Stoke- on-Trent Safer City Partnership Emma June 2017

Chair and Overview report Author Simon Hill

Completed 26.11.19

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2. Introduction

1. ***At the start of this Domestic Homicide Review, the Chair and Panel members would wish to put on record their sincere condolences to Emma's family, friends and work colleagues, for their tragic loss. We thank them for engaging with the Review and helping us to understand Emma's life and what she meant to everyone who met her.***

2. This report of a Domestic Homicide Review (DHR) examines the agency responses and support given to Emma, a resident of Stoke-on-Trent prior to the point of her death in June 2017.
3. Emma died from strangulation at the hands of her husband, Andrew. The homicide occurred in the family home when Emma returned to collect personal belongings, having separated from her husband four days before.
4. In addition to agency involvement, the review examined the past to identify any relevant background that may have indicated the presence of a history of domestic abuse as a relevant factor. The review sought to establish whether Emma or Andrew accessed support in the community, and also whether there were any barriers to accessing that support.
5. The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.
6. The review considered agencies contact/involvement with Emma and Andrew from April 2015, the year in which Emma reported some signs of depression caused by social stressors, until June 2017, when she was found deceased in her home.
7. Individual Management Review (IMR) authors were asked to include any relevant information held by their agency from outside this time period, if they believe it would shed light on either Emma or Andrew or assist in identifying the learning sought in the terms of reference.

3. Timescales

1. This review began on 20 /07/17 and was concluded on 26/11/19.

4. Confidentiality

1. In order to protect the identity of the victim's family, the review has agreed with family the use of a preferred pseudonym (Emma). The family did not express any preference for their own or other pseudonyms, which have been designated by the Chair.
2. Participants to this review all signed a confidentiality agreement and information that could identify any party was only shared between participants to the review and their line managers and the signatories to the Independent Management Reviews (IMRs) and Summary Reports.

Pseudonym	Relationship
Emma	Victim
Andrew	Perpetrator (husband of Emma)
Daniel	Son of Emma and Andrew
Mary	Emma's mother
Frank	Emma's father
Laura	Emma's younger sister
Peter	Andrew's father
Susan	Andrew's mother

5. Methodology

1. On the 10/07/17 a Scoping Panel meeting was held to consider the circumstances of this case in accordance with the Home Office multi-agency guidance for the Conduct of Domestic Homicide Reviews. An independent chair (serving only for the scoping meeting), and panel reviewed the available information and concluded that the criteria for a full Domestic Homicide Review as defined under section 9 of the Domestic Violence, Crime and Victims act 2004 had been met.

2. This creates an expectation that local areas will undertake a multi-agency Review following a domestic violence homicide. This provision came into force on 13 April 2011.
3. Domestic Homicide Review (DHR) means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:
    a) A person to whom they were related or with whom they were or had been in an intimate personal relationship.
    b) A member of the same household as themselves.
4. The panel agreed that a recommendation should be made to the Chair of Responsible Authorities Group that a DHR be commenced. The scoping panel agreed a draft Terms of Reference that would be approved by the Independent Chair of the DHR (once appointed) and the panel at their first DHR panel meeting.
5. In relation to the IMRs and summary reports undertaken, the DHR asked agencies to follow the preferred methodology described in section 7 of the Multi-agency statutory Guidance for the Conduct of DHRs.
6. The Stoke-on-Trent CCG required consent from the perpetrator to release records held and this was communicated to them on the 24/07/18

6. Terms of Reference

1. In addition to the relevant generic questions, included from Appendix one of the 'Multi-agency Statutory Guidance for the Conduct of DHRs' the key areas for consideration by IMR authors were:
    - Foreseeability of the risk of violence posed by the perpetrator to the victim and to others
    - Disclosure of domestic abuse by the victim to others, including family, friends, neighbours and work colleagues

7. Involvement of family, friends, work colleagues, Neighbours and wider community

1. The Domestic Homicide Review Scoping Panel Chair emphasised that the DHR '*should seek to engage with the families of the victim and perpetrator, and if possible, also with their friends and any work colleagues and neighbours with whom they had a personal friendship/relationship*.' Panel members supported this suggestion, commenting that '*engagement with family and friends would help to build up the picture of the victim's life in the past two years particularly when she appeared to make changes in her lifestyle and behaviour.*'
2. The Safer City Partnership put Emma's family in contact with Advocacy After Fatal Domestic Abuse (AAFDA) and they chose to engage with an advocate from AAFDA who offered support and was in frequent direct contact with the Chair who updated them with the progress of the Review.
3. The DHR consulted with the police Family Liaison Officer (FLO) and Senior Investigating Officer (SIO) to identify both the victim and perpetrator's family, friends and work colleagues. The review sought the view of the FLO and SIO regarding the best way to communicate with them; generally via letters delivered by the FLO, who had an established relationship with many of the key individuals. These letters were delivered in January 2018.
4. The Safer City Partnership therefore wrote to all relevant family members, friends and work colleagues, offering them the opportunity to engage with the review in whichever way they preferred; in person, by email, telephone or written submissions.
5. Daniel, (Emma's and Andrew's adult son), chose not to engage with the review. During a prison visit, Andrew told the Chair that he would have liked his son to take part and would encourage him to do so. This wish was communicated to Daniel in a further letter from the Chair in late August 2018. The Review has had no indication from Daniel that he would want to participate in any way.
6. Responding to the suggestions of the DHR Scoping panel that in a case with very little agency involvement, a better understanding of the family dynamic could be

obtained by engaging with the perpetrator's family, (who actually lived only a few doors away from Emma and Andrew), letters offering the opportunity to engage with the DHR were sent. However, Andrew's parents, Peter and Susan chose not to engage directly with the DHR.

7. An approach was made to the man with whom Emma had started a relationship; however he did not want to be contacted in relation to the Domestic Homicide Review.
8. The DHR made contact with Emma's last employer, a major UK retail business. They provided assurances that they had a robust domestic abuse policy and had support processes for staff experiencing domestic abuse or mental health concerns. The DHR had no concerns about the role of Emma's employers in this case.
9. Emma's parents Mary and Frank, and sister Laura asked to meet with the Chair at Laura's home and this meeting occurred in April 2018. They understood and agreed with the Terms of Reference and the scope and purpose of the Review. They were happy with the level and extent of their direct involvement with the Review.
10. They were provided with a copy of the draft Overview Report in May 2019 and were able to provide comments and encouraged to add a written response to be included in the report if they so desired. The Chair met with the family to discuss the learning from the Review in early June 2019
11. This Overview Report has drawn upon the meeting with Emma's family for insights into her life and views and where this is the source, it will be indicated in the Overview Report. The police IMR shared with the DHR only the most relevant views and opinions of Emma's family, other family members and friends drawn from their statements in the criminal process. Where this information is cited in the report the sources will also be indicated.

8. Perpetrator's involvement with the review

1. The Chair felt that the perpetrator, in line with Home Office Guidance should be given the opportunity to identify what the circumstances were leading to him

committing the homicide and reflect on what (if anything) could have been done to prevent this tragedy, with a view to providing learning to professionals dealing with similar cases.

