

OVERVIEW REPORT

DOMESTIC HOMICIDE REVIEW

in respect of

Y/2013

Deceased December 2013

Age 42 years

Chris Few

January 2015

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INTRODUCTION

- 1.1 Domestic Homicide Reviews were introduced by the Domestic Violence, Crime and Victims Act (2004), section 9.
- 1.2 A duty on a relevant Community Safety Partnership to undertake Domestic Homicide Reviews was implemented by the Home Office through statutory guidance in April 2011. The 'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' was updated in August 2013 and that revision provided the framework within which this Review was conducted¹.

- 1.3 A Domestic Homicide Review (DHR) is defined² as:

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 person to whom he was related or with whom he was or had been in an intimate personal relationship, or
- a member of the same household as himself,

held with a view to identifying the lessons to be learnt from the death.

- 1.4 The purpose of a DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

- 1.5 DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for Coroners and criminal courts. They are also not specifically part of any disciplinary enquiry or process; or part of the process for managing operational responses to the safeguarding or other needs of individuals. These are the responsibility of agencies working within existing policies and procedural frameworks.

¹ www.homeoffice.gov.uk.

² Domestic Violence, Crime and Victims Act (2004), section 9 (1).

2 Summary of Circumstances Leading to the Review

- 2.1 In December 2013 West Midlands Ambulance Service and Staffordshire Police responded to a call from X reporting that Y was unconscious at his home address following an argument. Y was found to have substantial head and facial injuries and was pronounced dead at the scene.
- 2.2 A homicide investigation was commenced by the Police. X was arrested at the scene and subsequently charged with the murder of Y.
- 2.3 Police records indicate Y and X had been in a relationship for approximately 9 years and that X was known to stay at Y's address on a regular basis.
- 2.4 On 21 January 2014 a Scoping Panel convened on behalf of the Stoke-on-Trent Responsible Authorities Group considered the circumstances of the case and concluded that the criteria for conducting a Domestic Homicide Review were met. A recommendation to commission a Domestic Homicide Review was endorsed by the Chair of the Responsible Authorities Group who was present at the meeting.
- 2.5 In 2014 X was convicted of murder at Crown Court and sentenced to life imprisonment.

3 Terms of Reference

- 3.1 The full Terms of Reference for this Review are at Appendix A. The following is a summary of the key points.
- 3.2 The Review considered in detail the period from 1 January 2006 (from when X was resident in Staffordshire) to the date of Y's death. X's child (Z) from a previous relationship was only resident with X from October to December 2013 and was included in the detailed consideration from 1 October 2013 onwards. Summary information regarding significant events outside of this period was also considered.
- 3.3 The focus of the Review was on the following individuals:

Name	Y	X	Z
Relationship	Victim	Partner	Partner's Child
Gender	Male	Female	
Age (December 2013)	42 years	40 years	16 years
Ethnicity	Asian	White British	White British
Address of Y:	Stoke-on-Trent		

- 3.4 Specific issues considered by the Review were:
- Substance (including alcohol) misuse by the victim and perpetrator, and the effectiveness of related services
 - Mental health of the victim and perpetrator, and the effectiveness of related services

- Domestic abuse involving the victim and perpetrator, the effectiveness of related services, including of a MARAC held in November 2011 and wider issues connected with domestic abuse of male victims
- Ethnicity of the victim.

4 Review Panel Chair and Independent Overview Report Author

4.1 The Review Panel was chaired and this report of the Review was written by Chris Few, an Independent Consultant. Mr Few has chaired review panels and written overview reports on behalf of numerous Community Safety Partnerships, Local Safeguarding Children Boards and Local Authorities in connection with Domestic Homicide Reviews and Serious Case Reviews³. He has no professional connection with any of the agencies and professionals involved in the events considered by this Review.

5 Review Panel Members

5.1 The Review Panel comprised the following post holders:

- Domestic Abuse Service Manager
Arch
- Neighbourhood Manager
Aspire Housing Association
- Community Safety Officer – Domestic Violence Lead
Newcastle-under-Lyme Borough Council
- Lead Nurse Adult Safeguarding
North Staffordshire and Stoke-on-Trent Clinical Commissioning Groups
(On behalf of NHS England)
- Named Nurse for Safeguarding
North Staffordshire Combined Healthcare NHS Trust
- County Manager, Responsive Services
Staffordshire County Council Children and Young People Service
- Head of Probation
Staffordshire and West Midlands Probation Trust (now West Midlands Community Rehabilitation Company)
- Head of Probation – Staffordshire and Stoke-on-Trent
National Probation Service
- Senior Investigating Officer
Staffordshire Police
- Detective Sergeant
Investigative Services Policy, Review and Development Unit
Staffordshire Police

³ Under the Children Act (2004) and its associated statutory guidance.

- Lead for Crime and Disorder
Stoke-on-Trent City Council
- Personal Crime Programme Lead
Stoke-on-Trent City Council
- Lead Nurse Adult Safeguarding
University Hospital of North Staffordshire NHS Trust (now University Hospitals of North Midlands NHS Trust)
- Safeguarding Manager
West Midlands Ambulance Service NHS Trust.

6 Review Process

- 6.1 The Review Panel met on three occasions to consider contributions to and emerging findings of the Review:
- 20 March 2014
 - 21 May 2014
 - 1 December 2014.
- 6.2 This Overview Report was endorsed by the Review Panel on 1 December 2014 and forwarded to the Chair of the Stoke-on-Trent Responsible Authorities Group. On 27 January 2015 was presented to and endorsed by the Responsible Authorities Group.

7 Contributions to the Review

- 7.1 Requests to confirm the extent of their involvement with the subjects of this Review were sent to all statutory and voluntary agencies in Stoke-on-Trent, Staffordshire and the West Midlands who may potentially have had such involvement. This scoping process was used as the basis for more targeted requests for Management Review and Summary Information Reports. Birmingham Community Safety Partnership provided considerable assistance in facilitating this process in respect of West Midlands organisations.
- 7.2 Management Review and Summary Information Reports were submitted by:
- Arch
 - Aspire Housing Association
 - Birmingham City Council Children's Services
 - Newcastle-under-Lyme Borough Council
 - NHS England (Primary Care Services)
 - North Staffordshire Combined Healthcare NHS Trust
 - Staffordshire County Council Children's Services
 - Staffordshire and West Midlands Probation Trust (now National Probation Service & Staffordshire and West Midlands Community Rehabilitation Company)
 - Staffordshire Police
 - Stoke-on-Trent City Council
 - University Hospital of North Staffordshire NHS Trust (now University Hospitals of North Midlands NHS Trust)
 - Victim Support
 - West Midlands Ambulance Service NHS Trust

- West Midlands Police
- High School in Staffordshire for perpetrator's child.

7.3 The Crown Prosecution Service was requested to provide an analysis of their involvement with three criminal investigations involving X as a perpetrator and alleged victim prior to the homicide enquiry. They did so in November 2014 following conclusion of X's trial for murder. In accordance with established retention policies, the relevant CPS case files had been destroyed prior to the establishment of this review. The CPS' analysis was therefore restricted to reviewing documents provided by the Police. Correspondence between the Police and Crown Prosecution Service, and some other relevant documents were not included in the Police retained files.

7.4 Other sources of information accessed to inform the Review included:

- North Staffordshire Combined Healthcare NHS Trust Serious Incident Investigation Report
- Archived records of Staffordshire County Council Adult Mental Health and Social Care involvement with X in 2006⁴
- An overview of domestic violence and abuse services in Stoke-on-Trent prepared by the City Council Personal Crime Programme Lead.
- Respect Toolkit for Working with Male Victims of Domestic Violence, 2nd Edition (2013).
- CPS Guidance self-defence and Counter Allegations
http://www.cps.gov.uk/legal/d_to_g/domestic_violence_aide-memoire/#a21
- Coordinated Action against Domestic Abuse (CAADA) guidance on responding to counter allegations
<http://www.caada.org.uk/news/caada-enevs-Mar2012-responding-to-counter-allegations.html>
- North Staffordshire MARAC Self-Assessment and CAADA Development Officer visit Observation Summary (February 2013)
- Letter from the Legal Advisor to the Chief Crown Prosecutor, Crown Prosecution Service West Midlands dated 24 November 2014
- NICE Public Health Guidance 50 - Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively (February 2014)
- Reducing the impact of Violence - draft Scoping Document, Association of Directors of Public Health (West Midlands). (November 2014).

