Bournemouth Community Safety Partnership

Domestic Homicide Review

Anita
Date of death May 2016

Executive Summary

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1 INTRODUCTION

1.1. This Domestic Homicide Review was commissioned following the death of Anita a 44-year-old white British woman with no known disabilities. Her death occurred as a direct result of the actions of her male partner 36-year-old John. Anita was a victim of domestic abuse and her cause of death was a head injury for which John was arrested and charged.

1.2. Having considered the circumstances surrounding Anita's death, Bournemouth Community Safety Partnership Chair jointly with the Adult Safeguarding Review Group Chair commissioned a Domestic Homicide Review, having identified that it met the requirements as set out in the Guidance for Conduct of Domestic Homicide Reviews (Home Office 2013). Pseudonyms have been in used in this review for the victim (Anita) and perpetrator (John), to protect their identities and those of their family members.

1.3. Criminal proceedings were completed in 25th October 2016 and the perpetrator was convicted of manslaughter and required to serve a prison sentence of 5 years and 4 months.

2 DOMESTIC HOMICIDE REVIEW METHODOLOGY

2.1. In line with local protocols a request for scoping information was sent to all agencies that potentially had contact with Anita and John prior to her death. After a delay caused by being unable to find an appropriate Independent Chair for the review, the initial panel meeting was held on the 9th August 2016 with further meetings on the 29th September 2016, 22nd February 2nd May and 18th July 2017.

2.2. Fifteen of the seventeen agencies contacted confirmed they had information held regarding the victim and/or perpetrator and were asked to secure their files. Eleven agencies produced Individual Management Reviews.

2.3. A Domestic Homicide Review panel was appointed to support the lead reviewer. The panel members were:

- DCI Joan Carmichael (up to July 2017) DCI Gavin Dudfeild (from July 2017) - Dorset Police, Adult Public Protection Lead
- Stewart Balmer – Dorset Police, Force Review Officer
- Pamela O'Shea – Dorset CCG, Head of Quality Improvement, Quality Directorate
- Anne Humphries - Business Manager (Bournemouth and Poole Adult Safeguarding Board)
- Sian Jenkins - Community Safety Partnership Officer, Bournemouth Borough Council

- Barbara O'Brien - Interim Service Manager, Safeguarding Adults and Statutory Mental Health, Adult Social Care, Borough of Poole
- Hayley Verrico (Mtg 1) Sarah Webb (Mtg 2) - Joint Service Manager Statutory Services (Principal Social Worker – Bournemouth) Adult Social Care, Bournemouth & Poole Borough Councils
- Deborah Bilton - Named Professional + Safeguarding, South Western Ambulance Service NHS Foundation Trust
- Cara Southgate - Associate Director of Nursing & Quality, DHUFT
- Tonia Redvers - Head of Domestic Violence and Abuse Services, The YOU Trust (Independent Domestic Abuse Expert)
- Karen Wood, Senior Commissioner, Bournemouth Drug & Alcohol Commissioning Team

Family Involvement

2.4. Anita's father was informed of the review and asked if he would like to be involved. This letter was followed up, but he has not responded to date.

Perpetrator Involvement

2.5. The perpetrator was asked via letter if he would participate in the review, but the review has received no response.

Independence of the Chair of the Domestic Homicide Review

2.6. The Review was Chaired by Mr Barrie Crook. He is the independent Chair of the Safeguarding Adults Board.

Independence of Panel members and Independent Management Review authors

2.7. All Panel members and Independent Management Review authors had not been in direct contact with Anita or John, however some of them had supervised staff who had direct involvement with them as several organisations are small and do not have capacity for alternative panel members e.g. Providence Surgery.

Independence of the author of the Domestic Homicide Review

2.8. The independent overview author is Brian Boxall, a retired Detective Superintendent who served with Surrey Police for 30 years. Since his retirement in 2007, he has as an independent consultant, undertaken several Domestic Homicide Reviews and children and adult serious case reviews. He is an Independent Chair of both a Safeguarding Children and Adult Board. He is not currently employed by any of the statutory agencies involved in the review and has had no previous involvement or contact with the family or any of the other parties involved in the events under review

The Terms of Reference of the Domestic Homicide Review

2.9. Whilst respecting Anita the review sought to do the following:

- Consider in detail the period of May 2013 to May 2016 prior to the events leading to the death of Anita.

