with

associated personality problems. After assessment, in which no associated risks were identified, she was discharged home with no need for psychiatric follow up.

In September 1998, Miss B was referred to the CPN team for assessment by her GP. The CPN assessment indicated some depressive symptoms reactive to a degenerative back condition. Further assessment by a Psychiatrist indicated that she had an affective disorder closely associated to her back condition and that she was socially isolated. The Psychiatrist discharged Miss B and asked the GP to prescribe an antidepressant. The CPN also discharged her after writing to the Benefits Agency requesting a re assessment for Disability Living Allowance.

Police intelligence records indicate that Miss B made two historical allegations of domestic violence. It is not clear whether these are in relation to the same partner. There are limited records available to the police as names of partners are removed from historical information that is held.

On 02 September 1997 Miss B made allegations of indecent assault against her boyfriend of four weeks. She retracted the allegation before any arrest was made.

On 17 October 1997 Miss B gave a statement regarding an affray committed by a boyfriend. An arrest was made, however when the matter was due to go to court, she refused to attend and retracted her statement.

Adult Services records indicate that Miss B came back to Newcastle in 1998 from Gateshead to be nearer her family; it was recorded that she felt socially isolated; she also said that she did not see much of her father as he was an alcoholic and had schizophrenia.

Adult Services carried out a community care assessment and assisted with other issues such as applying for a community care grant, debt advice, application for Disability Living Allowance and referral for aids and adaptations.

Miss B received a housework and shopping service from 15 December 1998 to 8 May 2012 through the Supporting People Scheme, a contracted service designed to help people maintain their rented property through a grant funded initiative.

Over this time period, records show that Miss B made contact with Adult Services when she felt she needed to and that any 'no replies' that the care provider encountered when visiting her, were dealt with appropriately. Miss B also received input for aids and adaptations from 1998, the most recent involvement being in April and May 2012.

Adult Services expressed concern regarding Miss B's mental health and use of alcohol. In May 2005 it is recorded that Miss B was drinking in the street. She was distressed, saying that she had drowned her gerbils and that she might not be there when the carer next called in week. The carer believed this to be an indication of suicidal thoughts.

In July 2005, Miss B had conflict with her neighbours. The worker from Adult Services recorded that Miss B had mental health problems, over the weekend neighbours had threatened to shoot her, that the police were involved and were very concerned about her. She wouldn't go into a safe house because she didn't want to leave her cats and she was awaiting rehousing.

In 2004, Miss B moved around a number of YHN properties within a short timeframe. The reasons for the moves are at times unclear, however, when moving from one address, she noted one of her reasons on the registration form as 'domestic violence, harassment or racial harassment'. This was a tick box form that grouped together reasons for the move to another property.

In July 2005 Miss B complained about anti social behaviour from a neighbour. Miss B attended a meeting at the Community Housing Office to discuss the incidents with YHN staff. YHN staff issued a letter to the resident about the incidents. Miss B advised she was taking a lot of medication at the time. No other details were provided on the reasons for the medication. Miss B was offered another property, which she accepted in August 2005.

In November 2005, Miss B complained about a leak from an upstairs property, which was causing damp in her property. Investigations by YHN revealed that the damp was caused by dogs urinating and this was travelling downwards into her property. Action was taken by YHN against the tenant; however Miss B continued to complain about his behaviour intermittently until late 2007. There was Police involvement and threats made by Miss B towards the tenant, which were recorded. Graffiti was also scribed on the wall outside her property although it was not clear who did this.

#### **2.4 History of domestic violence in the relationship and agency involvement from 1 July 2010 to the date of the murder**

Prior to the murder of Mr A, there were 5 primary incidents where the police were involved. Three of these incidents were recorded as being domestic violence. There were two additional incidents in relation to suicide attempts / self-harm by Miss B, which were not classified as being domestic violence. The following is a chronology

highlighting agency involvement in these key incidents and other relevant contacts that agencies had from 1 July 2010 with Mr A and Miss B. Within these contacts, there were other significant incidents identified.

## **July 2010**

Information from GP Services indicates that Mr A suffered from hypertension. As a result of routine blood tests in July 2010 he was diagnosed as suffering from diabetes. This was treated initially with diet and was followed up by the GP and practice nurse. He was also referred to a dietician and the retinal screening service. In August 2010 his alcohol consumption was recorded as 40 units per week and he was advised about this with regard to his diabetes. There is no indication that this was causing him other problems. In October 2010 he was prescribed Sildenafil after complaining of erectile dysfunction. In November this was noted as being helpful and he continued to receive prescriptions for this. In February 2011 he was commenced on Metformin to control his diabetes, as diet alone was proving ineffective.

### **Key incident 1: 20 July 2010 – Overdose by Miss B**

On 19 July 2010 a GP took a phone call from an unidentified male friend of Miss B who was concerned about her mood, weight loss and vaginal bleeding. The GP tried unsuccessfully to phone her.

On 20 July 2010 at 21.58 hours (according to the police log), a call was received by the police from Mr D, reporting that Miss B had called him and threatened suicide. Officers attended with an ambulance and found Miss B vomiting. There was a large quantity of tablets and alcohol in the premises. Miss B was taken to hospital and admitted to the assessment ward following review in Accident and Emergency. The reason for admission was alcohol-related. A condition check was later carried out where it was ascertained that she had been checked by a doctor and was to be seen by the self-harm team. She identified that the overdose was due to the recent death of her cat.

This incident occurred 3 months after a similar incident; Miss B failed to attend a follow-up appointment with the self-harm team on that occasion.

The assessment on 21 July did not indicate Miss B was in any relationship at that time. She was seen by the Liaison Psychiatry team who noted recent bereavements (her father and sister). They also recorded a history of domestic violence throughout childhood and during a long-term relationship, which resulted in her being raped by a partner. It was not deemed that follow-up from Psychiatric services was necessary but she was given out of hours contact numbers for the Crisis Team. A request was

sent by letter to the GP to refer her to counselling services and she was discharged. There was no further mention of this in the GP records, which suggests that no correspondence was received back and that Miss B probably did not attend to see a counsellor.

**Miss B was seen at the GP Surgery by Dr J on 30 July 2010, 18 August 2010 and 8 September 2010.** Her mood was low and she was complaining of weight loss. Her weight was 47Kg compared to 58Kg a year earlier. Her antidepressant was changed and blood tests were done in an attempt to identify a physical cause for the weight loss. These tests were normal. At that time she did not volunteer any information about domestic violence but she was not specifically asked about it.

**Key Incident 2: 26 October 2010 - Police attendance leading to Protection Of Vulnerable Adult report regarding Miss B**

Police were contacted by Mr A expressing concern for Miss B as she had sent a text stating she was pregnant and threatening suicide. When Police spoke to Miss B she reported that Mr A kept ringing her and that she had told him that if he did not stop she would kill herself. She stated that this was an empty threat. Police made a Protection of Vulnerable Adults referral to Social Services and notified Miss B's GP.

On 9 November 2010 Adult Services received a Protection of Vulnerable Adult (POVA) notification form from the police in relation to the above incident- this was classed by the police as a Vulnerable Adult *notification*. POVA notifications (now referred to as Adult Concerns) are police notifications when there are concerns about the welfare of a vulnerable adult (but no abuse or neglect is suspected) as opposed to a POVA *referral*, which is when there is a concern that a vulnerable adult has been abused or neglected.

SW4 from Social Care Direct (first point of entry) recorded the POVA notification on an Adult Referral Form. SW4's recording shows that on 10 November 2010 they spoke to a GP at Miss B's GP practice who knew her. The GP was unaware of any pregnancy. The GP said she would make a note of the concerns and follow them up as necessary.

On 11 November 2010 the POVA notification was signed off by SW5 (Manager), outcome recorded as "GP informed NFA" (by Adult Services).

This incident was not recorded or flagged on CareFirst as a domestic violence incident and a relationship was not created between Miss B and Mr A.

No risk assessment was undertaken as the information was passed to the GP who said they would follow up the concerns as necessary. There was no follow-up with the GP or with Miss B by Adult Services.

The POVA notification from the Police did not result in a Safeguarding Adults Notification of Alert being raised. The Social Care Direct Social Worker passed the information onto the GP and decided there was to be no further action.

On 12 November 2010 Miss B was seen by a final year medical student in a parallel surgery with Dr G. Dr G saw her and agreed to see her again the following week as the issues presented were complex and chaotic. The records indicate that Miss B had been the victim of domestic violence and that the police were involved. Miss B reported no contact with her ex partner. No specific code was entered for domestic violence. A pregnancy test was taken and was negative.

On 15 November 2010 Miss B saw Dr G complaining about weakness in her left leg and a numb left arm. She reported being punched in the chest wall by her "husband" 9 days earlier and had chest pain when she moved. This was treated as a possible stroke and she was referred urgently to the stroke clinic. An MRI scan was performed and was normal. It was concluded that she had not suffered a stroke. On 22 December 2010 it was noted that she had reduced her cigarettes from 60 to 20 per day and was off alcohol. During three consultations in October to December 2010 no further detail was recorded about domestic violence as the focus moved to her possible stroke and physical problems.

NTW were not involved with Mr A or Miss B at the time of this incident. Within the chronology of Miss B it is identified that she overdosed whilst intoxicated in July 2010; she was seen for an assessment and discharged by the Psychiatrist.

**Key incident 3: 12 January 2011 - Incident of domestic violence, Mr A assessed as the victim.**

A member of the public contacted Northumbria Police reporting a female assaulting an elderly male outside the Metropolitan bar. When the police attended it was noted that one of the parties, Mr A, had a facial injury but he would not state how he came about this. Both parties stated that they had a verbal argument over their relationship. No arrests were made. They were separated by police and sent to their respective homes.

Police assessed Mr A as the victim in this incident. In the risk assessment carried out by police officers he was initially graded as being at medium risk as 6 concerns had been identified, including 3 significant concerns. These were:

- No 1. Previous violence/drugs
- No 2. Victim injuries
- No 5. Suspect mental/alcohol/drugs
- No7. Jealous/controlling
- No 8. Separation
- No14. Victim/suspect attempt suicide

In accordance with force policy, this was reviewed after 12 weeks and as, there were no further incidents or ongoing court cases, Mr was regarded as standard risk with no further action being taken.

Contact was made with Mr A by phone on the fourth attempt. Mr A was asked if he wished for a referral to an Independent Domestic Violence Advocate (IDVA). He was fully informed of the services offered and when he declined the referral this was respected, as per police policy.

No agencies other than the police were involved in this incident.

**On 19 January 2011** Miss B was admitted to hospital as a day case for investigatory procedure. She failed to attend an outpatient appointment on 21 January 2011.

**On 28 January 2011 Miss B was noted by Dr J (GP) to be in “an abusive relationship”.**

She was prescribed contraception and given contact details for Women’s Aid but no further detail was recorded. No follow up was arranged. Over the next five months she had further consultations regarding weight loss and blood tests were checked. These were normal. No further information about domestic violence or her social situation was noted.

**Key Incident 4: 5 May 2011 - Domestic violence incident**

In an abandoned 999 call, a female was heard crying and asking for the police. On attendance this was recorded as a verbal dispute. Miss B stated that she thought that she and Mr A were incompatible, but that she loved him and wanted to marry him. No offences were recorded and no arrests were made. Mr A was asked to leave the property.

When the Domestic Violence Notification (DVN) was raised for Miss B after this verbal altercation at her address, it was noted that, although she had been advised to seek counselling regarding her relationship with Mr A, she was graded as a standard risk and therefore, in accordance with procedure would not have been referred to other services. It did note on the DVN that Miss B declined to engage in

the undertaking of a risk assessment and did not wish to be referred to any support agency. The decision to grade Miss B at standard risk was because officers identified only one risk indicator on the risk assessment form.

Again, no agencies had any involvement with either Mr A or Miss B following this incident.

### **12 July 2011 – 11 November 2011: Miss B's contact with GP Services**

Miss B presented in the GP Surgery reception area very distressed and drunk on 12 July 2011. The receptionist arranged for her to see Dr B although she was not conducting a surgery at the time. Miss B saw Dr B and reported being raped 10 days earlier in a back alley by an ex boyfriend who had abused her many times before. She reported that the assailant could not maintain an erection and had used his hand. She had bled for 3 days following the assault. On examination her vulva was very swollen and bruised. She would not allow further examination. Miss B was advised to report the incident to the police but she said nobody listens to her and that it was too late now. A review appointment was made but Miss B cancelled it because she was unable to sit down in the waiting room when she arrived. The GP (Dr G) tried to call her back but got no reply.

Miss B saw Dr G on 16 August 2011 and again on 14 September 2011 and 11 November 2011. The focus of these consultations was her weight loss and erratic periods. Dr G made no further reference in his notes to domestic violence although his recollection is that he was seeking to keep her under review and asking general open questions about her social situation.

### **31 October 2011**

A visit was undertaken by SW1 from Newcastle Adult Services on 31 October 2011 to routinely reassess Miss B's eligibility for services and her package was reduced to one hour per week. This assessment was undertaken as part of the Supporting People Project to review eligibility for Supporting People services.

### **9 January 2012**

On 09 January 2012 Miss B was seen at the GP Practice by a practice nurse for a cervical smear test. She noticed a cyst in the vagina, which she asked Dr G to review. He then referred her to Gynaecology. Letters back from the gynaecologist noted a benign vaginal cyst and described the history of sexual abuse by her partner. The letters were discussed with Miss B by Dr G on 24 February 2012, who noted that the ex-partner lived locally and continued to text her.

### **30 January 2012**

Miss B was seen by Newcastle Hospitals Doctor (ST3) in the Women's Health Clinic and alleged domestic abuse by an unnamed partner. She also informed the doctor that the police had been involved but that the matter had been discontinued. Miss B was given a leaflet and advised to contact the Rape Crisis Centre.

At a Consultant review in women's Health Clinic on 31 January 2012 no further advice was given in respect of the domestic abuse. A letter was sent to the GP indicating that Miss B had disclosed domestic abuse and the advice given by the doctor.

