

DOMESTIC HOMICIDE REVIEW
REPORT INTO THE DEATH OF Mr
COOPER – Executive Summary

REPORT PRODUCED BY
GRAHAM BARTLETT

SECTION ONE – INTRODUCTION AND BACKGROUND

1 Introduction

1.1 This report of a domestic homicide review (DHR) examines agency responses and support given to Mr Cooper, a resident of the Isle of Wight prior to him being found dead at his home address Spring 2016. The review will consider agencies contact/ involvement with him and other subjects of the review from Spring 2011 to the Spring 2016.

1.2 The circumstances of him being found dead are that during the afternoon, Hampshire Constabulary had received an abandoned 999 call within which an argument could be heard between a male and female with each party shouting abusive language. The phone number was attributed to Ms Blake. In keeping with normal practice, the Force Control Room returned the call. A woman answered and told the operator 'I think I might have killed him.'

1.3 The police attended and discovered the deceased body of Mr Cooper. They saw that Ms Blake was injured with bruising. In view of the assessment of this incident and the call, Ms Blake was arrested on suspicion of murder and a full homicide investigation commenced.

1.4 In the Winter of 2016, following a trial at Winchester Crown Court, Ms Blake was convicted of the murder of Mr Cooper and, the following day, sentenced to life imprisonment with a minimum tariff of thirteen and a half years.

1.5 The Domestic Homicide Review Panel and the Isle Of Wight Community Safety Partnership offer their sincere condolences to Mr Cooper's family and friends on their sad and tragic loss.

2 Process of the Review

2.1 This review was commissioned at a meeting of the Isle of Wight (IOW) Community Safety Partnership in spring 2016 in line with the Multi Agency Guidance for the Conduct of Domestic Homicide Reviews 2013¹. The chair and author was appointed shortly afterwards and the review started immediately. It should be pointed out that in December 2016 revised Multi Agency Guidance was published by HM Government but in light of this review being commissioned some six months beforehand, this review complies with the 2013 Guidance.

2.2 Mr Graham Bartlett was appointed to chair and be the author for this review. He is the Director of South Downs Leadership and Management Services Ltd and Independent Chair of Brighton and Hove Local Safeguarding Children Board. He also Independently Chairs the East Sussex and Brighton and Hove Safeguarding Adults Boards. He has completed the Home Office on line training for independent chairs of Domestic Homicide Reviews and has the Social Care Institute for Excellence Learning Together Foundation Course. He has experience of chairing and writing Domestic Homicide Reviews. He is a retired Chief Superintendent from Sussex Police latterly as the Divisional Commander for the city of Brighton and Hove. He had previously been the Detective Superintendent for Public Protection which entailed being the senior officer responsible for the Force's approach to Child Protection, Domestic Abuse, Multi Agency Public Protection Arrangements (MAPP), Missing Persons, Hate Crime, Vulnerable Adults and Sexual Offences. He retired in March 2013. He had no involvement or responsibility for any policing in Hampshire or the Isle of Wight.

2.3 A Domestic Homicide Review panel was established which set the terms of reference for the review and whose report this is. The Panel comprised:

Graham Bartlett	Independent Chair and Reviewer
Amanda Gregory	Isle of Wight Council (IOWC) – Regulatory and Community Safety Services Manager
Helen Turner	IOWC - Community Safety Operations Manager
Collette Puntis	IOW NHS Trust
Carol Tozer	IOWC –Director Adult Social Care
Jane Janvrin	IOW Community Rehabilitation Company
Val Bell	IOWC Housing
Su Tomkins	IOW NHS Trust
Mandy Tyson	IOW Clinical Commissioning Group
Bruce Marr	Independent Domestic Abuse (DA) Advisor
Ruth Attfield	Hampshire Constabulary
Moray Henderson	Safer North Hampshire Community Safety Team

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https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/209020/DHR_Guidance_refresh_HO_final_WEB.pdf

3 Terms of Reference

The specific terms of reference set for this review to consider were:

- *Whilst Mr Cooper had no known contact with any specialist domestic abuse agencies or services, the DHR will review the history of domestic abuse involving Mr Cooper / Ms Blake and assess whether there were any warning signs of escalation or vulnerability.*
- *Whether there were opportunities for professionals to refer any reports of domestic abuse or sexual violence experienced or committed by either the victim or the alleged perpetrator, (towards each other or any other partner) to other agencies and whether those opportunities were taken.*
- *Whether the quality of risk assessments undertaken were of a suitable standard and whether the thresholds for referral into Multi Agency Risk Assessment Conference (MARAC) were appropriate.*
- *Whether the services available for victims who are assessed as being below the threshold for MARAC are accessible and suitable for their needs and effective at reducing or preventing escalation of risk.*
- *Whether there were opportunities for professionals to ‘routinely enquire’ as to any domestic abuse or sexual violence experienced by the victim or alleged perpetrator that were missed.*
- *Whether there were opportunities for agency intervention in relation to domestic abuse regarding Mr Cooper, Ms Blake or Miss Cooper that were missed or could have been improved.*
- *Whether agencies, either singly or together, took sufficient account of the dependency Mr Cooper and Ms Blake had on alcohol and on each other and what they did to support them around reducing those dependencies to improve their health and wellbeing*
- *Whether there were any barriers or disincentives experienced or perceived by Mr Cooper, Ms Blake or their family/ friends/ colleagues in reporting any abuse including whether they knew how to report domestic abuse should they have wanted to and whether they knew what the outcomes of such reporting might be.*
- *Whether family, friends or colleagues were aware of any abusive behaviour from or towards the alleged perpetrator or the victim prior to the homicide and what they did or did not do as a consequence.*
- *Whether more could be done in the locality to raise awareness or accessibility of services available to victims of domestic violence, their families, friends or perpetrators.*
- *Whether Mr Cooper or Ms Blake had experienced abuse in previous relationships during the time period under review, and whether this experience impacted on their likelihood of seeking support in the period under review.*
- *Whether the homicide could have been accurately predicted and prevented.*

In addition:

- *The review will give appropriate consideration to any equality and diversity issues that appear pertinent to the victim, perpetrator and dependent children e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.*
- *The review will identify any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and / or services on the Isle of Wight.*

While it is not the purpose of this review to analyse the handling of child or adult safeguarding concerns related to the case there may be issues that arise from the review that relate to the safeguarding of children or adults who may be affected by domestic abuse. If this is the case these issues will be raised with the Isle of Wight Safeguarding Children Board or Safeguarding Adults Board.

3.1 The period set for the review to consider was Spring 2011 to Spring 2016.

3.2 Following the decision to commission this Domestic Homicide Review, Isle of Wight Council wrote to a number of agencies requesting they return Summaries of Involvement to help the panel understand which agencies had relevant involvement with the subjects of this review within the time period of this review:

3.3 Having considered these Summaries of Involvement, it was decided that the following agencies would be asked to submit Individual Management Reviews (IMR):

- Hampshire Constabulary
- South Central Ambulance Service NHS Foundation Trust
- Hampshire Hospitals NHS Trust
- Isle of Wight NHS Trust (Ambulance Service and St Mary's Hospital)
- Isle of Wight Council Children's Services
- Spectrum Housing
- Island Recovery Integrated Services
- Isle of Wight Council Housing Options
- Primary Care
- Department of Work and Pensions
- Hampshire County Council Adult Services
- Isle of Wight Fire and Rescue Service

3.4 The authors of the IMRs are, as far as possible, independent in accordance with the guidance.

3.5 The objective of the IMRs, which form the basis of this DHR, is to give an accurate account as possible of what originally transpired in an agency's response, to evaluate it fairly and, if necessary, to identify any improvements for future practice. IMRs also propose specific solutions, which are likely to provide a more effective response to a similar situation in the future. The IMRs have assessed any changes that may have taken place in service provision during the timescale of the review and considered if further changes are required to better meet the needs of individuals at risk of or experiencing domestic abuse. This report is based upon those IMRs, reflections of friends and family, information obtained from selected statements made to the police during the murder enquiry and considerations of the DHR Panel.

3.6 The report's conclusions and recommendations are the collective views of the Panel, which has the responsibility, through its constituent agencies, for implementing the recommendations.

3. Findings of the Review

3.1 During the review period and prior to the murder, the police recorded nine incidents of domestic abuse relating to Ms Blake, eight of which involved Mr Cooper. Five of these were at Ms Blake's address in Basingstoke and three at Mr Cooper's on the Isle of Wight.

3.2 Of the incidents involving Mr Cooper, the first was in the spring of 2013 and then there were none until early 2015. Over that year there were five incidents including approximately one a month in the spring and early summer, all but one in Basingstoke. The following year there were two in the spring, one in Basingstoke and one in the Isle of Wight.