8 Parallel Processes

- 8.1 The criminal investigation into the murder of Y was conducted in parallel with this Review. In 2014 X was convicted of murder at Crown Court and sentenced to life imprisonment.
- 8.2 HM Coroner for Stoke-on-Trent and North Staffordshire opened and adjourned an inquest pending the outcome of the criminal trial. That inquest will not now be reconvened.
- 8.3 North Staffordshire Combined Healthcare NHS Trust conducted a Serious Incident Investigation, focussing on data sharing across the different databases operated by the Trust. This was concluded on 21 February 2014 and informed the Management Review report provided by that Trust.

⁴ From 2009 adult mental health social work services in the Newcastle-under-Lyme area have been provided by North Staffordshire Combined Healthcare NHS Trust. At the time of the transfer of this service from Staffordshire County Council all non-current case records were archived.

8.4 Staffordshire and West Midlands Probation Trust conducted an internal 'Serious Further Offence' review⁵ on their involvement with X. This was completed by the Trust's IMR author and informed their contribution to the Review.

9 Family Engagement

9.1 Members of Y's family were advised of the Review at its outset and invited to contribute. Y's sister agreed to meet with the Independent Chair on behalf of the family and did so on 17 July 2014. She was accompanied by a mutual friend of Y and herself.

9.2 As part of the homicide investigation the Police also interviewed a number of Y's friends and relatives, obtaining wide ranging background information regarding Y and his relationship with X. The statements provided were made available to the Review.

9.3 The Review Panel is grateful for the valuable insight regarding Y, his relationship with X and their perspectives on local services provided by the family and friends of Y, which has informed and been incorporated into this report.

9.4 X was informed of the Review at its outset and invited to contribute. No response was received from her or her legal advisors.

9.5 Y's sister and the friend who contributed to the Review were offered sight of this report on its completion and prior to its submission to the Home Office. Y's sister took up this offer and met with the Independent Chair to go through the report in March 2015. She did not request any amendments and agreed to take back the findings of the Review to other members of Y's family.

⁵ There have been procedures in place for the reporting and case review of Serious Further Offending by offenders subject to supervision in the community by Probation Trusts for over ten years. The 'Serious Further Offence' notification and review procedure is intended to ensure rigorous scrutiny of relevant case and contribute to continuous improvement in how offenders are managed.

ORGANISATIONAL CONTEXT

10 Stoke-on-Trent Profile

- 10.1 The unitary authority of the City of Stoke-on-Trent lies within the county of Staffordshire. It became a unitary authority in 1997. Y resided in a small town in the West of Stoke-on-Trent.
- 10.2 Stoke-on-Trent is bordered to the West by Newcastle-under-Lyme which is served by Staffordshire County Council and by its own Borough Council. X resided within the borough of Newcastle-under-Lyme.
- 10.3 According to the English Indices of Deprivation 2010, Stoke-on-Trent is the 3rd most deprived local authority in the West Midlands (out of 30) and the 16th most deprived local authority in England (out of 326).
- 10.4 The 2011 census recorded the population of Stoke-on-Trent as 249,000, residing in 107900 households. There were 124,000 males, (49.8%) and 125,000 females, (50.2%).
- 10.5 89.37% described themselves as White British, 5.02% as Asian or Asian British and 1.55% as Black or Black British.

11 Local Strategic Context

- 11.1 The Stoke-on-Trent City Council “Mandate for Change” sets out the Council’s vision to ‘Make Stoke-on-Trent a Great Working City’. Provision of services for high risk victims of domestic violence and abuse contributes to this vision.
- 11.2 The Stoke-on-Trent Joint Health and Wellbeing Board Strategy 2013-2016 prioritises reducing the negative impact of domestic abuse. It is recognised that the cost of domestic abuse to the public sector is high and that the experience of domestic abuse on victims and their children is devastating.
- 11.3 The Stoke-on-Trent Safeguarding Children Board has three strategic priorities for 2013-2014, one of which is domestic abuse. The Board’s objectives are to raise awareness of domestic abuse, promote co-ordination between agencies in preventing and responding to domestic abuse and encourage the development of services.
- 11.4 Stoke-on-Trent’s Safer City Partnership delivers the national crime, disorder and substance misuse strategies at a local level. In November 2012, the Safer City Partnership developed a three year Partnership Plan within which violent crime, including domestic abuse, was identified as a priority.
- 11.5 The Stoke-on-Trent Domestic Abuse Partnership has been in place since 2008 and reports directly to the Safer City Partnership’s Responsible Authorities Group, the Local Safeguarding Children Board and the Children and Young People’s Strategic Partnership Board. Membership consists of statutory sector, third sector and community group representatives.
- 11.6 In order to support the national priorities at a local level, the Domestic Abuse Partnership has the following priorities in their Domestic Abuse Strategy for 2013-16:
- Prevention – increase awareness and change attitudes, especially in young people.

- Provision of Services – access to specialist support for victims, children and young people.
- Partnership Working – co-ordinated actions are in place to enable partners to deliver services efficiently, effectively and in a cost effective way.
- Justice Outcomes and Risk Reduction – ensure victims are fully supported through the court process, partners are signed up to the domestic homicide review process and perpetrators are informed about voluntary programmes.

11.7 Staffordshire Criminal Justice Board Victims and Witnesses sub-group receives performance information concerning, inter alia, domestic violence and abuse, with actions identified and implemented for service improvements.

11.8 This group, together with the Domestic Abuse Partnership, receives feedback from victims of domestic violence and abuse regarding Criminal Justice Services to inform the identification and implementation of service improvements.

12 Incidence / Impact of Domestic Violence and Abuse in Stoke-on-Trent

12.1 Based on national research 1 in 4 women and 1 in 6 men experience domestic violence and abuse at some point in their lives. This means that Stoke-on-Trent, with a population of 249,000, potentially has 31,250 women and 20,666 men in the City who will at some time experience domestic violence and abuse.

12.2 The Joint Strategic Needs Assessment 2010-2015 (JSNA) reports that domestic abuse continues to be a major cause of family distress and social exclusion⁶ and accounts for around a quarter of all reported violent crime in Stoke-on-Trent.

12.3 Domestic violence with injury offences continue to account for around a third of the violence with injury offences that are recorded in Stoke-on-Trent.

12.4 In 2012-13 there were 823 (a 7% increase on the previous year) such offences recorded in Stoke-on-Trent.

12.5 However, the reporting of domestic violence and abuse incidents as a whole presents a better perspective on the volume of victims. In the 12 months to November 2013, 8201 such incidents were reported, a 4% reduction on the previous rolling 12 months. There was also a similar downward trend in the data on repeat incidents which is used by the agencies responsible for managing the Multi-Agency Risk Assessment Conferences (MARACs) and nationally by Co-ordinated Action Against Domestic Abuse (CAADA) on behalf of the government to monitor the impact of intervention.

12.6 Whilst the information is not directly comparable, data for the Staffordshire Police area as a whole provides an indication of the incidence of domestic violence and abuse incidents involving male victims. Between February 2012 and January 2014 18% (5713) of 31,357 crime and non-crime domestic incidents where gender was recorded had male victims⁷.

12.7 MARAC data suggests that the reported incidence of domestic violence and abuse towards men is increasing. Between March 2013 and February 2014, the number of male high risk victims referred to MARAC had increased by 23% over the total for the previous year.

⁶ The percentage of customers presenting as homeless due to domestic violence and abuse (11-13%) is the fourth highest reason for homelessness in Stoke-on-Trent.

⁷ 324 incidents during this period did not have the victim's gender recorded.