### **Key Incident 5: 5 March 2012 - Report to police of rape allegation**

Miss B reported to the police that there was ongoing abuse from Mr A. She reported being sexually assaulted by him. When he was arrested it was found that Mr A had taken an overdose and as a result he was taken to hospital. Following investigation no further action was taken relating to the sexual assault. This incident was not recorded as a domestic violence incident by the police.

Miss B reported to police that Mr A had assaulted her that morning. When she told him she was reporting this to the police he threatened to kill himself. In interview Miss B stated that Mr A had sexually assaulted her and it had happened previously, although this had never been reported to police. She stated she had disclosed this information to her GP and other healthcare professionals.

Officers attended and as a result of Miss B alleging that Mr A had raped her, a SOLO (Sexual Offences Liaison Officer) was allocated. Miss B was taken to hospital for examination.

Officers attended Mr A's home address where he was arrested and subsequently taken to hospital due to disclosure that he had taken a quantity of tablets.

Mr A was seen by the Self Harm Team at North Tyneside District General Hospital after being admitted having taken the intentional overdose. During this assessment he reported he had taken the overdose due to his arrest in relation to the allegation of sexual assault made by Miss B. Within assessment, Mr A indicated he had been in a relationship with Miss B for 18 months. He was assessed as high risk of intent. There was no previous evidence of self-harm or major mental illness and there was evidence of him having short term future planning. There was no indication for Mental Health Act assessment, psychiatric admission or Crisis team intervention required at that time. Mr A denied any thoughts or intent to harm others including his partner.

Mr A was given contact information for the Crisis Team and GP. He was discharged into Police custody once medically fit. The Police were made fully aware of the ongoing high level of risk and asked to pass this onto the Custody Sergeant. There was deemed to be no further role for Liaison Psychiatry.

Mr A was interviewed regarding the allegations. He stated that all sexual activity between him and Miss B had been consensual and if she had ever asked him to stop then he did. He stated that they had been arguing over the previous few days during which Miss B had assaulted him, causing injury to his lower lip and ear. Information from the Police report prepared for the Murder trial indicates that Mr A stated that it was at the behest of Miss B that he agreed to commit suicide based on the allegation of rape that she was going to make against him.

In relation to criminal proceedings, a file was submitted to the Crown Prosecution Service and they made the decision not to charge Mr A as there was not a realistic prospect of conviction giving the main reasons below:

- There were three previous domestic related incidents, which undermined the prosecution case as some of the logs referred to the victim not assisting the police and in other cases being unstable and stating that she wanted to marry Mr A but then stating she felt they should separate.
- There were discrepancies between Miss B's initial account and her Achieving Best Evidence (ABE) interview, in particular the sequence of events in relation to the actual assault.
- Miss B did not make any reference to the sexual assault to her GP on the following day (6<sup>th</sup> March), but stated that she reported him to police because of "things" on his mobile phone. Mr A's phone was seized and examined and found not to contain any evidence of criminal offences.

In March 2012 letters were received by the GP following Mr A's admission to hospital informing that he had been transferred to hospital from police custody having taken an overdose of his prescribed medication. The assessment by the liaison psychiatry team noted that he had a high level of intent in light of the allegations of a sexual nature by his girlfriend. On receiving these letters Dr B reduced his supply of medication to one month at a time. He consulted Dr B on 5 April 2012 when he complained of vertigo since being hit around the head at the beginning of March 2012. He reported being very stressed in view of the impending court case. Dr B reports that he was indignant rather than depressed and that his distress appeared proportionate to the stress he was in. He did not appear to be suicidal. No review appointment was arranged at the time and this was his last GP appointment.

Miss B spoke to a number of agencies about the allegation that Mr A had sexually assaulted her. Details of these contacts are outlined below:

On 06 March 2012 Miss B saw Dr F. She alleged that her ex-partner had forced his way into her house. She said that she had attacked him to get him off. She stated that he had shown her photographs of other women and admitted to her that he was interested in children. Miss B said that the police were involved and that her injuries were to be photographed by the police. She was given some Temazepam to help her sleep and was given the phone number for REACH. The police were not contacted by the GP, as she understood they were already involved. It was noted by the GP that Miss B might return to discuss these issues.

This information that Miss B disclosed to the GP about being sexually assaulted evidently contradicts the information above in relation to one of the grounds for the CPS not to proceed with the prosecution, namely that Miss B had not referred to the sexual assault in this consultation.

Miss B's final consultation at this GP practice was on 21 March 2012 for contraception and no mention was made of the assault. She had an appointment to see a GP on 29 June 2012 but did not attend.

On 9 March 2012, Miss B contacted Adult Social Care. Recording on an observation by SW1 stated that they received a telephone call from Miss B. She appeared very distressed and said that she needed some social work involvement because she felt that she couldn't cope. She told the Social Worker that she had been recently raped and that she felt that everything was getting on top of her. The case was allocated to the long-term team (Physical Disability) for a community care reassessment.

SW2 recorded on the same day following contact with Miss B's care provider that there was minimal involvement with Miss B, that she never let the worker into the house and always saw them in the hallway.

On 12 March 2012 SW2 telephoned Miss B and again talked about having been raped by her partner. Miss B informed SW2 that the police were currently investigating the situation. She stated that her partner had been "hounding and stalking" her for the past two years. When SW2 asked about whether they were living together, Miss B stated that he was on bail and that he lived round the corner.

SW2 contacted Northumbria Police's Vulnerable Adult Unit, via email, on 13 March 2012 for further information in relation to Miss B's ex-partner and to ascertain if

there was a known risk to visiting. This email was sent using SW3's secure email address. On 03 April 2012 SW3 advised that she had spoken to a Police Officer at Northumbria Police's Public Protection Unit who advised there were no adult concerns in relation this person. Information in email was correct and Mr A was indeed on bail for alleged rape of Miss B. There was no Police intelligence to suggest he was a danger to workers. SW3 advised SW2 to speak with their Team Manager, visit in twos, and leave if he turned up.

Miss B also spoke about the allegation of sexual assault in a meeting with Housing Officer 1 (HSO1) at her tenancy on 20 March 2012. This was arranged to discuss the condition of Miss B's property following a fire safety report. No specific details of the meeting were held on the house file so HSO1 was interviewed to gain a better understanding of what was discussed during the visit.

HSO1 explained that the visit took place, as there were concerns at the amount of clutter in her property as some of it was blocking exits, which was considered dangerous if a fire broke out. Miss B was advised to move the items away from the exits to allow her to get out of the property safely if a fire occurred. Miss B agreed to do this straight away.

During the visit HSO1 reported that Miss B seemed nervous and spoke quite fast during the discussions. Miss B was very talkative and spoke openly about the need to move to get away from her ex boyfriend. No name was mentioned, nor did HSO1 enquire about the identity of the ex-boyfriend. Miss B stated the ex boyfriend had held her captive for three days suffering sexual abuse and was raped on numerous occasions. There were no signs of physical abuse and HSO1 reported that Miss B seemed quite calm when advising of the incidents that had taken place. There were no signs of alcohol abuse taking place and Miss B seemed quite lucid during the conversations.

The visit ended and HSO1 returned to the Community Housing Office (CHO). There is regular contact with the Police at the CHO and HSO1 informed the Police of the information that was provided by Miss B during the visit. The Police advised they knew about the incidents and to leave it with them.

A second visit took place at Miss B's tenancy by HSO1 in April 2012 shortly afterwards to check the de-cluttering had taken place as agreed at the previous visit. Miss B had cleared away some of her belongings making the property safer in case of fire. Miss B advised HSO1 that her neighbour upstairs had recently died and that she was the Next of Kin. HSO1 advised the Housing staff would look at his

records to determine if he had any family, as normally they would be classed as Next Of Kin.

Miss B stated during the visit she was annoyed at the outcome of her complaints about her ex boyfriend to the Police. HSO1 reported she didn't seem too distressed given the accusations made during the previous visit. Miss B didn't make any threats towards her ex boyfriend or indicate any aggressive behaviour towards him.

### **Assessment of Miss B by Adult Services**

An adult reassessment for community care services was completed by SW6 on 3 March 2012. The outcome of this was that Miss B was no longer eligible for services and her services were cancelled as of 08 May 2012. Information recorded in the community care reassessment shows that Miss B possibly identified Mr C as an informal carer who "visits her daily and provides support". He is only referred to as "J who lives in the nearby flats".

### **Medical records re Mr A: 7 April 2012 – 15 June 2012**

On 7 April 2012 Mr A was admitted to hospital because he had collapsed after drinking. He suffered a fractured right ankle, which was followed up in fracture clinic and he was referred for physiotherapy.

Mr A saw practice nurses for review of his diabetes. On 15 June 2012 his alcohol consumption was noted to be 30 units per week and he was asked routine screening questions for depression, which did not indicate any depression.

### **9 May 2012 – 5 November 2012: YHN Contact with Miss B**

On the 9 May 2012, HSO2 held a meeting with Miss B on YHN premises to complete a form giving notice to leave the current tenancy and move into a new tenancy in a different part of Newcastle. The information held on file confirmed the meeting took place but no further details about the meeting were recorded. The IMR author interviewed HSO2 to gain a better understanding of what was discussed during the visit. The following information was provided at the interview:

HSO2 advised that she did remember Miss B and the meeting although there was nothing out of the ordinary that was took place and they just went through the formality of completing the forms. Miss B did not mention Mr A, Mr C or Mr D at all and seemed quite relaxed throughout the discussions. She did not have any signs of physical injury or any indications of alcohol abuse. She was a little concerned about taking her dog to the next property and had a general conversation about the new welfare reform changes due the following year specifically around the bedroom tax. HSO2 reported that there was nothing that caused her concern during the meeting.

HSO2 confirmed she was aware of the process to follow if she suspected domestic violence was taking place when dealing with YHN tenants.

17 May 2012 – Miss B handed in the keys for her tenancy at the Housing Office.

25 May 2012 - A Financial Inclusion Officer (FIO) from YHN's Financial Inclusion Team agreed to meet Miss B at her property on 28 May 2012 to carry out a finance health check to help her with her finances. The FIO contacted Miss B prior to the meeting on the 28 May where she reported she was locked out of her property due to faulty locks. The FIO reported this to the Repairs service and a joiner carried out the work later that day. Miss B also reported a bees' nest under her patio, which was also reported to Envirocall by the FIO; this was dealt with the following day.

29 May 2012 – The FIO met with Miss B at her new property to run through a financial health check. She was in desperate need of items for her property and the FIO provided assistance in obtaining them.

5 July 2012 – The FIO advised Miss B her charity application for carpets had been declined. Miss B advised the FIO that she was very happy with the furniture pack for her property from YHN and that she had set up a bank account with Barclays. The Financial Inclusion Team closed the case on Miss B as no further help could be offered.

### **30 August 2012 onwards: Information from GP Practice re Miss B**

Having moved to the Walker area of Newcastle Miss B registered at a different GP practice on 30 August 2012 and saw a practice nurse for a new patient consultation. She saw a GP there on 3 September 2012 and 11 October 2012 in relation to a flare up of her chronic back pain and sciatica. She was referred for an MRI scan. The results of these arrived on 5 December 2012. Her previous medical records were not available at the time she was seen so the recent history was not known. No disclosure concerning domestic violence was documented during these appointments.

Miss B's medical records were summarised by a medical student at the new practice on 6 March 2013. The code "victim of domestic violence" was added to her summary as an active problem.

### **19 September 2012: Mr A's last appointment at GP surgery**

Mr A's last appointment was on 19 September 2012. Nurse K who saw him on this occasion reports that he appeared happy with no obvious concerns.

**30 November 2012: Report from Concierge Team Leader, YHN**

A Concierge Team Leader (CTL) responded to a report of a foul smell coming from an area around Mr C's property. The CTL spoke to Mr C at the property who told him the toilet was blocked and it had just been unblocked, hence the smell. The toilet had lots of bleach in it. There were lots of black bags in the passage way with foodstuff on the top. Mr C was advised to put the black bags down the chute to help get rid of the foul smell.

1 - 3 December 2012 – A Concierge Team Leader (CTL) was made aware a body was found in Mr C's property. Arrests were made and the area had been sealed off.

### 3 Analysis of Independent Management Reviews (IMRs)

In this section the individual management reviews completed by the key organisations participating in this review are considered in relation to the terms of reference as set out in the introduction of the report. This analysis addresses agency responses to key incidents prior to the homicide and the questions posed by the panel in relation to policy and practice of individual agencies and how agencies worked together.

One of the key points to note in this report is that the majority of agency involvement, both historically and within the review timeframe, was not with the victim, Mr A, but with his ex-partner, the perpetrator, Miss B. Furthermore many of the incidents of agency involvement with Miss B being considered by this report were in relation to her as an alleged victim of domestic violence.

In completion of their chronologies and IMRs all agencies concluded that there was no relevant information to consider in relation to either of the other convicted perpetrators, Mr C or Mr D.

#### 3.1 Analysis of Identified Key Incidents

The five key incidents identified in this DHR report are addressed in relation to the terms of reference as outlined below:

- **How were the incidents recorded? Were they identified as domestic violence incidents?**

The first key incident on 20 July 2010, when the police and ambulance staff attended following Miss B's threats of suicide was not recorded as a domestic violence incident. She did not disclose to the Police or the Hospital Self-Harm Team (NTW) that she was in a relationship and it would not appear that there was any link between her threats of suicide and relationship issues. The Self-Harm Team did note that she had a history of suffering from domestic violence, both in childhood and a past relationship. This suggests that the issue of domestic violence was raised in the interview.

In the follow-up appointment with her GP, Miss B again did not refer to currently being in a relationship nor did she mention any link between her suicidal thoughts and any relationship issues.