3.3 The majority of these incidents were either verbal arguments or pleas for the police to attend to remove Mr Cooper from Ms Blake's address. Six of the eight calls were from Ms Blake, one from a neighbour and one, it appears, from Mr Cooper. Four of the eight incidents involved allegations or suggestions of assault albeit in the case of the last one, perhaps the most serious, this was said to have been from a fall.

3.4 There was no particular correlation between those police calls and calls to other services that, had they been put together would have indicated increased escalation or vulnerability. The police calls themselves, while relatively frequent (especially in the first half of 2015) were often ambiguous with no particular sign that their severity was increasing.

3.5 Injuries were minor on all but the last occasion, and this was explained away as a fall and, where assaults were reported, there were often counter allegations. It was notable that at no time was Mr Cooper treated as a victim despite his assertions that he had been attacked. Ms Blake's previous partner, Mr Allen, was once assessed as a victim but then told to leave the house and threatened with arrest if he did not.

3.6 In the main the incidents were responded to as if they were 'stand-alone' and the history rarely influenced the police response. In most cases where there was a power of arrest this was exercised and the relevant risk assessments were carried out, albeit it to a variable standard. Beyond the investigation of criminal offences and twice offering Ms Blake support from specialist agencies not much more was done to understand any deeper rooted issues particularly around their alcohol dependencies.

3.7 Mr Cooper's neighbours, for example, lived with the almost constant arguments and noise coming from his flat, mainly when Ms Blake was there. While few suspected this involved violence it was enough for their lives to be severely disrupted. There is no evidence from the statements provided that they were ever spoken to so as to glean another

perspective on the disputes and, even on the occasions that the Neighbourhood Policing Team became involved, this seemed to just involve an offer of services rather than any activity to seek from neighbours a deeper understanding and prevalence of the disputes.

3.8 It is debatable whether any such further enquiry would have revealed any evidence of escalation or warning signs, no neighbour suggested that in their statement following the murder. However, the police would have understood the frequency of the arguments and probably property damage and that may have triggered a different response.

3.9 That said, the history shows that both Mr Cooper and Ms Blake were only inclined to request the support of services in the moment of crisis. Two attempts by the police to provide Ms Blake with ongoing support and IRIS attempting to engage Mr Cooper were rebuffed.

3.10 Other than the police, no other agency received reports that domestic abuse was taking place between Mr Cooper and Ms Blake. Whether they could have elicited such reports will be discussed later.

3.11 Mr Cooper and Ms Blake were both heavy drinkers who, when together, would have a fractious relationship typified by constant and noisy arguments and, on occasions, violence. In proportion to the frequency of their rows heard by the neighbours, they rarely called for help and, it seems, then only in desperation. Often when that help was made available (be that by the police, ambulance service, the hospital or alcohol misuse services) they would refuse intervention or follow up.

3.12 On two occasions, the risk assessment having not met the threshold for MARAC (Multi agency risk assessment conference), the police offered to refer Ms Blake to specialist services. On both occasions she declined. While Spectrum Housing did not know domestic abuse was occurring, they referred Mr Cooper to IRIS (Island recovery integrated service). He did not accept the appointments offered. Often, while in hospital following overdoses, Ms Blake would discharge herself before she could be seen by mental health professionals. The tendency to decline services was very apparent.

3.13 Opportunities were missed in relation to Mr Cooper. He was never seen as a victim of domestic abuse even when he made clear that he too had been assaulted or threatened. He was only ever treated as an offender. This removed the opportunity for him to be referred to any services which may have helped him understand that he was a victim and therefore work with him to develop his own safety plan. It is worthy of note that Mr Allen was regarded as a victim given facts that emerged during the police attendance despite Ms Blake making the initial call. A risk assessment form was completed in respect of him but no services offered as a result. However, despite recognising him as a victim he was told he would be arrested if he returned to Ms Blake's house.

3.14 Mr Cooper's history of non engagement with services may indicate that he would not have been inclined to accept, or even agree to, any referrals but the fact that he was never considered as needing support himself denied him the opportunity to decide.

3.15 Information sharing from the police to Children's Social Care was good where Mr Cooper's daughter, Miss Cooper was concerned, even following a case in Basingstoke at which she was not present. Other domestic incidents did not prompt a social care referral but given the ambiguity about where Miss Cooper was living, and that she was not present, that is understandable.

3.16 Following seven of the nine domestic abuse incidents that came to the notice of the police, a DASH risk assessment was carried out. These were of variable quality, for example once there was an absence of historical information because Ms Blake declined to answer questions.