13 Domestic Violence and Abuse Services in Stoke-on-Trent

13.1 In August 2013 Stoke-on-Trent City Council awarded a three year contract to Arch (North Staffs Ltd.) to provide the following domestic violence and abuse services for men, women and children:

- Julia House - a purpose built refuge for women and children who have been subject to, or are at risk of, domestic abuse
- A local telephone helpline
- An outreach service, including one to one practical and emotional support for women and children (and a small number of men)
- Counselling by trained counsellors
- Tailored support to individuals whose spouse or partner is attending a perpetrator programme
- Personal safety advice and support including the installation of security equipment where appropriate
- A school based educational project, providing children and young people the opportunity to explore and understand the effects abusive and/or controlling relationships have and educate children and young people around relationships
- A domestic abuse recovery programme (RISE) working with children, young people and their mothers recovering from living with domestic violence and abuse. The programme takes place over 10 weeks with groups for children, young people and their mothers running in parallel to each other.
- An accredited perpetrator programme

13.2 Additional services which are provided within the City outside of this contract include:

- The Freedom Programme - A 12-week course open to any woman who wants to learn more about the realities of domestic abuse. It is designed to empower women, increase their self-confidence and help to improve the quality of their lives.
- Sunrise Centre - The Sunrise Centre is a safe and welcoming service for women, men, young people and children who have survived domestic abuse.
- Training Programmes - educating professionals about the issues surrounding domestic violence and abuse.
- Practical and emotional support for men and women by an Independent Domestic Violence Advisor (IDVA), who supports victims before, during and after the court process.
- A target hardening scheme provided by Revival, which provides low level measures to help people feel safe within their home.

13.3 Specialist Domestic Violence Courts

13.3.1 During 2006 North Staffordshire (Newcastle-under-Lyme) Magistrates Court became one of 64 areas⁸ to be accredited with specialist domestic violence court status (SDVC). Cases are heard from Stoke-on-Trent, Newcastle-under-Lyme and Staffordshire Moorlands.

13.3.2 These court systems are part of the Government's efforts to improve the support and care provided for victims of domestic violence and abuse. The specialist domestic violence court programme promotes a combined approach to tackling domestic violence by the Police, the Crown Prosecution Service (CPS), Magistrates, Courts and Probation together with specialist support services for victims as part of a community-wide response to domestic violence. During 2010/11 there were 726 domestic violence cases heard at Newcastle-under-Lyme Magistrates Court. This nearly doubled to 1318 in 2011/12 and 1250 in 2012/13. The

⁸ There are now over 100 specialist courts nationally.

conviction rate for prosecuted offences was 65% for 2010/11, 73% for 2011/12 and 70% in 2012/13.

13.3.3 Each SDVC should have Independent Domestic Violence Advisors (IDVA) who have attended accredited training to provide support for service users and whose goal is the safety of their service users and their children. There are currently 4 IDVAs employed by Stoke-on-Trent City Council who fulfil these responsibilities.

13.4 **Stoke-on-Trent Domestic Abuse Partnership Achievements**

13.4.1 In addition to the development and strategic oversight of the services mentioned above, between 2011 and 2013 the Stoke-on-Trent Domestic Abuse Partnership:

- Undertook a number of comprehensive media campaigns to encourage the reporting of domestic violence and abuse. Examples included campaigns that were held during the 2012 European Football Cup competition and during the weeks leading up to Valentine's Day in February 2013.
- Jointly hosted with Newcastle-Under-Lyme Safer Communities Partnership and Arch North Staffordshire the fourth Annual North Staffordshire Domestic Violence Conference in November 2012 entitled 'Prevention, not Cure'. This was attended by around 100 delegates and highlighted developments in perpetrator work both nationally and locally.
- Trained 25 officers from across the Partnership to enable them to act as facilitators within the RISE group work recovery programme.
- Following a review of Stoke-on-Trent City Council Housing Services Sanctuary scheme, decided that more people could be protected by providing lower-level measures to customers experiencing, or at risk of, domestic abuse. A target hardening service was put out to tender, and was awarded to the Revival Home Improvement Agency in April 2013.

13.4.2 Notwithstanding the breadth of services being provided it has been identified that more could be done in the following areas:

- Early intervention and prevention support with key workers dedicated to supporting victims at the earliest opportunity therefore reducing the number of victims reaching crisis point
- Support for victims attending court who do not meet the MARAC threshold or who are not supported by IDVAs.
- Specialist support for young people aged 16 and 17 who have suffered abuse. Young people aged 16-17 were recently included in the government definition of domestic violence and abuse and there has been steady rise in referrals for this age group.
- A specific age appropriate perpetrator programme for young people aged between 11 and 20 who are perpetrating violence on family members and/or partners.
- Specialist support for South Asian women and victims of forced marriage.

14 **Key Agency Context**

14.1 **Arch**

14.1.1 Arch is a registered charity that, since 1989, has been providing a diverse range of services for children, young people, adults and families in local communities across Stoke-on-Trent, Staffordshire and more recently Cheshire East. Each year Arch works with over 3000 people who are in housing need or crisis, including but not solely victims and perpetrators of domestic violence and abuse.

- 14.1.2 The Arch Domestic Violence Outreach Service has historically offered a range of interventions to survivors and perpetrators of domestic violence; including a service to male victims which were first commissioned in 2010. Referrals come from a range of agencies with a significant proportion made by the MASH (Multi-Agency Safeguarding Hub). Self-referrals are also accepted.
- 14.1.3 The Arch Domestic Violence Outreach Service is funded from numerous sources including Stoke-on-Trent City Council, Newcastle-under-Lyme Borough Council, Staffordshire County Council and Cheshire East Council. It also receives funds from Charitable Trusts, the Ministry of Justice, Department of Health and public donations.
- 14.1.4 The interventions delivered by the Domestic Violence Outreach Service include one to one and group work interventions delivered to female, male and child victims of domestic abuse and a 30 week group programme which is delivered to male perpetrators on a rolling basis.
- 14.1.5 In September 2013 a major fire in the Stoke-on-Trent premises of Arch resulted in the destruction of a significant number of case files, including that relating to Y.
- 14.1.6 Both Y and X presented as victims to different Arch Domestic Violence Outreach Services. Y requested information by telephone from the Arch male victims service on the 31 October 2011. X engaged with the Arch IDVA (Independent Domestic Violence Advisor for Newcastle-under-Lyme Borough area) from the 5 November 2011 until 13 February 2012.

14.2 **North Staffordshire Combined Healthcare NHS Trust**

- 14.2.1 North Staffordshire Combined Healthcare NHS Trust (NSCHT) provides Mental Health, Substance Misuse and Learning Disability Services to the population of Stoke-on-Trent, Newcastle under Lyme and Staffordshire Moorlands.
- 14.2.2 NSCHT did not have a trust-wide policy in place regarding domestic abuse until December 2013 when a Policy Framework was ratified by the NSCHT Trust Board. Consequent to this NSCHT commissioned Domestic Abuse Awareness Training from Arch which commenced in April 2014.
- 14.2.3 NSCHT services involved with X include:
 - Crisis Resolution / Home Treatment Team
The Crisis Resolution/Home Treatment Teams helps avoid admission to a mental health inpatient ward by supporting people in acute mental crisis in their homes. The teams have doctors, nurses, social workers, occupational therapists and support workers who are available to support patients, carers and their families. The teams also help people who have been discharged from hospital as they make the transition back into the community. All patients are provided with a crisis card with details of who to call in an emergency.
 - Ward 3 Harplands Hospital
Ward 3 is an acute inpatient ward which cares for female patients between the ages of 18 and 65.
 - Community Addiction Team
There are two Community Addiction Teams providing services for people experiencing difficulties as a result of either alcohol or drug use in the communities of Newcastle and Staffordshire Moorlands, and an alcohol detoxification service in Stoke-on-Trent.

- Lymebrook Mental Health Resource Centre
Community Mental Health and Social Care Teams provide mental health services to adults across North Staffordshire, one of which is based at the Lymebrook Centre. Assessment, treatment and care is provided through a process known as Care Co-ordination and each person using services will be appointed a Care Co-ordinator. Services provided include advice, support, assessment of Mental Health and Social Care needs and treatment and care for people and their carers who have identified mental health needs which cannot be met in primary care.

14.2.4 The NSCHT service relevant to Y is:

- Healthy Minds:

The Healthy Minds service is provided through a consortium of providers, including NSCHT, and two charities; Changes and North Staffs Mind. The service provides talking therapy and self-help courses for people with common mental health difficulties such as mild to moderate anxiety and depression and can be stand alone or be used alongside medication.

14.2.5 Although referred to Healthy Minds, Y did not attend for an initial assessment and no service was provided prior to his death. The involvement of Healthy Minds and Y was subject of a Serious Incident Investigation by NSCHT and a copy of the report from that investigation was provided to this Review.

14.3 **Staffordshire County Council Children's Services** (Hereafter referred to as Children's Social Care)

14.3.1 Staffordshire County Council Children's Services provide statutory Children's Social Care services in Staffordshire.

14.3.2 Their involvement focussed on Z in relation to her care arrangements and as a missing child (and involved contact with Birmingham Children's Social Care).