- To highlight any relevant information prior to May 2013 which could be considered important for the review.
- Request Individual Management Reviews by each of the agencies defined in Section 9 of the Act and invite responses from any other relevant agencies or individuals identified through the process of the review.
- Seek the involvement of the family, employers, neighbours & friends to provide a robust analysis of the events.
- Produce a report which summarises the chronology of the events, including the actions of involved agencies, analysis and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.

2.10. Questions in the terms of reference relate to:

- In the knowledge that both Anita and the John were known to services, was the information available acted upon in a timely manner.
- The involvement of the Multi Agency Risk Assessment Conference.
- In services where there was involvement with Anita or John were there adequate safeguarding and domestic abuse policies and procedures and were they followed.
- Was there sufficient good quality information sharing and communication between agencies in place to address the level of risk and safeguarding concerns?
- Were the appropriate actions taken to identify risk and were risk assessments conducted and robustly managed.
- If family, friends and colleagues are participating in the review, were they aware of any abuse that may have been taking place.
- Were there any barriers experienced by Anita or family, friends and colleagues in reporting the abuse.
- Was abuse present in any previous relationships, did this affect Anita's decision on whether to access support.
- Were there any opportunities for professionals to routinely enquire as to any domestic abuse experienced by Anita that were missed.
- Are there any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of the services available?
- Give appropriate consideration to any equality and diversity issues that appear pertinent to the victim, perpetrator and dependent children.

3 SUMMARY CHRONOLOGY

3.1. Anita moved to the Bournemouth area in 2011, and the evidence indicates that she was an individual with complex needs.

3.2. Anita had been heroin and alcohol dependent since 1996 and had been prescribed methadone as an Opioid Substitute Treatment (OST) since 2008. She was described as erratic with her methadone usage and her attendance at treatment appointments. She continued to use heroin and

alcohol on top of her opioid substitute treatment prescription, which placed her at great risk of a fatal overdose. Her previous partner had died some two years earlier. She had a son who lived approximately 2 hours from her.

3.3. Agencies first became aware of an abusive relationship between Anita and John in April 2013 when Anita attended a local hospital for a suspected broken rib. Anita disclosed to a Bournemouth Assessment Team [2](BAT) nurse that she was scared of John.

3.4. A further incident one month later led police to assess Anita as being at 'medium' risk of domestic abuse, a level that upon review was raised to 'high risk'. This resulted in a referral to Multi Agency Risk Assessment Conference (MARAC)[3]. This was the first of 7 MARACs held to discuss Anita. An Independent Domestic Violence Advisor (IDVA)[4] was allocated. The IDVA service was provided at the time by Bournemouth Churches Housing Association, from 2015 the IDVA service ceased and was replaced with Domestic Abuse Advisors in the Maple Project.[5]

3.5. The MARAC identified that Anita had separated from John but was still under threat from him and another male, the latter having threatened, to break her knee-caps. The MARAC identified several risks to Anita. The actions recorded did not fully address the risks identified.

3.6. Anita's heavy drinking at this time impacted on her ability to access support services. Anita had stated that she would accept a refuge place but was informed by the IDVA that she would not be accepted as she would not pass the required risk assessment due to her heavy drinking. This belief that she could not access refuge stayed with Anita even when refuge was later an option. During this time there is no evidence that the Housing Option's team or the out of hours service were contacted to discuss housing options.

3.7. An individual safety plan was created for Anita with the IDVA. It focussed on keeping her safe within her own flat. The flat was subject to target hardening, including the installation of a spy hole, chain and a fireproof letter-box.

3.8. The following months highlighted a pattern set to repeat over the next 3 years of Anita and John resuming their relationship and Anita withdrawing support for prosecutions. Police still arrested John, and whilst a police prosecution without a victim was considered, it was not pursued due to lack of corroborative evidence.

3.9. In August 2013 the police attended a domestic incident where John had

[2] BAT: Bournemouth Assessment Team (the care –coordinators for drug and alcohol services for drug and alcohol users) who at that time hosted the alcohol liaises nurse based in the local hospital

[3] MARAC: Multi Agency Risk Assessment Conference (MARAC) is a regular local meeting to discuss how to help victims at high risk of murder or serious harm.

[4] IDVA: The main purpose of independent domestic violence advisors (**IDVA**) is to address the safety of victims at high risk of harm from intimate partners, ex-partners or family members to secure their safety and the safety of their children.

[5] The Maple Project is a single, multi-functional domestic abuse team employed by Dorset Police

pinned Anita down. John was arrested. The Crown Prosecution Service would not pursue a prosecution due to Anita having previously received a fixed penalty notice for wasting police time in 2007. The Crown Prosecution Service[6] referred to this affecting her credibility as a witness. At this time Anita was still being supported by the IDVA service however, she disengaged with several agencies following this incident and the IDVA closed her case in September 2013.

