



Safer Lincolnshire Partnership

Domestic Homicide Review

The homicide of Peter

1st August 2016

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Report completed: 17th May 2018

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Appendix A: terms of reference

1. Introduction

1.1. The establishment of a Domestic Homicide Review (DHR) is set out under Section 9 of the Domestic Violence Crime and Victims Act 2004 which came into force on the 13th April 2011.

1.2. Multi-agency statutory guidance for the conduct of DHRs has been issued under Section 9 (3) of the Domestic Violence Crime & Victims Act 2004. Section 4 of the act places a duty on any person or body named within that section (4) to have regard to the guidance issued by the Secretary of State. The guidance states that the purpose of a DHR is to:

- Establish what lessons are to be learned from a 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.

Persons Covered by the Review

1.3. The principal focus of the Review is the victim, a male referred to as Peter. The other involved adult is the perpetrator, a female referred to as Janet. Janet pleaded guilty to the manslaughter of Peter and was sentenced to seven years imprisonment.

Confidentiality

1.4. The victim, Peter, was 44 years of age at the time of his death. He was White British.

1.5. The perpetrator, Janet, was 51 years of age at the time of the fatal incident. She is also White British.

Review Period

1.6. The scoping period is from 21st December 2012 (date of victim's attendance at Accident and Emergency) until 1st August 2016 (date of his death). Additional

relevant information outside of the scoping period has also been incorporated into this report (section 3).

Timescales for the review

- 1.7. The review commenced on 9th December 2016 and was completed on 30th April 2018. The delay was due to the Author/Chair having an extended period of sick leave and also to allow further time to attempt to engage family members and the perpetrator in the review process.

Methodology

- 1.8. The decision to undertake a Review was made by Safer Communities, Lincolnshire on 13th September 2016.
- 1.9. Agencies identified completed an Individual Management Review report and were represented on a DHR Panel convened to oversee the Review. Agency records were used to complete the IMRs and in some cases, staff members were spoken to by the IMR author. Hayley Frame, Independent Safeguarding Consultant, was appointed as the independent chair and author for this DHR.

Terms of reference:

The following areas were addressed in the Individual Management Reviews and has shaped the analysis of this Overview Report:

- a) To examine whether there were any previous concerns, incidents, significant life events or indications which might have signalled the risk of violence to any of the subjects, or given rise to other concerns or instigated other interventions.
- b) When and in what way were practitioners sensitive to the needs of the subjects, knowledgeable about potential indicators of domestic violence and abuse 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 fulfil these expectations?
- c) When, and in what way, were the subject's wishes and feelings ascertained and considered? Were the subjects informed of options/choices to make informed decisions? Were they signposted to other agencies and how accessible were these services to the subjects?
- d) 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?

- e) Was appropriate professional curiosity exercised by those professionals and agencies working with the individuals in the case, this includes whether professionals analysed any relevant historical information and acted upon it?
- f) Were the actions of agencies in contact with all subjects appropriate, relevant and effective to the individual and collective family needs and risks identified at the time and continually monitored and reviewed?
- g) Did the agency have policies and procedures for Domestic Abuse and Safeguarding and were any assessments correctly used in the case of the subjects? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC or other multi-agency fora?
- h) 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?
- i) Were any issues of disability, diversity, culture or identity relevant?
- j) To consider whether there are training needs arising from this case
- k) To consider the management oversight and supervision provided to workers involved
- l) Did any restructuring during the period under review likely to have had an impact on the quality of the service delivered?

Contributors

- 1.10. Agencies participating in this Review and commissioned to prepare Individual Management Reviews/summary reports are:
- Lincolnshire Community Health Services NHS Trust
 - United Lincolnshire Hospitals NHS Trust
 - Lincolnshire Police
 - GP practice
 - East Midlands Ambulance Service
 - The District Council

Individual Management Review authors were all independent from any direct management of the case.

Involvement of family, friends, work colleagues, neighbours and wider community

- 1.11. Letters were written on two occasions to the family of the victim and these were passed onto them via the Police Family Liaison Officer (FLO). The letters contained the direct telephone number for the Independent Author/Chair and the recipients were

invited to contact her in order to contribute to the Review. No contact was received on either occasion.

- 1.12. In addition, checks were made with the Police to see whether anything was recorded or said by family members on receiving the initial letter that outlined the introduction to the DHR process. The FLO remembered handing the letters to the victim's mother and father and also to his son. With regards to the victim's parents, they simply did not want any involvement in the Review process and were just happy for matters to proceed without their involvement. The son also did not want to contribute to the Review but was wishing to meet with the perpetrator.
- 1.13. The son subsequently made contact with the Restorative Justice Service with a view to a meeting with the perpetrator. It was hoped that this might be a way in which to further encourage his contribution to the Review. However this relative subsequently decided against pursuing a meeting, prior to any discussions about the Review process taking place.
- 1.14. A separate letter was written to the perpetrator in prison. Again, no contact was received. It had been hoped that after meeting her she would give her permission for her family and friends to be contacted. A further letter was written to the perpetrator who, as a result, acknowledged receipt of the original letter and confirmed that she did not wish to contribute to the Review.
- 1.15. Due to the information obtained during the criminal investigation, the Review was able to consider perspectives shared by the victim's mother and son, and a friend of both the victim and perpetrator, whose account appears, on reading, to have a degree of objectivity.