14.4 **Staffordshire Police**

14.4.1 Staffordshire Police provide policing services for Staffordshire and Stoke-on-Trent.

14.4.2 Police had contact with X as an offender, as an alleged victim and also as a person in need of assistance to safeguard their welfare. Involvement with Y was limited to one occasion, in 2011, as an alleged perpetrator of domestic violence. Involvement with Z was in relation to her care arrangements and as a missing child (both of which involved contact with West Midlands Police).

14.4.3 All front line police officers in Staffordshire undertake mandatory training on recognising and responding to domestic violence and abuse and to mental health issues. Mental health professionals are available in custody suites to support detainees with mental health problems.

14.5 **Staffordshire and West Midlands Probation Trust** (now National Probation Service & Staffordshire and West Midlands Community Rehabilitation Company)

- 14.5.1 Staffordshire and West Midlands Probation Trust was an amalgamation of two former Probation Areas (i.e. Staffordshire and West Midlands). The merged Trust came into being on the 1 April 2010.
- 14.5.2 From 1 June 2014 the responsibilities formerly undertaken by the Staffordshire and West Midlands Probation Trust were split between two new organisations; the National Probation Service, responsible for high risk offenders and the Staffordshire and West Midlands Community Rehabilitation Company responsible for medium and low risk offenders.
- 14.5.3 The Staffordshire and West Midlands Probation Trust representative on the Review Panel has confirmed that the current policies (including those relating to Domestic abuse) of that organisation are being carried across local and national level to the two new bodies. In respect of MARAC it is intended that both organisations would engage with the process.
- 14.5.4 Staffordshire and West Midlands Probation Trust has responsibilities for the safe and proper oversight of persons under its supervision in the community. These responsibilities are discharged by three key processes namely; Risk Assessment, risk management and offender management. The Trust also has responsibilities for liaison with victims of qualifying offences.
- 14.5.5 The involvement of Staffordshire and West Midlands Probation Trust was with X only, and covered two distinct periods of Assessment and Supervision under Community Order sentences. The first period was from February 2007 until March 2008 and the second period was from July 2013 to the current time.
- 14.5.6 The Trust launched its first integrated Domestic Abuse strategy in April 2013. Following this strategy the Trust conducted an internal audit of Domestic Abuse practice in December 2013 from which a report was produced in March 2014. Following receipt of this report a specific action plan was commissioned for implementation by all local managers to improve practice. The audit identified a number of positives as well as areas for improvement.
- 14.6 West Midlands Ambulance Service NHS Trust**
- 14.6.1 The Trust provides Ambulance Services across the West Midlands including Stoke-on Trent.
- 14.6.2 West Midlands Ambulance Services Adult Safeguarding Policy was updated in January 2013 to include domestic violence and abuse. A stand-alone Domestic Violence and Abuse Policy has been developed and is undergoing ratification. The implementation of this is being supported by a mandatory training program all front line staff during 2014/15 and inclusion of a domestic abuse question set within their 24 hour Safeguarding Referral line arrangements. Links have been made with each Police force in the West Midlands for the WMAS Safeguarding Hub to refer domestic abuse concerns directly to the Police.
- 14.6.3 Ambulance Service staff attended a number of calls for assistance to X in 2006, 2011 and 2013 as well as responding to the injuries from which Y died in December 2013.
- 14.7 University Hospital of North Staffordshire NHS Trust (now University Hospitals of North Midlands NHS Trust)**
- 14.7.1 University Hospital of North Staffordshire NHS Trust (UHNS) is located in Stoke-on-Trent and provides a full range of general acute hospital services for approximately half a million people living in and around North Staffordshire. The Trust also provides specialised services for three million people in a wider area, including neighbouring counties and North Wales

- 14.7.2 Since 2012 the Trust has been developing and strengthening services and policies to increase staff awareness of domestic violence and abuse particularly within emergency settings. In April 2012 a partnership was formed with Arch to provide a follow-up clinic.
- 14.7.3 Full implementation of a trust-wide policy for responding to domestic violence and abuse is coming to fruition to reflect processes at both Hospital sites.
- 14.7.4 The Trust provides representation at MARAC meetings and is currently developing an enhanced "ALERT" system that will raise staff awareness of those patients who are deemed to be at risk.
- 14.7.5 In August 2011 an Alcohol Liaison Nurse post was established; with two additional Nurses being appointed in March 2012. One of the team is dedicated to the A&E Department to offer support and refer on to appropriate agencies. All clinical areas have a toolkit which contains advice for patients and forms for referral to the Alcohol Liaison Nurse.
- 14.7.6 Prior to 2013 hard copies of A&E Department notes were stored both on and off site and despite all efforts documentation regarding 4 attendances by X these records have not been located. Since April 2013 the Emergency Department has implemented real time scanning of patients A&E Department notes in order that they are available electronically for clinicians to review in a timely manner.
- 14.7.7 X attended the A&E Department on numerous occasions in early 2006, largely as a consequence of alcohol misuse and self-harm, with further attendances in 2011 and 2013. UHNS had no contact with Y during review period.

THE FACTS

15 Family Background

15.1 Y

- 15.1.1 Y was born in 1971 in Stoke-on-Trent where was educated in local schools until he left education at the age of sixteen. Y's parents were of Asian heritage but by the time of Y's birth had adopted a largely westernised lifestyle. Y and his sister are reported to have been more westernised than their parents.
- 15.1.2 In June 1986 Y became a trainee paint sprayer on a Youth Training Scheme for a local car recovery firm and was still doing this work in 1988 when he (aged 17) was arrested for taking his mother's car without consent, resulting in his only criminal conviction.
- 15.1.3 Y was described as Asian male 5 ft. 6 inches tall, of medium build with dark brown/ black hair and a heavy beard. He was a non-practicing Sikh. Y lived alone in a rented flat, was never married and had no children. He is reported to have had only one previous serious relationship, which ended some years before he met X
- 15.1.4 In 2011 (when was arrested for an alleged assault on X) Y stated that he was unemployed and in 2013 informed his GP that he had been unemployed since 2000. There is no record of any further employment.
- 15.1.5 Y had a keen interest in music and was an accomplished guitar player. He had been a member of local bands and performed at various locations in the West Midlands. Y's social life revolved around his fellow band members and they would go for a drink in local pubs or visit Y at his flat.
- 15.1.6 Y's sister has described him as shy and liking his own space; being uncomfortable engaging in large social situations.
- 15.1.7 Long term friends of Y have described his nature:

"My opinion of Y was that he would never harm a fly. I enjoyed his company as he was very calm and did not once raise his voice in my presence. He was not a confrontational sort of person; and would avoid arguing whenever he could".

"I can only describe Y as the nicest bloke I have ever met. He was gentle and very caring and would always try to help people with their problems. He was quiet spoken and in all the years I have known him I never saw him lose his temper once".

15.2 X

- 15.2.1 X was born in 1973 in Stoke-on-Trent.
- 15.2.2 Between 1991 and 1995 X (then aged 18-21) was dealt with by criminal justice agencies for offences connected with prostitution on 12 occasions in London and then latterly in Bedford and Stoke-on-Trent. During this period she was also dealt with for Criminal Damage and Assault on another sex worker. This was the first indication that X had the propensity to be violent. None of these offences resulted in community or custodial sentences.

