Bournemouth Community Safety Partnership

Domestic Homicide Review

Holly
Date of death September 2016

Executive Summary
February 2018

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1 The Review process.

1.1 This Domestic Homicide Review was commissioned following the death of Holly. Her death occurred as a direct result of the actions of her male partner John. Holly was a victim of domestic abuse and her cause of death was a head injury for which John was arrested and charged. Holly was a 38 year old white woman and had a learning disability, that is, a lower intellectual ability and a significant impairment of social or adaptive functioning. John is a 50 year old white man, he has been brain injured since 2007.

1.2 The Bournemouth Community Safety Partnership was informed of a domestic homicide by Dorset Police in September 2016. The first Panel meeting concerning "Holly's" murder was held in March 2017. This significant delay was caused by issues finding a suitable independent chair, a delay in the criminal trial and an ineffective decision making system relating to initiating the DHR process (which has now been resolved). This determined that the relevant agencies to be involved included Dorset HealthCare University NHS Foundation Trust, Dorset Police, Dorset Clinical Commissioning Group and Bournemouth Adult Social Care.
The second panel meeting in May 2017 considered the information that was known to the agencies. There were two further Panel Meetings in August and September 2017 to review the final report.

1.3 Instrumental to the review has been the information provided by Holly's family; both in the information gathering stage and in commenting on the report.

1.4 The Bournemouth Community Safety Partnership determined that the scope of the review should include relevant events prior to, and including, the final 12 months of Holly's life. Pseudonyms have been used in this review for the victim (Holly) and perpetrator (John), to protect their identities and those of their family members.

2 Contributors to the Review

2.1 Review Panel Members

Andrew Clowser	Independent Chair
Joan Carmichael*	DCI Adult Public Protection, Dorset Police
Caroline Garrett	Note taker, Dorset Police
Fiona Holder	Safeguarding Adults Lead, Dorset HealthCare University NHS Foundation Trust
Anne Humphries	Bournemouth and Poole Adult Safeguarding Board
Sian Jenkins	Partnership Officer, Bournemouth Borough Council

Pam O'Shea	Head of Quality Improvement, Quality Directorate Dorset Clinical Commissioning Group
Tonia Redvers	Independent Domestic Abuse Advisor
Hayley Verrico*	Service Manager, Adult Disabilities and Long Term Conditions
Karen Wood	Senior Commissioner, Drug and Alcohol Commissioning Team, Bournemouth Borough Council

*Replaced by DCI Gavin Dudfield ; then replaced by D/Supt Fiona Grant

*Replaced by Sarah Webb after April 2017

2.2 IMR's were provided from the following:

Stewart Balmer	Force Review Officer, Dorset Police
Fiona Grant	Director of Public Protection, Dorset Police
Jo Booth	Operations Manager, PAS Ltd
Verena Cooper	Designated Adult Safeguarding Manager, Dorset Clinical Commissioning Group
Lisa Ferrie	Commissioning Assistant, Drug and Alcohol Team, Bournemouth Borough Council
Simon Harridge	Revenues and Benefits
Caroline Telford and Sian Jenkins	Policy and Service Development Officer and Partnership Officer for Community Safety respectively at Bournemouth Borough Council
Ben Tomlin	Housing Services Manager
Sandra Wood and Fiona Holder	Safeguarding Adults Advisor and Safeguarding Lead respectively at Dorset HealthCare University NHS Foundation Trust

3 Independence of Chair, Panel members, Independent Management Review authors, Overview Author.

3.1 The review was Chaired by Andrew Clowser, he is a retired Detective Superintendent who retired from Dorset Police in 2015 where he was Head of Public Protection. He is not currently employed by any of the statutory agencies involved in the DHR process. He has had no previous involvement or contact with the family or any of the other parties directly involved in the events under review.