2. The Chair met with Andrew on the 23/07/18 and his observations (where relevant) were included in the Overview report, together with an assessment of the weight they should be given.

9. Contributors to the review

1. The following agencies contributed Individual Management Reviews (IMRs)
   - North Staffordshire Combined Healthcare NHS Trust
   - Staffordshire Police
   - Stoke-on-Trent Clinical Commissioning Group
2. The following agencies contributed Summary reports
   - Staffordshire County Council – Adult Social Care
   - University Hospital North Midlands
3. The authors of all IMRs and Summary reports were independent of any of the events described in this DHR and undertakings to this effect were received from the senior managers signing these submissions.

10. The Review panel members

1. The DHR panel consisted of the following members, who were all independent of the events reviewed:

Name	**Job Title and agency**
Simon Hill	Independent Chair and Author
Nathan Dawkins	Community Safety Partnership Commissioning Officer
Dave Mellor	Staffordshire Police Major Crime Review Team
Sarah Curran	University Hospitals North Midlands Adult Safeguarding Nurse
Vicki Baxendale	North Staffordshire Combined Healthcare Trust Head of Safeguarding (until January 2018)

Amy Davidson	North Staffordshire Combined Healthcare Trust Head of Safeguarding (from January 2018)
Rachael Fitton	Stoke-on-Trent Clinical Commissioning Group Adult Safeguarding Nurse Specialist
Kim Gunn	Stoke-on-Trent Clinical Commissioning Group Designated Nurse Adult safeguarding
Dr. Lorna MacColl	Stoke-on-Trent Clinical Commissioning Group Designated GP
Paula Brogan (Specialist Advisor)	Arch North Staffordshire (domestic abuse support provider until September 2018) New Era (current domestic abuse support provider)

2. An Independent Chair/Author was commissioned to manage the process and compile the report. The chair, Simon Hill, is a retired police public protection investigator with twelve years' experience of child and adult safeguarding and major investigations. Prior to leaving the police service he managed the Public Protection Review Team, responsible for writing the force's IMRs and contributing to over thirty DHR and child and adult SCRs. He has chaired eleven DHRs and adult SCRs/SARs in the region. He has had no involvement with the case subject of this DHR. He also has had no professional involvement with any of the agencies participating in this DHR.
3. In addition to the Scoping Panel held on 10/7/17, the Review panel met on:
   - 20/10/17
   - 25/10/18
   - 17/12/18
4. The DHR was approved by the Responsible Authority (Stoke-on-Trent Community Safety Partnership) on 26/11/19.

11. Parallel reviews

1. A coroner's inquest was opened in October 2017 and concluded in December 2017 that the death in this case was the result of mechanical asphyxiation.

12. Equality and diversity

1. The DHR considered the nine protected characteristics under the Equality Act 2010:

- Age.
- Disability.
- Gender reassignment.
- Marriage or civil partnership (in employment only)
- Pregnancy and maternity.
- Race.
- Religion or belief.
- Sex.

2. The DHR did not find any evidence that any of the protected characteristics were relevant to this review. The victim was of white European origin and was born and lived in the area for her entire life and was well established within the community, with a supportive family network.
3. There was no evidence that Emma felt unable to access services or that she encountered barriers of any kind. This was indicated by her engagement with both primary and secondary health services.
4. Andrew, similarly, had grown up in the Stoke-on-Trent area and accessed primary and secondary health care services. There was nothing to suggest he would have experienced any difficulty accessing available services.
5. The DHR took into account the gendered nature of domestic abuse. Women's Aid describe how '*Whilst both men and women may experience incidents of inter-personal violence and abuse, women are considerably more likely to experience repeated and severe forms of abuse, including sexual violence. They are also more likely to have experienced sustained physical, psychological or emotional abuse, or violence which results in injury or death.'*

13. Dissemination

1. The following agencies will receive a copy of the Overview report:

- The agencies contributing IMRs, Summary Reports or providing specialist advice

- Members of the Staffordshire and Stoke-on-Trent Domestic Abuse Commissioning and Development Board

14. Background Information (the facts)

1. Emma (who was 48 years old at the time of the homicide) had been in a relationship with Andrew (51 years old) for around 28 years and had been married since 2003. They had one son, Daniel, who was 20 years old at the time of his mother's death. They had lived at the family home in Stoke-on-Trent since 1999.
2. Andrew's parents, Peter and Susan lived in the same street just a few doors away. They therefore had more direct contact with their son and daughter-in –law and helped with the care of Daniel as he grew up. Emma's parents lived in Stoke but although contact was reasonably regular, they were not as involved in the family's life as Peter and Susan.
3. Emma had worked in various retail posts as both shop floor staff and section manager, but also had been a mortgage advisor for a firm of estate agents. From 2015 until the homicide, Emma worked in an administrative role for a major UK retailer. Andrew worked as a postman for 28 years. When he was made redundant, he found work as a minibus driver for a local special education needs (SEN) school. At the time of the homicide, Andrew worked at a local plant machinery company.
4. It appears that Emma was according to her extended family a '*strong personality*'. She left home at 19 and was apparently very organised, in her father's view she was '*a doer'*; she controlled the family finances and was according to her father the '*decision maker…the brains in the operation*.' This interpretation was echoed in the police statements of Andrew's parents. In his interview with the Chair, Andrew himself acknowledged this and said he had *'always deferred to Emma'*.
5. There were however aspects of family life where Andrew took the lead. He liked the family home, garden and car to be immaculate and tidy. Emma's family recollected that if they went for a meal, Andrew would be tidying up around them. He would clean his car very frequently and scrupulously and would apparently

become upset if he could not maintain things to his standard. (Emma's family recollected in conversation with the chair her anxiety and reluctance to return home when she caused a minor scratch to the car.) When asked by the chair what caused family tension, Andrew complained that Emma could have '*done more cleaning and tidying*.' Wanting things to be maintained his way apparently led to other problems including neighbour disputes over boundaries and dog barking.

6. It was the view of Emma's family that because of Andrew's rather compulsive character, small incidents became '*major dramas*. 'On occasion when visiting her family, Emma apparently felt she had to leave early because Andrew called to tell her about a new '*incident'* at home. Whilst these incidents were seemingly important to Andrew, it was the view of her sister and parents that these were always inconsequential. They felt they were a pretext to reduce the time Emma spent with them. The DHR panel considered they were evidence of Andrew's coercive and controlling behaviour.
7. In Emma's father's view, expressed in his police statement and in conversation with the Chair, the relationship worried him; '*because she did not have a happy marriage at all*.' The marriage was punctuated by significant arguments. In Mary's police statement she claimed Andrew; '*could be volatile and had got a temper. We knew this because they argued in front of us*.' Frank was clear in both his conversation with the Chair and in police statements that he always felt Andrew was '*very controlling'* of Emma. Laura reflected that Andrew was often derogatory and '*belittled*' or '*mocked*' Emma's abilities. Andrew's abusive behaviours were a strong indicator of a controlling and coercive relationship.
8. According to their statements given to police, on several occasions between 2015 and the eventual homicide, Emma had chosen to separate and returned to her parents. In the family's opinion, explained to the Chair, this was a coping mechanism and a response to an unhappy family life. On these occasions, Andrew came to Frank and Mary's home and '*begged'* for her to return. For his part ,Frank (but also Mary), had tried to persuade her that if she was unhappy she should leave the marriage, but Andrew had promised to give her '*more freedom'* and she chose to go home. It was not until the day she finally separated and came to stay

at her parent's house that her mother recollected in conversation with the chair that she said to her; *'oh, mum, I'm free.'*