3.10. In October 2013 Anita was again subject to domestic abuse and police referred the incidents to the MARAC. The same IDVA was allocated to Anita. Following this incident, the IDVA made an adult safeguarding alert to Care Direct[7] (Adult Social Care), this was the first of several referrals to Adult Social Care and it led to the first of four safeguarding meeting to discuss Anita. A MARAC and a safeguarding meeting took place within days of each other. During the safeguarding meeting an investigative action plan was created which saw several positive actions to help Anita stay safe, and to address her alcohol and substance misuse, during this meeting domestic abuse was specifically discussed but no mention of co-ordinating with the MARAC process was made.

3.11. A serious incident in December 2013 (Anita had bitten John and he had in turn hit Anita on the head with a mug) saw Anita agreeing to support a prosecution and John, who had been arrested, was bailed to an address in Poole. John was subsequently charged with an offence of actual bodily harm. The police sought to remand him in custody, but John was bailed by the court with conditions not to contact Anita and not to enter the Bournemouth area. This bail was breached several times over the following weeks, however there is no evidence that any action was taken because of these breaches. The Crown Prosecution Service, in July 2014 discontinued the case when Anita withdraw her support and stated her evidence was untrue, which the police were unable to refute.

3.12. In July 2014, following an assault, the police were successful in obtaining the first [8]Domestic Violence Prevention Notice (DVPN). The Court then issued a Domestic Violence Prevention Order (DVPO). This lasted for 28 days and prohibited John from having contact with Anita. Despite this Anita continued to meet with John. John was arrested for breach of the DVPO, but he was released with no further action, due to Anita refusing to support the evidence. It was at this stage that she disclosed she believed she was three months pregnant. The suspected pregnancy was mentioned for up to 12 months following this initial disclosure and agencies are unsure if the pregnancy was confirmed or if it was more than one pregnancy. She had stated early on that she intended to have an abortion, but no evidence of an abortion could be found.

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[6] The Crown Prosecution Service (CPS) is the principal prosecuting authority for England and Wales, acting independently in criminal cases investigated by the police.

[7] Care Direct: Local authority care, safeguarding adult assessment team

[8] An initial temporary notice, the Domestic Violence Protection Notice (DVPN) can be issued when authorised by a senior police officer, and this is then followed by a **DVPO** which will be imposed at the magistrates' court. It does not require a victim's support.

3.13. In September 2014 Anita reported that John had been abusive towards her. He had pinned her down removed her bra, bit her on the chest and stomach and tried to strangle her. She started to make a victim statement but stopped prior to the statement being completed. John was arrested and bailed, and significant attempts were made by police and the BAT social worker to get Anita to support a prosecution. She refused and over the following days she visited John's address and had to be physically removed. The police case review officer concluded that the case against John could not continue.

3.14. A further adult safeguarding strategy meeting was held following this. The risks identified included increased risk of abuse due to possible pregnancy and risks associated with drug and alcohol use. The action plan however focussed entirely on her possible pregnancy and the risk to the unborn child, in effect the possible pregnancy became the primary concern and masked the domestic abuse.

3.15. In December 2014, following a series of further attacks, Anita spoke with a police domestic abuse officer stating that she had had enough. She was desperate to move away but she herself explained that she could not go into refuge as she was an alcoholic. She would not let John in, stating that "*he is so jealous, isolates me, bullies me and takes my money.*" John was arrested, and consideration was given to the service of a further DVPN, but as Anita continued to engage with John the request had to be withdrawn. Another MARAC referral was made.

3.16. That same month police received intelligence indicating that Anita's address might be being 'cuckooed' by drugs dealers. During this time Anita's son stayed with her. Her son seemed to briefly be a protective factor and he would not let John into Anita's home. It is during this time John began to be known to services for self-harming.

3.17. A MARAC was held in early January 2015. The recorded action plan however was limited in its actions, it could be summarised that MARAC members were at a loss of how to protect Anita.

3.18. In mid-January 2015, to protect Anita and John from a perceived threat from London drugs gang, police agreed to pay for them to stay in a hotel separately, however they wanted to stay in the same room. Whilst together at the hotel John and Anita were involved in a domestic incident resulting in John being moved to a different hotel.

3.19. An adult safeguarding strategy meeting was held on the 28th January 2015. Present were the Chair, BAT social worker and the IDVA. The case was closed with Anita being informed that she could still seek help when needed.