- 15.2.3 In 1992 X had her first child, the father of whom is a man believed to have introduced X to prostitution⁹. He had little to do with X at the time of the birth and has had no subsequent involvement with his child.
- 15.2.4 The Police have identified that from this point there was no significant period when X was without a relationship for any length of time and that a number her relationships overlapped, with one beginning as the preceding one was drawing to a close. The Police have observed that there may have been other men in her life who have not been identified during their investigation.
- 15.2.5 In 1992 Partner 1 began a relationship with X who was at that time living in Stoke-on-Trent.
- 15.2.6 In 1994/95 X moved from to the Birmingham area, purportedly to be nearer to Partner 1, although he now believes that this was to be near her best friend as much as it was to be with him.
- 15.2.7 In 1995 and 1997 X had her second and third children, the father of both being Partner 1. The youngest child is Z.
- 15.2.8 Despite having two children Partner 1 states that as a couple they did not live together for “any long length of time” and their relationship was conducted on X’s terms. Partner 1 has stated that both he and X drank socially but that X was not an alcoholic at that time. He describes her as “very quick verbally and by that I mean she would shout and swear a lot, but she was not violent towards me”.
- 15.2.9 On 4 August 1999 West Midlands Police attended a domestic incident involving X and Partner 1. It was established that a verbal argument had taken place and no offences were recorded. No further action was taken. It was recorded that 3 children were present at the time.
- 15.2.10 On 3 March 2001 West Midlands Police attended an incident where X was described as going berserk. X continued to shout and swear when the officers arrived and she was arrested to prevent a breach of the peace. She was subsequently released with no further action being taken once she had calmed down. X’s three children were present during the incident.
- 15.2.11 Around this time the relationship between Partner 1 and X ended although he did keep in contact with his children and X’s older child.
- 15.2.12 After the relationship ended Partner 1 was informed by X’s oldest child that things in X’s house were “not right”; she was drinking more and during the day, the children were being left alone for long periods of time and that her oldest child had to look after her younger siblings and take them to school.
- 15.2.13 On 4 November 2005 West Midlands Police attended a report by Partner 2¹⁰ that X had assaulted him whilst trying to take property from his house. On their arrival the Police ascertained that a verbal argument had taken place but no assault. X’s children were present during this incident.
- 15.2.14 Shortly after this incident X and her three children moved into a hostel in the Stoke-on-Trent area.

⁹ This man was not traced for interview as part of the homicide investigation and only the little anecdotal information provided by one of X’s children and the man’s brother (see 16.16.6) regarding their relationship is known.

¹⁰ Only the details recorded in 2005 by West Midlands Police are known regarding Partner 2 and his relationship with X. Partner 2 was approached as part of the homicide investigation and denied any knowledge of the incident or of X.

15.2.15 Around this time X's oldest child asked to live with Partner 1 and his wife in Birmingham. This was agreed.

16 Summary of Events

16.1 The following is a narrative summary of professional contact with Y and X. Information provided to the investigation of Y's murder but which was unknown to professionals at the time is included (*in italics*) at relevant points to provide additional insight into the context of the professional involvement.

16.2 During the earlier parts of the period under review there were changes in commissioning and provider organisations for addiction and mental health services. Consequent to this the record base is fragmented and while some archived hard copy records have been traced it is recognised that these remain incomplete. The Review has attempted to extrapolate the extant records into a coherent narrative but it is clear that, particularly in relation to X's alcohol addiction in 2006, more services were provided than those which are able to be included in this narrative.

16.3 Application of information management policies by the Police and Crown Prosecution Service (CPS) have also adversely impacted on the Review's ability to gain a full understanding of some decisions and actions connected with investigations and prosecutions in 2006-7 and 2011-12.

16.4 X Move to Staffordshire

16.4.1 In January 2006 X was granted tenancy of a three bedroom house for herself and her children in Newcastle-under-Lyme by the Aspire Housing Association. In support of her application for the tenancy X stated that she had escaped from a violent relationship¹¹. She reported staying at her sister's address in Newcastle-under-Lyme, but having had to leave due to her alcohol problems, finding temporary accommodation through Gingerbread.

16.5 X relationship with Partner 3 and crises in March - May 2006

16.5.1 In January 2006 X commenced a relationship with Partner 3 whom she had met in a pub in December 2005. Partner 3 has described the relationship as "stormy" and lasting for 6-7 months during which she assaulted him on 6 occasions before he decided to have no more involvement with her.

16.5.2 On 3 March 2006 X saw her GP reporting that she had taken an overdose of paracetamol and cut her wrists whilst under the influence of alcohol. She was recorded as "rocking" with suicidal thoughts, worked up and concerned regarding past abuse of her child and angry with her previous partner. She reported consuming 140 units of alcohol per week (the recommended maximum consumption level for women is 21 units per week). She stated that she had previously been on medication for alcohol abuse but had stopped taking it. X was referred to the University Hospital of North Staffordshire NHS Trust (UHNS) Emergency

¹¹ The only agency record of domestic abuse involving X immediately prior to her move to Staffordshire relates to the verbal argument with Partner 2 in November 2005. Neither X nor Partner 2 (see footnote 10) have provided any further information regarding their relationship.

Department. Tests identified that she did not have raised paracetamol levels and the cuts to her wrist were superficial.

- 16.5.3 X was seen at the hospital by the North Staffordshire Combined Healthcare NHS Trust (NSCHT) Crisis Resolution Team, and described herself as having an alcohol dependency which she felt was the reason for her low mood. She reported that she had previously had an alcohol detox and had remained abstinent for three years but had started drinking alcohol again 6 months previously. She reiterated that she had been a victim of domestic abuse and had moved to the Newcastle-under Lyme area of Staffordshire to flee this abusive relationship. X stated that she was in a new relationship and was well supported by her new partner. X was offered 72 hours crisis support and discharged from the hospital.
- 16.5.4 On 4 March 2006 X reported to Staffordshire Police that Partner 1 had removed his two children from her address (X's oldest child had already been living with him in the West Midlands for 2 months). Partner 1 was contacted and reported that he had removed the children as he was concerned for their safety. Arrangements were made for West Midlands Police to conduct a safe and well check on the children.
- 16.5.5 The children were seen and no concerns for them were identified. Partner 1 stated that he had taken the children to live with him in Birmingham because he had grave concern for their welfare whilst they were living with X due to her alcoholism and mental instability. It was decided by the Police to leave the children with Partner 1. Police records include a check with the Head Teacher of the younger two children's school which indicated that they had been missing a lot of school time. Staffordshire Children's Social Care was informed of these events by the Police and recorded it for information purposes only.
- 16.5.6 On 4 March 2006 X was again seen at the UHNS Emergency Department having self-harmed whilst under the influence of alcohol. X reported feeling suicidal and being upset that her children had been taken from her. On the advice of the Crisis Resolution Team she was discharged pending a home visit the following morning. During that visit X's mood was recorded as improved and it was identified that her main issue was alcohol misuse. She was provided with information on ADSIS¹² and referred to the Newcastle-under-Lyme Community Addiction Team.
- 16.5.7 On 6 March 2006 the Crisis Resolution Team conducted a further home visit during which X was intoxicated and stated that she had taken an overdose. An ambulance was called and X was taken to the UHNS Emergency Department. There she stated that she wanted help with her alcohol misuse and that she had already been referred to the Community Addiction Team. Following assessment X was admitted to Ward 3 at the Harplands Hospital for alcohol detoxification and for assessment of her mood.
- 16.5.8 X was discharged from the Harplands Hospital on 20 March 2006 having completed her alcohol detoxification. She was referred to the O'Connor Centre¹³ for assessment the following day (21 March 2006) with a view to completing an alcohol abuse rehabilitation

¹² Adsis were offering Tier 2 services both in Stoke on Trent and Staffordshire. They were established as an alcohol support service 'Staffordshire Alcohol Advisory Service (SAAS) in 1986. In 2002 they further developed into alcohol and drug service support and renamed themselves 'Adsis'. Adsis provided free and confidential advice, support and information to anyone affected by their own or someone else's drinking, misuse of other substances or dependencies.

¹³ O'Connor Centres provide substance misuse rehabilitation and are located in Burton-on-Trent (formerly known as the Burton Addiction Centre) and Newcastle-under-Lyme. The centres are operated by a private provider commissioned on an individual bed basis by various local authorities and were not commissioned on a block basis by any of the agencies covered by this Review.

programme and arrangements made for outpatient review at the Lymebrook Centre in respect of her self-harming.