DHR Panel members

- 1.16. DHR Panel members consisted of senior representatives from the following agencies:
 - Lincolnshire Community Health Services NHS Trust – Barbara Mitchell
 - United Lincolnshire Hospitals NHS Trust – Elaine Todd
 - Lincolnshire Police – Rick Hatton
 - GP practice – Glenis Grandorge
 - The District Council – Michelle Howard
 - Lincolnshire Clinical Commissioning Group – Claire Tozer

In addition the DHR had the benefit of a Domestic Abuse Project Officer employed by Lincolnshire County Council who acted as advisor to the Panel. The Panel was also supported by a legal adviser Toni Geraghty, from Legal Services Lincolnshire.

- 1.17. The Independent Author/Chair is a qualified and HCPC registered Social Worker having qualified in 1995. Since 2010, she has authored serious case reviews, safeguarding adults reviews and domestic homicide reviews. This is the 7th domestic homicide review authored by Hayley. She has had no connection with the Community Safety Partnership or with any of the agencies involved in the Review.

Parallel Reviews

- 1.18. The inquest in respect of the victim was formally opened on 18th August 2016 but as a result of the criminal trial and the fact that it was clear that the death was as a result of a stab wound to the chest, it was decided that there was no need for a full Inquest therefore the Coroner suspended it on 5th January 2017 and on 9th January the victim's family and the Registrar's Office were formally notified that the death could be registered.

Equality and Diversity

- 1.19. This is explored further within the analysis section of this report.

2. The Facts

- 2.1. At 00:55 on Monday 1st August 2016, Lincolnshire Police were informed by East Midlands Ambulance Service that a male had been stabbed at a private residence. Officers attended and found Peter lying on his back in the kitchen with what appeared to be a stab wound to his upper chest. Janet was administering first aid by placing a towel over the wound.
- 2.2. When one of the officers tried to give first aid to Peter, Janet became aggressive and started to hit the officer and had to be restrained. Peter was gasping for breath and then his pulse stopped. Other officers had arrived at the scene enabling CPR to be administered. The ambulance crew also arrived at the scene however life was pronounced extinct at 01:32.
- 2.3. A post mortem examination revealed that Peter had died as a result of a single 6cm deep stab wound to the heart. He had no other injuries.
- 2.4. It is believed that the victim and perpetrator had been in relationship for around 8 years. They did not live together. The homicide occurred in the home of Janet where she lived with her adult son.
- 2.5. Janet was taken to the Police Station and provided an initial account of events. She stated that they had been out together that day at the races but they had later become separated. She stated that when she arrived home she found Peter lying on his side in the kitchen and saw he was bleeding. She rang her son who then arrived at the address and he rang for an ambulance.
- 2.6. Janet was arrested that day and during her subsequent interviews gave an account that she had caused the injury but claimed that it was self-defence after Peter had demanded sex and made physical advances towards her. She initially maintained that he was at home before her but when confronted with evidence to the contrary she accepted that she got home before he did, denied any intention to cause serious harm and maintained her claim that she had stabbed him in self-defence. She was subsequently charged with murder.
- 2.7. On 16th December 2016, Janet appeared before the Crown Court where she pleaded guilty to the manslaughter of Peter. She was sentenced to 7 years imprisonment when she appeared before the same court on 21st December 2016.

3. Summary of relevant individual agency contact/involvement prior to scoping period

- 3.1. Janet has 7 convictions between 1996 and 2003 for 11 offences including possession and supply of controlled drugs, handling stolen goods and offences of violence including wounding, assault occasioning actual bodily harm and common assault.
- 3.2. Janet was also arrested on a number of occasions between 1996 and 2008 for violent offences but these did not lead to criminal convictions.
- 3.3. Peter was known to be alcohol dependent and to have long standing sciatica which prevented him from working.
- 3.4. No incidents of domestic abuse involving Janet and Peter were reported to or known to Lincolnshire Police prior to the death of Peter. No agency that had contact with either the victim or perpetrator had concerns about domestic abuse.
- 3.5. There were a number of incidents of domestic abuse reported to Lincolnshire Police involving Janet and a previous partner but these are historic (1997, 1999 and 2008) and therefore well outside the scope of this review. These incidents indicate that Janet had been the victim of domestic abuse in the past.