The second key incident on 26 October 2010 was similar to the above incident; on this occasion Mr A contacted the police in relation to Miss B threatening suicide. When the police spoke to Miss B, she alleged that Mr A was harassing her and that she had made an empty suicide threat to stop him doing this. Again this incident

was not recorded as a domestic violence incident, despite the allegation of harassment. The police treated it as a case of Miss B being a vulnerable adult and completed a Protection of Vulnerable Adults (POVA) form alerting Adult Services and her GP. POVA submissions fall under two categories, notifications and referrals. Notifications are submitted for information where there is no expectation of any action to be taken. Referrals are made with the expectation of further action by other agencies. In this case the police took the decision that the POVA should be a notification with no expectation of action. Accordingly no follow up took place. No link made between this incident and the previous incident in July, and a similar incident noted by NTW in April 2010. If this had been done, it is possible that the POVA would have been submitted as a referral, thus creating the opportunity for information-sharing across agencies.

The Adult Services Social Worker SW4 followed up receipt of the POVA notification by recording it on an Adult Referral Form. SW4's recording shows that they spoke to a GP at Miss B's GP practice who knew her. The GP was unaware of any pregnancy. The GP said she would make a note of the concerns and follow them up as necessary. The POVA notification was signed off by SW5 (Manager) noting that Miss B's GP had been informed and there was to be no further action. The recording of the reasons behind the decision to take "no further action" by Adult Services could have been clearer as there were indicators of domestic violence and abuse, particularly Miss B's allegation that Mr A kept "ringing her and pestering her". However this was not further explored by Social Worker SW4.

This incident was not recorded or flagged on CareFirst as a domestic violence incident and a relationship was not created between Miss B and Mr A. Within Adult Services there is not specific guidance on when relationships should be created. Usually they are created when a person is involved in a caring role or deemed to have significant involvement in a person's care or life. Currently, warnings are only added to a person's record for domestic violence when the case has been considered by MARAC, i.e. the victim is considered to be a high risk, which was not the case in this incident.

Adult Services contacted Miss B's GP in relation to this incident. Miss B was subsequently seen at her GP practice on three occasions in the period following the incident. The GP consultation notes indicate that domestic violence was discussed but that no specific code was entered to flag up domestic violence as a pertinent issue. In a subsequent appointment, Miss B made disclosure that she had been punched by her "husband". However, there was no note of the identity of her "husband" and no follow-up on initial disclosure. Rather, the focus of consultation was on presenting physical health problems.

The third key incident was on 12 January 2011, when the police attended as a result of Mr A receiving facial injuries, evidently as a result of an assault by Miss B. However, he declined to say to the police how he had received the injuries. The police did record this incident as one of domestic violence, assessing him as being at medium risk of harm. Mr A declined referral for victim support but his details were shared with the Neighbourhood Policing Team. They managed to make contact with Mr A by telephone on the fourth attempt. He declined offers of ongoing assistance and stated that he was now engaged to Miss B.

No other agencies were involved with this incident.

The fourth key incident 5<sup>th</sup> May 2011 involved the police attending at Miss B's property following an incomplete 999 call. This was recorded as being a verbal dispute and a Domestic Violence Notification was submitted, with the incident being recorded as being standard risk based on there only being one identified risk indicator. There was no follow-up requested or made and no other agencies were involved.

The fifth key incident was on 5 March 2012 when Miss B made an allegation to the police that Mr A had sexually assaulted her that morning. She also stated that he had previously sexually assaulted her. Mr A was arrested but initially taken to the hospital and assessed by the Self-Harm Team (NTW) as he had taken an overdose of tablets.

Miss B was initially referred to a Sexual Offences Liaison Officer. As noted in the chronology, no Domestic Violence Notification (DVN) was raised in this case, despite it being clear that Mr A and Miss B were in an intimate relationship. The police acknowledge that this should have happened. Analysis by the IMR author of similar incidents indicates that there has not been a routine failure to submit DVNs in cases of sexual assault where the alleged perpetrator and victim are in a relationship. The IMR author has looked at 150 reports of rape/sexual assault made in 2012/2013. Whilst almost all cases showed that the victim and offender were known to each other, only 34 reported that they were in a relationship. In all but two reports a DVN was submitted. In light of this it would appear that the failure to submit a DVN in this case was an anomaly and not reflective of Northumbria Police practice. However, the Police have acknowledged that they need to ensure that in all such cases a DVN should be submitted. Northumbria Police have included this as an individual agency recommendation as a result of this review. The police are to be commended for the depth to which they have investigated their practice around this issue to ensure future practice is in line with force policy.

As outlined in the chronology, after investigation no charges were made against Mr A in relation to the sexual assault.

GP records note that Miss B disclosed on 6 March 2012 that she had been sexually assaulted by her “ex-partner” and that the police were involved. However, there was no specific recording of this as an incident of domestic violence. This was also the case when Miss B disclosed to the GP on 12 July 2011 that she had been sexually assaulted. The GP recorded that there was physical evidence of sexual assault in this case but the identity of the perpetrator was not recorded and after Miss B’s failure to attend a review appointment or to respond to a telephone call, the incident was not followed up.

Adult Services did not have a referral from the police following the fifth key incident. However, Miss B did contact Adult Services four days later on 9 March 2012, disclosing that she had been raped and that the Police were investigating. This disclosure was followed up by Adult Services, the case being allocated to the physical disability team for a community care assessment. Liaison with the care provider disclosed that they had minimal involvement with Miss B. The assessing Social Worker followed up contact with Miss B on 12 March 2012 and made contact with the police vulnerable adult unit. Police confirmed that Mr A was subject to bail conditions. Adult Services did not record this as an incident of domestic violence.

Miss B also made disclosure to a Housing Worker on 20 March 2012, alleging that her “ex-boyfriend” had sexually assaulted her. The Housing Officer made contact with the police through their liaison partnership. The police informed the Housing Officer that they had the matter in hand so there was no further action taken. Whilst the Housing Officer did record the disclosure, they did not pass information onto their line manager. It was not recorded as a domestic violence incident and the identity of Miss B’s “ex-boyfriend” was not explored.

In relation to the response to Mr A taking an overdose, Police Officers could have considered completing a POVA on this occasion. However, they deemed that Mr A did not fit the criteria as outlined in the Department of Health document ‘No Secrets’. Additionally, he had been taken to hospital where a referral was made to the self-harm team to undertake an assessment. The incident of overdose by Mr A was recorded as a self-harm reactive to the allegations of a sexual nature resulting in an arrest by the Police.

There is an evident pattern in this case that there was a lack of consistency in agencies identifying and recording incidents of domestic violence. This, together with the failure to consistently record the identity of partners against whom Miss B

made allegations, contributed to the difficulty in building up a clear picture of the case.

- **Were any risk assessments undertaken? What were the conclusions? In cases where they were not, why was this decision taken?**

The Hospital Self-Harm Team (NTW) undertook an assessment of Miss B in relation to further risk of self-harm in the first key incident in July 2010 where Miss B was threatening suicide. Following the second key incident in October 2010 where again Miss B was threatening self-harm, the decision was taken by the police based on the evidence at the time to submit a POVA notification to Adult Services, which did not automatically trigger any risk assessment process. Miss B was not seen by NTW on this occasion and no information was sought from them in relation to the previous incident. They had also assessed Miss B in relation to a similar incident in April 2010.

Adult Services recorded that no risk assessment was undertaken by them because information had been shared with the GP, who said that they would follow up concerns as necessary. In the IMR completed by Adult Services, there is an acknowledgment that they could have recorded more clearly their decision to take no further action subsequent to sharing information with the GP. In relation to this, Adult Services introduced new recording forms (in April 2013) for all safeguarding adults information that comes into Adult Services. This ensures that all safeguarding adults related intelligence is recorded in one place in the same format. It also allows for the clear recording of decision-making, with Social Workers being asked to answer whether the alleged victim is a vulnerable adult and whether they have suffered or are at risk of significant harm. They also require recording of action taken if safeguarding procedures are deemed not to be appropriate.

The police did undertake domestic violence risk assessments in the third and fourth key incidents. Mr A was assessed as being at medium risk. As with all medium risk victims, Mr A was routinely reviewed after 12 weeks in order to establish if the risk level could be reduced. The following criteria were used during the review in line with the MARAC model that was in use at that time:

- All relevant actions/safety plans in place
- No new incidents within the 12 week period
- No current intelligence of concern
- Relevant partner agency information shows no concern including Children's Services
- Also consider ongoing investigation/court proceedings

As these criteria had been met Mr A was reduced to Standard Risk. He was not contacted regarding this.

In the fourth key incident, Miss B was assessed as being at standard risk by the police and no further action was taken.

In the fifth key incident, where Miss B alleged that Mr A had sexually assaulted her, no domestic violence risk assessment was undertaken by any agency.

The failure of the police to submit a Domestic Violence Notification (DVN) led to there being no domestic violence risk assessment completed by them in this key incident. Miss B was assessed by PVP (Protecting Vulnerable People) officers following this key incident in relation to risk of further sexual assault. As she was initially assessed as being at standard risk, there was no ongoing risk management plan put in place. It would appear that the imposition of bail conditions on Mr A was sufficient to manage potential risk at that time as there was no evidence of any ongoing contact between Mr A and Miss B for some months following this incident.

If a DVN had been submitted, it would have been wholly dependant on how many concerns were identified with regard to assessing the level of risk. In this case, without interviewing the Officer completing the risk assessment, it is only possible to speculate how many would have been deemed relevant. At the time of the incident the original ACPO DASH, which was in place, required officers to complete the assessment with the victim in the same way the current model is operated. This assessment would have been submitted and reviewed by the Domestic Violence unit covering each area command. It would be fair to say that, had a risk assessment form been completed at the relevant time irrespective of how many risk indicators being identified, the case would have been assessed as high on the basis of professional judgment due to the nature of the incident being an allegation of sexual assault.

Despite Miss B making disclosure that she had been sexually assaulted to a number of other agencies, none of them undertook any risk assessment of domestic violence in relation to this incident.

The only risk assessment undertaken by Adult Services in response to the disclosure by Miss B was in relation to the potential risk posed to workers by Mr A should he be around in the event of them visiting Miss B – this was based on information provided by the police.

It appears that the staff from Adult Services and Your Homes Newcastle made an assumption that the police were dealing with an ongoing criminal case and that there was no need for them to make any further risk assessment or formulate a response in relation to the disclosure by Miss B. They were aware from liaison with

the police that Mr A had been given bail conditions to stay away from Miss B. There is an acknowledgement from the IMR authors of both agencies that the opportunity to explore potential safety plans was lost at this time. There was an assumption made that the police had the matter in hand and that there was no ongoing role for them in managing potential risk.

Whilst the disclosures made by Miss B that she had been sexually assaulted were recorded by GPs, there was no risk assessment undertaken. It must also be noted that Miss B had previously reported on 12 July 2011 that she had been sexually assaulted by an ex-partner. The examination undertaken by the GP on that date confirmed that she had suffered injury consistent with sexual assault. However, they did not report this to the police or follow through after initially attempting to follow up with Miss B. The IMR author notes that GPs do not currently have training or awareness of domestic violence risk assessment tools. This issue and steps being taken to address this gap are explored further in subsequent sections of this report and consequent recommendations are outlined.

In relation to Mr A's intentional overdose assessment by the Self Harm Team Nurse, a full assessment of risk of self-harm was undertaken. He was deemed as having numerous short-term risk factors:

- his complicated relationship issues
- accusations of offences of a sexual nature by Miss B
- the impact of his arrest
- his continued contact with Miss B and his assertion that she agreed with his intention to end his life having dramatically increased his impulsivity.

Mr A was assessed as high risk of further suicide attempts. He denied any thoughts or intent to harm others, including his partner. The conclusion indicated Mr A did not require any further psychiatric input at that time.

The associated high suicide risk identified was communicated to the Ward and the Police were fully aware of the associated high suicide risk to ensure a plan of observation when Mr A returned to Police custody once medically fit.

Mr A's GP was provided with the assessment undertaken by the Self Harm Team Nurse by letter.

The Self Harm Team Nurse ensured that the Ward, Police and GP were informed of the assessment undertaken with consent provided by Mr A. Contact information was provided to Mr A for the Crisis Team should he need support in the future. The assessment information was recorded fully on NTW Electronic Health Records should he be referred to NTW services.

- **What plans were put in place to address any risks that were identified?  
In cases where no plans were identified, why this was decision taken?**

No clear risk management plan was put in place following any of the key incidents. This was primarily because the first four incidents were not seen to meet agency criteria for ongoing engagement with either Mr A or Miss B. The fifth incident did present an opportunity for more comprehensive risk assessments to be undertaken. However, it was not treated as a domestic violence incident but solely as investigation into a sexual allegation and there was no ongoing involvement once the decision was taken not to charge Mr A. Mr A was made subject to bail conditions to stay away from Miss B. Miss B was also re-housed shortly after the allegation was made with Mr A unaware of her new address. These measures appeared to be sufficient to safeguard Miss B. Miss B declined the offer of further safety planning following the decision not to proceed with the criminal case.

It was only following key incident five in March 2012 that GPs became aware of the probable connection between Mr A and Miss B. This was not documented in the records but led to some concern being expressed amongst themselves at his prescription of Sildenafil to address erectile dysfunction. They did reduce the amount of medication Mr A received in response to this concern. The IMR author has commented that this appears to have been a reasonable judgement given the circumstances.

At no point did Mr A present to his GP as a victim of domestic violence and there was nothing to suggest to the practice that he was at any risk.

- **Was relevant information shared with other agencies? How? If not, why was the information not shared?**

There is evidence of a generally good level of information-sharing between agencies. In the first key incident where Miss B was threatening suicide, the self-harm team at the hospital (NTW) passed on information to the GP practice and this was picked up by the GP in a subsequent appointment.

In the second incident information was shared by the police with Adult Services via a POVA notification. There was, however, a two-week gap between the incident and Adult Services receiving the POVA notification. IMRs do not make reasons for this delay clear. However, it is unlikely that this delay had any negative impact on the response of Adult Services. The social worker undertaking the assessment following receipt of the POVA liaised with the GP practice, although this initial contact was not followed up.