3.2 All Panel members and Independent Management Review authors had not been in direct contact with Holly or John, however some of them had supervised staff who had direct involvement with them as a number organisation are small and do not have capacity for alternative panel members.

3.3 Margaret Flynn was appointed as the Independent Overview Author. She is a former academic researcher. She Chairs the National Independent Safeguarding Board in Wales and is a co-editor of the Journal of Adult Protection. She has undertaken Serious Case Reviews, Safeguarding Adult Reviews and latterly a review commissioned by the First Minister of Wales. She had no prior connection with the Community Safety Partnership or any of the agencies which contributed to this review.

4 The Terms of Reference of the Domestic Homicide Review

4.1 Whilst respecting Holly the review sought to do the following:

- Contribute to a better understanding of the nature of domestic abuse and to highlight good practice.
- Establish the facts that led to the incident in September 2016 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family
- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working

4.2 Particular questions in the terms of reference relate to:

- Was Holly known to local domestic abuse services, was the incident a one off or where there any warning signs. Could more be done to raise awareness of services available to victims of domestic abuse.
- Was Holly involved in the MARAC or other multi-agency processes.
- Are family, friends, colleagues participating in the review, were they aware of any abuse that may have been taking place.
- Were there any barriers experienced by Holly or her family, friends and colleagues in reporting the abuse.
- Was abuse present in any previous relationships, did this affect Holly's decision on whether to access support.
- Were there any opportunities for professionals to routinely enquire about any domestic abuse experienced by Holly 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 Holly and John.

- An understanding of the context and environment in which professionals made decisions and took or did not take actions, for example culture, training, supervision and leadership.
- Going beyond focusing on whether policies and procedures was followed to evaluate whether the policy and procedure is sounds and appropriate.
- Consideration of Holly and John's housing status and its impact on identifying abuse.

5 Summary Chronology

5.1 Holly was 38 when she was murdered at her Bournemouth flat during 2016. Her death resulted from severe head injuries. She had been hit repeatedly with a lump hammer causing skull fractures and swelling to the brain. John, her partner of a few months, was convicted during 2017. He was sentenced to life imprisonment with a minimum term of 20 years which was reduced to 18 years on appeal.

5.2 Holly had been diagnosed as having a learning disability in January 2016, eight months before she was murdered by John. Holly sought a learning disability assessment via her GP since she felt she had not achieved at school. She received a psychology assessment which noted that she had an IQ score of 57 which placed her in the 'mild learning disability' category and eligible to receive support from statutory services. Holly accepted this support and admitted she was struggling to manage things at home. She was referred to the Community Team for People with a Learning Disability. One of the recommendations from the team was that, "Holly may benefit from having information presented visually and broken down into simple steps in order to help her remember what she is expected to do. Holly may find larger quantities of information overwhelming and may struggle to understand and remember new information."

5.3 Holly lived a chaotic life. She became known to the police during 1999 when she was charged with credit card offences. In 2006 her medical records revealed a previous history of homelessness, sexual assault for which she reported experiencing flashbacks, nightmares, low mood and insomnia. She had a history of alcohol related problems and cannabis use. When Holly came to the attention of the police she was frequently intoxicated and perceived as uncooperative.

5.4 The first reported domestic abuse incident occurred in 2007. This and the "large number" of subsequent ones involved four different partners.

5.5 Holly had been introduced to John by Dev, a violent ex-partner with whom she had remained reluctantly in contact, her relationship with Dev was characterised by violence.

5.6 Holly used to drink with her father who commented that she had had issues with alcohol for about 10 years. He didn't believe she was alcohol dependent but instead more of a binge drinker. Holly's father acknowledged that although there were periods when she did not drink, he believed it was her excessive

drinking in combination with some bad relationships that placed her in harm's way.