9. If there was therefore an element of Andrew's behaviour that was controlling, it was not something the family felt able to challenge and did not apparently lead Emma to make clear disclosures of domestic abuse. None of Emma's family had ever had a disclosure of domestic abuse or violence until the final separation in June 2017. (From their statements to police, it does not appear that Andrew's family did either). The DHR was mindful of the strong evidence from studies and Reviews that point out that the absence of a disclosure of domestic abuse is not evidence that it was not present. It is also clear from previous DHRs across the country that victims and families frequently do not recognise controlling behaviour as domestic abuse where no violence is reported**.**
10. Emma was very close to Laura, her younger sister. On an almost weekly basis, on her days off (and when Andrew was working), she visited Laura and stayed over. Laura recollected however that on occasions, Andrew purposely made this '*tricky'* by not letting Emma take the family car. This is a recognised form of economic abuse as a feature of an abusive relationship; controlling access to resources, such as transport.
11. In the period under review, Laura recollected that although her sister would not complain about her own marriage directly and did not make disclosures of domestic abuse, she would often comment on Laura's happy and close family life and appeared to be contrasting it with her own.
12. During periods of marital tension or separation, Andrew frequently called Laura to discuss Emma. With hindsight, Laura felt this was an indicator of when '*he felt he was losing control over Emma'.*
13. After reflecting on the power balance and nature of their relationship, Laura expressed a view that when Emma was suffering her worst mental health episodes (described below) and was failing to care for herself, Andrew had been seen by both her and their parents as an apparently devoted and caring husband, meeting all her needs. Laura observed that this was actually a period when '*he had total control over Emma'*.

14. It was evident to the review panel from the family contributions and witness statements to police, that Emma and Andrew doted on their son Daniel.
15. There were significant issues impacting upon Daniel and consequently his parents, through the years from childhood into adulthood. It does appear that the challenge of coping with these caused very real tensions between Emma and Andrew. Differences of opinion over parenting styles also led to tensions between Andrew and Emma and the wider family.
16. It led eventually according to evidence in police statements, to an argument between Emma and Peter, (Andrew's father) when they were '*again'* asked to help with Daniel. His remark that Mary and Frank were '*never called upon to help*', led to a row with Emma and an almost complete estrangement of Emma from Andrew's parents, from around 2016. (There is however no evidence that Emma thereafter tried to prevent contact between Andrew, Daniel, Peter and Susan, however it must have caused significant tensions in a family that were very close.
17. Daniel's account of family life, in his statement to police painted a different picture. He felt they had had a '*very happy family life'* and his parents were '*inseparable'*. They apparently may have occasionally bickered, but did not argue. His parents '*spoiled'* him and were always there for him.
18. In April 2017, Emma started a relationship with a work colleague and it was the discovery of this by Andrew that led to separation and the eventual tragic outcome.
19. According to Police statements, on a day in early June 2017, Andrew contacted Staffordshire Police Control Room saying he believed he had killed his wife following an argument.
20. Emma had left the family home a few days before, after an argument leading to the separation of Andrew and Emma. On that day, Andrew had become suspicious that text messages Emma received were from another man. She tried to prevent Andrew taking her phone, but he took it, nonetheless. He was trying to access her messages when the phone rang, and he answered it. The caller was the man with whom Emma had started a relationship. Upon hearing Andrew answer he apparently immediately terminated the call.

21. In the ensuing argument between Emma and Andrew, Emma told her husband she was having a relationship with her work colleague and indicated that she wanted to separate. The domestic incident allegedly involved some degree of physical confrontation. Andrew later claimed in a police interview that Emma bit him on the head. Some possessions were damaged, including Emma's phone. Andrew called Emma's mother, Mary telling her to come and take Emma away. Emma left without any personal possessions staying with her parents and then her sister Laura in the days before the homicide.
22. A few days later Emma had returned to the matrimonial home to collect some belongings. She drove to her home with Frank, her father, but chose to go into her house alone. She apparently knew Andrew would be present but stated to her father she did not want to inflame a difficult situation and therefore insisted on being unaccompanied. She also according to her father, put her wedding ring back on. She was in the home for over one hour before the homicide.
23. In his police interview, Andrew told investigators that he had asked Emma not to leave, but she affirmed her intention to move in with her parents. When she went upstairs, she had discovered items of her clothing had been destroyed by Andrew and demanded he replace them. Andrew was clear that Emma was neither physically violent nor confrontational to him. He apparently begged her to stay and then approached her with outstretched arms in an attempt to hold her. When she attempted to push him away, Andrew started to strangle Emma. They fell to the floor where upon he used the flex of Emma's hair straighteners as a ligature. According to the Postmortem examination, Emma's death was caused by the combined effect of manual and ligature strangulation.
24. A Coroner's Inquest in October 2017 held death was caused by mechanical asphyxiation.
25. Andrew was charged with Emma's murder and pleaded guilty. In December 2017, he was sentenced to life imprisonment with a recommendation he serve a minimum of eleven years.

15. Overview

1. The picture of Emma's life drawn from the accounts of her family, from witness statements given during the criminal process, give some insight into her day to day lived experience. That she apparently made no disclosure of domestic abuse may indicate either that she did not consider herself to be a victim of it, or indeed that she was not experiencing it, or alternatively that she felt unable to articulate her experiences or report them to professionals or her family.
2. It is clear therefore that the few professionals that came into contact with Emma had to be alert to possible indicators of domestic abuse and be prepared to make discrete safe enquiries of Emma in line with best practice.
3. What has emerged from evidence collected by the police and accounts to the DHR, is that although there were periods of happiness in the marriage, there were also significant low points. These led to short separations from Andrew. In Emma's mind, according to her GP records, her life decisions around the time of her separations left her feeling very depressed. She experienced self-doubt, a lack of self-esteem and a sense of shame concerning those decisions, although not the decisions to separate, because she was clear that they were necessary. Emma may have felt this way as part of her emotional processing regarding making the decision to end her marriage or as a result of undisclosed domestic abuse. Her sister in conversation with the chair indicated that she was seeking an '*escape route'* out of her marriage. In her police statement Laura said,' *I know she felt trapped because she felt she could not leave*.'
4. During the Chair's conversation with Andrew in prison, it appeared that he believed that Emma's depression was entirely triggered by the pressures of her jobs, and most significantly by the bullying by a supervisor in her last job. (There was little evidence in the GP notes or Mental Health records that suggested that work related issues were a trigger for her depression.) Andrew apparently saw no connection and made no reference to family pressures, matrimonial difficulties or the three separations they had undergone before the homicide.
5. It is evident that whilst there was very limited direct agency involvement with Emma and Andrew, (and no domestic abuse reported to any agency), for a period

of 6-7months from November 2015 until mid-2016, Emma had a considerable degree of contact with her GPs. Emma was also seen by Mental Health Services from the 25th April to the 5th May 2016. The Acute Home Treatment Team (ACHTT) saw Emma seven times during this period, with her care also being reviewed once by a Community Consultant Psychiatrist.