3.17 On three occasions the risk was graded as medium but on one this was reduced to standard. Where the assessments were complete and of a good standard, the risk

assessment appears appropriate given the information available. On one occasion, the exclusion of any historical information may have been the reason the risk was not graded as medium.

3.18 A MARAC is a *'meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors... [where] the representatives discuss options for increasing the safety of the victim and turn these into a co-ordinated action plan.'*²

3.19 MARAC is not intended to be a forum where medium or standard risk cases are considered. They would not have the capacity for this and that may dilute their focus on the highest risk victims. Risk is determined by the completion of a DASH Risk Assessment.

3.20 There is nothing seen by this review, those responding to or supervising the incidents reported or the murder enquiry team that would suggest that, even if all the DASH risk assessments had been completed fully, either Ms Blake or Mr Cooper would have been a High Risk Victim requiring referral into MARAC. Therefore, despite some assessments being of variable standard, from the evidence considered by this review the thresholds into MARAC appear appropriate.

3.21 Given that MARAC, quite properly, focuses on high-risk cases there is a gap for those falling below that threshold. This is not only an issue in the Hampshire and Isle of Wight areas but is a challenge to partnerships across the country.

3.22 During the time of this review there were few opportunities for multi-agency information to be brought together and assessed for cases of medium or standard risk. It is a challenge for professionals to fully understand those cases which may be, like this one, multi-faceted. Hampshire Constabulary, through their review of domestic abuse responses developed an arrangement so that neighbourhood policing teams carry out the same safeguarding assessments as safeguarding officers but given the lack of a true multi agency assessment for cases not involving children, these do not take into account the full range of information that may otherwise be available.

3.23 It is understood that new arrangements are now being developed to ensure that the sharing of safeguarding information includes the whole range of knowledge including domestic abuse risk assessments and all adult and children safeguarding referrals. This will then be considered in the MASH (described as a mini-MARAC) so that as fuller multi-agency picture as possible can be gained enabling a more comprehensive partnership safety plan.

3.24 The extent of the services available to those falling below the MARAC threshold is not differentiated for different risk categories nor from the universal services available.

3.25 The development of the new arrangements, including those already in place with the police, are encouraging and should be assessed and evaluated once they are embedded to fully understand how they improve outcomes for victims and reduce of prevent risk.

3.26 Ms Blake presented to the ambulance service, to acute hospital, to mental health professionals and to her GP with agoraphobia, panic attacks and behavioural issues together with alcoholism and self harm through overdosing. She would often disengage from services, including discharging herself from hospital and would not access community services she had been signposted to.

3.27 She had a history of domestic violence and childhood abuse. However there is no evidence that Ms Blake directly told anyone that she was currently suffering or fearing domestic abuse. She did disclose some history and, during a mental health assessment, say she had argued with her partner.

² <http://www.safelives.org.uk/sites/default/files/resources/MARAC%20FAQs%20General%20FINAL.pdf>

3.28 Even by considering some of these factors – accepting that not all may have been apparent – they should have been recognised as possible indicators for potential abuse. They were not and therefore no-one took the opportunity to enquire whether, in fact, domestic abuse was at the root of some of her problems.

3.29 Recommendation 6 of NICE Public Health Guidance (PH50) says *‘Domestic violence and abuse: multi-agency working’*³ states that *‘health and social care managers and professionals should ‘Ensure frontline staff in all services are trained to recognise the indicators of domestic violence and abuse and can ask relevant questions to help people disclose their past or current experiences of such violence or abuse. The enquiry should be made in private on a one-to-one basis in an environment where the person feels safe, and in a kind, sensitive manner.’ and ‘Ensure trained staff in antenatal, postnatal, reproductive care, sexual health, alcohol or drug misuse, mental health, children’s and vulnerable adults’ services ask service users whether they have experienced domestic violence and abuse. This should be a routine part of good clinical practice, even where there are no indicators of such violence and abuse.’*

3.30 There were many opportunities to do this and, on the evidence available to this review, none were taken. While Mr Cooper’s presentations were fewer, there was an opportunity to consider whether he was a victim or perpetrator when he underwent a mental health assessment at St Mary’s Hospital, and this was not taken either.

3.31 It is a moot point whether either would have revealed that domestic abuse was a factor in their lives, the point is they were not given the opportunity in those settings.