3.20. In March 2015 Police executed a drug warrant at Anita's address. Drugs were found, and Anita was arrested. Police believed that her flat was still

being used by London drugs dealers. A safety plan was devised with police. A panic alarm and a response plan were put in place to try and minimise the risk to Anita from the drugs gang. This issue again became the main concern for agencies and masked the domestic abuse Anita was living with.

3.21. In early July 2015, the Multi-Disciplinary Panel authorised the application for an inpatient detox for Anita. The BAT care co-ordinator arranged for a 21-day in-patient detoxification out of the area. The intention was for Anita, after the detox, to relocate out of Bournemouth and as part of her aftercare package and to engage in treatment services in Oxford. It was identified that she may not yet be ready for detox, but it was approved based on the risk to her, due to her relationship with John and her health difficulties i.e. heart problems, injecting in her groin, swollen legs. John was also subject to a plan for a detox and structured treatment with accommodation in a dry house but was unaware that it involved separating them. For the detox to be commenced, the requirement was for Anita to attend 3 weeks of preparation work (6 sessions) with the BAT care co-ordinator to prepare her for detoxification, motivate her for treatment and prepare her for aftercare. She failed to attend one session and was late for another.

3.22. Later in July 2015 John threatened to jump off a car park. He was taken to a local hospital for a Mental Health Act assessment. John was still indicating that Anita may be pregnant. He stated he was on witness protection scheme and was consuming cider sherry, heroin and crack cocaine most days. He had fleeting thoughts to harm others and felt low and scared. Domestic Abuse incidents, including strangulation, continued to be committed by John against Anita, and some by Anita against John, throughout this time.

3.23. Just a few weeks later, the BAT care co-ordinator received a call from Salisbury Hospital, informing them that Anita was having surgery on her wrists. The circumstances were that John was self-harming with a knife, Anita took the knife from him saying “stop doing that it hurts see,” then she cut her own wrist but went too deep. The doctor did not believe that she was trying to hurt herself and therefore no safeguarding referral was made. This was the first instance of Anita self-harming, which she later admitted to her BAT care co-ordinator. No safeguarding referral was made.

3.24. In early August 2015 Anita’s case was closed due to her not engaging in any treatment. Anita no longer wanted to have an inpatient detox or relocate out of the area, she wanted to stay and have a community detox in Bournemouth. The BAT care co-ordinator made a referral to a community service (Progress Project) to prepare Anita for detox. Despite phone contact with Anita she did not engage, and the case was closed to drug and alcohol services on 2nd October 2015.

3.25. The sixth MARAC took place on the 19th November 2015. It was identified that there had been nine incidents since the previous MARAC in June 2015. Actions identified were again basic and did not match the risks

identified.

3.26. Domestic abuse incidents between Anita and John continued to be reported over the following months. The potential threat of drugs gangs was still present. In early April 2016, John was arrested for an incident involving Anita and was served his second Domestic Violence Prevention Order (DVPO). On the same day, Anita was visited by a police domestic abuse officer. She described the hopelessness of the situation she found herself in, and she feared that she would come to some harm at the hands of John.

3.27. In May 2016, witnesses contacted the police and described how Anita was being assaulted by John. Anita was punched in the face and was seen to strike her head on the ground as she fell. John then walked her away from the area. A few hours later John called 999 for an ambulance. Anita was taken to the hospital where she died a few days later from the injuries that she had sustained during the attack. John was arrested, charged and subsequently convicted of manslaughter.

4 KEY ISSUES ARISING FROM THE REVIEW

Multi Agency Working

4.1. Anita and John were subject to two processes through the time covered by this review. The MARAC process in response to domestic abuse and the adult safeguarding multi agency processes.

MARAC

4.2. Anita was subject to seven MARAC's during the period under review. At each MARAC referral she was allocated an IDVA and post October 2015 a Domestic Abuse Advisor (DAA – which replaced the IDVA service) who supported/represented Anita at the MARAC.

4.3. Whilst most of the MARAC minutes identified risk and protective factors adequality, they were mostly weak in identifying specific actions designed to reduce the risks. For example, the MARAC held in July 2013 identified 11 risks including chaotic lifestyle, domestic abuse and harassment by John. Only two actions were recorded:

- *IDVA: update victim ref MARAC*
- *Police: Itask/briefing slide for staff*

4.4. This was replicated in MARACs over the following three years, and whilst each MARAC explored the latest set of circumstances, they did not fully consider the impact successful or otherwise of actions from previous MARACs.