6. On these eight occasions, Emma was seen once with her sister but without her husband and on six occasions, she was seen alone. An initial risk assessment was completed on the first assessment visit during which Emma denied having ever experienced any form of abuse. The risk assessment was revisited a further four times during the time she was seen by mental health services. Although Emma discussed her marital disharmony and uncertainty about the future of her marriage, she made no disclosure of domestic abuse, although there were opportunities for her to do so.
7. It is well established in domestic abuse support that the absence of disclosures or signs of domestic abuse cannot be taken as an indication that it is not occurring. For that reason, guidance issued to health professionals (both primary care and mental health services) has been that they must be aware of the 'health markers' of domestic abuse. One of the most consistently present in victims of domestic abuse being,' *when patients present with depression, anxiety, tiredness, chronic pain or non-specific symptoms*.'
8. Clearly a direct disclosure of marital disharmony, in the context of separations, should alert professionals to the possibility of domestic abuse. Faced with these facts, initial denials of the presence of domestic abuse should not permanently deflect professionals from asking questions.
9. The need for GPs to make safe enquiry when there is evidence of possible abuse is stressed by the Royal College of General Practitioners [1] and in Department of Health Guidance[2] professionals are asked to not only make safe enquiry when a patient presents with indicators of potential domestic abuse, but also '*if things are not adding up.'* The guidance says,' *some victims also drop hints in their*

[1] Responding to domestic abuse: Guidance for general practices (2012) Royal College of General Practitioners (RCGP)

[2] Responding to Domestic Abuse: A resource for health professionals Section 4 Practitioners responding to victims. Dept. of Health (2017)

interactions with health and care staff and their behaviours may also be telling. They rely on staff to listen, persist and enquire about signs and cues.'

10. Emma was seen 11 times (by three different GPs) at the practice at which she was registered, between 2015 and May 2016.
11. Six of these presentations related to depression. It is of note that Andrew told the chair that he had wanted to attend with his wife, but she specifically chose not to, preferring to attend initially with her mother. He stated he never attended the GPs with his wife in relation to her mental health.
12. Emma first disclosed low mood to GP1 in November 2015.The doctor at this first presentation recorded that she had '*Depression. Mood is very low weepy and irritable not sleeping, cannot switch off, started when split up from her husband now has gone back together*.' The GP provided Emma with information about Healthy Minds, a service that could provide cognitive behavioural therapies. (This is generally recognised to be the appropriate treatment for mild depression when first reported according to the 'stepped care approach.'[3]).
13. The GP did apparently prescribe citalopram (a commonly used anti-depressant) on the first consultation. According to the stepped care approach in NICE Clinical guidelines, the use of medication should only occur when sub-threshold signs of depression, or mild to moderate depression are '*persistent*'. They should not be used in patients with no history of depression unless sub-threshold symptoms have persisted for two years or after other interventions.[4] (Often services that provide low intensity psycho-social interventions are hard to access, leaving GPs little choice but to prescribe anti-depressants immediately.)
14. The CCG IMR acknowledged,' *whilst the documentation showed good recording of symptomology in terms of mental health there is no indication that domestic abuse was alluded to and no evidence that the GP considered any indication of domestic abuse which could be related to Emma's presentation (low mood, marital problems.'* There is therefore no recorded evidence that GP1 recognised the need to ask questions, to provide Emma with the opportunity to disclose domestic

[3] Depression in adults: recognition and management NICE Clinical Guideline CG90

[4] Depression in adults: recognition and management NICE Clinical Guideline CG90 1.4.4.

abuse, if it was present, despite the clear disclosures of marital disharmony. This was a first missed opportunity to 'ask the question' and record doing so.

15. She was reviewed again in appropriate timescales, two weeks later by GP2 and this was good practice. It was established she had not yet called Healthy Minds, but GP2 also did not apparently ask any appropriate domestic abuse screening questions and this represented a second missed opportunity.
16. In November and December 2015, the surgery wrote to Emma to request she arrange an appointment with GP1 for a mental health review, but she did not respond. In fact, it was nearly four months (February 2015) before Emma herself contacted the surgery asking to see GP1 or GP2. (The CCG IMR indicated that she would have needed a repeat prescription at this point). She had a telephone consultation with a Practice Nurse expressing '*concern she has had a bad few days*'. Even if the practice nurse had been minded to enquire about any domestic abuse, it is unlikely that a telephone call would be considered a 'safe' opportunity for such a conversation, since abusers are known to monitor their victim's calls.
17. Emma was however reviewed the next day by GP2. This was good practice, ensuring that Emma had prompt access to a GP. According to GP2 they had a '*long chat'* during which '*alcohol and problems at work'* were apparently excluded as a cause of her low mood. Regrettably this did not apparently include a review of her home circumstances and relationship, or at least it was not recorded on the patient notes. These three successive missed opportunities to ask Emma what would have felt entirely natural questions in the circumstances, suggest that there were gaps in understanding of the GP's role in identifying the potential of domestic abuse.
18. In late April 2016, Emma mental health deteriorated, and she consequently saw GP3. She revealed extreme mood swings, anxiety, struggling to eat and not sleeping. She described the impact of her feelings of disappointment with herself over choices she had made. She had thought about suicide but had not attempted or planned it. The only indication in the GP records that her home circumstances were considered in any way, appeared to be that the notes showed that Emma's mother, Mary, was staying with her.

19. GP3 considered bi-polar disorder or possible cyclothymia.[5] (This was later discounted as a diagnosis by the Community psychiatrist). She was referred to the Access Team in late April 2016, and they in turn referred her to the Acute Home Treatment Team to '*monitor and prevent hospital admission.'*
20. Emma was seen by a Community Consultant psychiatrist, (Psych1), and a mental health assessment was completed. Psych1 concluded that she was experiencing a moderate depressive episode and that Emma required continued support from the Acute Home Treatment Team (ACHTT) and also support from 'Improving access to psychological therapies' (IAPT) a pathway into CBT (Cognitive Behavioural Therapy).
21. The initial mental health assessment concluded Emma had been experiencing intrusive thoughts of self-harm, but '*felt able to resist them.*' The assessment considered 'Harm from others' (it is this component of the assessment which NSCHT indicated in their IMR could identify domestic abuse.) There was however, no evidence offered to the DHR that Psych1 made the kind of routine enquiry that best practice required and that could have allowed Emma to disclose any experience of domestic abuse. If such questions were asked, they were not recorded. This was a further missed opportunity.
22. The NSCHT IMR indicated that the original mental health assessment was reviewed a further three times over the three-week period of engagement with the ACHTT and the Consultant Psychiatrist and that no new risks were identified. This was in the context of eight face-to-face contacts and four telephone consultations. As previously discussed Emma was seen on five of these occasions alone giving opportunity for a potential disclosure of domestic abuse. NSCHT were clear that Emma never disclosed behaviours from Andrew that were coercive or controlling. These were further missed opportunities.
23. Emma's mental health improved to the point she was discharged from the service towards the end of May 2016.