3.32 Aside from the lack of professional curiosity there does not appear to have been a consideration for safeguarding concerns to have been raised following any of the admissions to hospital, consultations with mental health professionals or the GP or ambulance attendances. There was concern expressed in the panel regarding the ambiguity of referral pathways and responsibilities across the safeguarding system.

3.33 Given that only the police had direct information that domestic abuse was occurring, it follows that no other agency would have triggered any further intervention around this. However, on a wider safeguarding level, while there is an argument for not undertaking Section.42 CareAct enquiries, information suggests that either may have had care and support needs, with an element of self-neglect. Therefore it is not unreasonable to expect a multi-agency response to look at safeguarding plans for both individuals giving an opportunity for agencies to explore if they have taken appropriate action and what other agencies should be involved. This did not happen.

3.34 The Isle of Wight Safeguarding Adults Board set up a Vulnerable Adults panel in 2015. Its purpose is to receive referrals from all agencies of adults who have a vulnerability but who do not meet the criteria to be provided with statutory safeguarding provision. The panel is multi agency consisting of the Local Authority, Fire Service, Police, NHS Trust, Public Health and housing providers. The panel considers referrals and provides or recommends interventions from partners. Many referrals are made where individuals are not engaging with other services but are perceived to be vulnerable or at risk.

3.35 North Hampshire have a similar body, the Safer North Hampshire Vulnerabilities Board and Vulnerabilities Operational Group. Cases referred into and considered by this panel span a range of vulnerability and safeguarding themes. The organisations who can refer include all those subject of this review that operate in the North Hants area. The Group develops multi agency plans which are managed, driven and monitored through the shared Anti Social Behaviour database ‘Safetynet.’

3.36 These groups appear to be useful fora for helping those who, due to eligibility thresholds, may fall between the gaps of statutory services yet still have need. Had Ms

³ <https://www.nice.org.uk/guidance/ph50>

Blake and Mr Cooper been referred to such a panel, a multi agency plan **may** have been developed and there **may** have been suitable interventions to address one or more of their vulnerabilities

3.37 The findings of Alcohol Concern and Against Violence and Abuse joint report '*Domestic abuse and change resistant drinkers: preventing and reducing the harm*'⁴ are particularly reflective of this case. Among other conclusions the report finds alcohol misuse was a central element in the domestic abuse but was never effectively tackled, there is often non-engagement with alcohol services, the complex relationship between alcohol misuse and domestic abuse was often misunderstood and working with couples who drink is particularly problematic as is effectively assessing risk where violence and alcohol misuse co-exist.

3.38 It would be disingenuous to regard Mr Cooper's or Ms Blake's drinking as lifestyle choice. The root to addiction is complex but few decide to become alcoholics. Their condition was part of who they became over a number of years and they should have received services that sought to help them recover, rather than seeing their addiction as an aggravating factor. Whilst the evidence of this case does not overtly point to alcohol misuse being a coping mechanism for either Mr Cooper or Ms Blake, the findings of the joint report referred to in the previous paragraph serve as a reminder that this could well be an underlying cause of addiction which should trigger professional curiosity as to whether that may be the case.

3.39 Nearly all agencies who had involvement with Ms Blake and Mr Cooper were aware of their alcohol dependency in some form or another. It was such a factor in their lives that it would have been impossible for anyone to have been oblivious to it. However, only one attempt was made to refer either to alcohol services. Spectrum Housing recognised that an underlying factor in the poor condition of Mr Cooper's property was his drinking. Their referral was unsuccessful and he did not take up the appointments but it was reassuring that they at least tried.

3.40 Despite their many contacts with services, however, it was only the police and the ambulance services in Basingstoke and the Isle of Wight that knew about them as a couple. The police made safeguarding referrals but did not refer them to any substance misuse services and the ambulance services made no referrals.

3.41 Given the numerous times that the police were called to either or both, and the nature of those calls, they will have been well aware of the dependency they had on one another and on alcohol. That is not to say that the police were called every day, sometimes there were months between calls, it is just that when they were the themes remained constant.

3.42 Had health practitioners been more inquisitive regarding the socio-economic circumstances of either, or indeed if they were suffering domestic abuse, they may have become more aware of the dependencies and would probably have been better placed to try to reduce them.