It is important to note that there does not appear have been any linking of information between the first two key incidents. NTW may have been able to share information from assessments undertaken in relation to Miss B in April 2010 and July 2010. However, neither of these assessments pertained to domestic violence.

The third and fourth key incidents were dealt with purely by the police and referral to other support agencies was declined by Mr A.

In the fifth key incident, both the Adult Services Social worker and the Housing Officer contacted the police to confirm the information that had been shared by Miss B in relation to the allegation of sexual assault. However, there was no follow-up after their initial enquiries, presuming that the police were dealing with the matter. Indeed the police had confirmed that bail conditions were in place.

Miss B also shared this information with the GP on 6 March 2012, the day after she contacted the police. The GP did not share the information disclosed on the basis that the police were already involved and that they had been informed that photographs were to be taken later that day. This appears to have been a reasonable decision to make in the circumstances. However the GP practice had recorded information in relation to previous disclosures made by Miss B in 2011 in relation to sexual assault, including observation of physical injuries. This may have contributed to a risk assessment being undertaken by the police. However, the identity of the alleged perpetrator was not clear in the GP notes, although this information could have been sought from Miss B.

- **Was any multi agency working undertaken? What did this involve? What were the results? Were there any difficulties in undertaking this?**

Whilst there were examples of good sharing of information between agencies, at no point did this progress to multi-agency plans. As already noted in relation to comments on the lack of risk management plans, this was primarily because the case was not seen to meet the criteria of referral into existing multi-agency arrangements such as MARAC or Vulnerable Adults. The fifth key incident could have provided an opportunity for referral into either of these frameworks but the focus of agencies appears to have been on criminal proceedings as a means of addressing potential risk and, as already stated, the case was not dealt with by the police as a domestic violence incident.

- **Information in relation to key incidents from interview of with Miss B by panel chair and panel member**

Miss B made a number of comments in relation to involvement of agencies when interviewed as part of the DHR process. She said there were a number of incidents when the police just separated them and took no action. During interview Miss B

also reported that Mr A had sexually assaulted her on a number of occasions, and in relation to key Incident 5 she felt that the police had not believed her. In relation to other agencies, she commented that she felt supported by the GP practices but had no expectation that Adult Services would support her around issues of domestic violence. In relation to YHN, she said that, when she needed to move house because of the situation with Mr A, they didn't explore this with her.

### 3.2 Additional issues to be addressed

The following four issues were also addressed as appropriate within IMRs completed by participating agencies:

- **Issues relating to Miss B's mental health and how this was identified and addressed.**

As outlined previously in this report, Miss B has a long-standing history of mental health problems. She had active involvement with Mental Health Services, being under the care of Consultant Psychologist and linked with a Community Psychiatric Nurse over a number of years until 1998. It is noted that she did not engage consistently with services. She did not have any allocated mental health worker during the period being considered by this DHR. Indeed it was twelve years since she was actively involved in working with Mental Health Services.

The first two key incidents in 2010 identified in this report related to Miss B being assessed by the Self-Harm Team at Accident and Emergency after impulsive alcohol fuelled overdoses. The assessments concluded that there was no evidence of any mental illness and that she did not wish to seek support for alcohol misuse. Miss B was advised to contact her GP for counselling when discharged from hospital. The full assessment was communicated to her GP by letter.

In the second of these incidents of overdose in October 2010 the police submitted a POVA notification to Adult Services. Adult Services made contact with Miss B's GP but there was no follow-up on this initial contact by Adult Services with either the GP or Miss B.

It is noted by the Adult Services IMR author that staff who assessed Miss B for Community Care services felt that she presented well and did not deem there to be a need to consider a referral for her mental health. Most of the information in relation to her mental health was provided by Miss B herself and not clarified by the named professionals. On occasions, advice was given to Miss B to contact her GP in relation to her mental health.

Miss B did receive support from the GP practice during the period of the review in relation to her mental health. The focus was on providing her with support to contain her mental health issues rather than seeking any significant improvement. This was done by offering follow up appointments and seeking to maintain continuity of care. She did not seem to have a mental health condition that was thought likely to change significantly with either psychological or pharmacological treatments although changes were made to her antidepressant on several occasions.

Miss B also presented with concerns about weight loss. Her weight fell from 64 Kg in March 2009 to 43 Kg in January 2012. This dramatic change led to a search for a physical explanation and the GPs carried out blood tests, a chest x-ray and a pelvic ultrasound. These were all normal but the concern that something was being missed in view of her heavy smoking and alcohol consumption persisted. In an attempt to limit her weight loss the levothyroxine she had been prescribed for hypothyroidism was stopped but she continued to lose weight.

In 1996 Miss B had been diagnosed as suffering from anorexia nervosa but this did not appear to be a likely diagnosis during 2010-12 as she was concerned by her weight loss. She complained of a poor appetite during the autumn of 2010 but generally had a good appetite.

The GPs believed that Miss B's unhappiness and social situation might also be contributing to the weight loss. Interviews with the GPs confirm that her social situation was discussed without a comprehensive assessment of this, including the contribution of domestic abuse, being documented. It does not appear that Miss B was asked directly about ongoing domestic abuse even though it was a known problem.

- **Issues relating to the alcohol use of all parties, the extent to which this was identified as playing a part in the relationship between them, and how this was addressed.**

Mr A's assessment by the Self Harm Team Nurse in March 2012 did not identify alcohol as an issue for him. This again was a one off assessment communicated to the Hospital Ward, Police and GP.

Mr A's GP noted in a consultation on 15 June 2012 that his alcohol consumption was above recommended limits and he was advised regarding this as part of the management of his diabetes and hypertension. There was no indication to the GP practice until the incident on 7 April 2012, which led to his fractured ankle, that his alcohol consumption was having any other untoward consequences. It is not clear in what depth this issue was explored.

A number of agencies, namely Adult Services, NTW and the GP Practice, were aware that Miss B had previous issues in relation to alcohol use. They all commented that she wouldn't acknowledge this as a significant issue nor accept support to address it.

In the community care reassessment visit completed by Adult Services on 3 April 2012, Miss B stated that "she did not drink alcohol at all". Practitioners undertaking

the assessment noted that there was no evidence in Miss B's property that she was drinking.

GP services also indicated that Miss B's alcohol problems were longstanding. She had seen counsellors in the past but without major sustained change to her situation. Her alcohol consumption had been 100 units per week in 2006 and 200 units per week in 2008. By 2010-11 she was binge drinking but her consumption had fallen significantly.

It was noted that Miss B was under the influence of alcohol in the first three key incidents identified – overdoses taken by Miss B in July 2010, October 2010 and the assault against Mr A outside a public house on 12 January 2011. In the third incident, the police risk assessment identified 'suspecting mental health, alcohol or drugs' as being a relevant risk factor. Mr A was involved in the second and third key incidents, having contacted the police in relation to his concerns about Miss B in October 2010 and being the injured party in the incident in January 2011. Whilst this suggests that alcohol may have played a significant role in the relationship between Mr A and Miss B, there is no evidence presented beyond these key incidents. This is indicative of the general lack of insight the panel has been able to gain into the nature of the relationship between Mr A and Miss B.

- **Within the chronologies a number of references were made within agency records to 'partners' without it being made clear as to whom this referred. It was been identified that this may be one of the lessons to be learnt around clarity required in recording. This should therefore be further considered within the review.**

It is clear from IMRs that, when disclosures about incidents of domestic violence were made by Miss B, both historically and within the timeframe of the DHR, staff from a number of agencies did not enquire about the identity of the alleged perpetrator. This may have been due to a lack of confidence in how to deal with disclosure. There is also evidence that, on occasions, the primary focus of staff from some agencies was on what they perceived to be their primary tasks, rather than on exploring initial disclosure of domestic violence. The failure to identify the alleged perpetrator and/or to record this has inevitably contributed to the difficulty agencies had in establishing a clear picture of the nature of the relationship between Mr A and Miss B and effectively sharing information with each other.

Adult Services have identified that within records the word 'partner' was used without further clarification of the name of that partner in written records.

Following allegations made by Miss B on 9 March 2012 and 12 March 2012 that she had been repeatedly raped by her "partner", SW2 did ask for further clarification

from the Police Public Protection Unit as to the identity of this partner. SW2 made the connection between the recent allegations and the previous POVA notification that was received from the police on 9 November 2010 and specifically asked if the partner Miss B referred to was Mr A. This was confirmed by the Public Protection Unit.

Despite this confirmation, Mr A was not named in any further documentation completed by Adult Services as being Miss B's partner or ex-partner. There was no relationship created between Miss B and Mr A on CareFirst. As stated previously, there is no clear guidance for Adult Services staff when relationships between people should be created on the electronic recording system.

In interview, Adult Services Staff confirmed that they were not aware whom the allegation was made against until this was confirmed by the Public Protection Unit.

Miss B was seen by NTW staff in July 2010 in a one-off assessment; she did not disclose to the psychiatrist that she was in a relationship at that time. The assessment by the Psychiatrist may have been prior to the relationship commencing.

Newcastle Hospitals Doctor (ST3), who interviewed Miss B in January 2012 documented in the notes that Miss B spoke about having been subjected to sexual abuse for several years and had been raped by a partner in 2011. However, again it was not clear who the partner was as no names were mentioned, nor were requested. This predated the allegation made against Mr A in March 2012.

YHN staff also failed to ask about or record the identity of the alleged perpetrator when Miss B spoke to the Housing Officer on 20 March 2012. They simply referred to an 'ex-boyfriend'.

The same omission of any recording of the identity of Miss B's partner or ex-partner was evident in GP records. In her records there is mention of "partner", "ex-partner", "ex-boyfriend" and "husband" but no clarity as to whom these terms refer. This information was not necessarily shared with the GP although further clarity could have been sought.

- **Within the chronologies a gap was identified between September 2009 and March 2012 when the perpetrator, Miss B appeared to stop accessing all services. The review was to be aware of this and seek to identify any further information available that may indicate why this was the case, or whether Miss B accessed other services during this time that should be included within the review.**

This was an issue that was highlighted in the initial stages of the DHR process. However, having analysed the IMRs completed, it is evident that Miss B was accessing support via her GP and the Supporting People Service provided by Adult Services. Adult Services have noted that her engagement with them was intermittent and that appointments were regularly cancelled. However, there does not appear to have been any particular significance in any disengagement from services at this time. Indeed, as outlined earlier in the report, historical records of agencies working with Miss B observe that she was inconsistent in her engagement.

Miss B was in receipt of support via Supporting People Services that were delivered by a third sector agency. This service was gradually reduced, partially in response to Miss B's non-engagement with the service provider. The manager of this service advised that calls were cancelled regularly. It should be noted that Adult Services were not aware of the extent of Miss B's disengagement with the Supporting People Service Provider until March 2012.

There was ongoing involvement from Adult Services Occupational Therapists, assessing for and providing aids and adaptations to assist Miss B with activities of daily living during April and May 2012.

### 3.3 Analysis of agency practice in relation to Policies and Procedures

The following questions were also agreed for consideration in relation to any agency contact with the parties involved. We must reiterate that, in the majority of cases, agency contact was primarily with the perpetrator, Miss B, and she was identified and responded to as a potential victim within disclosures made.

- **Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic violence and aware of what to do if they had concerns about a victim or perpetrator?**

Agencies had only limited contact with Mr A. On the occasion that he was assaulted by Miss B, he was assessed by the police who attended the incident as being at medium risk. He was offered advice and follow-up support via Neighbourhood Police but he chose not to pursue these. At the time of his arrest by the police in relation to the allegation of sexual assault, he was seen to have injuries to his lower lip and ear that he claimed were inflicted by Miss B. It does not appear that these were followed up, presumably because of the context of him being arrested and viewed as the perpetrator. Further enquiry into these injuries may have provided opportunity for the police to gain more information about the nature of the relationship between Mr A and Miss B and any indicators of domestic violence in their relationship.

Mr A was assessed by the Self-Harm Team in March 2012, having taken an overdose of tablets prior to being arrested in relation to the allegation of sexual assault against Miss B. In the interview with the Self-harm team, he did talk about Miss B having agreed that he should kill himself in light of the allegation of sexual assault she was making. However, this was again in the context of him having been arrested and being assessed in relation to potential self-harm prior to being interviewed by the police. Presumably, the Self-Harm Team would have seen the injuries to Mr A but there is no mention of this in the IMR completed by NTW. The Self-Harm Team offered Mr A follow-up via the Crisis Team and his GP.

The majority of Mr A's contacts with the GP practice were with regard to the management of his diabetes and hypertension and constituted routine chronic disease management. Mr A was seen as a follow-up to the overdose referred to above. The GP noted that he appeared indignant and distressed but not depressed as a result of the nature of the potential criminal charges he was facing. The fact that he was not depressed was confirmed at his diabetic clinic appointment on 15 June 2012 as part of routine assessment.

All agencies participating in the Review received disclosure from Miss B in relation to her presenting as a victim of domestic violence, both prior to and during the time-frame of the Review. She clearly felt able to talk to practitioners who recorded the disclosures and in some cases she was given information about other support agencies she could contact. However, in a number of cases, initial disclosure was not followed up with Miss B herself in subsequent contacts nor was signposting to other agencies followed up.

Miss B made allegations in relation to having been raped by her partner to Adult Services Social Workers, SW1 and SW2, on 9 March and 12 March 2012. She also alleged that her partner has been “hounding and stalking” her for the past two years. She disclosed to SW2 that the Police were currently investigating the situation. This allegation of “hounding and stalking” was further supported by the POVA Notification made by Northumbria Police on 9 November 2010, that “Mr A kept ringing her” and also the information given by Miss B’s main carer on 12 March 2012, that “people had been phoning the house”. SW2 asked if they were living together and Miss B informed them that the allegation was being investigated by Northumbria Police, that Mr A was on bail, and that they were not living together.

Despite these disclosures, the case was not followed up as a domestic violence incident or through a safeguarding adults alert. Additionally, the Supporting People Service provider only reported the disclosures about someone phoning the house when contacted in March 2012 and not at the time. Consideration was not given to undertaking a risk assessment with a view to referral to MARAC.