[5] **Cyclothymia** -- or **cyclothymic** disorder -- is a relatively mild mood disorder. In **cyclothymic** disorder, moods swing between short periods of mild depression and hypomania, an elevated mood. The low and high mood swings never reach the severity or duration of major depressive or full mania episodes.

16. Analysis

1. The DHR gathered information from agency IMRs, conversations with professionals and family, as well as statements to police and events in the chronology to seek to identify whether Emma could have been supported more effectively. The panel considered carefully the information available and conceded that it was not possible in this case to say unequivocally that domestic abuse was or was not present before the homicide.
2. However to assist the panel's deliberation and with the advantage of hindsight, (taking into account all the information known to the DHR), the domestic abuse specialist advisor on the panel carried out a DASH[6] Risk identification checklist. It yielded a score of 10. This would lead to the offer of 1:1 support for a person in Emma's situation. (See: section 19 paragraph 15)
3. This DASH assessment clearly could not take into account any additional risks that may have been identified, had Emma 'been asked the question.' It does evidence how hard coercive and controlling behaviour can be to identify, for the victim, the family and professionals, before all the information is drawn together. This makes the opportunities professionals had to allow Emma to disclose domestic abuse all the more significant.
4. Analysis of health professionals' involvement with Emma in this case must be viewed against the guidance offered to them by the National Institute for Health and Care Excellence (NICE) in their recommendation to service commissioners on 'asking the question'[7] which states:

Health and social care managers and professionals should:

[6] DASH Domestic abuse Stalking and Harassment risk indicator checklist The Dash risk checklist can be used for all intimate partner relationships, including LGBT relationships, as well as for 'honour'-based violence and family violence. It is primarily intended for professionals – both specialist domestic violence workers, such as independent domestic violence advisors (IDVAs), and other professionals working for mainstream services. It aims to provide a uniform understanding of risk across professions. There is a specific police version of the risk checklist, which is used by most police forces in England and Wales.

[7] National Institute for Health and Care Excellence (NICE) public Health Guidance 50 (Feb 2014) Domestic abuse: how health services, social care and the organisations they work with can respond effectively

- *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 and 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.*
- *Ensure trained staff in…. mental health…ask 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.***

5. The current best practice is therefore clearly established. All health care frontline staff should be trained to be able to ask the questions sensitively. GPs should be aware of known health markers as triggers for sensitive enquiry. Mental health professionals should routinely ask questions even where there are no indicators. It is not enough to provide a person with the opportunity to disclose; they should be supported to do so with appropriate questions. The learning from this DHR would identify the need for the recording of the response to this questioning even in cases where the response is negative.
6. The Quality Standard on Domestic Violence and Abuse [8] requires of providers (secondary and tertiary providers of health services) and commissioners (CCGs) that they '*ensure that health…practitioners are trained to recognise the indicators of domestic violence and abuse* 'and that practitioners '*recognise indicators of domestic violence and abuse and respond immediately. They make sensitive enquiry of people presenting with indicators of domestic violence or abuse about experiences as part of a private discussion and in an environment in which the person feels safe.* '
7. The practice of the GPs in this case was clearly supportive of Emma in relation to her depressive symptoms and they secured access to Mental Health support in a timely way. In relation to Emma's mental health, care provided by NSCHT was timely, supportive and in line with best practice.

[8] NICE : Domestic violence and abuse QS 116 published 29 February 2016

8. In relation to all three GPs who saw Emma at that time, there appeared to be an incomplete understanding of the significant impact that domestic abuse can have upon mental health. They apparently failed to see Emma's depression or her marital disharmony as a possible indicator of the presence of domestic abuse and did not explore this area with the kind of questions that their professional bodies and NICE guidance requires, or if they did, did not record the fact.
9. In replies to requests for further information during the DHR process, the Stoke-on-Trent CCG acknowledged they were not able to offer any assurances that the NICE Public Health Guidance 50 (2014) or the Quality standard 116 (2016) had been acted upon during the time period covered by the review to ensure safe enquiry occurred, or that quality measures were in place to provide evidence of such local arrangements.
10. The CCG were however able to provide evidence of both current and proposed domestic abuse training (described below) that could provide the improvements that would meet the quality measures.
11. The DHR had similar concerns about the ability of the NSCHT to provide evidence that as mental health providers they had addressed the NICE recommendations (2014) and Quality Standard 116 statements (2016) that represent best practice in relation to domestic violence and abuse. This in turn led to a need for the DHR to seek assurance that routine enquiry is embedded across the NSCHT.
12. NSCHT has a domestic abuse policy that identifies the importance being alert to the indicators of domestic abuse and asking questions regarding domestic abuse and dealing with disclosures in a sensitive and supportive manner. The policy directs frontline staff on what steps to take next in order to access support for individuals making a disclosure.
13. The NSCHT IMR author was unfortunately not able to provide recorded evidence that the kind of explicit routine enquiry about domestic abuse recommended by NICE had occurred during the period covered in this review. If it did occur over the seven direct encounters with Emma where Andrew was not present, it was not recorded or evidenced. This apparent lack of recorded evidence could be because such enquiry is expected to occur as part of a wider consideration of risk in mental health assessments. It is also possible that the absence of clear policy or best

practice guidance or of direct prompts on the assessment modules, make routine questioning less likely to be well embedded. This appeared to be partly due to absence of a domestic abuse routine enquiry '*prompt*' on Trust documentation.

14. The AHTTs and Consultant Psychiatrist, were expected in their assessments to identify 'exploitation and harm by others', the risk assessment document includes free text in order to encourage the asking of open sensitive questions and to prompt dialogue between the professional and the individual being assessed. The decision whether or not to disclose any potential risks remained with Emma. However, the recording of routine domestic abuse enquiry, including negative responses would in future, remove any doubt concerning whether Trust professionals follow best practice.
15. The NSCHT provided the DHR with the risk assessment documentation used in mental health assessments[9] The risk assessment under the heading '*exploitation and Harm by others*' lists:

- Risk of physical abuse
- Risk of sexual abuse
- Risk of social abuse
- Risk of emotional abuse
- Risk of financial abuse

The documentation used by staff in this case, made no mention of referral or pathways to domestic abuse support. The form simply stated; '*Practitioners must discuss with their line manager whether to refer to the following processes: Child Protection, Vulnerable Adults. Multi Agency Public protection Arrangements (MAPPA) if there is any identified risk of self-neglect or harm to others.'* There was no mention on the form of domestic abuse or any prompts in relation to routine enquiry. The abuse listed does sometimes form part of domestic abuse, but can just as well be a sign of the abuse of an adult at risk requiring adult safeguarding.