3.43 An article in the Medical Council on Alcohol journal '*Alcohol and Alcoholism*'⁵ found that, '*compared with people suffering from other, substance-unrelated mental disorders, alcohol-dependent people are less frequently regarded as mentally ill, are held much more responsible for their condition, provoke more social rejection and more negative emotions.*'

⁴ <https://avaproject.org.uk/wp-content/uploads/2016/09/Alcohol-Concern-AVA-guidance-on-DA-and-change-resistant-drinkers.pdf>

⁵ Georg Schomerus, Michael Lucht, Anita Holzinger, Herbert Matschinger, Mauro G. Carta, Matthias C. Angermeyer; The Stigma of Alcohol Dependence Compared with Other Mental Disorders: A Review of Population Studies. *Alcohol and Alcoholism* 2010; 46 (2): 105-112. doi: 10.1093/alcalc/agq089

3.44 While, other than an assessment by a custody sergeant and detective sergeant, few minimised the impact of Ms Blake and Mr Cooper's alcohol dependency at the same time few took the initiative to try to reduce it in any meaningful way. This may have been because it was seen as a lesser condition than other disorders or, as implied by the two sergeants, of their own making.

3.45 Mr Cooper and Ms Blake were, at the point of crisis, well aware that they should call the police. For other reasons, known only to them, they were never supportive of any police investigation that followed nor, in the case of Ms Blake, accepting of further services.

3.46 Neither reported, or even mentioned, any ongoing abuse to other agencies they presented to and it is not known whether they would have responded if asked.

3.47 Mr Cooper's family did not specifically perceive any barriers or disincentives. They suspected that he was suffering from domestic abuse and, following one incident close to the time he was killed, he revealed that to his siblings. However, they did not feel it their place to report their suspicions to the police or anyone else without the specific consent of Mr Cooper. This was for no other reason than it had never occurred to them and if Mr Cooper did not want to report his abuse, he may resent it if they did.

3.48 Friends said to the police after the murder that they had witnessed violence between the pair but did not report it. It is likely that this was not part of their culture given they were part of Mr Cooper and Ms Blake's drinking fraternity and presumably had a loyalty to both.

3.49 Neighbours of Mr Cooper were aware of the constant arguments and the noise that would go on all night. On only one occasion was that reported to the police, albeit they could find no trace of either Mr Cooper or Ms Blake when they attended. Otherwise the noise would be reported to the housing association. None of those spoken to following the murder regarded the noise as indicative of what they perceived as domestic abuse as they heard nothing physical.

3.50 The provision of domestic abuse services on the Island is chiefly through Island Refuge and Outreach Services. A simple Google search identifies, through the Isle of Wight Council website, the nature of domestic abuse, basic safety measures people can take and available help lines including Island Women's Refuge and Outreach Team, Police Public Protection, National Domestic Abuse Helpline, Broken Rainbow (for LGBT victims) and Men's Advice Line.

3.51 When asked, the family did not know which agencies, other than the police they should report the domestic abuse they suspected. This was not because they had tried to find out rather, like so many families, they did not think they would ever need to know.

3.52 There is no evidence that Mr Cooper, Ms Blake or anyone connected to them were struggling to find support. It would be impossible for services to saturate communities with information and pathways but given the lack of onward referrals from the health sector (chiefly because there was a lack of routine enquiry) more should be done to highlight services and referral routes to other service providers as part of a wider communication and engagement strategy.

3.53 There is no evidence to suggest that Mr Cooper experienced any previous domestic abuse and, only at the very beginning of the time period under review were agencies involved in a domestic abuse involving Ms Blake with a previous partner (Mr Allen).

3.54 Ms Blake had experienced domestic violence in a previous marriage but her experiences of this and the services she may or may not have received were in the 1980s and outside the scope of this review.

3.55 The call she made regarding Mr Allen was her calling for help as she felt she was going to harm him. He was removed from the address and no further services were provided. It is unknown whether this experience impacted on her seeking support.

3.56 Despite the lifestyle of Ms Blake and Mr Cooper, the number of calls to the police for domestic abuse and other matters, the hospital admissions and health issues Ms Blake experienced, there was not a discernable escalation of harm or abuse that was seen, or indeed should have been seen by agencies.

3.57 On risk assessment, Ms Blake was graded as either medium or standard risk. Mr Cooper was not risk assessed as he was never seen as the victim but, had he been, he would, in all likelihood, have been graded standard risk.

3.58 There were occasions when Ms Blake was said to have been in possession of a knife and these were dealt with appropriately. The nature of the assaults she inflicted on Mr Cooper, that came to the attention of agencies, was minor, likewise for those assaults by Mr Cooper on Ms Blake.

3.59 They were a difficult couple to engage with and would present aggressively at times, would decline services and sometimes when professionals tried to assess them, in whatever setting they would not cooperate.