5.7 Holly was a very private person and initiated infrequent contact with her family because she sensed that her relatives were 'prying'. Holly's family acknowledged that with Dev she became more secretive, they believe because of the violence she suffered. They report that her whole attitude as a person changed with her becoming more withdrawn and nervous. It is known that Dev didn't like her ringing anyone and he would snatch the phone out of her hand. They believe Dev caused a lot of problems for her and he had a hold over her. The family state she changed when she met Dev and that he destroyed her mentally. She did not receive any specific domestic abuse support with Dev (until shortly before her death – see 5.15 below).

5.8 Holly had talked to her mother about studying nursing online. However, Holly's ambitions were displaced by her deteriorating living circumstances and an associated general decline in her appearance. Holly's mother noted that when Holly became depressed, she presented as if nothing was wrong and that she was very good at putting on a front and making everything seem like it was ok. Her mother reported that if Holly got cross or upset she would drink. It was her way of blocking things out and she believed it was a real problem that Holly couldn't find anywhere safe to live. Holly's mother states the only places she could get were the shared houses where there were people on drugs and people who drank and that no one cared.

5.9 Holly was referred to the Community Mental Health Team during 2011 and 2012, however she was later discharged because she failed to engage. During 2012, two episodes of domestic abuse were recorded in Holly's medical record concerning a previous partner. One led to her arrest and a strip search and another resulted in a referral to Multi-Agency Risk Assessment Conference (MARAC), this identifies how Holly was seen as both an offender and a victim. The GP provided support options and Domestic Violence information. Just months later, she visited her GP having sustained facial bruising. This glimpsed the regular violence to which she was subject. During September 2014, Holly approached housing services and stated that she had been "homeless for three years since leaving supported accommodation in Bournemouth" which she left due to harassment from an ex-partner.

5.10 In May 2016, the police received a telephone call from a social worker reporting concern for welfare of Holly and that her flatmate 'Lily' was taking advantage of her. She was described as a vulnerable female with learning difficulties who is financially incapable. Police records in response to this state there was no requirement for police involvement. Holly was not referred to the Adult at Risk desk in the Safeguarding Referral Unit. The police acknowledge that the matter should have been looked at more intrusively.

5.11 In August, Holly's neighbour, Adrian, telephoned Care Direct, Social Services to express his concern that Holly is a vulnerable adult and Social Services were not supporting her adequately. He reported she was living with another adult who is unsuitable and there were drugs in the property. Adrian recalled

that he was told by social services he was doing the right thing not phoning the police as services didn't want to upset Holly.

5.12 In mid August, the social worker from the Learning Disability team again reported a concern for Holly's welfare to the police since Adrian had contacted Social Services once again to express concern. Adrian had reported that Holly was using crack cocaine and John has recently moved in, was controlling her and she had bruising to her arm and needed to be moved somewhere where she couldn't be manipulated.

5.13 A welfare check between the police and social services took place. It was reported that Holly had no visible injuries and she said that because her neighbours were causing problems she didn't want to stay at the flat. The police noted "all in order" and no SCARF or risk assessment was completed. The police subsequently noted that this effectively made the fact that Holly and John are in a relationship "*unknown*" for the purposes of checking records. It meant that Holly's circumstances were not added to the police records and John's violence to four previous partners was not highlighted. Had the records been checked then a multi-agency response should have resulted including the assessment and mitigation of risks to Holly and the introduction of safeguarding measures.

5.14 Later in August a further joint visit between social services and the Police was held. The social worker saw that Holly's arms were covered in bruises of various ages. Holly let John do all the talking and seemed submissive to him. It was John who mentioned Holly's bruises, he stated he had a confrontation with Dev. This resulted in a scuffle and that Holly had tried to intervene, and this was how she received her bruises. When Holly left the room, the social worker followed her to check that she was alright. The Social Worker had recognised John from a service she had worked in previously where he was known to be violent. It does not appear that anyone asked Holly how she came to be bruised.

5.15 In September, Dev visited again and took her mobile phone. At this point a SCARF was completed, although in relation to Dev and not John. A referral was made for a Domestic Abuse Advisor (DAA) to make contact with Holly. This referral was made just days before her death.