16. As a result of the Learning from this Domestic Homicide Review, the explicit question regarding a previous or current experience of domestic abuse has been added to the list, in addition to the pre-existing free text box identifying any

[9] Safety/Hazard assessment Module-self neglect and exploitation 3. Current presentation 'Exploitation and Harm from Others. Form 6 risk module Harm to self or others adapted from STAR Bolton, Salford and Trafford Mental Health NHS Trust

potential risk of harm from others. In addition, NSCHT policy documents provided to the DHR now include flowcharts to guide practitioners supporting a patient who has made disclosures of domestic abuse.

17. The DHR has concluded that whilst the Healthcare Emma received was timely and appropriate, if she had been experiencing domestic abuse, it is unclear from records as to whether direct questioning regarding domestic abuse took place either by her GPs or the Mental Health Team. Given that Emma never disclosed domestic abuse to her family, it is not certain she would have done had she been asked by any of the professionals she came into contact with. (However there are signs that she had a good relationship with GPs 1, 2, and 3. and may have responded to empathetic questioning).
18. At the very least, best practice would require that in similar circumstances patient records of both GPs and Mental Health would show that Emma was asked questions about domestic abuse at least once, but ideally on several occasions. Without evidence that professionals had addressed this issue by means of domestic abuse specific direct questioning in this case, domestic abuse remained a potential risk.
19. The Stoke-on- Trent CCG and the named GP for Adult Safeguarding expressed the view that this apparent failure to ask questions may reflect wider practice locally and indeed nationally. It is the DHR Chair's view from his experience drawn from 13 DHRs, that there is indeed a widespread weakness in practice, where safe enquiry does not yet form part of routine practice.
20. The NICE guidance gives both commissioners and providers guidance on suitable measures of effective implementation.

    In the NICE Quality Standard of 2016, the quality measure is a **structure**; '*evidence of local arrangements to ensure that people presenting to frontline staff with indicators of possible domestic violence and abuse are asked about their experience in a private discussion'* The **process; '***is the proportion of people presenting to frontline staff with indicators of possible domestic violence or abuse who are asked about their experience in a private discussion***.**

    This is now reflected in the NSCHT domestic abuse policy; however it has been further enhanced by the addition of a direct question regarding domestic abuse

to the risk assessment documentation in order to prompt frontline staff to routinely ask the question regarding experiences domestic abuse as part of the risk assessment process.

21. Thereafter following disclosure, the Quality standard **structure**: states '*referral to specialist support for people experiencing domestic violence and abuse requires evidence of local referral pathways and evidence that specialist support services are available'*. **Process**: *proportion of people who disclose that they are experiencing domestic violence or abuse who are referred to specialist support services.*
22. NSCHT's domestic abuse policy identifies the importance of discussions regarding domestic abuse taking place in a private discussion and in a sensitive and supportive way and identifies referral routes into locally commissioned services. Further information on domestic abuse and referral pathways into MARAC and New Era as the locally commissioned service for both victims and perpetrators are available to all frontline staff via the Trust's intranet.
23. Reliable statistics to demonstrate how frequently sensitive questioning about domestic abuse is occurring during Health professionals contacts with patients do not currently exist. Similarly, no statistics are available to indicate where such questioning leads to victims being referred or self-referring for domestic abuse support in Stoke-on-Trent. The only figures available are of referrals to domestic abuse support from the CCG and Trusts and these are not broken down to show individual team or practice referral rates. This has been further complicated by the recent change of provider. (It will be part of the recommendation of this DHR that better data sets are required in this area.)
24. It was a concern to the panel that such statistics as are available, would appear to indicate that the domestic abuse referral rates from GPs and Mental Health services in Stoke are low. (This is judged against the assumed frequency with which patients would present with possible health indicators of domestic abuse, and the prevalence[10] of domestic abuse within the community.)

[10] Office for National Statistics (ONS) (2016) 'Focus on Violent Crime and Sexual Offences: Year ending March 2015'. (Accessed Nov 2016). Domestic abuse affects around 4.6m women (28% of the adult population) in England and Wales in their lifetime, and 13.2% of men.

25. It could be seen as evidence of the frequency with which domestic abuse screening questions are presently asked, and the quality of that questioning, when it is undertaken. Addressing this concern will be a key recommendation of this review.
26. Whilst all training that raises general awareness of domestic abuse is an essential part of raising the profile of domestic abuse (and local provision is described below), the specific skills needed to carry out safe enquiry (or routine enquiry in the case of Adult Mental Health Services) need to be a distinct part of a training session.
27. At NSCHT, key messages regarding domestic abuse are now delivered through level 3 child safeguarding training (3.5hours), level 3 adult safeguarding training (3.5 hours). The DHR has been provided with evidence that both level 3 safeguarding courses include guidance on 'asking the question' and use case studies involving domestic abuse to encourage professional discussion and challenge. In addition to this full day domestic abuse training is delivered by Women's Aid to frontline staff.
28. The DHR is aware that the accessing of mandatory Safeguarding training is the responsibility of individual GPs practices, and that DA and Level I and II Safeguarding training online training is provided by NHS England. Therefore, it seems appropriate for this DHR to recommend that guidance on recognising the health indicators of domestic abuse and 'asking the question' safely be included in online training provided by NHS England. However, CCGs do have some scope to provide training to GPs practices.
29. In response to the learning from this DHR, the CCG supported by one of their designated General Practitioners, have now provided training to around 200 of their practitioners on recognising the health indicators of domestic abuse and 'asking the question' as an addition to their Level III Safeguarding. Further detail is provided in Section 19.

Read more: http://www.healthtalk.org/peoples-experiences/domestic-violence-abuse/womens-experiences-domestic-violence-and-abuse/what-domestic-violence-and-abuse#ixzz5p7mvn7qO

30. The Chair provided a regional example of what was in his view good practice by Sandwell & West Birmingham CCG. They had committed to a rolling programme of mandatory 3.5-hour Level III Child Safeguarding Training which included learning from DHRs/SCRs and a 1.5 hour case study on domestic abuse indicators and 'asking the question.'
31. The NICE Guidance 50(2014) and QS 116 (2016) are the current benchmark for best practice, and in the light of the current reviews finding, the CCG and NSCHT should consider written best practice guidance to remind professionals of the expectation that they will ask the questions of patients who present with indicators of domestic abuse. Professionals do need to be given ideas of 'framing questions' and an opportunity to practice the kind of targeted questions they should consider afterwards. The DHR would seek assurances from the CCG and the NSCHT that their current trainings and guidance is sufficient to equip their professionals to routinely enquire around domestic abuse, or recognise the health indicators that should prompt such questioning.
32. Stoke-on-Trent's first DHR, (DHR1) into the homicide of Y in 2013, concluded in January 2015. It included the recommendation that; '*The Stoke-on-Trent Domestic Abuse Partnership should consider whether current arrangements for the identification and referral by GPs of domestic abuse and violence are sufficiently robust and whether implementation of a programme such as IRIS[11] would improve their contribution to keeping victims safe.'*
33. This issue has been recognised in the Staffordshire and Stoke-on-Trent Domestic Abuse Strategy 2017-2020, 'Breaking the Cycle'. A key deliverable in the action plan states:

Ensure the relevant agencies (including health/GPs and Social Care professionals and their frontline workforce) have the skills and confidence to encourage people to disclose/discuss domestic abuse.