The Supporting People Service Provider made contact with the Police Public Protection Unit. The purpose of this contact was to establish whether the Police were investigating the rape and to whom the allegation referred. They were also trying to ascertain whether there were any potential risks to staff. The consideration of risk was not in relation to Miss B, nor was there enquiry about what support was being offered to Miss B.

Adult Services Staff who were interviewed by the IMR author acknowledged that they were aware of domestic violence via either safeguarding adults training or common sense. They stated that their action on receipt of a concern about domestic violence would be to use safeguarding adults procedures and/or seek advice from their manager. Staff did liaise with their managers and managers signed off assessments.

In March 2012, Your Homes Newcastle (YHN) Housing Officer, HSO1, was informed by Miss B about the alleged rape and abuse suffered from her ex-boyfriend. HSO1 relayed the information to the Police and was told they were dealing with it. The

information was not shared with any senior staff in YHN, any other agency nor recorded in the house file for Miss B's tenancy. YHN's computerised system was not updated with the details of the conversation. The conversation only became known when it was disclosed during an interview as part of this review.

The YHN IMR author has acknowledged that failure to notify senior staff by the Housing Officer prevented appropriate action being taken. The Housing Officer should have known that this was the appropriate course of action having recently attended relevant training.

Miss B did disclose she had been a victim of historical domestic abuse with previous partners in her historical involvement with Mental Health Services (NTW) but made no disclosure during the assessment by the Hospital Self-Harm Team in July 2010.

In relation to Miss B's disclosure to the Newcastle Hospitals Doctor in January 2012, the doctor's notes detail that Miss B alleged she experienced domestic abuse on a regular basis for a period of two years and that she was subjected to sexual abuse for several years and had been raped in 2011. The information also indicated that the rape charge was not upheld. This consultation took place within the Women's Health Unit and it appears that the doctor was non-judgmental and facilitated disclosure, documenting that Miss B was open with her. As mentioned previously, the identity of the partner being discussed was not clear as no names were mentioned. Miss B advised that the police had been involved but the matter was not upheld and did not proceed to prosecution.

This was the first time that Miss B disclosed abuse to any Newcastle Hospitals' staff. The doctor gave a leaflet to Miss B to contact the rape crisis centre. This information was shared with Miss B's GP practice.

It is evident that GPs responded sensitively to disclosures of domestic violence made by Miss B and that they provided her with good continuity of care. However, as with other agencies, there was a pattern of failing to follow up on initial disclosure. There were five occasions during the period of this review when Miss B shared information with GPs regarding current domestic violence and abuse. However, the issue of domestic violence was not highlighted as an alert or summary in the records. This would have been good practice as it enables clinicians seeing patients to quickly review the background before a consultation. This probably would not have had an adverse impact on the care provided in this case as it appears that staff within the practice were aware of the issue of domestic violence in relation to Miss B. Discussion with the GPs in the practice during the preparation of the IMR suggests that one reason why this did not happen is because the process

for adding problems to the summary is focused on information within hospital letters and review of new patient records rather than on problems that are dealt with solely during face-to-face consultations.

Miss B changed GP practice in August 2012 and the new practice is to be commended that her records had an appropriate code for “victim of domestic violence” added as part of the summarisation process. There was a significant delay in summarising her medical records, which appears to have been due to the fact that the records were being copied for solicitors in view of the criminal investigation. GP practices have a target of summarising new patient records within eight weeks of receipt and this was not met. However, even if it had been the records would not have been available when she was last seen on 11 October 2012. There is no evidence that this lack of background information at this crucial point caused any problems. However, if the GP and nurse had been aware of the history they may have enquired regarding Miss B’s situation rather than focusing only on her physical problem.

- **Was it reasonable to expect staff, given their level of training and knowledge, to fulfill expectations in relation to identification and disclosure of domestic violence?**

Within the Review process, training has been highlighted as a key issue to be addressed. It is clear that there is some disparity in the availability of training in relation to domestic violence across agencies. Some agencies have highlighted that staff to whom disclosure was made had not had specific domestic violence training. There is an acknowledgement that this may have contributed to them not recording or following up appropriately. In the case of Adult Services and the GPs, they tended to focus on the primary tasks within their role rather than follow up on initial disclosure. The failure of a Housing Officer to share information with their line manager in relation to disclosure by Miss B of sexual assault less than two weeks after safeguarding training highlights the need to monitor effectiveness of training rather than simply ensuring staff attend appropriate training. This issue is further addressed in the recommendations in this report.

All officers within Northumbria Police receive specific domestic violence training. On the whole, police officers involved in this case followed force procedures in addressing individual incidents. The exception to this is the failure to raise a Domestic Violence Notification during the investigation into the allegation of sexual assault made by Miss B in March 2012, which was clearly poor practice. However, it would appear that this was an isolated failure rather than highlighting a wider training need.

In relation to Adult Services, none of the staff spoken to had completed specific domestic violence training but they had completed appropriate levels of safeguarding adults training. It would be reasonable to expect, therefore, that the staff would use safeguarding adults procedures and/or seek advice from managers about the allegation that Miss B made. Some of the staff with key involvement were unqualified workers. However there were appropriate supervision arrangements in place to support them via Social Workers, Senior Practitioners and Team Managers.

YHN has classed Safeguarding Adults training as a mandatory training course that all frontline staff must attend. The HSOs involved in this case attended this training during 2011/2012. HSO1, received the training on 9 March 2012 and carried out the visit on 20 March 2012 when Miss B made the allegation about the rape and abuse from her ex-boyfriend. This visit took place less than two weeks after the training was delivered. The training covered areas such as recognising the signs and indicators of abuse and responsibilities of the person identifying the vulnerable adult. The Safeguarding Adults procedures were followed in part in this case as HSO1 contacted the Police about the allegation but did not bring it to the attention of her manager who may have explored possible safety plans and/or completed a referral to a relevant agency.

All NTW NHS Trust staff have access to domestic violence training, although it is not mandatory. In this case, there was no specific disclosure of domestic violence made by either Mr A or Miss B within the timeframe of the review.

The doctor who saw Miss B within The Women's Health Unit of Newcastle Hospitals in January 2012 clearly documented her disclosure of domestic violence and offered signposting to another agency. Given that she was not a domestic violence specialist and that the disclosure was non-specific and historical, her actions were deemed to be appropriate. The training offered to the medical team does not cover MARAC; therefore the doctor would not have an understanding of this particular process. However the doctor would have had an understanding of the referral process and who to contact for advice and support. It is not evident in the notes whether the doctor explored the issue of risk at the time of the consultation. Miss B reported that at the time of the alleged domestic abuse and rape there had been police involvement but that the allegations were not upheld. The doctor could have contacted the safeguarding team for advice. However the IMR author was unable to interview the doctor so therefore could not be sure of her rationale for not seeking advice.

As already commented in this report, GPs responded sensitively to the disclosures made by Miss B and did raise concerns in relation to domestic violence. However, their lack of specific training in domestic violence is highlighted in their failure to

follow up effectively on disclosure. There is a strong desire within the Clinical Commissioning Group to engage GPs in domestic violence training. However, it is acknowledged that, given that General Practices have individual autonomy in relation to setting training plans for staff, this cannot be made mandatory. The recently published NICE guidance will be an additional lever encouraging this.

- **Did the agency have policies and procedures for risk assessment and risk management for domestic violence victims or perpetrators and were those assessments correctly used in the case of this victim/perpetrator? Did the agency have policies and procedures in place for dealing with concerns about domestic violence? Were these assessment tools, procedures and policies professionally accepted as being effective?**

All participating agencies contribute to the MARAC process in Newcastle City and thus have staff who are trained and familiar with using CAADA risk assessment tools that are used routinely across the country. However, many of the staff who had contact with the victim and perpetrators in this case were unfamiliar with these risk assessment tools or the procedures in place for passing on information or instituting a risk assessment. In some instances, there was an assumption made that the case would not reach the threshold for inclusion in the MARAC process so no risk assessment was undertaken. It is evident that for cases that fall outside of the MARAC process and there are no children or identified vulnerable adults, as in this case, there is no clearly identified process for sharing information across agencies.

All agencies excepting the Newcastle Clinical Commissioning Groups (GPs services) have policies and procedures in relation to domestic violence in place. If these are not specifically in relation to domestic violence, the issue is clearly addressed within safeguarding policies and procedures. A draft 'GP Practice Domestic Violence and Abuse Policy' has been prepared in response to findings from a previous DHR. The effectiveness of Policies and Procedures was seen to be related to staff being able to access training in relation to such. As noted above, not all staff from participating agencies had attended training and, in the case of YHN, did not follow procedures having recently attended training. This highlights the further issue of the necessity of ensuring that learning from training is translated into practice.

A summary of the specific risk assessments undertaken and any risk management plans put in place by agencies in response to the five key incidents identified in this case is outlined on pages 35-37 of this report.

Northumbria Police has a clear policy regarding domestic violence. This is set out on the force intranet and is available to all officers and staff. The procedure clearly defines the responsibilities of all officers and staff when dealing with cases of domestic abuse. During the period of this review Northumbria Police followed the

Multi Agency Risk Assessment Conference (MARAC) risk assessment model. This was upgraded to the Domestic Abuse, Stalking and Harassment (DASH) model in 2013, after the period covered by this DHR. Risk assessments were undertaken in relation to two identified incidents of Domestic Violence in this case. The conclusions reached by these risk assessments have already been outlined in this report. A risk assessment was undertaken in relation to the allegation made by Miss B of sexual assault but, as already outlined in the report, this was not using the MARAC framework following the failure of the investigating officer to submit a DVN.

In relation to Adult Services, Newcastle City Council have a Domestic Violence policy in place, however this does not include risk assessment and management tools in relation to potential victims and perpetrators of domestic violence. The primary focus is on where a staff member is a victim or perpetrator of domestic violence rather than on responses to service users.

There is reference in the Newcastle Safeguarding Adults Board multi-agency safeguarding adults policy and procedure to responding to allegations of domestic violence or domestic abuse. This makes it clear that where adults are eligible for community care services and are victims of domestic abuse, consideration should be given to making a referral to MARAC. However, this case was not considered to meet MARAC criteria.

In this case, risk screening was carried out as part of the community care assessment that was completed on 3 April 2012. This assessment was undertaken following Miss B's disclosure that she had suffered a sexual assault from Mr A. Miss B was identified as a "low apparent risk" of both "suicide/self-harm" and "risk of abuse/exploitation of others". In light of this a more in depth FACE risk assessment was not deemed to be required. It appears that the reason the risks were identified as being low within this community care reassessment was a focus on the task in hand, i.e. assessing Miss B's need for domestic support. There was a feeling that the issues in relation to the disclosure of rape and hounding and stalking were being dealt with by others, i.e. the Police, or another worker within Adult Services.

New Threshold Guidance for safeguarding adults was introduced for Adult Services in May 2012. This identifies that "sex without valid consent (rape)" perpetrated against a vulnerable adult as identified under 'No Secrets' guidance is at a "critical" threshold and therefore should be dealt with via safeguarding adults procedures. Had this guidance been in place at the time, Miss B would have met the referral criteria for safeguarding adults, given that at the time she made the disclosure she was receiving community care services.

The Housing Officer to whom Miss B disclosed that she had suffered sexual assault in March 2012 failed to follow YHN's Safeguarding Procedures correctly in that they did not share information with their line manager. This was only two weeks after completion of training that addressed Safeguarding issues. Had procedures been followed, this would have led to a consideration of assessing risk, liaison with Adult Social Care Services and potentially considering the case within the MARAC process. As with Adult Services, this failure to follow through from initial disclosure to assessment was primarily due to an assumption that the Police were dealing with the matter and that sufficient safety measures were in place.

NTW have a Domestic Abuse Policy that was last updated in 2013 and outlines the course of action if employees have concerns regarding domestic abuse and actions required to be taken. The Trust has a Safeguarding and Public Protection Team, including a specific full-time dedicated Domestic Abuse Senior Nurse who provides advice, support and supervision for staff when necessary. Domestic Abuse awareness is part of induction for all new staff into the organization, in addition to ongoing training within the Trust training strategy. The Senior Nurse for Domestic Abuse, in discussion with the IMR author, informed he has provided bespoke training to all Crisis Teams and Self Harm Teams within the organisation on Domestic Abuse, including how to complete a Risk Indicator Checklist and making a referral to MARAC. The Domestic Abuse Nurse confirmed that he does receive requests for advice and support from those services when necessary and quality checks all MARAC referrals prior to submission to the Police MARAC Coordinator.

NTW undertook risk assessments in relation to self-harm with both Mr A, following his overdose in Key Incident 5, and Miss B in Key Incident 1. NTW clinicians undertook FACE risk profiles as per Care Coordination policy, documented these within health records and communicated to their respective GPs and, in Mr A's case, the police. No direct disclosure of domestic abuse was made by either Mr A or Miss B within their contact with NTW so no reference was made to domestic abuse in the assessments and there was no liaison with the Domestic Abuse Senior Nurse.

Newcastle Hospitals Trust has a Domestic Violence Policy that provides guidance for all staff in how to deal with disclosure of domestic violence by patients. Routine enquiry in relation to domestic violence is embedded in practice within Women's Services. The IMR author considered that the doctor to whom Miss B disclosed in January 2012 would have had basic knowledge of what to do following this disclosure, i.e. her role and responsibilities in making a referral and who to contact to seek further advice. In line with agency policy, she attended safeguarding training at level 1 of her induction. This training addresses dealing with disclosure of domestic violence.

The hospital doctor documented that Miss B was open with her and indicated that she had been raped in 2011 by her partner and that she been subjected to sexual abuse. However it is not clear who the partner was as no names were mentioned and there is no evidence of the frequency or the dates of this alleged abuse in the medical notes. Miss B also advised that the police had been involved in relation to the allegation of rape in 2011 but that the matter did not proceed to prosecution. In light of this, the doctor did not take any further action but gave Miss B a leaflet and advised her to contact Rape Crisis. There was no evidence that this referral was followed up.