5.16 On 16 September, John presented at Bournemouth Police Station where he was arrested for the murder of Holly having made disclosures to officers outside the police station.

5.17 Although little is known about John within the relevant timeframe, a great deal was known about his previous offending history. He had a complex medical history and a diagnosed brain injury associated with mini strokes caused by temporary disruption to the blood supply to parts of the brain. He was flagged in his medical records as a vulnerable patient with a history of excessive alcohol consumption, poly drug use and long-term conditions. John was known as non-compliant and non-engaging with medical services. He was estranged from his family and homeless. Police records revealed that he was a serial perpetrator of domestic abuse against four previous partners. Holly was not warned about John's history of violence, principally as very few

services made a connection between John and Holly. During this timeframe John was checked by the police as part of an ongoing policing investigation where all rough sleepers are roused and checked. He was known to be a regular user of homeless facilities.

5.18 John had received housing support from PAS Ltd before he moved in with Holly. Its assessments determined that he was a very high risk to others because of his excessive drinking and known violence towards former partners (which included two allegations of rape). PAS Ltd had witnessed John's verbal aggression when he was under the influence of alcohol and drugs. He also made inappropriate sexual references to staff and women visitors but downplayed this claiming that he was only joking.

6 Key issues arising from the review

6.1 Learning Disability / mental capacity

Holly had a learning disability, that is, she had an impairment that started before adulthood with a lasting effect on her development; she had a significantly reduced ability to understand new or complex information and to learn new skills and a reduced ability to cope independently.

Holly's learning disability appears to have been downplayed from the point of the psychologist's assessment just eight months before her murder. Arguably also, the determination that her learning disability was "mild" may have led professionals to believe that she was wholly responsible for her living circumstances and her long-standing reliance on alcohol and, latterly, possibly drugs. Learning disabilities are different from specific learning difficulties such as dyslexia, which do not affect intellectual ability.

One of the recommendations was that, "Holly may benefit from having information presented visually and broken down into simple steps in order to help her remember what she is expected to do. Holly may find larger quantities of information overwhelming and may struggle to understand and remember new information." There is limited evidence to support this occurring and not any in relation to Domestic Abuse or healthy relationships.

In addition to Holly's learning disability the Overview Author had concerns about agencies abilities to assess Holly's capacity. The Author stated that Dorset Healthcare Trust (DHUFT) should have established whether or not Holly had capacity to make particular decisions, but it did not do so. The Mental Capacity Act 2005, requires that the incapacitated person must be unable to understand the reasonably foreseeable consequences of deciding one way or another and of failing to decide (S.3 (4)). This includes the reasonably foreseeable risks and benefits flowing from the various decisions possible, or of failing to make a decision. No agency explored Holly's wishes, choices and decision-making in situations of significant and growing risk. While the presumption of capacity was followed without question the wider duty of care to Holly was not considered.

6.2 Awareness of Holly and John's relationship.

Holly and John had only been in a relationship for a very short time. However during this time there were a number of agencies contacts with both of them. There do not appear to have been any occasions when the police documented the names of the people present when contact was made with Holly. Holly was a known victim of previous domestic abuse and John had a police record for violence towards four former partners. Although information concerning John's violence was also known to Holly's social worker, the Domestic Violence Disclosure Scheme was not considered. More significantly, the MARAC was not invoked. In the absence of any proactive intervention, Holly was left without any tangible means of support.

Dorset Police have acknowledged that there was a clear lack of research and use of police information to inform risk assessments and proposed actions.

It is remarkable that Holly was not made known to domestic abuse services until the end of her life. Her circumstances were of concern to her social worker and occupational therapist and she was very visible to the police, yet she was not directed to special services for victims of domestic abuse as no link was formally made between her and John.