3.60 There had been no suggestion that either felt seriously threatened by the other nor that they were hiding more serious abuse. For all these reasons, despite the observations and recommendations made in this review, this homicide could not have been predicted or prevented.

4 Good Practice Points

4.1 The diligence that the police applied in ensuring that the home that a vulnerable child was to be cared for within was notable. They went to extensive efforts to ensure she would be safe and nurtured at that home and also at her father's home where they predicted she may visit.

4.2 That South Central Ambulance Service paramedics undertake capacity assessments when faced with patients who refuse medical treatment or decline to be transported to hospital. This shows a recognition that adults are entitled to make unwise decisions but that those decisions are considered in light of the Mental Capacity Act 2005.

4.3 The recognition that the condition of Mr Cooper's flat may have been, in part, due to his alcohol dependency prompted Spectrum to make a referral to the alcohol misuse service. Despite him not engaging they then tried to make further enquiries. While these were not successful it was good that they should proactively seek to source support for one of their tenants to help them recover from addiction.

5 Lessons Learned

5.1 Officers do not always appreciate the dynamics of domestic abuse and are at risk of categorising the victim and perpetrator before undertaking an initial investigation thereby potentially failing to recognise the vulnerabilities and support needs of the all of the parties involved.

5.2 There may be a lack of awareness in the police of the added vulnerabilities that substance misuse and mental ill health can bring to people, especially in relationships where both parties are affected by this. This can lead to over optimism in how effective some safety measures may be.

5.3 Paramedics and ambulance technicians may not understand the definition of a vulnerable adult nor their responsibilities to raise safeguarding concerns when they encounter them. This could lead to people remaining unprotected and without the support they require.

5.4 Clinical staff in Hampshire Hospital NHS Foundation Trust do not routinely enquire of patients whether they are experiencing domestic violence even when known indicators of risk are disclosed to them.

5.5 There may be a gap in the arrangements which enable partners to develop multi-agency plans to help safeguard those who fall below thresholds for specific services or the Care Act 2014 eligibility criteria. (Recommendation 18 refers)

5.6 There is a worrying gap in emergency response procedures at Isle of Wight Ferry Terminals in Portsmouth as there is an actual or perceived lack of understanding as to how emergency vehicles access docked vessels leading to a tendency to return sick passengers to the Isle of Wight rather than wait for medical assistance at the mainland terminal.

5.7 There is a lack of clarity as to who should make safeguarding/ vulnerable persons referrals where it is believed that a person may have unmet needs or would benefit from additional services. There can be a tendency to assume others will do this. There can also be the tendency for those carrying out assessments for other purposes (e.g. mental health) not to consider need that falls outwith the objects of that assessment. (Recommendation 18 refers)

5.8 There may be a tendency in primary care to undertake medication reviews in absentia or without all of the relevant information, even with those who have added vulnerabilities or who have demonstrated poor compliance. This is not effective practice.

5.9 Some Primary Care practitioners have a poor knowledge base or understanding of the prevalence and risk factors for domestic violence and do not routinely enquire whether it is a factor in their patients' lives.

5.10 Mandatory Read Codes are not routinely applied to patient's records in primary care meaning key information regarding conditions or vulnerabilities can be missed in ongoing patient care.

5.11 Where agencies receive safeguarding referrals that are incomplete they may not always challenge the referrer to provide the information they require to undertake effective assessments.

5.12 There may be a lack of awareness on the Isle of Wight and Hampshire of the referral responsibilities and pathways that exist for those who encounter adults who are vulnerable or are experiencing safeguarding needs, especially those that fall below other statutory criteria for services (e.g. Mental health services, Section 42 Care Act 2014)

6 Recommendations

6.1 That Hampshire Constabulary remind all officers and staff of the importance of fully understanding the nature of domestic abuse and applying the principles of the College of Policing Authorised Professional Practice regarding counter allegations in domestic abuse investigations, thereby enabling them to risk assess and offer services to *all* vulnerable victims.

6.2 Once embedded, Hampshire Constabulary should audit the compliance with the elements of the Domestic Abuse Force Action Plan surrounding the assessment of risk, thresholds and interventions so as to ensure a consistent and evidence based approach to risk assessment, clarity around supervision and robust and proportionate interventions for those victims at all levels risk. This should include ensuring that efforts are made to reveal the prevalence of unreported abuse, for example from neighbours or others connected with the parties involved.