4. Summary of key events within the scoping period (author notes in bold)

4.1. On 21st December 2012, Peter attended the Accident and Emergency Department with a laceration to the left side of his chest. He reported being drunk at the time of the injury and wearing inappropriate footwear when he fell onto a fence. Peter reported living alone and named his mother as his next of kin. He reported a history of problematic alcohol use. The injury was deemed to be consistent with the account given and was sutured and dressed. Peter was admitted overnight for observation but discharged the next day.

As there was no disclosure of domestic abuse and the injury appeared to be consistent with the description provided, Peter's account was accepted. Practice was in line with agency policy and procedure and to admit Peter overnight for observation demonstrated a focus upon his needs and ongoing welfare.

4.2. On 15th June 2014, it was recorded by the District Council Benefits office that Peter had moved property, where he was residing alone. Information recorded indicates that Peter was having his housing benefit and Department of Work and Pensions Benefits paid into the account of Janet.

There was no policy or process in place at the time to explore whether such scenarios were indicative of financial abuse or exploitation. This is an area where there have been changes to practice as identified later in this report.

4.3. Peter attended his GP on 23rd July 2014 with a small hematoma to his abdominal wall. No history of trauma was given and as such routine bloods were ordered. Peter was noted to still be alcohol dependent. The blood tests indicated no abnormalities with regard to clotting but were consistent with alcohol dependency.

4.4. At a review GP appointment held on 29th August 2014 a discussion took place regarding Peter's alcohol dependence. He was given an information leaflet regarding self-referral to Addaction – a drug and alcohol specialist service.

Given the confirmation of alcohol dependency, it was appropriate to sign post Peter to Addaction. It is not clear from the records whether he was, however, motivated to change.

4.5. Peter attended the GP surgery again on 18th February 2015, reporting numbness in his right foot but denying any trauma. Alcohol consumption was discussed; he was noted to still be alcohol dependent but did not attend Addaction. Routine bloods were taken which again were consistent with alcohol dependence.

4.6. On 8th July 2015, Peter visited the GP with hearing loss due to impacted wax and requesting analgesia for chronic lower back pain. An Addaction referral was discussed but declined and Peter was advised to cut down his alcohol intake.

It is evident that Peter was not willing to consider an Addaction referral despite ongoing alcohol dependence. It is good practice however that the GP continued to revisit this.

- 4.7. Peter attended the minor injuries unit with a painful foot on 8th August 2015. It was assessed as a possible fracture and he was advised to attend the Accident and Emergency Department. The nurse practitioner documented that he smelt strongly of alcohol.

There is no record of him attending A&E as advised. There is no evidence of alcohol support services being discussed with Peter despite him smelling strongly of alcohol, which would have been expected practice.

- 4.8. Peter attended the minor injuries unit again on 27th August 2015 with a swollen upper left eyelid. He was seen by the same nurse practitioner. Peter reported having been hit with a TV remote control 2 days previously. It was also recorded that he was an alcoholic. An attendance notification was recorded on his GP notes.

It was not recorded in the notes who had thrown the remote control or if domestic abuse had been considered. This sort of enquiry would have been expected practice within the agency at the time.

Again, this was opportunity to discuss alcohol support services but there is no record of this.

- 4.9. On 21st September 2015, Peter attended his GP with a swollen left ankle which he reported having broken 15 years ago. An urgent X-ray and ultrasound scan was ordered. The subsequent X-ray detected a large un-united fracture to his left ankle. Upon receipt of the results on 12th October 2015, Peter was contacted by phone and letter to make a follow up GP appointment, which occurred on 27th October 2015. At this appointment Peter asked for a list of medications as he was intending to refer himself back to Addaction as he wanted to stop drinking so that he could have treatment for his chronic back pain.

The back pain that Peter was experiencing would appear to be his motivation to address his alcohol use. This would undoubtedly have been seen as a positive development given his previous refusal to address this.

- 4.10. On 31st December 2015, Peter attended an outpatient appointment with the hospital surgical team with regard to his left ankle. An ultrasound scan was completed which confirmed a cystic lesion. Excision was arranged for 10th March 2016. In the notes it was recorded that his partner was called 'J'. Peter was noted to smoke '1 joint per night'. Surgery was subsequently postponed due to on-going high blood pressure. A 24 hour blood pressure machine was later fitted which indicated average blood pressure. Peter was seen again by the surgical team on 18th March 2016, given advice regarding pre/post-operative smoking and alcohol use and surgery took place on 14th April 2016.

This would appear to be a reference to Janet.

Pre and post-op lifestyle advice was given relating to smoking and alcohol use. Although Peter disclosed that he smoked 1 joint per night, there is no other

disclosure of drug use noted in any of Peter's other attendances. It is unclear whether the advice in relation to smoking related solely to tobacco, or whether smoking other substances would be included in this reference.

4.11. Peter attended his GP again on 18th May 2016 requesting a referral back to the spinal department for chronic back pain. It was recorded that Peter reported being back on the Addaction programme and so his drinking was reduced.

There are no Addaction records to support this, so it is unclear whether Peter was being honest with the GP about his alcohol use and any reported reduction.