- *Identify agencies requiring skills.*
- *Develop customised training and support that all staff should receive.*

[11] Identification and Referral for Improved Safety (IRIS) is a general practice-based domestic violence and abuse (DVA) training support and referral programme.

- *Check use of skills through supervision and number of referrals made.*

34. It is the view of the DHR that the CCG and NSCHT should provide assurances that their additional training of healthcare professionals to identify the indicators of domestic abuse, ask appropriate questions and record where this is done, are embedded and can be evidenced in case file audits, audits of domestic abuse referrals made and 'flagging' on patient records.

17. Conclusions

1. The DHR has concluded that the risk that Andrew would react so violently to Emma's decision to separate was not foreseeable. There was no indication that Andrew had a propensity to violence and there was no relevant police involvement with either Andrew or Emma. As far as the close family were concerned, there was nothing to suggest Andrew had been violent in the past.
2. The DHR panel was fully aware of the numerous studies that point to the amount of contacts victims have with professionals before they seek or receive support. 85% of victims sought help from professionals five times, on average in the year before they got effective help to stop the abuse.[12]
3. It is in this context that Health Professionals are instructed to make safe enquiry of potential victims of abuse. It is vital that where potential indicators of abuse are present, every opportunity is taken to make safe enquiry, using carefully chosen non-blame attaching questions. It is not necessarily after a serious incident that victims will disclose; professionals must take advantage of every window of opportunity, however apparently minor, to make enquiry and ensure that safe opportunities are provided or engineered.
4. In this case a number of opportunities presented themselves for both GPs and Mental Health professionals to make and record specific enquiries regarding domestic abuse with Emma, but these do not appear to have been taken.

[12] SafeLives (2015), Insights Idva National Dataset 2013-14. Bristol: SafeLives.

5. There is a pressing need to provide evidence that the improvements to the policy and procedures and training that the DHR has been assured healthcare professionals in Stoke-on-Trent now receive to ensure they enquire sensitively and safely of patients and to facilitate disclosures where domestic abuse has been or is being experienced, has a demonstrable impact upon outcomes for patients.
6. They must make use of referral pathways to secure appropriate support. This must be accompanied by robust evidence that the NICE recommendations and quality standards relating to domestic violence and abuse are being met in Stoke-on-Trent.
7. The tragic circumstances of this case reinforced for the DHR Panel the need for the friends and family of women leaving relationships to be alert to risk even when they only have a slight suspicion that there may have been any domestic abuse that was coercive or controlling in nature.
8. Emma's parents were aware that on the day of their separation there had been a physical confrontation and that damage had been done to property. This was one of the reasons Frank accompanied Emma when she went back to the family home to collect her work uniform and possessions. Laura had offered to lend Emma money to buy replacement clothes so that she would not have to return but Emma was adamant she wanted to collect her property.
9. There was no evidence that Emma was fearful of Andrew. When she arrived at her house with her father, she asked him to stop short of the address, so Andrew, who had asked that none of their parents be present, would not see him. Emma was clear she wanted to see Andrew on her own and her father respected that wish. Frank recollected asking Emma; '*are you sure you're happy to go in on your own?*' and she replied '*it'll be fine. Oh, Dad don't worry!*'. Emma had apparently walked off in Frank's own words, '*with a smile and wave.*' She spent over an hour in the house with Andrew before the homicide. It seems that Emma herself underestimated the risk that Andrew posed, albeit she knew how emotional and upset he was over the separation.
10. Evidence from DHRs and research shows that the risk to women who have been in abusive relationships increases following separation, as this DHR tragically illustrates. This DHR also suggests that the perception of risk of the family and

indeed the person leaving a relationship may not be accurate. It may be safer for individuals to collect possessions when their former partners are absent, or better still, seek assistance from an uninvolved third party. (To reduce subsequent risk, it may be unwise do this without expressing the intention to the other party, unless doing this may actually increase risk of a confrontation.) Victims of domestic abuse, seeking to re-enter their home in similar circumstances as Emma, could seek the assistance of the police to prevent a breach of the peace using the 101-phone number for non-urgent calls for assistance. This is particularly so if there was a physical confrontation upon separation, (as happened in this case), however uncharacteristic this behaviour seemed. This learning should be emphasised by domestic abuse support groups and police.

11. There are lessons to be learnt from Andrew's demeanour and reactions in the days following the separation that may help to inform not only professionals but also the families of potential victims of controlling behaviour and raise their awareness of risk. Getting support to all the parties involved is also crucial particularly where it can be identified that domestic abuse is a potential risk and that either party is experiencing mental health difficulties.

18. Lessons to be learnt

1. In his interview with police and his conversation with the Chair of this review, it appears that Andrew was experiencing mental health deterioration in the days immediately following the separation from Emma. He claimed that he made two attempts to kill himself; one by hanging and a second by taking an overdose of Emma's anti-depressants. He stated that he passed out when he attempted to hang himself and this actually released the pressure from the ligature. These attempts cannot be independently corroborated because no medical treatment was sought and the incidents only came to light in post-arrest interviews with police.

2. It is clear from the evidence of friends and family that in the four days between separation and the homicide Andrew was according to police statements, '*extremely emotional, upset and tearful.*'
3. In such circumstances, prompt action by friends and family to support either party to the acrimonious separation, may reduce risk of harm to them or others. The Chair therefore also asked Andrew whether he had sought help from professionals. He stated that he would not have known who to go to. Although many years before, he had apparently experienced a mental health episode when a girlfriend left him and had seen a GP, he did not appear to see his GP as being a pathway to mental health support in the situation in which he found himself.
4. Without overstating what a GP could have done for Andrew at this point, had Andrew sought help from professionals it is possible that a GP may have suggested coping strategies or mental health support services that may have reduced the risk. Potentially had Andrew used helplines, a phone call may have helped Andrew to understand his vulnerability, his anger with Emma, and may have persuaded him to reduce the potential for conflict by asking a third party to be present. There are telephone Helplines and DA support charities such as Gingerbread, Mind and the Samaritans who would have been able to provide guidance for Andrew. The current domestic abuse service New Era will also offer support to domestic abusers who want to change. It is however unclear as to whether there was a history of domestic abuse prior to the incident which led to Emma's death and if there was an undisclosed prior history, whether or not Andrew saw himself as a perpetrator of domestic abuse.
5. There is evidence that in the days post separation, Andrew visited Emma at her parent's house pleading with her to come back and they spoke on the phone on the day of the homicide and she agreed to visit and collect her possessions.
6. In a 2017 study by Jane Monkton-Smith of over 358, domestic homicides[13] suicidal threats (or indeed attempts) were present in 23% of the cases (the study consider this to be an underestimate of the number of homicides where this risk marker

[13] Monkton-Smith, Jane et al University of Gloucestershire: Exploring the relationship between Stalking and Homicide. The Suzy Lamplugh Trust

was probably present.) Where a high-risk marker such as suicide is coupled with particular behaviours and there is a trigger such as separation, there is according to the study, a significant risk of escalation. This case highlights the difficulties of mitigating against these risks when they may not be known to professionals or family members and friends.