- 16.5.9 X did not attend the appointment at the O'Connor Centre on 21 March 2006.
- 16.5.10 On 27 March 2006 an ambulance was called to X's address (by staff at the Harplands Hospital who had been contacted by X) where she was reported to have taken an overdose. The ambulance crew were assisted by police to gain entry and found X unconscious with superficial cuts to her wrists. She was taken to the UHNS Emergency Department and reviewed there by the Crisis Resolution Team. No signs were identified of depression, psychotic features or self-harm ideation. X was advised to make a new appointment with the O'Connor Centre and was discharged from the hospital on the afternoon of 28 March 2006.
- 16.5.11 On the evening of 28 March 2006 X was again taken to the UHNS Emergency Department by ambulance having apparently taken an overdose and been found by Partner 3. She was admitted to the Emergency Assessment Unit from where she was discharged on 30 March 2006.
- 16.5.12 On 2 April 2006 X was arrested by West Midlands Police to prevent a Breach of the Peace after she was verbally aggressive when she visited the address of Partner 1 whilst intoxicated seeking to have her children returned. X was subsequently taken to the local Emergency Department and then transferred to the Harplands Hospital. She was discharged after a psychiatric assessment identified only symptoms of alcohol withdrawal and a plan was made to chase up her referral to the Community Addiction Team. Birmingham Children's Social Care was informed of the incident by the Police.
- 16.5.13 X was visited at home by the Crisis Resolution Team on 4 April 2006 and a further visit planned for the next day.
- 16.5.14 Later on 4 April 2006 X was again admitted to the UHNS Emergency Department having been found by Partner 3 after apparently taken a paracetamol overdose. She informed a Psychiatrist of events on 2 April 2006 stating that she had gone to Partner 1's address to attempt to bring her children back with her. She reported that she had then fought with Partner 1 who rang the Police. X was transferred to a ward and subsequently discharged on 6 April 2006 with planned follow up by the Community Addiction Team and at the O'Connor Centre.

16.6 **Assaults on Partner 3 by X**

- 16.6.1 On 6 April 2006 X's sister contacted the Police and expressed concern for X who had "kicked out" Partner 3 and was at home alone getting drunk. She asked that they check on X's welfare. Police Officers could get no reply at X's address and after forcing entry found X unresponsive. She was taken to UHNS and admitted. She was subsequently discharged on 9 April 2006 with planned follow up at the Lymebrook Centre.
- 16.6.2 *In his statement to the homicide investigation Partner 3 stated that he was at X's address when her sister arrived there. X was in bed because she had been drinking and did not want to be seen in a drunken state but Partner 3 let the sister in and she went upstairs to X. An argument then followed between the sisters resulting in X's sister leaving. X then got angry with Partner 3 for letting her sister in. As he was climbing the stairs X threw an empty two foot high whisky bottle at him. The bottle missed and smashed at the bottom of the stairs. Partner 3 then left the address. He did not report this incident to the Police until interviewed in connection with the death of Y.*

- 16.6.3 X's behaviour and the succession of visits to her address by emergency services were reported to the Aspire Housing Association by neighbours. Consequent to the reported aggressiveness of X a decision was made that staff should not visit her alone. The Housing Association made contact with Children's Social Care who confirmed that they were aware of the situation and that X's children were safe with their "father" in Birmingham.
- 16.6.4 On 11 April 2006 an assessment of X was commenced at the O'Connor Centre by the Community Mental Health and Social Care Team with input from the Community Addiction Service. Whilst the assessment was ongoing X was, between then and August 2006, provided with support and assistance with benefits claims and accessing other services, although her engagement was at best sporadic.
- 16.6.5 On 12 April 2006 X visited her GP with Partner 3 and requested admission to the Harplands Hospital as she was in crisis with her drinking and at risk of taking an overdose. Following liaison with the hospital X was taken there by Partner 3 and assessed. It was identified that X's primary issue was a need for detoxification and X's GP¹⁴ was requested on 13 April 2006 to refer her to the Community Addiction Team for inpatient detoxification.
- 16.6.6 On 18 April 2006 Partner 3 reported to the Police having been called by X, who was hearing voices telling her to kill herself and had become aggressive with him. Police Officers found X intoxicated but talking about detoxification. She reported not have taken any medication, that there were no tablets in the house and that she had no intentions of harming herself. X presented as being quite stable to the officers. Partner 3 was updated by the Police.
- 16.6.7 On 19 April 2006 Partner 1 contacted the West Midlands Ambulance Service and reported concerns for the welfare of X who had called and told him their children would not see her again. This was passed on to the Police and attending Officers again found X intoxicated but stating that she had not taken anything and asking them to leave. There were no signs that X had taken anything and no indication that she might do so. The Officers therefore complied with X's request to leave.
- 16.6.8 Later on 19 April 2006 X attended the UHNS Emergency Department and reported that she had been hearing voices telling her to kill herself and that she had taken an overdose of paracetamol. She was admitted and subsequently discharged on 22 April 2006 after referral to the Community Addiction Service in accordance with her wish for detoxification at home. She was prescribed a reducing dose regime of medication for anxiety.
- 16.6.9 On 29 April 2006 Partner 3 contacted the Police to report that he had received a call from X who had taken drink and tablets and that he was en-route to her address. Attending Police Officers received no response and after forcing entry found X unresponsive. X was taken to UHNS by ambulance and admitted. Partner 3 informed the hospital that X had been using cocaine¹⁵. The Police confirmed with Partner 1 that X's children were staying with him.
- 16.6.10 X was subsequently discharged on 2 May 2006. It was noted that she was awaiting rehabilitation at the O'Connor Centre.

¹⁴ At that time all referrals to addiction services needed to come via the GP, this has since changed and all agencies are able to refer to a central referral point for addiction services.

¹⁵ This is the only time that any suggestion of illicit drug use by X is documented. All other hospital attendances due to an overdose involved X ingesting over the counter / prescribed medication and / or alcohol. There is no evidence to corroborate that X had used cocaine on this occasion and no other information to suggest that she used illicit drugs at any time during the period under review.

- 16.6.11 On 2 May 2006 a neighbour of X reported to the Police that an argument was taking place at her address. They were concerned because they had heard a 'Stanley knife' being mentioned and were also aware of X's recent suicide attempts. Attending Police Officers established that there had been a verbal argument between Partner 3 and X following her discharge from hospital. No offences were identified.
- 16.6.12 The incident was assessed as low risk from the DIAL¹⁶ risk assessment form. This was on the basis that it was a verbal argument between partners that was reported by a neighbour, that both parties lived separately and 'no previous domestics have been reported by either partner'.
- 16.6.13 *The Police were at this time unaware of the incident on 6 April 2006 which was subsequently reported by Partner 3 when interviewed during the homicide investigation (see 16.6.2).*
- 16.6.14 *In his statement to the homicide investigation Partner 3 stated that he collected X from hospital and he had bought her flowers in a glass vase to lift her spirits. Soon after arriving at X's home she became angry that Partner 3 had spoken to a doctor at the hospital about her condition and an argument followed. Partner 3 collected his belongings and went outside to his car followed by X who smashed the vase on the ground.*
- 16.6.15 On 12 May 2006 X attended the UHNS Emergency Department reporting that she had taken an overdose. She was discharged on 13 May 2006 with a follow up home visit by the Crisis Resolution Team that day and a request made to her GP for referral to the Community Addiction Team.
- 16.6.16 On 14 May 2006 a Police Community Beat Officer proactively visited and spoke with X regarding her welfare and previous threats to take her own life. X informed the Officer that she was an alcoholic and it was noted that she appeared to be in withdrawal. During the visit X called her best friend and the Officer spoke with her on the telephone. The friend stated that she was in daily contact with X who had mental health and emotional problems, was having difficulty in coping without her children and was in 'rehab'. The friend stated that she would inform the authorities if X did not keep up her 'rehab'. The Officer agreed to also attempt to monitor this.
- 16.6.17 On 15 May 2006 calls were received by the Police from passers by reporting a female running out in front of traffic on a dual carriageway in Newcastle-Under-Lyme. X was seen doing this by an ambulance crew who intervened and took X to UHNS where she was sedated, suffering from acute alcohol withdrawal. She was admitted to the Medical Assessment Unit where she remained until she discharged herself on 17 May 2006.
- 16.6.18 Whilst with Police Officers at the hospital X informed them that her ex-partner's friend had historically sexually abused one of her children and that this had resulted in a prosecution where the man had been found not guilty. This investigation and its outcome were verified with West Midlands Police and no further action taken.
- 16.6.19 X was seen at the hospital by her Social Worker from the Community Mental Health Team. The Social Worker contacted First Response¹⁷ on behalf of X seeking advice regarding access to her children. It was advised that X should speak to the Police and Children's Social Care in the West Midlands and obtain legal advice.

¹⁶ Staffordshire Police use the DIAL (Domestic Incident Assessment Log) risk assessment which is similar to the DASH (Domestic Abuse, Stalking & Harassment) model used by most Police forces.

¹⁷ The access point for Children's Social Care.