4.5. For a MARAC to be effective, individual risks and desired outcomes should be identified, linked to agreed actions that might help secure the desired outcome.

4.6. It was identified at a MARAC in January 2015 that her son was a protective factor, from feedback by the IDVA. He is not referred to in the adult strategy meeting minutes in the same month. No action linked to engaging with him were recorded in either the MARAC minutes or the strategy minutes.

4.7. *As a direct result of the lessons coming out of this review, Dorset Police have now put in place a new process. If a victim is referred to MARAC three times in 12 months the case will be allocated to a plan owner (a Detective Sergeant from the public protection team).*

Adult Social Care Safeguarding Meetings

4.8. Anita was subject to four (section 42[9]) strategy meetings / Enquiry Planning meetings during the period under review.

4.9. A meeting held in 2013 identified risks to Anita around her drug and alcohol use and exposure to domestic abuse. This led to the production of a detailed action plan, and for a short period of time Anita appeared to respond positively.

4.10. Similar risks were identified in 2014, but the meeting was influenced by the belief that Anita was pregnant and the potential risks to her unborn child. The resultant action plan was focussed on the pregnancy. The meeting did not produce a comprehensive plan that would address the other risks Anita still faced. The domestic abuse she was suffering and the compromised life she was leading was masked by the concerns regarding a possible pregnancy.

4.11. The January 2015 meeting focused on the risks posed by drugs gangs. As a result, the action plan focussed on just this issue. Again, the underlying issues regarding domestic abuse were masked by what agencies viewed as more prominent or pressing concerns.

4.12. On occasions the MARAC and Adult Safeguarding meetings took place at similar times. This should have enabled the two processes to support and complement each other. However, there is little in the way to suggest that the range of multi agency meetings that were aimed at supporting Anita created a coordinated a response to managing the risks Anita faced.

4.13. As John's BAT care co-ordinator was not involved in any MARAC, updates to John's current situation, other than from police, could not be fully

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9 *Section 42 Enquiries[9]*

A statutory Section 42 Enquiry refers to the local authority being in receipt of information about an individual aged 18 or over who has care and support needs (whether these needs meet the National Eligibility criteria):

- *has needs for care and support (whether or not the local authority is meeting any of those needs) and;*
- *is experiencing, or at risk of, abuse or neglect; and*
- *as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.*

considered. Agencies working with victim's abusers should be invited to support the MARAC process.

4.14. *It is important that all agencies have a responsibility to safeguard adults and address domestic abuse as part of that work. To address this Dorset Police have now in place an Adults at Risk Desk[10]. This post should be able to pick up adult safeguarding issues that have an element of domestic abuse. Had this position been in place for Anita they may have provided a coordinating link between safeguarding and domestic abuse.*

A couple with complex lifestyles.

4.15. Professionals face major challenges when working with adults at risk living a complex lifestyle, like Anita. Risk assessments continually concluded that Anita had capacity to make decisions regarding her lifestyle. What is not recorded is how her capacity was evidenced. Capacity can fluctuate and affect an individual who may be in a controlling relationship and who is being coerced, this does not seem to have been considered in professionals contact with Anita.

4.16. A major difficulty for those trying to support Anita was the continued presence of John in her life. Plans to support her needed to consider John's situation and plans to support him needed to be cognisant of the impact on Anita. Whilst there is evidence of joint assessments in areas such as their detox treatment, this was not consistently present across all multi-agency actions and was not clearly recorded in either the MARAC or safeguarding meeting minutes.

4.17. John was assessed by adult mental health services for threatening and attempting suicide several times. These attempts were sometimes in Anita's presence. His actions could be considered as evidence of his attempts to control her. Anita displayed similar behaviour when she cut her wrists. The actions of both individuals should have been fully assessed so that when formulating action plans the impact of a proposed action on the other person could also be taken into consideration.

4.18. There is evidence that some agencies' actions inadvertently pulled Anita and John together or negatively impacted on Anita's ability to engage with services. For example, Anita was an important witness in potentially convicting dangerous individuals (the London drugs gangs). However, the risk to Anita from both the gang individuals themselves and to her own mental health resulting from fear and pressure increased at the prospect of being a witness. This provided her with a reason to stay with John, thereby reducing the chances of agencies engaging with her successfully.

[10] Post report completion note: This is inaccurate as the Maple Project should pick up all issues that have an element of Domestic abuse, the adults at risk desk would pick up all other safeguarding issues (where there was no element of domestic abuse). However, in response to this and other DHRs the Maple project now have a closer working arrangement with adult safeguarding and they would make Alerts if they identified safeguarding issues, MARM and MARAC liaison has improved, and the adult safeguarding procedures have been updated to reflect this.