4.12. On 27th June 2016, Peter attended the GP surgery reporting numbness and tingling to his right foot. It was reported that he already took medication for alcohol induced neuropathy and the dosage was therefore increased.

There is no record of alcohol advice being given on this occasion.

4.13. On 1st August 2016, Peter died.

5. Information that came to light as part of the criminal investigation:

- 5.1. In the statement that Peter's mother made to the police, she stated that on 1st March 2016 Peter visited her and she saw that his right eye was red and bloodshot and that the next day it was swollen and bruised. Peter did not say what had happened but was reported to have said '*yeah look what she's bloody done to my eye*'. Peter's mother had recorded this in her diary.
- 5.2. Peter's mother also said that Peter would often have scratches or marks on his head or face and that he would just say that he got in her (Janet's) way. Peter's mother described one occasion when Peter showed her a cut around the middle area of his body. He told her that he had fallen on a fence but later reportedly stated '*it's not as bad as it could be when she's got a knife in her hand*'. This incident potentially correlates to the attendance at A&E on 21st December 2012.
- 5.3. One of Peter's friends told investigating officers that he had known Peter for 20 years and said that Peter and Janet had been in a relationship for approximately 7 years. He described their relationship as good but acknowledged that they had '*blazing rows*'. He said that he had seen Janet screaming at Peter and him screaming back at her. Peter's alcohol use appeared to be an area of conflict between the couple.
- 5.4. The friend also said that he had never seen Peter with injuries but was aware that he had had an injury which he said was caused by being cut on a fence as a result of an argument. The friend stated that he knew that Peter received hospital treatment for that injury. Again, this incident potentially correlates to the attendance at A&E on 21st December 2012.
- 5.5. In the statement that he made to the Police, Peter's son said that he had witnessed his father and Janet arguing and said that Janet would be very aggressive towards Peter. He stated that over the last couple of years his father had turned up during the night with scratches to his head and face on 4 or 5 occasions. He said that his father had told him that Janet had caused the injuries and said she would lash out at him and scratch him with her fingernails. Peter's son said that the problems would mainly occur when Peter and Janet had been drinking.
- 5.6. Peter's son also witnessed an injury to Peter's eye. He said that Peter had blood on his face and a cut to his right eye near to his nose, caused by being hit by Janet. Peter's son was also aware of the injury which his father said was caused by him falling on a fence. He said that Janet assaulted his father on a monthly basis and that Peter would only tell him and his (Peter's) mother that Janet had caused his injuries.
- 5.7. The sentencing remarks of His Honour Judge Heath made at the conclusion of the criminal trial on 21st December 2016, outlined that Janet and Peter had been in a relationship for about 8 years and that the couple would often both drink to excess. It is stated that the consensus was that their relationship was a '*good one*' but that they would often argue and that these arguments were frequently more vociferous and loud when they had both been drinking. The sentencing remarks also confirmed that Janet did not kill Peter in any form of self-defence and that they had both been drunk on the evening that he died.

6. Terms of Reference

- 6.1. **To examine whether there were any previous concerns, incidents, significant life events or indications which might have signalled the risk of violence to any of the subjects, or given rise to other concerns or instigated other interventions.**
- 6.2. There was no record of any agency concern in relation to domestic abuse between Janet and Peter. The Police had never attended any incident between the couple prior to Peter's death. Although Janet was known to the Police historically for incidents relating to her being the survivor of domestic abuse in a previous relationship, there was little professional knowledge of Janet and Peter being a couple. There was some indication in June 2014 that there was a possible risk of financial abuse but this was not explored.
- 6.3. Peter was described by his GP surgery as a vulnerable adult who was alcohol dependent. The surgery was unaware that Peter and Janet were partners, they were not registered at the same address and no disclosure had been made during any of the GP consultations from either party of being in a relationship. There is consistency in the agency records regarding the descriptions of Peter.
- 6.4. Peter did not disclose he was experiencing domestic abuse to his GP and many of his reported injuries could be accountable to his problematic alcohol use, for which he received information, and advice regarding specialist treatment on several occasions during GP consultations. He was actively advised to seek referral back to the Addaction service.
- 6.5. The hospital trust documentation provides little additional insight into Peter's relationship with Janet. During all but one of Peter's attendances, he reports to live alone, with his mother documented as Next of Kin. Peter attended appointments alone and the only attendance in which reference to Janet was made was Peter's attendance for excision of the cystic lesion on 31st December 2015. Janet's details were provided as the first contact (should complications arise) as Peter reported that his mother was currently unwell.
- 6.6. Similarly, with the exception of one attendance, documentation relating to the hospital's involvement with Janet (all of which related to medical needs) reports her to live 'with her son – 18 years' and her Next of Kin is reported to be her daughter. Peter is only visible during one A&E attendance (19th July 2015 where Janet attended due to reflux) where Peter is described as her 'husband'. Both individuals were seen in isolation and on an irregular basis, in response to health issues which, following a relevant degree of investigation and intervention, were deemed to require no further involvement from hospital trust services; resulting in both being discharged.
- 6.7. There were no known life events which might have signalled the risk of violence to Peter. Although there was one attendance at the minor injuries clinic for an injury that should have led to a greater degree of professional curiosity. Peter attended the minor injuries unit on two occasions – once due to a pain in his foot but on the second occasion he attended with a swollen left eyelid which he said was caused by being hit by a remote control. The same nurse practitioner saw Peter on both attendances and it was documented that he smelt strongly of alcohol. It is not evident within the records who had thrown the TV remote or if domestic abuse had been considered. It would be expected practice within LCHS that professional curiosity should have resulted in additional questioning to explore the mode of injury. Had domestic abuse been