Miss B was given a follow up appointment in relation to her physical health with a consultant. There is no evidence that the issue of domestic violence was raised at this appointment. A summary of the disclosure made by Miss B in relation to domestic violence was communicated to her GP practice via letter.

The training offered to the medical team does not cover MARAC. Therefore the doctor would not have had an understanding of this process but would have had an understanding of the referral process and to contact the Safeguarding Team for advice and support. There was no evidence in the doctor's notes of a risk assessment having been undertaken or that any contact was made with the Safeguarding Team. It is possible that the doctor considered that Miss B was not at risk because she did not live with her partner and the rape that she disclosed occurred in 2011 and there was no ongoing police involvement. However, in the absence of being able to interview the doctor, it has not been possible to be sure of her rationale for not making contact with the Safeguarding Team. It is normal practice for medical staff to record positive findings only, therefore to document concerns identified but not to record that none were identified.

Newcastle Hospitals have previously had access to an IDVA who was based on site but this resource was discontinued after an initial trial period. A business case was submitted for consideration within the organisation. It was however felt that the business case should not be pursued by the commissioners. It is disappointing that such a valuable resource is no longer available to Newcastle Hospital medical staff. However, it is not possible to say whether the outcome of this engagement with Miss B would have been any different if this resource had still been in place.

It is not currently standard practice within primary care for a formal risk assessment to be carried out so it is not surprising that this was not undertaken. Many GPs are unaware of how this can be done and in this case there was no documented record of consideration of the level of risk. It has been proposed within "Responding to Domestic Abuse: guidance for general practices" produced by the Royal College of General Practitioners (RCGP) and Co-ordinated Action against Domestic Abuse

(CAADA) that practices should be able to refer victims for a risk assessment using the CAADA-DASH tool either by an external domestic abuse service or a trained member of the practice team.

- **Did the agency comply with domestic violence protocols agreed with other agencies, including any information-sharing protocols?**

Information was shared appropriately within and between agencies, primarily as a follow-up to incidents of self-harm by both Mr A and Miss B and to allegations made by Miss B in relation to sexual assault. The issue of information-sharing in relation to the five identified key incidents has been outlined in this report on page 37. As already commented, information-sharing did not progress beyond initial sharing of information that had been disclosed.

In this case, domestic violence was never identified as a key issue. Agencies tended to focus on other presenting issues such as health or housing in relation to Miss B. The two incidents that were recorded as domestic violence incidents by the police, the third and fourth key incidents, were assessed as Mr A being at medium risk (and subsequently standard risk following him declining the offer of follow-up support) and Miss B being standard risk. There was therefore no involvement of other agencies. The fifth key incident was not dealt with by the police as a domestic violence incident; thus once the criminal proceedings were discontinued, there was no framework for information-sharing. GPs failed to share information with any agency following Miss B's disclosure on 12 July 2011 that she had been sexually assaulted.

- **What were the key points or opportunities for assessment and decision making in this case?**

There were no evident opportunities for further assessment in relation to Mr A. There were two occasions when appropriate assessments were undertaken, by the police in Key Incident 3 when he was seen to have facial injuries and Key Incident 5 when he was assessed in terms of self-harm. Mr A was offered follow-up appointments on both occasions but declined in the first and was seen by his GP following the second. He did not present as being at ongoing risk of self-harm at this appointment.

One of the features of this case is that each key incident and other interventions with Miss B where she presented as a victim of domestic violence were dealt with as separate incidents. At no point were there any links made between incidents. This is primarily because none of the incidents was considered of significantly high risk to warrant ongoing assessment. Additionally, as noted in section 3.2 of this report, the failure of agencies to record the identity of partners or ex-partners of Miss B, made it difficult to obtain a clear picture of the nature of the relationship between Mr A and Miss B. It is not clear on occasions to whom Miss B was referring. For example,

when she made allegations of sexual assault to her GP in July 2011 and the Hospital doctor in January 2012, there was no record of the identity of the alleged perpetrator.

Adult Services have acknowledged that the receipt of the POVA notification from the Police on 9 November 2010 provided an opportunity for them to make an assessment of risk. However, the staff undertaking the assessment were overly 'task focused' in assessing Miss B's physical needs.

YHN identified that the failure of the Housing Officer to inform their line manager following Miss B's disclosure in March 2012 that she had suffered a sexual assault was a missed opportunity to undertake a more in-depth risk assessment and to put potential safety measures in place.

There were four identified opportunities for Miss B's GP practice to have undertaken a risk assessment in relation to domestic violence. It is evident that initial disclosure was facilitated positively by GPs but that this was not followed up in subsequent appointments, when presenting physical symptoms became the focus. The first was in November 2010 following the joint consultation with the medical student. This took place shortly after the practice had received a phone call from Social Services regarding her threatened overdose. It was entirely reasonable to arrange a follow up appointment for the following week to review the situation in more detail but unfortunately Miss B then presented with physical symptoms, which became the focus and the momentum to explore the domestic abuse further was lost. This was despite her report of being punched in the chest.

On 28 January 2011 Miss B was noted to be in an abusive relationship but no further details of this were noted and they were not recalled by the GP in interview with the IMR author. She was given a number for Women's Aid but from the GP records it is not clear that she ever made contact. There is no record of discussion of domestic abuse or Women's Aid in subsequent consultations.

When seen on 12 July 2011 following a reported rape Miss B was intoxicated and not in a fit state for a risk assessment to be carried out. As the incident had been 10 days earlier and involved an ex-partner it did not appear that she was at immediate risk and she had a follow up appointment booked in three days time. Unfortunately she failed to attend and the matter was not followed up. Dr B had updated Dr G following the consultation on 12 July 2011, which is an example of good information sharing within the practice. It is good practice that the GP attempted to contact her but this was unsuccessful. When she was next seen a month later and in subsequent consultations the incident was not directly referred to. The GP recalls asking general open questions about her social situation but did not ask directly about domestic violence or sexual abuse.

The final potential opportunity for one of the GPs to undertake a risk assessment was on 6 March 2012 and is addressed below.

It is evident that Key Incident 5 in March 2012 offered the best opportunity to undertake further assessment. In addition to police involvement, Miss B made disclosures to a number of agencies that she had suffered sexual assault.

Adult Services and Your Homes Newcastle staff did share with the police the disclosures made by Miss B. However, there was an assumption made that no further assessment was necessary because the police were dealing with the matter through criminal proceedings.

Adult Services undertook a Community Care Assessment but the focus of this was on her immediate physical needs rather than any follow-up on the disclosure of domestic violence.

Miss B also made disclosure to her GP practice at this time. The GP was aware that the police were involved so assumed that there was no additional information that they could provide and focused on providing support.

As already documented, this incident was not recorded as a domestic violence incident because of the failure of the police to submit a DVN. Therefore, once the sexual assault criminal case was discontinued, there was no ongoing framework for a multi-agency risk assessment. In hindsight, this may not have had any significant impact on the case as it would appear that there was no contact between Mr A and Miss B from the imposition of bail conditions in March 2012 agencies and October / November 2012 when it is believed that Mr A renewed contact with Miss B.

- **Do assessments and decisions appear to have been reached in an informed and professional way?**

Assessments completed by police and health professionals in relation to Mr A were undertaken in an appropriate manner and using accredited risk assessment tools. In Key Incident 3, Mr A was assessed as being at medium risk and offered follow-up advice and support through the neighbourhood police team. His risk was re-assessed after 12 weeks as being at a standard risk in line with Northumbria Police policy, there having been no ongoing incidents or contact. In Key Incident 5, after assessment in relation to self-harm, Mr A was offered follow-up support via the Crisis Team and his GP. GP services followed up appropriately and no further concerns were identified.

Miss B was assessed by Northumbria Police as being at standard risk of domestic violence in Key Incident 4, which was a verbal dispute with Mr A. In line with police practice, she was given information containing safety planning and contact details of support organisations.

In Key Incident 5 Miss B was assessed as a standard risk of sexual assault because of safety measures put in place at the time. Because of this and there having been no DVN submitted, there was no ongoing assessment by Protecting Vulnerable People officers. If a DVN had been submitted, it is wholly dependant on how many concerns would have been identified with regard to setting the risk assessment level. The police have stated that it cannot be ascertained that Miss B would have been assessed as high risk. However it may be reasonable to assume that, in light of the allegation of rape, had a DVN been submitted, even if it had not met the criteria for high risk, the DAIU Detective Sergeant would have been likely to assess it as such based on their discretion. This may have led to the case being considered in MARAC and thus there being a framework for agencies involved in this review to share the information that they held.

Adult Services' staff undertook a community care assessment in April 2012 as a follow-up to Miss B's disclosure of sexual abuse. The staff who visited Miss B for this assessment appear to have relied too heavily on Miss B's presentation at that time rather than using any accredited risk assessment tool to focus the assessment. They advised that Miss B presented well and didn't seem to display the distress or upset captured when she contacted Adult Social Care on 9 March 2012. Whilst they did not prompt discussion around the allegations, they observed that Miss B did not seem to want to talk about them either but only referred to it when she said that she was waiting for the outcome of the Police investigation. The staff spoken to had no in depth knowledge of MARAC and were not familiar with the CAADA-DASH Risk Indicator Checklist.

The referral into the Physical Disability Team was dealt with by on-call workers rather than an allocated worker. The on-call role is often very task-focused. The worker that completed the assessment talked about focusing on Miss B's needs for domestic support as opposed to wider issues and their feeling that the rape allegations were being dealt with elsewhere (the Police or another worker). If a case is not allocated or dealt with by one worker it can result in a lack of ownership for the wider issues and information not being fully passed on.

The risk-screening element of assessment documentation within Adult Services has been recently changed so that practitioners record reasoning behind their judgement. As stated previously, safeguarding adults' documentation has also been

changed so that there is clear record of the decision to proceed (or not) with safeguarding adults' procedures. These changes in procedure postdate this case.

- **Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?**

As already outlined in the report, apart from Mr A being subject to bail conditions imposed by the police following the allegation of sexual assault in March 2012, no risk management plans were put in place by any agencies. The imposition of these bail conditions would appear to have been effective in ending contact between Mr A and Miss B in the months after this incident.

Whilst on occasions signposting was offered to Miss B, there were clearly a number of missed opportunities to share information and put safety measures in place.

Further enquiries and risk assessments should have been made by Adult Services into the disclosure that Miss B made on 9 March 2012 that she had been repeatedly raped and was being hounded and stalked. Staff did not signpost or make referrals to any services for Miss B in light of these disclosures, other than to check with the Police that they were investigating, who the allegation was about and whether there were any risks to staff. One of the staff interviewed said that Miss B had said she was awaiting the outcome of the Police investigation and would get support from there.

Information was shared and gathered from Miss B's care provider and also YHN. This was mainly to assist in the community care assessment process as opposed to assessing and managing any risks in relation to domestic violence.

YHN launched a Safeguarding Adults policy in March 2010 and a Domestic Violence policy in March 2011, providing clear guidance on what action should be taken by staff when they are made aware of domestic violence taking place. As noted in this report, HSO1 did not fully follow the Domestic Violence Policy.

In addition to the Safeguarding/Domestic Violence procedures, YHN staff carry out additional risk assessments and actions to safeguard tenants. In this particular case, depending on the outcome of the assessment, there could have been a number of safeguarding measures put in place. They could have made contact with Victim Support Services, considered emergency and / or permanent re-housing for Miss B to reduce the risk of further abuse or provided additional home security. They could also have issued a personal alarm.

There would also have been the options of referral to YHN's 'Anti-Social Behaviour and Enforcement Team' (for action against the perpetrator) and their 'Advice and Support Service' (to assist with any financial issues and provide support for re-housing).

The record keeping after individual consultations with GPs was generally very good. However, due to missed appointments, the complexity of the issues presented and changing priorities such as the possible stroke and weight loss some issues were not followed through. This is outlined in the exploration of opportunities missed for undertaking risk assessment on page 52 of this report.

It is possible that opportunities might have been taken for more in-depth assessment of domestic violence had GPs been more explicit in their record keeping concerning their management plan and desired outcomes for subsequent consultations. This might have prevented the focus being diverted to the same extent by new issues presenting. GPs are in the habit of focusing on desired outcomes when treating chronic physical problems, acknowledging that outcomes are less easy to define in chronic psychosocial situations and are much less frequently made explicit by GPs. Miss B had a large number of GP consultations which were providing support and seeking to problem solve in terms of her weight loss. It does not appear that Miss B and the GPs agreed on what outcomes were expected from the consultations. Doing so might have enabled greater clarity and consistency of purpose in addition to the less specific aim of providing support.

- **When, and in what way, were the victim's wishes and feelings ascertained and considered. Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they sign-posted to other agencies?**

One of the difficulties in this case was that there was very limited contact from agencies with the victim, Mr A. In Key Incident 3, following risk assessment he was offered follow-up via the Neighbourhood Police Team but he declined ongoing support.

Within his assessment by the Self Harm Team Nurse, Mr A did discuss his thoughts and feelings regarding his arrest, the allegations made by Miss B and his high risk to further self harm. He understood the reason for the assessment, the requirement to share the risk concerns with the Police and the Ward and GP. Mr A was offered the contact details for the Crisis Team if he required any support in the future. He was also encouraged to discuss matters with his GP. Indeed, he did see the GP in a follow-up appointment. There were no presenting concerns in that contact.

As already stated, the majority of agencies encountered Miss B as an alleged victim. Agencies did generally engage with her well in enabling disclosure. She was signposted to appropriate services by her GP and the Newcastle Hospitals Doctor; however there was no follow-up to check if she had taken up these services. As already observed, there was a pattern of there being no follow-up assessment on initial disclosure with most agency involvement. Staff from a number of agencies did note that, on a number of occasions, in follow-up appointments, her focus was on other presenting issues such as housing or health rather than on the initial disclosure of abuse being suffered.