6.3 Hampshire Constabulary should, as part of its drive to promote positive action, ensure that any intervention around domestic abuse, both as part of the investigation and

safeguarding responses, includes enquiries being made to reveal the prevalence of any unreported abuse so as to assist in establishing a fuller history and a more accurate identification of risk thereby enabling appropriate interventions to be made.

6.4 That Hampshire Constabulary audit the quality of the new single risk form to ensure that its implementation has improved information sharing with partners and is enabling a more holistic risk assessment process.

6.5 That Hampshire Constabulary, Isle of Wight Council and Hampshire County Council together with the respective Clinical Commissioning Groups develops mechanisms, whether through MASH or otherwise, to ensure that risk and vulnerability of children and adults, including domestic abuse victims, is dynamically and collectively assessed and information shared across all relevant agencies so that meaningful multi-agency action plans are developed and delivered as a consequence.

6.6 That Hampshire Constabulary strengthen its guidance surrounding the impact of substance misuse in relationships, the nature of co-dependence of those who suffer from disorders related to addiction and effective interventions to support them so as to protect vulnerable people in such settings.

6.7 That South Central Ambulance Service review its guidance to staff regarding their responsibilities to identify vulnerable people when they encounter them and their subsequent responsibility to raise safeguarding concerns through the established routes in such cases.

6.8 That Hampshire Hospital NHS Foundation Trust review their guidance surrounding, and its professionals' compliance with, Recommendation 6 of the National Institute for Healthcare and Excellence (NICE) public health guidance 50 – Domestic Violence and Abuse Multi Agency Working, regarding making routine enquires into domestic abuse.

6.9 As a basic principle of emergency response, South Central Ambulance Service should work with Wightlink to ensure that there is a mutual understanding of how to access ferry terminals and that Wightlink reinforce their operating instructions that ensure that emergency services are called to the first available terminal and that sick passengers are not carried back to the port of embarkation prior to receiving medical attention.

6.10 The Local Safeguarding Children Board should consider the issues raised in this report (specifically those highlighted in paragraph 2.12.25) and assure itself that, through the improvement journey the Isle of Wight Children's Services are on, such measures are in place to have radically reduced the possibility of similar issues from occurring again and that mechanisms are in place to address them should they re-occur.

6.11 That Sovereign Housing examines how it enables tenants to report to them concerns around crime and anti social behaviour connected with their or another's tenancy so as to ensure there is clarity and confidence in the reporting mechanisms such that Sovereign are aware of the range and nature of behaviour and escalate their intervention as appropriate.

6.12 That the commissioners and providers of Isle of Wight drugs and alcohol treatment services examine the feasibility of ensuring that multiple offers of service are made in varied ways based on the hypothesis that some clients may respond to different types of approach thereby increasing the likelihood of engagement.

6.13 NHS England and the North Hampshire Clinical Commissioning Group should ensure that primary care providers undertake proactive medication reviews with all patients especially those who have added vulnerabilities or who have demonstrated poor compliance.

6.14 That NHS England and the North Hampshire Clinical Commissioning Group, develop mandatory workforce development measures for Primary Care to ensure that the knowledge and understanding of the prevalence and risk factors around domestic abuse are fully

understood enabling them to embed the NICE Quality Standards on domestic violence and abuse into practice.

6.15 That NHS England and the North Hampshire Clinical Commissioning Group remind primary care practitioners of the importance of attaching relevant read codes to patients records to ensure that vulnerabilities or specific needs are clear and accessible to all clinicians.

6.16 That NHS England and the North Hampshire Clinical Commissioning Group remind primary care practitioners of the importance of complying with Recommendation 6 of the National Institute for Healthcare and Excellence (NICE) public health guidance 50 – Domestic Violence and Abuse Multi Agency Working, regarding making routine enquires into domestic abuse and finding opportunities to do so safely.

6.17 That Hampshire Adults Social Care ensure that in the event of them receiving incomplete safeguarding referrals or concerns that they challenge those agencies providing them to submit the information required to enable them to undertake effective assessments.

6.18 That the Isle of Wight and Hampshire Safeguarding Adults Boards (SABs) develop clear and simple referral pathways for all agencies and professionals who encounter vulnerable adults and/ or those with safeguarding needs (including those who may fall below eligibility thresholds.) That the SABs then ensure agencies take responsibility to use these so as to enable effective multi agency information sharing and planning which provides the most appropriate services to meet the identified need. This should be underpinned by the Hampshire SABs Multi Agency Risk Management Framework