explicitly considered, and a disclosure made, this could have led to the completion of a Domestic Abuse Stalking and Harassment Risk Assessment Checklist (DASH RIC). That said, it is evident from the information shared by family and friends as part of the criminal investigation, that Peter may not have been honest with agencies with regard to his injuries and chose to disclose being subjected to domestic abuse to his mother and son only.

6.8. When and in what way were practitioners sensitive to the needs of the subjects, knowledgeable about potential indicators of domestic violence and abuse 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 fulfil these expectations?

6.9. Due to the lack of indicators of domestic abuse evident within agency records, there was little opportunity for practitioners to evidence sensitivity and knowledge in this subject area.

6.10. The GP was reported to have a good relationship with Peter, but at no stage did he disclose domestic abuse and the injuries that he had were seen in the context of his problematic alcohol use, for which he was signposted to specialist services.

6.11. Within the LCHS minor injuries clinic, there is no evidence within the electronic records to suggest that the nurse practitioner considered domestic abuse during her consultations with Peter. However this practitioner had not received any training on domestic abuse prior to the contact with Peter and it would therefore be unreasonable to have expected the same level of professional curiosity to that of a practitioner that *had* received this training. LCHS practitioners are now required to complete induction training prior to commencing any patient contact. This induction training includes level 1&2 safeguarding training.

6.12. When, and in what way, were the subject's wishes and feelings ascertained and considered? Were the subjects informed of options/choices to make informed decisions? Were they signposted to other agencies and how accessible were these services to the subjects?

6.13. There is evidence in Peter's GP records that his long standing alcohol abuse was clearly documented and clinicians, who came into contact with him, assessed the risk associated with alcohol abuse and advised him of appropriate pathways, in particular to the specialist alcohol service Addaction. It would appear however that this relied upon self-referral and despite Peter's claims to his GP, Peter was never known to Addaction. Communication between the GP and Addaction, with the consent of Peter, would have been a way in which to monitor his engagement and share information with regard to his problematic alcohol use.

6.14. A&E documentation alludes to Peter's past history as an 'alcoholic' whilst Clinic records suggest a history of alcohol use and a recent history of drug use. Whilst there was acknowledgement of this during the pre-assessment appointment on 18th March 2016, with relevant lifestyle advice provided, there was no indication of substance or problematic alcohol use support being directly offered by Clinic and/or A&E staff.

6.15. Similar learning, from a Review recently undertaken, has resulted in hospital staff being reminded via policy amendments, awareness-raising and training of the need for them to consider direct referrals to support services for patients with an enduring history of alcohol/substance use. As Peter's attendances occurred prior to this additional work being undertaken by the Trust, this would explain the lack of formal intervention on that occasion.

6.16. 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?

6.17. Exploration of the chronology has highlighted that there was little opportunity for assessment of domestic abuse in this case. When Peter came to the attention of health professionals with injuries, his explanations were felt to be reasonable and there was no recorded suspicion of domestic abuse. He did not disclose domestic abuse to any agency. The attendance at the minor injuries clinic with a black eye was the only occasion where a greater degree of professional curiosity could have been exercised (see 6.7) and where assessments could have then been reached in a more informed manner.

6.18. Was appropriate professional curiosity exercised by those professionals and agencies working with the individuals in the case, this includes whether professionals analysed any relevant historical information and acted upon it?

6.19. Professionals who came into contact with Peter were aware of and concerned about his problematic alcohol use. The GP signposted Peter to support services but it would appear that he never engaged with this. Lifestyle advice was given by other health professionals. There was not a pattern of injury or presentation that could have led to professionals exercising a greater degree of professional curiosity with regard to domestic abuse.

6.20. It is not clear from the records that the minor injuries clinic nurse practitioner demonstrated professional curiosity to determine who had thrown the TV remote resulting in the black eye and upper eye lid swelling to Peter. The practitioner was interviewed as part of the IMR and was unable to recall the consultation but stated that she was new in post at the time and would not have questioned the information to the same degree that she would today; as she has now received additional training with regard to domestic abuse. LCHS practitioners now have to complete induction training prior to commencing any patient contact. This induction training includes level 2 safeguarding children and adults training followed by level 3 safeguarding training within the first six months. Both of these training days include recognition of and response to domestic abuse.