Miss B was fully involved in the Community Care re-assessment process that was undertaken by Adult Services in March 2012. However, within this assessment, the focus was on her community care needs as opposed to any risks related to domestic violence. Similarly, there was no follow-up with her by the YHN Housing Officer after initial disclosure of sexual assault.

- **Had the victim disclosed to anyone and if so, was the response appropriate?**

In the incident on 12 January 2011, when it was reported to the police that Miss B assaulted Mr A, he was assessed as medium risk. He declined to say how he came about the injuries and also declined referral to victim support at the time. His details were shared with the Neighbourhood Policing Team and they made contact with Mr A by phone on the fourth attempt. He again declined offers of assistance/referral to the DVLA. As detailed earlier in this report, following a standard 12-week period of review and no further or incidents, Mr A's risk was downgraded to 'standard'. In this incident, the police followed appropriate procedures in undertaking an assessment of risk and offering support.

Following Mr A's arrest on 5 March 2012 in relation to the allegation of sexual assault, he did disclose that he had suffered injuries to his bottom lip and ear from Miss B. These were noted by the police but no action was taken, presumably because he was the alleged perpetrator in this incident and because he had taken an overdose of tablets at that time and was being assessed in relation to risk of self-harm.

Although stating that Miss B had told him to go ahead with taking an overdose as a reaction to her telling him she was planning to report him to the police, Mr A did not specifically disclose that he was a victim of domestic violence to the Self Harm Team Nurse when he was seen in March 2012. He did acknowledge he had a complicated relationship with Miss B and he was distressed, related to his overdose and arrest and could not see his way out in relation to the charge against him. The

Self Harm Team Nurse was informed by Mr A that he was an alleged perpetrator of sexual abuse towards Miss B at the time of the assessment.

Both the police and Self-Harm Team could have explored further the nature of Mr A's injuries in this incident. However, it is reasonable in the context of him having been arrested as an alleged perpetrator of sexual assault that these were seen in terms of Miss B acting in self-defence. Mr A did speak about the complicated nature of the relationship but did not allege that he had been suffering from domestic violence.

The responses to allegations made by Miss B are already outlined in the report.

- **Was this information related to disclosure recorded and shared, where appropriate?**

The police were the only agency involved in Key Incident 3. They undertook a domestic violence risk assessment and Mr A declined referral to Victim Support.

The assessment information undertaken by the self-harm team in relation to Mr A in Key Incident 5 was recorded and shared appropriately with the police. The assessment undertaken was also shared with hospital ward staff and put in writing to the GP, who offered a follow-up appointment.

- **Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary?**

Within assessments there were no identified additional issues pertaining to ethnicity, language or religious faith. The primary issue in relation to both Mr A and Miss B was vulnerability following incidents of self-harm and as a result of identified mental and physical health history in relation to Miss B.

Mr A was assessed by the Hospital Self-Harm Team in relation to his vulnerability following him taking an overdose of tablets in March 2012. This was in the context of him being arrested and ascertaining suitability for interview by the police. He was appropriately assessed and a summary of concerns was shared with the hospital ward and police and a letter sent to his GP following Mr A's giving consent for this information sharing.

Miss B was considered to be vulnerable in relation to her history of mental and physical ill health. She was in receipt of Supporting People Services through Adult Services and accessed Health services following incidents of self-harm and as a result of physical health issues. On the whole she did receive appropriately supportive responses from agencies, although there was a pattern of agencies not

following through after initial disclosure. Historical records, particularly from Mental Health Services who had the most involvement historically, indicate that Miss B was reluctant to discuss presenting issues such as alcohol misuse or relationship problems. There appears to be a pattern of disclosure not being followed up because her presentation varied from one appointment to the next, i.e. being distressed in disclosing sexual abuse and then subsequently focusing on presenting issues such as housing with no mention of sexual abuse. GP records indicate that she turned up to one appointment in an intoxicated state and that she also failed to attend other appointments, reinforcing the view that she was encountered by agencies as being somewhat chaotic.

- **Are there ways of working effectively that could be passed on to other organisations or individuals?**

This question is primarily addressed within the conclusions and recommendations sections of this report. A key issue is access to consistent training and ensuring its effective implementation. In this case, there was an inconsistency in following up on disclosures made by Miss B, possibly because she was seen as somewhat chaotic and inconsistent in her engagement.

Within adult services all staff interviewed referenced knowledge about domestic violence from safeguarding adults procedures and training. It is important that the link between domestic abuse and safeguarding adults continues to be highlighted.

Your Homes Newcastle highlighted the need for learning from training to be taken forward into practice.

The issue of recording of information, particularly in this case in relation to the identity of partners where domestic violence is disclosed, was also highlighted. A number of participating agencies have already made changes in recording procedures as a result of a previous DHR.

Adult Services commented that recent updates to recording documentation (for care management and safeguarding adults) were welcomed by staff as they challenged workers to provide reasons for particular decisions. In the case of the safeguarding adults documentation, it also allows staff to record lower level concerns and for these to be visible to people accessing the record at a later date.

As a result of this review, a flow chart/process for dealing with domestic abuse incidents or disclosures has been drafted by Adult Services that can be used by practitioners from all agencies. This is to include options for victims who do not meet the criteria for MARAC and where there are no children involved. This is included as Appendix Two to this report.

- **Were senior managers or other agencies and professionals involved at the appropriate points?**

On the whole, information was shared appropriately within agencies and passed on to partner agencies at the appropriate point. However, as previously outlined, there was a failure to follow up on initial information sharing with other agencies. This does raise a key concern that a sense of responsibility was discharged with the sharing of information. This was particularly the case when Miss B disclosed sexual assault to a number of agencies. The failure to follow up in this incidence was an assumption that, as the police were involved, there would be criminal proceedings. There was an evident presumption that this was sufficient to manage any risk.

In relation to the involvement of senior managers, as already noted in this report, Housing Officer HSO1 from YHN failed to inform his line manager of the disclosure of sexual assault made by Miss B in March 2012.

- **Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?**

These questions are addressed in the Conclusions and Recommendations sections following in this report.

- **How accessible were the services for the victim and perpetrator?**

There does not appear to have been any difficulty in relation to accessing services for either Mr A and Miss B. As commented previously, Mr A did not routinely access services beyond his health needs and he did not access services offered in relation to domestic violence. Having said that, it generally remains the case that men suffering from domestic violence are less likely to access services as the majority of services are promoted as services for female victims. It is not possible to say whether Mr A would have accessed services were the situation different.

In relation to Miss B, she was seen at home by staff from Adult Services and YHN. She was given space to make disclosure to a range of professionals. Adult Services have commented that Miss B was fully involved in the community care reassessment. She was also seen by the Newcastle Hospitals doctor within the Women's Health Clinic, providing a safe space for disclosure.

Miss B would appear to have had good access to GP services. There was good continuity of care that was facilitated by GPs encouraging her to make follow up appointments so that they could monitor her situation. There is a good example of the flexibility and responsiveness of the practice in seeing Miss B immediately when she presented on 12 July 2011. In addition phone calls were made to contact her

when her friend contacted the practice with concerns on 19 July 2010 and following her non-attendance on 15 July 2011.

It wasn't possible to test whether domestic violence support services were accessible for Miss B. She was signposted; there is no evidence that she accessed these services. In constituting the panel membership, it was ascertained that she was not known to Domestic Violence services in Newcastle city.

- **Consideration should also be given to whether MARAC and MAPPAs processes should have been instigated, although there is no information at this time to suggest this to be the case.**

At no point would this case have been appropriate for MAPPAs processes as neither the victim nor perpetrator was a known offender or considered to be a significant risk to others.

The MARAC process may have been considered in March 2012 when Miss B was disclosing to a number of agencies that she had suffered a sexual assault from Mr A. However, in the absence of the police submitting a Domestic Violence Notification, the case was dealt with as a sexual assault and was discontinued. It is not possible to say whether the decision would have been taken to include this case in the MARAC process. Other agencies could have made referral into the MARAC process but they deferred to the police in this incident. Clearly, inclusion in MARAC would have provided the opportunity for agencies to share information held and to gain a clearer picture of the dynamics of the relationship between Mr A and Miss B.

## **4 Key Findings**

**4.1** It would appear from agency records that Mr A and Miss B were in an intimate relationship from July 2010. They only lived together for a short period from February 2012 – March 2012 and it would seem that there was no contact between them after this time until the end of October 2012, when Mr A was last seen. It is difficult to gain a clear picture of the nature of the relationship as agencies only had intermittent contact with Mr A and Miss B during this period. What we know of the relationship has come from a small number of incidents when the police were called and disclosures made by Miss B to Health and Social Care professionals – GPs, Hospital doctor, Adult Care Social Workers and agency staff, Housing Officers. Mr A also spoke about the relationship with the Self-Harm Nurse in March 2012, but only in relation to the allegation of sexual assault made by Miss B. The information we have suggests that the relationship was marked by conflict. More detail of the relationship did emerge from the criminal trial, primarily from prosecution witnesses, who described the controlling nature of the relationship, with Miss B exerting financial and sexual control over Mr A. However, even this information does not provide a clear picture of the nature of the relationship.

**4.2** Mr A was a retired Civil Servant who it appears was relatively socially isolated. Apart from the key incidents outlined in this report, he was largely unknown to agencies, only accessing routine medical services through his GP and Newcastle Hospitals.

**4.3** Miss B has a long history from 1989 of accessing services in relation to mental health, housing and physical health needs. Records from mental health services (1989 – 1998) indicate that she suffered from suicidal thoughts, depression linked to physical pain and that she misused alcohol, although she consistently refused to acknowledge this as a problem. It is also stated that she suffered from a personality disorder. Records also indicate that she has made historical disclosures that she was suffering from domestic abuse, including on two separate occasions to the police in 1997. Neither of these disclosures resulted in criminal proceedings due to Miss B retracting her statements. Staff working with Miss B state that she was difficult to engage, they were unable to explore presenting issues, including domestic abuse, any further than initial disclosure. Their observations were that she was more focused on gaining resolution to practical problems such as housing.

Miss B had intermittent involvement with agencies during the period in consideration in this report, July 2010 – December 2012. She accessed housing-related support via Adult Services and YHN, disclosing to both that she was suffering abuse from her partner. She also accessed routine medical care through GP services and

Newcastle Hospitals doctors, also disclosing to them that she was suffering ongoing domestic abuse.

**4.4** Both Mr A and Miss B made allegations of Domestic Violence against the other and both were recorded by Police as the victim in separate incidents. Miss B was reported to have assaulted Mr A on 12 January 2011 and he was seen to have a facial injury on this occasion. Miss B was recorded as the victim following a verbal dispute on 5 May 2011; no action was taken in either of these incidents. Mr A was arrested following an allegation of sexual assault by Miss B on 5 March 2012. Again, no further action was taken on this matter. Miss B alleged to Health and Social Care professionals on a number of occasions that she had been subject to physical, sexual and emotional abuse, including harassment from Mr A. However, there was a lack of clarity about the nature of the allegations and against whom they had been made.

**4.5** One of the features of this case is that agencies had very little contact with the victim, Mr A. Both historically and during the period of agency intervention being considered by the DHR, agencies had intermittent contact with the perpetrator, Miss B. During this contact she disclosed on a number of occasions that she was a victim of domestic abuse, both historically and from Mr A. In considering responses to these disclosures, it appears that professionals from agencies – Adult Services and contracted care providers, YHN, GP services, Newcastle Hospitals made initial positive responses to these disclosures. However, there is a pattern of these initial disclosures not being followed up by the workers to whom the disclosure had been made. Adult Services staff shared information with Miss B's GP following the POVA notification on 11 November 2010 but did not follow this up with either the GP or Miss B. Following the allegation of rape made by Miss B in March 2012, she made disclosures to Adult Services and YHN about suffering sexual abuse. After speaking to the police about this matter and being told that there was an ongoing criminal investigation into the matter, they took no further action. There was no follow up with the police, nor did they seek to discuss the matter further with Miss B, rather focusing on the practical tasks in hand. In mitigation, it appeared that Miss B's focus was also on practical concerns to do with housing and social needs.

There was a similar pattern in Miss B's involvement with Health Services. She made five separate disclosures of suffering domestic abuse to GP services between November 2010 and March 2012. There is evidence of a positive response in the doctors' notes but domestic abuse was not flagged as an issue on GP records. There is a pattern of disclosure not being followed up, either as a result of Miss B failing to attend appointments or a focus being on presenting physical health problems. Miss B disclosed a two-year history of domestic violence to a doctor in the Women's Health Clinic on 30 January 2012 but the identity of the alleged

perpetrator was not ascertained. She was given a leaflet and advised to contact the Rape Crisis Centre and a letter outlining the disclosure of domestic abuse was sent to her GP. However, the issue of domestic abuse was not raised at the Consultant Review the following day, nor is there any evidence that Miss B sought support from other agencies to which she had been signposted.

**4.6** One of the other features of agency engagement with Miss B was that, following disclosures of domestic abuse, the identity of the partner / ex-partner was either not asked or not recorded. This was both historical and within the timeframe of the DHR. This has contributed in part to the lack of clarity about the nature of the relationship between Mr A and Miss B. It also contributed to the failure of agencies on occasions to link separate incidents as the identity of the 'partner', 'boyfriend' or 'ex-partner / ex-boyfriend' to whom she was referring was not clear.

## **5 To What Extent Was Mr A's Death Predictable or Preventable?**

Agencies had very limited information about Mr A, particularly in relation to him as a potential homicide victim. There were two key incidents where we get a glimpse of potential indicators of risk of harm.

The incident on 12 January 2011 was the only occasion on which Mr A was identified as a victim of domestic abuse. He was seen to have a facial injury but would not say how it happened. The police did undertake a risk assessment that identified six risk indicators, including significant concerns – previous violence, visible injuries and jealous/controlling behaviours. The risk assessment, based on the information available, led to the decision to grade Mr A as being at medium risk of harm. He was offered a referral to an Independent Domestic Violence Advocate (IDVA) at the time but declined this. The Neighbourhood Policing Team followed up later with Mr A to assist with any safety planning but again he declined this offer.