Detoxification Treatment

4.19. Detox preparation sessions, whilst being an opportunity to assess commitment and plan for continuing support, for Anita were always going to prove problematic. Whilst the Multi-Disciplinary Team panel [11]had agreed that she required residential detox, an option not considered was to allow Anita to attend residential detox without preparation. The local Drug and Alcohol Commissioning Team have advised the review that a placement without preparation could increase the risk of harm for the individual in terms of relapse, overdose, blood borne viruses and the ability to reengage with services and support in the community when walking out of a detox early. Housing options may also be put at risk. Whilst these are understandable concerns, for Anita placement without preparation may have provided her with an opportunity to move away from her chaotic life style.

4.20. *The Multi-Disciplinary Team panel now, in evidenced complex cases, consider the option of a non-preparation placement taking into account the balance of current risk to the individual.*

General Practitioner (GP) Responses

4.21. In respect of Anita's GP, information was shared when she moved practices. Her vulnerabilities were identified, and attempts were made to ensure she saw the same GP. The practice did have in place a vulnerable patient list, but it was restricted to patients with learning disabilities and those at risk of repeated hospital admissions. Persons on the list were more routinely discussed. Anita's vulnerability did not come under the above remit, so her case was not regularly discussed. The vulnerability list is good practice but is of limited use for people with more complex health and wellbeing needs, such as dual diagnosis, drug and alcohol and domestic abuse.

4.22. It appears that her records contained detailed information including domestic abuse concerns with reference to the IDVA, actions from MARAC and her cycle of returning to the perpetrator. In comparison, John's GP practice gave more consideration to the wider environmental factors, identifying that interventions such as detox were compounded by his relationship with Anita. This practice has a complex cohort of patients, and there was an open and transparent policy for GPs to discuss and share their concerns.

Information Sharing

4.23. The Domestic Abuse Stalking and Honour Based Violence and Harassment (DASH) risk identification check list is a nationally used model

[11] There is a well-established MDT (multi-disciplinary team) panel approach which reviews applications from service providers for community detox, inpatient detox and residential rehabilitation and assesses them against agreed criteria. Commissioners and service providers are involved in the panel process and once a placement has been agreed, the service user is matched to the most appropriate registered provider based on need, cost and preference.

that indicates a level of risk. It is based on the responses to several questions along with the attending officer's assessment.

4.24. When discussed with the review panel and the Individual Management Review author's, it was identified that there was a lack of understanding by some agencies as to how the PPN/DASH was used and how the grading system worked. When explored there was a lack of clarity as to whom the PPN/DASH is circulated and how any agency should react.

4.25. It was identified that some agencies working with Anita and John had minimal knowledge of the level of domestic abuse taking place. Dorset Healthcare University Foundation Trust (DHFT) had no knowledge at all of domestic abuse. This was of concern and evidenced a problem with information sharing across all services. In respect of the MARAC, information should be being shared with all relevant agencies.

Family Support Networks

4.26. There were several occasions when Anita showed some signs of improved engagement, late 2014 being an example. coincided with her son staying with her. They indicate that he might have had a good influence on Anita's mood. When her son left, she reverted to relying on John to keep her safe, reducing her positive engagement.

4.27. Given the evidence that Anita appeared to respond better when her son was present, options as to how to engage him could have been considered and conclusions (positive and negative) recorded. Anita's son's criminal history may have led agencies to perceive that he was not an appropriate individual to support her. Whilst this may be the right conclusion there is no evidence recorded that indicates that this was fully assessed.

4.28. Anita's support networks were very limited, so not fully exploring the possibility of her son was a missed opportunity. This review highlights the need to consider the role friends and relatives could play in a support network.

Capacity/ Coercion and Control

4.29. Risk assessments concluded that Anita had capacity. What is not recorded is how her capacity was evidenced. The important point to highlight, is that capacity can fluctuate and affect an individual who may be in a controlling relationship and who is being coerced.

4.30. In this case there is evidence that Anita had been subject to controlling and coercive behaviour. Section 76 of the Serious Crime Act 2015. This created a new offence of controlling or coercive behaviour in an intimate or family relationship. The act came into force on 29th December 2015. In this case it would only have covered the last few months before the fatal incident but, is an offence that should now be considered when there is emerging evidence of controlling or coercive behaviour as well as traditional signs of domestic abuse.