- 16.6.20 When X attended a follow up outpatient appointment at the Lymebrook Centre on 23 May 2014 she reported to the Psychiatrist that she was having visual and auditory hallucinations of her child's abuser.
- 16.6.21 On 25 and 30 May 2006 X attended the UHNS Emergency Department having taken an overdose, on both occasions being admitted to the Medical Assessment Unit and then discharged the following day.
- 16.6.22 On 22 June 2006 X was seen as part of the Community Mental Health and Social Work Team assessment. The assessment concluded that X did not have a mental illness and her condition was to her misuse of alcohol. X stated that she had been abstinent from alcohol for 4-5 weeks. It was however identified that X would still benefit from a period of rehabilitation and the Community Addiction Team offered to continue to support her.
- 16.6.23 X was also offered support in respect of her low mood and associated self-harming behaviour and remained as an open case to the Community Mental Health and Social Care Team until 22 October 2006 when she was discharged consequent to her not attending three successive appointments.
- 16.6.24 X was also subsequently discharged from the Community Addiction Team following two missed appointments; in line with NSCHT Policy and following consultation with X's Community Mental Health and Social Work Team Social Worker.
- 16.6.25 On 26 June 2006 X had the first of a succession of review appointments at her GP surgery. She was prescribed anti-depressant and alcohol dependency medication, which continued throughout the period under review. Between reviews the medication was subject of repeat prescriptions.
- 16.6.26 Following the discharge of X from specialist mental health and alcohol misuse services full responsibility for her care during the period under review was assumed by her GP surgery.
- 16.6.27 Although prescribing of medication for X's alcohol dependency continued throughout the period under review and X consistently maintained to the GPs whom saw her that she had been abstinent since 2006 there are numerous occasions (in 2008, 2010, 2011 and 2012) when GPs noted evidence to the contrary. Information provided to the Review from a number of other sources also indicates that she continued to abuse alcohol throughout the period under review.
- 16.6.28 On 22 July 2006 the Police were called to X's address where an argument was taking place between her and Partner 3, who wished to collect his belongings and had been refused access. X informed the attending Officers that she no longer wished to be in a relationship with Partner 3. She also stated that she was drinking heavily and depressed. She was advised to seek medical help regarding her mental health and Partner 3 was advised to keep away from X's address.
- 16.6.29 Later that day X called the Police and reported receiving calls and text messages from partner 3 threatening to kill her and to "phone her kids and tell them everything". X subsequently recontacted the Police and stated that she no longer wished to make this complaint. Nevertheless, Officers visited Partner 3 and established that he had only sent a couple of text messages telling X that he loved her. The DIAL risk assessment indicated moderate harm risks owing to X's mental health issues. Lateral agency checks were completed and notification of the incident was sent to X's Community Mental Health Team Social Worker.

16.7 **Violence between X and Partner 3 – July / August 2006**

- 16.7.1 On the evening of 28 July 2006 Partner 3 contacted the Police and reported that X was at his address, was intoxicated, had head butted him and was attacking him at the time of the call. The attending Officers recorded that an argument had taken place over X being drunk but that no crime had been committed.
- 16.7.2 A DIAL risk assessment was completed with Partner 3 categorised as the injured party and X the perpetrator. It was recorded (inaccurately) that X was not on any prescribed medication; she had not previously attempted suicide and had not attempted self-harm.
- 16.7.3 X was allowed by the Police and Partner 3 to remain at his address.
- 16.7.4 *In his statement to the homicide investigation Partner 3 stated that on 28 July 2006 an argument developed about a forthcoming visit by X's best friend. X had been drinking and began hitting him in the face with her fists and spitting onto his face. He stated that he rang the Police as he wanted her out of his house and they were escorting her away when she pleaded with him to allow her to stay. In his words "I stupidly agreed to let her come back in my house. The Police left her with me".*
- 16.7.5 *Partner 3 went on to state that as soon as they were back in the house X began shouting at him again so he decided to take her home in his car. During the journey X began punching him in the face with her fists, which he was unable to ward off as he drove. The assault caused his nose to bleed and broke his glasses. He stopped the car and physically removed X, leaving her sitting on the pavement.*
- 16.7.6 *Partner 3 then visited his brother who has confirmed the account of the assault and the injuries sustained.*
- 16.7.7 *Partner 3 continued in his statement to the homicide investigation that he was so angered by the X's assault on him that later that evening he visited X's home in her absence and pulled up garden turf he had previously purchased and laid.*
- 16.7.8 *X phoned him the next day (29 July 2006) and he told her what he had done. He felt regretful and was worried that he would be in trouble for his actions. X told him to return and put the turf right which he did. As he put the turf back as X stood watching, drinking and swearing at him and the neighbours. Partner 3 stated that whilst at X's house, she again attacked him and he had to restrain her by the arms to stop her hitting him. She came at him several times and he pushed her back as a result of which she fell to the floor. He then left the house.*
- 16.7.9 *Partner 3 further stated that he felt intimidated by X and could not understand why he had gone back to her home after being twice assaulted by her the night before.*
- 16.7.10 *Partner 3 did not report the second assault or the subsequent events to the Police at the time.*
- 16.7.11 On 30 July 2006 X called the Police and said she wanted to die. She sounded upset and under the influence of drink or drugs; she then stopped talking. Police attended and forced entry, finding X unresponsive with an empty box of prescribed medication next to her. She was taken to UHNS by ambulance, admitted to the Emergency Assessment Unit and discharged the following day (31 July 2006). It was established that she already had an appointment with a Psychiatrist that day and no further follow up by the Crisis Resolution Team was thought necessary.

- 16.7.12 Whilst the Police were at X's address Partner 3 called her and was advised by the Police that she was being taken to hospital.
- 16.7.13 *In his statement to the homicide investigation Partner 3 related that 30 July 2006 he visited X in hospital and saw bruises on both of her arms which he accepted were caused by him whilst trying to protect himself and restrain her on 29 July 2006. X asked him to get her some underwear which he did and she seemed "alright" with him.*
- 16.7.14 On 1 August 2006 a member of the Community Mental Health and Social Work Team contacted the Police to report that X was with him and alleging that she had been assaulted by Partner 3 on 30 July 2006 but had not reported this as she had taken an overdose.
- 16.7.15 X alleged to the Police that Partner 3 had kicked her off a chair causing bruising and she had had to go to hospital for x-rays. Partner 3 was with her at hospital so X told doctors that she had fallen. She alleged she had been suffering physical and mental abuse from Partner 3 over the last 3 months of their relationship.
- 16.7.16 X further alleged that on 29 July 2006 Partner 3 had kicked her out of his car, leaving her to get a taxi home following an argument about X's children. Partner 3 was already at X's house when she arrived home and he ripped up new turf which he had laid previous day. X made Partner 3 put it back. As he began to apologise a further argument had occurred inside and Partner 3 had pushed X into a storage unit, dragged her across the floor into the hallway where he has repeatedly picked her up by her arms, thrown her to the ground and kicked her to the vaginal area, legs, arms and back. Partner 3 allegedly ceased the attack when X picked up a knife from her kitchen and told him to get out.
- 16.7.17 The attending Police Officer recorded that this incident was a 'nasty domestic assault' and that Partner 3 needed to be arrested from his home. X was recorded as having numerous bruises and abrasions to her legs, arms and lower body. The DIAL risk assessment relating to this incident indicated that X was at high risk of serious harm. A referral was made to Victim Support in respect of X.
- 16.7.18 An entry was placed on the Police intelligence system outlining the allegation made by X.
- 16.7.19 Related to this incident was information provided by neighbours to Aspire Housing Association on 31 July 2006 that X had been arguing and fighting with her partner and they had been threatening each other with knives and hammers.
- 16.7.20 In the early hours of 2 August 2006 Partner 3 was arrested at his home. When interviewed Partner 3 stated that he had previously been assaulted by X and accounted for the injuries to her body by describing that she frequently fell over while drunk and that the only time he had taken hold of her was to restrain her when acting in self-defence.
- 16.7.21 A charging decision was sought from the CPS on 2 August 2006 whilst Partner 3 was still in custody. However, the CPS required more lines of enquiry to be carried out before a decision could be made and Partner 3 was bailed¹⁸ until 29 August 2006 (subsequently extended).
- 16.7.22 On the afternoon of 7 August 2006 Police attended a report that a woman was at risk from her walking in the carriageway of the A50 road. They found X in the carriageway bringing traffic to a halt. X was detained under Section 136 Mental Health Act, 1983, and detained overnight.

¹⁸ Power to impose conditions on such bail was subsequently introduced on 15 January 2007 by the Police and Justice Act, 2006.