6.3 Unsafe living arrangements

A feature of Holly's life was her unsafe housing situation. She had made comments and raised concerns a number of times about her desire to feel safe in her home. She was troubled by her neighbours and felt unsafe at some of her addresses. Professionals undertook to visit the address in pairs due to the chaotic and dangerous nature of other tenants in the block of flats. It was not considered safe for her pregnant social worker to visit and so her case was handed over to an alternative social worker. Holly was socially isolated and allowed John to move in with her.

She had been confirmed as a "rough sleeper" by the Rough Sleeper Team. Her final address was known to the police due to "nuisance, drug use, domestics etc."

Holly's sibling confirmed that Holly had been "in contact with Shelter. She wanted a place of her own."

It appears that repeated attendance at the one location led to a fire fighting approach by police officers. The Neighbourhood Policing Team undertook the longer term problem solving with other agencies including housing and the council community safety team which eventually led to the house of multiple occupation (HMO) being closed down.

6.4 Risk Management over risk assessment.

Holly initiated contact with the police on 21 and 24 July, 20 and 21 August, 11, 14 and 16 September – the date of her murder when her "risk [was] assessed as high." On 21 August and 11 September, Holly contacted the police on more than one occasion. The police had person to person contact with Holly on 30 June, 21 July, 15, 20 and 21 August, 6, 7, 11 and 14 September. The social services made six calls to the police expressing concern about Holly on 20 May, 13 and 14 July, 1, 15 and 16 August. Also, a friend of Holly's contacted the police because access to Holly's

flat was obstructed (on 24 July). “Bystanders,” such as two of Holly’s concerned neighbours, formed an opinion about her deteriorating circumstances and contacted social services and yet professional intervention appeared to be preoccupied with securing a date for a meeting and unmerited respect for Holly’s “choices.”
Holly’s circumstances during the final months of her life triggered the prospect of

1. A Conference of Concern Meeting
2. A Safe Lives Risk Assessment Meeting
3. A Multi Agency Risk Assessment Conference (MARAC)
4. A Multi Agency Risk Management Meeting (MARMM)
5. A Single Combined Assessment of Risk Form (SCARF)
6. Mental Capacity assessment concerning specific decisions and “choices”
7. A DASH risk assessment

There were Multi-Disciplinary Team meetings during June, July and August 2016 and these hinged primarily on sharing concerns, information searches and securing a date for a MARMM. It is curious that risk “management” appeared to trump risk assessment: “risk management actions were reactive and based on asking Dorset Police to carry out welfare checks.

Neither MDT meetings nor the oversight of the Learning Disability Team triggered an Interim Risk Management Plan, a Conference of Concern Meeting, a MARAC referral, a safeguarding referral or a decisive professional response.

A lack of professional curiosity is also highlighted in that this resulted in key information not being obtained, linked or researched to enable effective risk assessments.

6.5 Non-engaging victims

The Author states that “Holly was disadvantaged by being labelled as “difficult to engage”, although evidence for this is not compelling.” Holly’s family acknowledge that she was a private person who largely kept events and her feelings from them but feel that there was insufficient thought given by agencies to engaging with her in different ways.

7 Conclusions

7.1 Holly was seen by agencies as a very difficult victim to engage with because she was regularly drunk, a private person and often an offender herself. On two occasions, she was discharged from services in the knowledge that she had a learning disability; she was at medium risk of harm from others; her accommodation was associated with anti-social behaviour, drugs and prostitution; and she told professionals that she did not feel safe. It does not appear that she benefitted from anyone setting out for her the characteristics of healthy, acceptable and safe relationships. It would appear that since public services failed Holly in terms of keeping her safe, she relied on her most recent partner. She had lost faith in some services and it was acknowledged that one allegation of abuse triggered a below standard investigation. She

became very anti-police and would not engage with them. It was with prescience that the police reviewing documentation during 2010 noted, "…this is the very type of scenario which has the potential to end in domestic homicide."