IDVA/DAA Service

4.31. Anita was referred to the IDVA service on several occasions. This service was restructured in October 2015 from BCHA to Maple Project. The IDVA's role was then undertaken by Domestic Abuse Advisors (DAA's).

4.32. The impact of the Maple Project has been to move the IDVA service under the control of Dorset Police (previously this service was with a 3rd sector provider). The IDVA role is now undertaken by Domestic Abuse Advisors (DAAs). All staff are employed by Dorset Police and work within the Safeguarding Referral Unit. This has major advantages in respect of their access to multi agency information.

4.33. It is of note that the DAAs make initial contact with victims on the phone then will meet the individual if necessary. Anita was difficult to contact by phone and could explain why contact with her failed to improve at the commencement of the Maple Project. It is also possible that victims when offered a service on the phone, may react differently to when they have a face to face contact. Alternative ways of contacting victims need to be considered before a conclusion that a victim does not want to engage is reached.

Support Options

4.34. Anita's behaviour/life style resulted in her appearing to some professionals not to be eligible for some support that she required to enable her to make changes in life.

4.35. An example was placement in a refuge. At the multi-agency meeting held in July 2013, Anita stated that she would be willing to accept a refuge place. This was an opportunity to try and (accepting that she may not have taken up a place) remove her from the controlling behaviour of her partner at the time. Unfortunately, Anita was informed that she would not pass the risk assessment for a placement as she was still drinking. The advice given was in fact incorrect. There are refuges that will accept individuals with complex needs.

4.36. Anita at one stage, wanted to go into bed and breakfast, but was informed that it was too late to arrange and that she could not be supported to housing for a couple of days. There is no evidence that the housing out of hours service were contacted.

4.37. Accommodation options needed to be explored, but housing officers where not invited to the meetings and there was no action for the Housing Options Officer to be contacted for guidance and advice.

Criminal Justice.

4.38. Police officers who attended the domestic abuse reports responded positively in most cases. This was good practice and led to the arrest of John and Anita on several occasions. The difficulty officers faced was that Anita was never in a position to support a prosecution, either declining to

make a written statement or failing to attend court to give evidence. Specialist domestic abuse officers (DAO's) worked with other agencies to try and persuade Anita to support a prosecution, but they were never able to maintain her support through to the final court appearance.
John breached his bail condition not to contact Anita on several occasions. No action was taken in response to his breach of bail. This was it appears, because on occasions Anita initiated the contact, turning up at John's address, along with Anita's reluctance to support the prosecution. A review of the circumstances and history of the case through experienced eyes might have helped to improve the chances of breach of bail prosecution. John was always correctly bailed to a Domestic Abuse Court. The difference this court made due to its increased understanding of domestic abuse is hard to gauge given the previously noted reluctance to remand John when requested by police.

5 CONCLUSIONS

5.1. It was established that Anita and John had been in a turbulent relationship since 2013, during which time police had attended numerous incidents of domestic abuse. They both were being supported by several agencies during this time.

5.2. Anita was a victim of domestic abuse, but there were many other factors that influenced how Anita and John lived their lives and how they reacted to professionals' attempts to support. These included:

- Substance misuse
- Domestic abuse/violence
- Criminal activity
- Gang threats
- Mental Health issues

5.3. The following comments contained within Individual Management Reviews sum up the difficulties the professionals faced:

- *Safeguarding plans were in place but almost impossible to implement with clarity due to the chaotic life style of Anita and John.*
- *Anita declared "I would rather be in a relationship with someone who hits me than be on my own.*
- *They described the sense of hopelessness in that Anita was almost accepting of her situation, impossible to reach out to and impossible to keep safe.*

5.4. The report has identified several changes in processes and agency structures that should address some of the issues that have arisen in the review. This is supported by the commencement of the Care Act 2014, which now requires a joined-up approach to safeguarding and domestic abuse. This requires good assessment of risk, good planning linked to the risk reduction, ownership and good coordination and review and

reassessment if actions are not working. These changes have reduced the number of recommendations.

5.5. The circumstances of this case would have been challenging to any set of professionals, hence the need to maximise the opportunity for professionals to work together, and it must be acknowledged that whilst issues identified in this review may have improved Anita's long-term chances, there is minimal evidence to suggest that this would have been the case. Nothing in this review suggests that the manner of Anita's death could have been predicted.