7. The combination of Andrew's emotional state, the presence of the kind of high-risk markers identified in the study and a trigger for escalation provides reinforcement of the now well-established learning from domestic abuse research; that the highest risk of harm is post separation.
8. Post separation, Andrew had destroyed a quantity of Emma's clothes and shoes; they appeared to have represented to him her new life and her intention to leave him. Destroying Emma's possessions, in this case her clothing, was a sign of using economic abuse as a method of control.
9. The sense of rejection and jealousy he felt, leading to his precarious emotional state and his high-risk behaviour (suicidal attempts) together with the trigger of separation can be seen with hindsight to have provided evidence of a real risk of escalation and harm which given the lack of disclosure and professional involvement with Andrew remained a hidden risk from all involved including Emma herself.

19. Steps Already taken to improve professionals responses to Domestic Abuse

1. Both the Stoke-on Trent CCG and the North Staffordshire Combined Healthcare Trust provided the DHR with outlines of the support and training already delivered to staff to improve awareness of domestic abuse and referral pathways.
2. The CCG are preparing a Domestic Abuse Case Scenario Training developed by the named GPs due for 'roll-out' imminently and this could offer an opportunity to emphasise 'asking the questions'.
3. Following the positive deliberations at the final DHR panel, the CCG immediately incorporated an increased focus on domestic abuse within the safeguarding training sessions that are currently part of the established children's safeguarding

Level III programme. The CCG have reinforced the need to recognise the health indicators of possible domestic abuse, that go beyond physical signs of injury, and thereafter 'ask the question'.

4. The first such session, in December 2018, was attended by 80 GPs. The Community Safety Partnership was assured by the CCG that this programme will continue and that they will be able to provide assurance of its scope through the percentage of staff requiring Level III safeguarding training who have attended.
5. In addition, the CCG has conducted 'light bite' shorter safeguarding sessions, attended by 163 staff from across primary care, which emphasised a focus on non-physical health indicators.
6. DA awareness and signposting feature in the GP newsletter posted on the CCG intranet. The CCG have informed staff of the provision of new Domestic abuse support services in Stoke provided by New Era.
7. The CCG has introduced a Joint Safeguarding Self-Assurance tool that has gone to all practices across Staffordshire. This will ensure that all practices can provide assurance that they have in place appropriate domestic abuse policies and procedures. They will also be able to indicate that staff have received appropriate Safeguarding training in line with the Adult and Child Intercollegiate documents.
8. In relation to the **specific GP practice** in this case:
    - The DHR was assured that GPs do now routinely ask the question, but may not record having done so in the absence of a disclosure. (In view of the NICE guidance and learning from this DHR, it is suggested that every time questions are asked, this should be recorded as an acknowledgement that domestic violence indicators have been identified.)
    - Where there is a disclosure this is recorded as a 'significant life issue' (that would allow a measurement of the frequency with which domestic abuse is disclosed.)
    - Monthly whole practice meetings take place where any DA issues would be discussed. The meetings include non-clinical staff, which is good practice.
    - The practice has appropriate Domestic Abuse support information displayed and freely available.

- Bespoke domestic abuse training was provided by the previous domestic abuse support service.
- All staff are up to date with their mandatory and statutory training.
- DA policies are in date and reviewed.
- As a result of regular audits of DA files, the practice has created an action plan to achieve more robust record keeping.

9. The North Staffordshire Combined Healthcare Trust stated that
    - *Domestic abuse training is delivered within the Trust as a stand-alone training session and as part of safeguarding training as a golden thread to enable staff to have the knowledge, skills and confidence to take appropriate action in asking the question and responding to disclosures; this is supported by advice and supervision from the safeguarding team and underpinned by the Trust Domestic Abuse Policy.*
    - *The Trust policy on domestic abuse provides clear guidance on allowing people who may be experiencing domestic violence and abuse to be seen on their own and in a quiet and private environment.*

      The Trust has an intranet site which contains the domestic abuse policy and a specific safeguarding site which contains information on accessing local partnership agencies and both national and local guidance in relation to domestic abuse.
    - *A specific question regarding domestic abuse has been added to the risk assessment used by the Trust and compliance with this is being monitored through the monthly community and inpatient safety matrix audit processes in order to evidence the routine questioning of service users regarding domestic abuse specifically.*
    - *There is a formal referral pathway in place as part of the domestic abuse policy containing information regarding people who disclose that they have been subjected to it; the perpetrators; and children who have been affected by it. This includes the local multi-agency risk assessment conference. (MARAC) process and referrals to the Multi Agency Safeguarding Hub (MASH).'*

10. New Era are the current holistic domestic abuse service operating across Staffordshire and Stoke-on-Trent from the 1st. October 2018.They provide support for victims but also services for perpetrators; *'anyone that's displaying unhealthy or abusive behaviour within their relationship and wants to change can access help.'*
11. They provide a Tiered support based upon the DASH
    - Tier one - Prevention
    - Tier two - Early Intervention (DA practitioner groupwork and 1:1 tailored support as required)
    - Tier three - Targeted Support (DA practitioner 1:1 tailored support)
    - Tier four - Acute Services (IDVA 1:1 tailored support, MARAC)

20. Recommendations

1. The Chair was provided assurances during the course of this DHR by both the CCG and the North Staffordshire Combined Healthcare Trust that they are committed to ensuring that their professionals are fully aware of the health indicators of domestic abuse and when it is required and appropriate to 'ask the question'.
2. It seems appropriate therefore that the Community Safety Partnership should ask the CCG and the North Staffordshire Trust to consolidate the changes and improvements made and provide the CSP with updated Policy and Procedures that reflect current improved practice to ensure that their professionals are properly supported.
3. It is critical that both the Stoke CCG and the North Staffordshire Combined Healthcare Trust are able to monitor the impact of these improvements over time. The CCG and North Staffordshire Combined Healthcare Trust should indicate how they will gather data that provides evidence of when their professionals identify health markers, when disclosures are then made and when referrals to appropriate domestic abuse support or other pathways are made. These data sets will provide evidence that practice has been embedded.
4. **Recommendation One:**

   That Stoke-on-Trent CCG and North Staffordshire Combined Healthcare Trust demonstrate that they have in place policies and procedures, best practice guidance and training that ensures that when people present to frontline staff with indicators of possible domestic abuse they are asked (and a record made of that enquiry) about their experiences in a sensitive and appropriate manner in a private discussion, in accordance with NICE Guidance 50 and Quality Standard 116.
5. **Recommendation Two:**

   That the Staffordshire and Stoke-on-Trent Domestic Abuse Commissioning and Development Board raise awareness of the significant adverse impact of coercive control in relationships so that not only victims are better able to recognise they are experiencing this form of domestic abuse and seek help and support, but also

their community, family, friends and colleagues are equipped to identify safe and effective pathways to provide that support.

6. **Recommendation Three:**

   That the Stoke-on-Trent Community Safety Partnership propose to NHS England that they review their current on-line Safeguarding Level III training to ensure that it provides guidance to health professionals that enables them to identify indicators of possible domestic violence or abuse in patients and also lists questions that would prompt a discussion about their experiences.