6.21. Were the actions of agencies in contact with all subjects appropriate, relevant and effective to the individual and collective family needs and risks identified at the time and continually monitored and reviewed?

6.22. This is partially covered by 6.19 above.

- 6.23. With regard to health practitioners who came into contact with Peter, they provided appropriate health care based on the presenting conditions. Staff within urgent care settings such as A&E; minor injury units and out of hours departments do not have ongoing direct responsibility for patient review and monitoring. It is routine practice for the GP to receive electronic notification when a patient has attended an urgent care setting. This was completed following Peter's attendances.
- 6.24. All hospital consultations were undertaken appropriately, in accordance with ULHT policies and procedures. Medical records for both Peter and Janet evidenced an appropriate level of discussion in order to obtain informed consent whilst evidencing information-sharing with health colleagues; and the findings from all appointments and procedures undertaken were relayed in writing to their respective GPs.
- 6.25. The GP, in receipt of all attendances, would not have been expected to identify any patterns in behaviours or presentations as none were evident. The GP was attempting to engage Peter in addressing his problematic alcohol use which was seen to be the most pressing concern.
- 6.26. Did the agency have policies and procedures for Domestic Abuse and Safeguarding and were any assessments correctly used in the case of the subjects? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC or other multi-agency fora?**
- 6.27. All agencies, bar the GP practice, had in place relevant policies and procedures. As there was no identified risk of domestic abuse, assessment tools were not utilised. Peter was not therefore subject to a Multiagency Risk Assessment Conference (MARAC) or other multi-agency fora.
- 6.28. LCHS safeguarding policies and procedures were in place throughout the period of the scope and included domestic abuse. The nurse practitioner who saw Peter with a black eye had only commenced employment with the trust three weeks prior to her first contact with Peter. When interviewed as part of the IMR, the nurse practitioner advised that she had not received her induction training with the trust at this time and that she had never received any training in relation to domestic abuse. She did not recognise a risk of domestic abuse and therefore did not utilise any assessment tools.
- 6.29. The GP surgery had inadequate policies and procedures for the risk assessment and management for domestic abuse. No assessment tools were easily available within the practice and there was little professional acceptance of the effectiveness of these tools. It is fair to say that in this scenario there was no impact given that Peter did not disclose domestic abuse. There is however now a dedicated site on the Clinical Commissioning Groups shared intranet which all GP practices and staff can access where tools; help and guidance for completing the Domestic Abuse Stalking Harassment Risk Identification Checklist (DASH RIC) and Multiagency Risk Assessment Conference (MARAC) referral can be found.
- 6.30. 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?**

6.31. Peter was offered appropriate services with regard to his health needs including his problematic alcohol use. Given what was known at the time about Peter, this was an appropriate professional response.

6.32. Disclosures made by friends and family within the criminal investigation would suggest that Peter had only confided to his mother and son of being subjected to domestic abuse. It would appear that he provided other explanations for injuries which were accepted by agencies. Given his presentation as an adult male with problematic alcohol use, it is unsurprising that, in the absence of any other indicator of domestic abuse, that they accepted what was self-reported.

6.33. Were any issues of disability, diversity, culture or identity relevant?

6.34. The Review panel has debated whether there was evidence of professional bias as a result of perceptions of male victims and perceptions of female perpetrators although there was no evidence of this in the agency records.

6.35. In addition, the panel has questioned whether Peter would have identified himself as experiencing domestic abuse and whether his family, some of which were aware of the nature of his relationship with Janet, would have identified him as being a victim of domestic abuse. Sadly without the contribution of family members, this is little more than speculation. The stigmatisation of male survivors of domestic abuse is considered in the research section below.

6.36. To consider whether there are training needs arising from this case

6.37. It is evident that there have been changes to the training delivered by agencies, as can be seen in the changes to practice section below.

6.38. To consider the management oversight and supervision provided to workers involved

6.39. There is minimal evidence of case specific management oversight, although this would not be expected given the nature of Peter's presentations to health agencies.

6.40. Staff within the minor injuries unit had access to clinical supervision via their line manager and could access their locality deputy named nurse for safeguarding advice and support. The nurse practitioner did not access advice and support with regard to Peter. Quarterly group safeguarding supervision is now available for staff working within the minor injuries unit.

6.41. There was little safeguarding supervision available at the GP surgery during the period of the review although this would not have impacted upon professional judgement in this case in the absence of a disclosure or evidence to suggest domestic abuse. There is however now a designated lead for domestic abuse and a quarterly safeguarding forum for GPs.

6.42. Did any restructuring during the period under review likely to have had an impact on the quality of the service delivered?