6 LESSONS TO BE LEARNED

6.1. Both John and Anita were in receipt of a significant level of support from several agencies and there is plenty of evidence that professionals worked with each other. This case highlights that to maximise the impact of the interventions by individual agencies, it is essential that the domestic abuse and safeguarding adult processes work together, to coordinate approaches to support the victims. and to work with abusers to reduce their impact on the abused. This includes being unclear about which agencies were at which meetings, health involvement in the process and agencies knowing how to respond to the notifications they received.

6.2. Whilst professionals were working to support Anita, there is a lack of clarity as to who was reviewing and coordinating support across the agencies. The conclusion from Individual Management Reviews was that there was 'no grip' and a 'lack of co-ordination'

6.3. Other factors experienced by Anita and John and their complex lifestyle continually diverted agencies' attention away from the underlying domestic abuse she was experiencing including a possible pregnancy and the threat from drug gangs. This review highlights that the risk of domestic abuse must be continually assessed and remain on the radar when other risk factors are identified.

6.4. Anita could not successfully reach a point where she could demonstrate her commitment to undertake a detox. Therefore, looking at alternative routes to detox for a couple with such a complex lifestyle may have provided more opportunities for Anita to address her substance misuse issues.

6.5. This review has identified the differing approaches and support given to vulnerability and complex patients across GP practices. It has also highlighted the lack of direct involvement by the GPs in the safeguarding and MARAC processes, and the difficulties of information sharing across the GP and the hospital network. The author fully appreciates the differences between practices in respect of size, funding, local environment and priorities, but good practice has emerged especially in respect of John's GP practice. This good practice should to be shared across the GP cohort, especially in respect of vulnerability, response to the

Care Act 2014 and self-neglect.

6.6. Anita's support networks were very limited, so not fully exploring the beneficial role apparently played by her son was a missed opportunity. This review highlights the need to consider the role friends and relatives could play in a support network.

6.7. There were some missed opportunities to take positive action in terms of prosecuting John and in dealing with the breaches of bail which may have given Anita more opportunities to address some of her own needs.

7 RECOMMENDATIONS FROM THE REVIEW

R! **Bournemouth Community Safety Partnership** to consider using the LGA/ADASS guidance re: Adult Safeguarding and Domestic Abuse (chapter 11) to inform a multi-agency audit to establish if good practice is in place locally.

R2 **Bournemouth and Poole Safeguarding Adult Board and Bournemouth Community Safety Partnership** to undertake a joint audit of recent MARAC and safeguarding meetings, to establish if changes have taken place following the recent MARAC review.

R3 **Dorset Police** to advise officers investigating serious crime that they should ascertain if victims/ witnesses are already open to any safeguarding processes. This is to work with agencies already involved with the individual and assess the impact of their continued involvement in the investigation on the any safeguarding concerns[12].

R4 **Bournemouth Community Safety Partnership** to reinforce that it is good practice for staff from statutory agencies to ascertain if individuals they are working with are already open to any safeguarding processes.

R5 **Bournemouth Community Safety Partnership** to advise that MARAC, as part of the assessment, should explore family/friend networks who might be able to provide additional support to the victim as part of the MARAC action plan.

R6 **Bournemouth Community Safety Partnership** to be assured that within current local policy and procedures there is clarity about the function of the police PPN/ DASH (formally SCARF), to include who should receive such

[12] Post report completion note: this would be done where possible, but that often these decisions (in this case this recommendation was based on the decision to house them together to protect them from drugs gangs) are often dynamic and based on a risk assessment at the time, it may not always be possible to seek out what partnership involvement there is. Dorset Police provide assurance to the CSP that officers investigating serious crimes should ascertain if victims/ witnesses are already open to any safeguarding processes, or in the case of dynamic decisions inform partners as soon as possible so that all can assess the impact of their continued involvement in the investigation on the any safeguarding concerns.

a notification and how they should respond.

R7 **Dorset Police** to reinforce the requirement by officers to respond positively to breaches of bail conditions in cases of domestic abuse, with a view to enforcement and prosecution. To assist decision making, officers should seek advice from the experienced domestic abuse officers.

R8 **Bournemouth Borough Council Drug & Alcohol Commissioning Team** to review the current MDT panel Public Health Dorset referral form, to ensure it enables additional information from other processes such as safeguarding and MARAC to be clearly referenced.

R9 **Bournemouth Community Safety Partnership** to work with NHS Dorset Clinical Commissioning Group to consider how to improve the involvement of GPs with the MARAC process.

R10 **Bournemouth Community Safety Partnership** to raise awareness of and promote the use of the Serious Crime Act 2015, when evidence of coercion and control of a victim is identified.