The second incident was following Mr A's arrest for the allegation of sexual assault made by Miss B. Mr A denied the allegation and was seen to have injuries to his lower lip and ear, which he said had been inflicted by Miss B. He was initially assessed by the police when he disclosed that he had taken an overdose of tablets and consequently taken to hospital, where he was seen by the Self-harm team. During their assessment, Mr A disclosed that he had taken the overdose at Miss B's behest, as she had stated that he would be better to kill himself than go to court to face an allegation of rape. It does not appear that this disclosure was explored any further, other than in the context of assessing his overall mental health and his fitness to face questioning by the police. It is important to note that this assessment was undertaken in the context of him having been arrested as a potential perpetrator. Mr A was given the contact details for the Crisis Team and encouraged to see his GP. He did see his GP on 5 April 2012 – he presented as stressed about the impending court case, feeling indignant about being in that position. Mr A did not have any contact with Miss B at this time as he was subject to bail conditions. Indeed, as far as we can be aware, he did not have any contact with her until October 2012.

Whilst there might have been opportunities for the Police, the Self-harm team and his GP to explore further with Mr A issues of domestic abuse in his relationship with Miss B, he did not take up the offers of support made. Indeed, it was clearly his prerogative to do this and there was nothing in any of the information received to suggest that he was at significant risk of harm. Additionally, it would appear that, following the allegation of sexual assault made in March 2012, Mr A had no ongoing contact with Miss B until October 2012.

In relation to the disclosure of information in both these incidents in relation to Mr A as a potential victim of domestic abuse, we need to acknowledge that there was limited disclosure and no previous context within which to place the information. There is an emerging picture through contact with the Respect National Male Telephone Helpline that there are some men who are reporting poor responses by agencies to disclosures of domestic abuse and a sense that they are not believed. However, these are generally men who have made numerous disclosures to a range of agencies. In this case, Mr A had only disclosed limited information in two crisis situations and, he did not take up the offer of ongoing support from the police or via the mental health Crisis Team. We could only speculate as to why Mr A did not make further disclosure or to access offered support. Possibly he didn't view the risk as being significant himself or he was not someone who had accessed support from agencies historically. Information from the criminal trial did disclose a picture of Mr A being subject to controlling behaviour from Miss B. However, this information was not known to agencies prior to his death.

In relation to Miss B as a potential perpetrator, historically and during the timeframe of the DHR, she presented to agencies as a victim of domestic violence. Excepting the incidents outlined above, and some historical disclosures that she carried a knife for self-protection, there was no indication that she could pose a potential high risk of harm to Mr A. Staff from all agencies working with her stated that she did not ever present in a threatening way. She was described as a vulnerable, frail woman who presented as having a somewhat chaotic lifestyle. Additionally, agencies had very little information to make a strong link between her and Mr C, who was also convicted of Mr A's murder, and nothing to suggest that Mr A was at risk from them.

The allegation of sexual assault made by Miss B in March 2012 evidently represented a missed opportunity to gain further information about the nature of their relationship. The failure of the Police Officer investigating to submit a Domestic Violence Notification meant that there was no domestic violence risk assessment undertaken. Miss B was disclosing to a number of agencies about this allegation and this information was not brought together by any agency. On reflection, a domestic violence assessment or inclusion in MARAC, although perhaps giving a clearer picture of their relationship may not have given any further indication that she posed a potential risk of harm to Mr A, particularly as inclusion in MARAC would have had a focus on Miss B as a victim.

From March / April 2012 to the discovery of Mr A's body on 1 December 2012, there were only occasional routine agency contacts with Mr A and Miss B and neither raised any issues about their relationship in these contacts, reinforcing the view that the relationship was not ongoing during this time. It would appear, based on

knowledge held by agencies, that the relationship had ended after the allegation of sexual assault made by Miss B and the imposition of bail conditions.

Given the observations above, we would conclude that Mr A's tragic death was neither predictable based on knowledge held by participating agencies nor preventable should different actions have been taken by agencies.

## 6 Conclusions and key learning points

This case is unusual in that, with the exception of the incident on 12 January 2011, there was no information available to suggest to agencies participating in the review that Mr A was a victim of domestic violence. This has led to the key points of learning from this review being largely focused on agency responses to the perpetrator, Miss B, in relation to her presentation as a victim of domestic violence. In doing this we are in no way taking any stance in relation to the veracity of her allegations against Mr A. We are simply seeking what lessons can be learnt in relation to agency responses to any person who presents as a potential victim of domestic violence. It is important to view the response of agencies in light of how little was known about the nature of the relationship between Mr A and Miss B at the time of these allegations being made, together with the knowledge that Miss B had previously been a victim of domestic violence and seen as generally vulnerable.

The key points of learning for agencies participating in this DHR were as follows:

- **Dealing with disclosure of domestic abuse**

Miss B's disclosures to a number of agency staff were documented in agency records of Adult Services, YHN, GP Services and Newcastle Hospitals. In some cases this information was shared with other agencies, e.g. letter from Newcastle Hospitals to the GP, Adult Services and YHN sharing information with the police in relation to the allegation of sexual assault made by Miss B. However, there was a pattern of staff not picking up on initial disclosures in subsequent contacts with Miss B, rather choosing to focus on the task in hand, whether this was housing issues or physical health problems. There was also a failure of staff to consistently seek and record the identity of partners and ex-partners to whom she was referring. Miss B could present as somewhat chaotic and had a history of inconsistent engagement with agencies. This presentation may have had an influence on the response of agency staff, where it was easier to focus on tasks that were the primary role of the agency, e.g. addressing physical health issues for the GP, discussing housing issues for the Housing Worker.

**See Recommendation 1: Addressing training -**

- Ensuring that, when there is disclosure of Domestic Violence, this is followed through and remains a focus of intervention, particularly where Domestic Violence is not the primary remit of the agency. This includes taking full details of the event and alleged perpetrator.

- **Improving recognition of risk around disclosure of sexual assault / rape and response to this**

Agencies failed to recognise that the disclosure of sexual assault by Miss A potentially presented a high level of risk in this case. Initial disclosure was facilitated but not followed up through clarification of information or undertaking of risk assessments.

**See Recommendation 1:** Addressing training – improving recognition of risk around disclosure of sexual assault

**See Recommendation 2:** To improve recognition of risk associated with disclosure of sexual assault /rape and the responses of agencies.

- **Working with clients with complex needs particularly mental health and alcohol use**

As commented above, one of the features of this case was the complexity of needs presented by the perpetrator Miss B both historically and during the timeframe of the Review. The presenting issues were particularly around alcohol and mental health. Indeed Miss B's alcohol misuse was a feature in a number of the key incidents. There is an acknowledgement from participating agencies that she was not easy to engage, that she would neither acknowledge nor willingly address either of these issues. This again highlights a training need in relation to staff focusing on assessing risk and devising support plans in response to information presented rather than the presentation of the individual victim and how easy or otherwise it is to engage with them. The recently published Home Office paper, 'Domestic Homicide Reviews: Common Themes Identified as Lessons to be Learned' highlighted the need to raise awareness and understanding of how best to engage and work with those with complex needs such as substance misuse and mental health. The panel have highlighted to agencies the 'Complicated Matters' eonline training produced by AVA ('Action Against Violence') as a resource that can be accessed by staff.

- **See Recommendation 1:** Addressing training - Working effectively with clients with complex needs, particularly mental health and alcohol use, who are disclosing issues of domestic violence.

- **Assumption that other agencies will address the risk**

In addition to a lack of confidence in taking forward initial disclosure of domestic violence to explore further, there were a number of occasions when agency staff made assumptions that their task was completed when they had shared information. This was particularly the case in relation to Key incident 5 in March 2012 when Miss B alleged that Mr A had sexually assaulted her. Through the process of the review Safe Newcastle and Newcastle Adult Services have developed a multi-agency domestic violence and abuse procedural flowchart outlining the process of dealing with disclosure and undertaking risk assessments with adults. This has already been circulated to, and adopted by many Newcastle agencies through a variety of channels (eg: MAPPA, MARAC, Newcastle Safeguarding Adults and Domestic Violence training). The flowchart has been produced in a number of accessible formats and is also available on the Safeguarding Adults' website. This has been a very positive and in-depth piece of work to emerge from this review process and is indicative of the desire of agencies to improve multi-agency responses by bringing greater consistency of practice around risk assessment.

- **See Recommendation 1:** Addressing training - Agencies to ensure that staff are aware of procedures following disclosure of domestic violence and that these are followed through fully, regardless of whether other agencies are involved in the case. This particularly applies to cases where there are criminal investigations or even proceedings.
- **See Recommendation 3:** Agencies to disseminate the Newcastle Multi-Agency Domestic Violence and Abuse Procedural Flowchart for Adults (Appendix 2 to this report) to all staff.

- **Risk assessment not consistently undertaken**

All participating agencies barring GP services have domestic violence risk assessment procedures in place and use accredited risk assessment tools. Work is underway with GP services to institute procedures and increase familiarity with risk assessment tools. However, in this case, risk assessments were only undertaken by the Police at the scene of reported domestic abuse incidents and by Mental Health Services in relation to Mr A's risk of self-harm. No risk assessments were undertaken in response to disclosure of domestic abuse by Miss B, namely by GPs, Adult Service Social Workers and agency staff, the Hospital doctor and Housing Officers. In some cases, the staff did not follow procedures by sharing information with line managers who were trained to undertake domestic violence risk

assessments. These omissions may have been down to a lack of awareness of agency procedures in relation to risk assessment or the assumption that risk was being addressed elsewhere, particularly by the police (as outlined above). Additionally, some agencies only have risk assessment procedures that apply to cases where risk is deemed to have reached the threshold for MARAC. Given the information available at the time, this case is unlikely to have reached the MARAC threshold.

**See Recommendation 3:** Agencies to disseminate the Newcastle Multi-Agency Domestic Violence and Abuse Procedural Flowchart for Adults (Appendix 2 to this report) to all staff. This will ensure that staff are familiar with the MARAC Risk Identification Checklist (CAADA DASH) and / or who within, or outside, the organisation is responsible for undertaking these risk assessments.

- **Identifying and working with male victims of domestic violence**

We have acknowledged in this report the lack of information available in relation to agencies identifying Mr A as a potential victim of domestic violence and to understand the nature of power dynamics that were present in his relationship with Miss B. However, it is important to highlight the issues of men being identified as victims of domestic violence as a learning point of this review.

For some years, there has been recognition that there is a high incidence of men suffering violence and abuse from women in intimate relationships. Data from Home Office statistical bulletins and the British Crime Survey show that men make up about 40% of domestic violence victims each year. However, these figures do not give any detailed indication of the nature of this reported violence. Research into the gendered nature of domestic violence indicates that, when women use violence in intimate relationships it is often, though not always, in self defence or defence of a child or as a form of resistance (Kimmel, 2002). However, it is also clear that some women do systematically and intentionally perpetrate domestic violence and abuse against their male partners (Hester, 2009).

The Hester research, based on police referrals of domestic violence in the North-East of England, found that the police descriptions characterised female perpetrators as to a greater extent having mental health or other health issues. It also found that male victims were much less likely to fear the female perpetrator and there were generally less incidents of violence being perpetrated by women and

suffered by men. The majority of the perpetrators appeared to abuse alcohol to some degree and more often in cases involving 'dual perpetrators'.

Findings from UK-based Telephone Helplines for male victims of domestic violence (Robinson & Rowlands, 2006; Respect 2013) bear out the findings of the above research. They indicate that, in relation to men contacting their services, there are generally three categories emerging:

- Men who are victims of domestic violence
- Relationships where there is mutual violence
- Men who are perpetrators presenting themselves as victims

The research undertaken by Robinson & Rowlands in relation to 171 men contacting a helpline run by the Dyn Project identified that there is often a blurring between the distinction of victim and perpetrator. They also concluded that the men at greatest risk were those who were also perpetrating violence against their partners.

In relation to this case, there are some features that are indicative of the research findings, namely the difficulty of identifying who was the primary perpetrator, the presence of mental health and alcohol as contributing factors. Participating agencies have acknowledged the importance of being more able to identify where men are victims of domestic violence and ensuring that this is incorporated into delivery of domestic violence training.

**See Recommendation 1:** Addressing training - Identifying and working with male victims of domestic violence.

Additional learning points identified by IMR authors for their respective agencies are included in Appendix One to this report.

## 7 Recommendations

The following recommendations are those agreed by the panel, as these relate to crosscutting issues affecting more than one agency. Detail of the implementation of these is given in the action plan contained in the full report. Additional recommendations identified by IMR authors as being relevant to their respective agency are included in Appendix One to this report.

- 1) All agencies to identify, and feedback to the Safe Newcastle Unit, whether key learning points from this review are already addressed in their existing local training programmes, and actions to be taken to incorporate it where gaps are identified. The key learning points have been identified as:
  - Ensuring that, when there is disclosure of Domestic Violence, this is followed through and remains a focus of intervention, particularly where Domestic Violence is not the primary remit of the agency. This includes taking full details of the event and alleged perpetrator.
  - Ensuring staff understand the level of risk associated with disclosure of sexual assault / rape and the responses required as a result of this.
  - Working effectively with clients with complex needs, particularly mental health and alcohol use, who are disclosing issues of domestic violence.
  - Agencies to ensure that staff are aware of procedures following disclosure of domestic violence and that these are followed through fully, regardless of whether other agencies are involved in the case. This particularly applies to cases where there are criminal investigations or even proceedings.
  - Identifying and working with male victims of domestic violence
- 2) To improve recognition of risk associated with disclosure of sexual assault / rape and the responses of agencies.
- 3) Agencies to disseminate the Newcastle Multi-Agency Domestic Violence and Abuse Procedural Flowchart for Adults (Appendix 2 to this report) to all staff. Feedback is to be provided to the Safe Newcastle as to how and when this has been achieved.