6.43. There is no evidence of restructuring during the period under review.

7. Overview analysis

7.1. Identification of domestic abuse

7.2. It is clear from this review that there was minimal information held by agencies in respect of Peter and Janet, and even less so with regard to them as a couple. Both individuals were seen by health agencies, although they were generally seen separately and on an irregular basis. Although they were registered at the same GP practice, they were not known to be in a relationship and were registered at separate addresses. There were no records of agency concern with regard to domestic abuse between the couple.

7.3. Although Peter did come to the attention of health agencies with a number of minor injuries, these appeared to be seen in the context of an individual with a known alcohol problem. He did not disclose domestic abuse to any professional and his self-reporting was accepted as accurate and truthful. The review has considered whether professional assumptions are made regarding people with alcohol and substance use difficulties, in that they may be more prone to accidental injury. The need for professional curiosity must continue to be reinforced via training and awareness raising.

7.4. When Peter attended the minor injury clinic on 27th August 2015 with a swollen and bruised eye, having been hit by a TV remote control, the nurse practitioner did not enquire who had thrown the remote control. It would have been expected practice for the nurse practitioner to have made further enquiries. This review has established that this practitioner had only been in post for three weeks and had not received any training with regard to domestic abuse. The practitioner has been spoken to as part of this review, and she feels that she would now respond differently to the same set of circumstances.

7.5. Within LCHS now, all practitioners must complete induction training prior to any clinical practice, and this induction training includes safeguarding children and adults with domestic abuse elements, such as professional curiosity, completion of DASH Risk Identification Checklist and referrals to MARAC. In addition, quarterly group safeguarding supervision is available to those working within the minor injuries unit.

7.6. Although the GP practice received notification of the attendance on 27th August 2015, as the attendance note did not identify any safeguarding concerns, the GP would not have been expected to take any further action.

7.7. Referrals for support services

7.8. A number of agency records refer to Peter's substance use, particularly problematic alcohol use. Despite Peter's many reports of engagement with Addaction, there is no evidence of him being in receipt of specialist alcohol support services to address his problematic alcohol use. He was given information by the GP practice for self-referral but would appear never to have self-referred. It is recognised that Peter would have needed to be motivated to address his problematic alcohol use.

7.9. Within hospital contacts, problematic alcohol use was recorded and relevant lifestyle advice was provided but direct referrals for support services were not made which would have been a more robust response. Action has been taken to address this.

7.10. Janet is not identified in any agency records as having problematic alcohol use although this would seem to be the case given the findings of the criminal trial.

7.11. There is no evidence of any referral being made in relation to domestic abuse support services for either Janet or Peter as domestic abuse was not an area of concern.

7.12. Agency policy, procedures and practice

7.13. The majority of agencies involved appeared to have appropriate policies and procedures in place with regard to safeguarding and domestic abuse. At the time of the incident, the GP practice had poor policies in place, and has recognised that practitioners were unaware of the potential indicators of domestic abuse.

7.14. There is evidence of interagency communication, however the Review has considered how there is often no duty to share information within the wider health community and that inter-agency health communication can face limitations given the ways that services are commissioned. For example, it might be assumed that if Peter had attended Addaction then the GP would have been made aware. This is not the case in practice. This challenge has been drawn to the attention of local commissioners.

8. Changes to practice

- 8.1. Clinical practice within the minor injuries unit is being audited by the LCHS safeguarding team with a focus on the quality of recording; safeguarding training undertaken; recognition of safeguarding concerns including domestic abuse and appropriate discharge pathways.
- 8.2. United Lincolnshire Hospitals Trust staff have now been urged via policy revision, training and awareness raising to consider direct referrals to support services for patients with an enduring history of alcohol and substance use. The Trust has amended their adult safeguarding policy with regard to direct referrals being made for patients with substance and problematic alcohol use. The safeguarding intranet pages now contain a bi-monthly newsletter which identifies lessons learned from reviews, and these too contain information about the need to signpost and refer on for support services. Addaction staff have also attended safeguarding meetings at UHLT to discuss referral routes into their services. A programme of continuous audit is ongoing to monitor whether appropriate signposting and/or referrals are undertaken when problematic substance use is noted. Initial findings indicate variable compliance. Findings are escalated to Clinical Leads and, in addition, this particular criteria is to be added to the Trust's Ward Accreditation Checklist to facilitate consistent monitoring and oversight by Managers, Quality Matrons and the Safeguarding Adults Lead.
- 8.3. The GP practice now has a training matrix in place for which the practice manager has oversight. The GP practice is to provide assurance to the CCG that staff continue to access appropriate safeguarding training to comply with mandatory requirements. A Designated GP lead for safeguarding has been identified within the GP practice.
- 8.4. A quarterly safeguarding forum has been set up by the CCG for GPs to attend. In addition, there is now a dedicated site on the CCG intranet which provides tools and guidance regarding the DASH RIC and referrals to MARAC. The CCG provide a quarterly newsletter which identifies lessons learned from DHRs and SCRs. This is available to GP practices.
- 8.5. An area of learning arising from this case is with regard to situations where benefits are paid into the account of someone other than the claimant. Within the Council this now triggers a review of the circumstances to ensure that there is no risk of coercion or exploitation. This process also includes a referral to the safeguarding team where required. This example of good practice is to be shared within all of the District Councils within Lincolnshire.