7.2 Police records revealed that John was "a serial perpetrator of domestic abuse against four previous partners." Holly was not warned about John's history of violence. Dorset Police highlight their failure to link police information to new incidents reported to police as a recurring theme throughout this case.

7.3 Since Holly's murder, the SCARF has been replaced by a Public Protection Notice; a Detective Sergeant works 24/7 in the Force Command and Control leading on intelligence development for incidents. This work is supported by the Risk Management Unit that researches police information systems for relevant background information that is shared with officers attending an incident; the completion of a *Public Protection Notice Domestic Abuse Stalking and Harassment* is a mandatory requirement for all domestic abuse incidents; training has been delivered; there are analysts and researchers identifying repeat victims and offenders; there is an Adult Safeguarding Team and the MARAC process has been developed to instigate a MARM for repeat MARAC cases or complex cases.

8 Lessons to be learned

8.1 Holly's circumstances reveal an under-developed approach to responding to domestic violence across the statutory sector. Although she felt "unsafe" she remained in her tenancy, professional responses were not characterised by urgency or credible collaboration.

8.2 Holly was viewed by agencies as a difficult character. In addition to being a vulnerable victim she was also seen as an offender, and as competent in making decisions about her own safety.

8.2 Holly had been diagnosed as having a learning disability eight months before she was murdered by John. It is not clear that all agencies understood the implication of Holly's learning disability.

8.3 Furthermore although all services used the language associated with the Mental Capacity Act, none demonstrated credible working knowledge.

8.4 A lack of adequate risk assessment (SCARF/PNN/other format) of Holly's situation led to a focus on risk management without the appropriate information to ensure that risk management was targeted as it should be.

8.5 Not recording the full names of other persons present when visiting Holly made the fact that Holly and John were in a relationship "*unknown*" for the purposes of checking records. It meant that Holly's circumstances were not added to the police records and John's violence to four previous partners was not highlighted. Had the records been checked then a multi-agency response

should have resulted including the assessment and mitigation of risks to Holly and the introduction of safeguarding measures.

9 Recommendations from the Review.

9.1 During September 2017, the review author identified topics for agencies to consider shaping into recommendations for action. These have been drawn together into a single action plan by the CSP Lead.

1) A pan-Dorset, evidence based approach to domestic abuse is adopted which puts victim safety at the centre, reduces bureaucratic fragmentation and uses consistent names for services, for example community team for people with learning disability.
2) A repeat, “High risk” victim of domestic violence should always trigger a referral to a Multi-Agency Risk Assessment Conference.
3) Since the *Single Combined Assessment of Risk Form* /PPNs system, procedures and training did not work, Dorset Police need to set out what has changed since Holly’s death.
4) A credible, pan Dorset approach to risk assessments is adopted.
5) There is an audit of all referrals into the Multi Agency Risk Assessment Conference.
6) The proliferation of approaches and protocols is “reality-checked” by women with experience of domestic violence and families with experience of attempting to protect their relatives.
7) The agencies that had supported Holly re-visit their protocols concerning non-engagement. Holly sent texts (which a clinical manager advised should be ignored), had a Facebook account and rang the police for help – and yet was described as “non-engaging”.
8) The combination of having a learning disability and being subject to domestic abuse should automatically result in a SafeLives Risk Assessment, that is to say, an evidence based approach and credible assistance.
9) There is purposeful exploration with women with learning disabilities of the characteristics of a reciprocal and loving relationship. It is not clear that Holly had any support in this area.
10) The support of women whose circumstances are seen as so dangerous that professionals visit in twos and/or require police attendance is routinely prioritised.
11) A pan-Dorset approach is adopted to respond to men with known medical problems and/or brain injuries and substance abusers who are also known to be dangerous.
12) Information about repeated visits to addresses associated with anti-social behaviour and domestic abuse is triangulated with data held by Adult Social Care, the NHS and housing providers.