9. Relevant Research

- 9.1. The ManKind Initiative publishes national research and statistical data in respect of male survivors of domestic abuse. Statistics published in 2018*, indicate that for every 3 victims of domestic abuse, two will be female and one will be male. The difference between the prevalence of domestic abuse for men and women is at its lowest since 2005. Of those that suffered partner abuse in 2014/15, 29% of men and 23% of women suffered a physical injury, a higher proportion of men suffering severe bruising or bleeding and internal injuries or broken bones/teeth than women. Interestingly only 27% of men sought medical advice whilst 73% of women did. The statistics indicated that male victims are over three times as likely as women *not* to tell anyone about the partner abuse they are experiencing. The data for prosecutions for domestic abuse by gender suggest that there is a slightly higher rate of successful prosecutions for male perpetrators of domestic abuse.
- 9.2. With regard to intimate partner homicide, ManKind have published data obtained via the ONS figures for overall homicides in England and Wales. From April 2012 until March 2015, 33 men were killed by a female (ex) intimate partner. In the vast majority of cases the victim died as a result of stabbing.
- 9.3. There are some features in this case that were identified in the Home Office Key Findings from Analysis of DHRs (December 2016) which reviewed 40 completed DHRs. The HO report identified that the most common method of killing was by knife or other sharp instrument; that in just over half of the DHRs substance misuse (and specifically problematic alcohol use) was mentioned. ? and that in the 33 cases of intimate partner homicides, 24 of the perpetrators had a history of violence. Janet did have a history of violence but nothing recorded since 2000. Knowledge in respect of her in relation to domestic abuse, was with her as a survivor rather than as a perpetrator.
- 9.4. In addition, the influence of gender is an area of consideration in the context of male survivors of domestic abuse. In a research document published by ManKind, reference is made to men feeling shame for being victims because of a societal view of what men are 'supposed to be', a sense of emasculation, and that a fear of not being believed prevented them from seeking help. In the case of Peter, he chose only to inform two of his immediate family members.

*Male victims of domestic and partner abuse, 35 Key Facts, March 2018; Mankind Initiative. <https://www.mankind.org.uk/wp-content/uploads/2018/04/35-Key-Facts-Male-Victims-March-2018-1.pdf>

10. Conclusions and lessons learned

- 10.1. With regard to positive agency practice, the Review has commended the actions of the GP in this case who tried hard to engage and support Peter with regard to his vulnerabilities and problematic alcohol misuse. The Review recognised the restrictions of Peter's self-reporting and his perceived lack of motivation to change which frustrated efforts to engage Peter.
- 10.2. There was no agency knowledge of the relationship between Janet and Peter and no reported concerns regarding domestic abuse. There is very little sense of their relationship as a result and this has been an area of difficulty for the review. The lack of family engagement has significantly impacted upon this review although it has been able to consider the sentencing remarks made following the conclusion of the criminal trial.
- 10.3. Information obtained within the criminal investigation would suggest that Peter only confided in his mother and son about the volatility and violence within his relationship with Janet. An area of learning is therefore required with regard to how families and friends can be encouraged to seek help and advice if they have concerns that someone close to them is being abused. Community awareness campaigns are a key area for development?. This was echoed by the Home Office Analysis of DHRs which states that the full extent of the violence often only came to light during the police investigation into the homicide. Thus revealing that friends, family and neighbours knew about the abuse but either did not know what to do about it or were asked by the victim to not report it. It was quoted from one DHR that these individuals held more information than agencies around the nature of the relationship between the victim and perpetrator.
- 10.4. Peter presented with minor injuries and his explanations were accepted. Although there is no evidence of this within agency records, the Review has considered how practitioners might be influenced in their judgement in the context of an individual reporting injuries who is known to have problematic alcohol use and whether this leads to assumptions being made.
- 10.5. That said, and as identified within the IMR written on behalf of the couple's registered GP practice, with little knowledge or disclosure of any relationship between Peter and Janet, professionals were sadly unable to predict or prevent the death of Peter.

11. Overview Recommendations

11.1. All agency IMRs recommendations are submitted as an appendix to this Review.

- a) Community awareness campaigns should be considered with a focus on how families and friends can be encouraged to seek help and advice if they have concerns that someone close to them is being abused or is an abuser.
- b) The example of good practice with regard to the process, to be followed in situations where benefits are paid into the account of someone other than the claimant is to be shared within all of the District Councils within Lincolnshire.
- c) The findings of this Review will be shared with local Commissioners and particular reference will be made regarding the need for commissioned services to meet the needs of both male and female survivors of domestic abuse.
- d) The findings of this review will also be shared with national research agencies who have a focus upon male victims.