- 16.7.23 Shortly after X was detained, Partner 3 contacted the Police to report that he was concerned about her. He volunteered that she had been in his car with him on the A50 and had assaulted him, damaged his car and then got out of his car. She had been drinking and was reported to have stated that she was going to kill herself. Partner 3 was advised that X had been detained and that he would be contacted later.
- 16.7.24 After making his initial call and not getting any update, Partner 3 contacted the Police a further four times enquiring as to when he was going to be seen by an officer. He informed the Police that he wished to make a complaint about being assaulted by X and the damage that she had caused to his car.
- 16.7.25 During his conversations with police call takers, Partner 3 expressed concern that X would contact him or come to his home. He repeated that he had been assaulted by her in the past. He was also concerned because his arrest for allegedly assaulting X was at that time unresolved.
- 16.7.26 It was not until the afternoon of 8 August 2006 that an appointment, for the following afternoon (9 August 2006), was made to take a statement from Partner 3 regarding the assault and damage.
- 16.7.27 In the interim, on the morning of 8 August 2006, X was assessed by a doctor as fit to be released. No action was taken to deal with X whilst in custody for the offences alleged by Partner 3 or to constrain her contacting him and she was unconditionally released.
- 16.7.28 Following X's release from custody, she attended a Police Station wishing to retract the statement that she had made on 1 August 2006 regarding her allegation against Partner 3.
- 16.7.29 This coincided with Partner 3 contacting the Police to report that he had been receiving apologetic text messages and phone calls from X. He stated that he was worried that she would visit his home. He wanted to make it clear that she was contacting him.
- 16.7.30 A statement was obtained from Partner 3 on 9 August 2006. In this he stated that following his arrest on 2 August he went sick from work because what was going on was making him unwell. On 7 August 2006 X had called and asked to meet him in a pub in Newcastle –under-Lyme. Partner 3 alleged that X told him that if he gave her £1000 she would drop the allegation of assault against him. Partner 3 flatly refused to consider it. X had then asked if they could go back to his house to talk about it and Partner 3 took her in his car, stopping on the way to buy strong cider. She started drinking in the car and once at Partner 3's home she continued to drink and loudly ask for £1000. Partner 3 told her that he was taking her home.
- 16.7.31 During the journey they continued to argue about the demand for £1000 and whilst on the A50 X opened the car window and threw out a can of cider she had been drinking. X started to pull at the steering wheel and tried to punch Partner 3 in the face. The car was doing about 50 mph and Partner 3 believed that X was trying to cause an accident. He left the A50 and stopped on a slip road. X had broken the gear stick and also the hand brake which she had applied with some force. X got out of the car and he lost sight of her but then saw her on the A50 carriageway walking amongst the traffic. He called the Police.
- 16.7.32 Partner 3 reported having received a puncture wound to his arm.
- 16.7.33 A DIAL risk assessment was completed but cannot now be located¹⁹.

¹⁹ It seems likely that this was destroyed in accordance with the Staffordshire Police Information Management and Retention Policy (see 16.3 & 20.3.14).

- 16.7.34 On 31 August 2006 X was arrested for the assault on Partner 3. She was released on bail and subsequently, on 27 September 2006 charged with assault on Partner 3 and criminal damage to his car.
- 16.7.35 By 15 November 2006 all outstanding lines of enquiry in relation to X's allegation that she had been assaulted by Partner 3, including obtaining information regarding her alcohol misuse and mental health from the Community Mental Health Team, had been concluded and the CPS were consulted. The CPS decided not to bring any charges against Partner 3 and he was released from his bail with no further action. The reviewing prosecutor made the observation that X's injuries were not consistent with her allegation and identified that the defence would point to her falls brought on by her intoxication as a cause of some of those injuries. The reviewing lawyer concluded that; "This is a case where resources could be employed endlessly in accordance with the DV policy but get no nearer the truth".
- 16.7.36 In March 2007 X appeared at North Staffordshire Magistrates Court and pleaded guilty to the assault on Partner 3 and causing damage to his car. She was given a community sentence (see 16.10).
- 16.7.37 Following the assault by X on 7 August 2006 Partner 3 terminated the relationship and did not see X again until the court case in March 2007, and never again thereafter.

16.8 Y Mental Health

- 16.8.1 On 27 September 2006 Y visited his GP reporting insomnia and increasing depression, apparently associated with him being a carer for his mother and deterioration in her health. He was prescribed medication for anxiety and depression, with this to be reviewed on 1 December 2006.
- 16.8.2 On 26 October and 8 November 2006 Y had further appointments at his GP surgery regarding his depression and anxiety. He was upset that his mother, for who he had cared for 7 years, was going into a nursing home and that he would then be on his own having fallen out with his family. His medication was changed on a number of occasions as an effective treatment was sought.
- 16.8.3 Between November 2006 and January 2013 Y had 35 contacts with GPs at two surgeries (he changed surgery in February 2012) in relation to his depression and anxiety, with intermediate repeat prescriptions for his medication which was periodically reviewed.

16.9 Aggressive incident involving X in November 2006

- 16.9.1 On 9 November 2006 X became abusive and threatening towards her sister and sister's partner whilst visiting their home. She was asked to leave and kicked her sister's car. Police Officers attended the incident and dealt with it as a non-crime domestic incident as there was no damage to the car and no other offences were reported.

16.10 X Conviction and Community Sentence in March 2007

- 16.10.1 In March 2007 X appeared at North Staffs Magistrates Court to answer the charges of assault to Partner 3 and criminal damage to his car on 7 August 2006. She pleaded guilty to both charges and was sentenced to a 12 month Community Order with a supervision requirement.

- 16.10.2 This sentence was informed by a pre-sentence report prepared by Staffordshire Probation area. The assessment of risk at that time, completed using the approved (OASys) risk assessment tool²⁰, was that X presented a medium risk of harm to the public overall with specific people identified as at risk being future partners, herself and children (neglect).
- 16.10.3 X's Sentence Plan objectives were to increase skills in dealing with others/difficult situations (related to partner abuse), tackle alcohol misuse and reconciling X's past experiences (specifically experience of violent relationships). Two other agencies, including the Freedom Programme, were named as being able to support the plan but were not engaged as it was accepted that X would find 'groupwork' difficult.
- 16.10.4 During contact with X on 18 and 27 April 2007 Probation staff were informed by X that she was in a relationship with a man and was staying at his address, although she would not disclose his address or provide contact details.
- 16.10.5 On 15 March 2008 X's Community Order came to an end. She was noted to have completed the objectives of the sentence.
- 16.10.6 In May 2009 Y's GP identified that he had abnormal liver function results from a blood test. Y acknowledged that his alcohol intake had been high recently. Y stated that he would try to reduce his alcohol intake. Referral for assistance from ADSIS was offered to Y if he wished it then or in the future but this was not taken up.
- 16.10.7 On 23 November 2010 X disclosed to her GP that she had been sexually abused by a friend of her father when she was 9 to 11 years old²¹. She stated that she had recently seen the man responsible and felt ready to address the abuse as she did not want to return to drinking. The GP contacted Singlepoint and on their advice wrote to X suggesting that she refer herself to SAIVE²². There is no indication that X ever contacted SAIVE.

16.11 **Alleged assault on X by Y in October 2011**

- 16.11.1 On 28 October 2011 the relationship between X and Y first came to the attention of agencies.
- 16.11.2 At 0503 hours on 28 October 2011 X called an ambulance to Y's address, stating that she had been assaulted by having her face stamped on causing injuries and was also grabbed round the throat. She stated that her attacker was at a neighbour's house. The Police were contacted and attended.
- 16.11.3 X was taken to the UHNS Emergency Department where numerous cuts and grazes to her arms, chest, back and cheek were noted. X was recorded as smelling of alcohol. Bruising was identified. X-rays and CT scans of X's neck revealed no fractures but some degeneration in X's cervical spine.
- 16.11.4 X's neck pain was the subject of follow up by X's GP surgery on 31 October 2011 and subsequently, including obtaining further scans, advice from a Consultant Rheumatologist and the provision of pain relief medication over the succeeding months.

²⁰ The pre-sentence assessment, and subsequent reviews, could have been better informed if a Spousal Abuse Risk Assessment (SARA) tool had been completed, although training on this was only being rolled out during 2007. Liaison with the Police would also have been beneficial although this was not 'required' practice at the time.

²¹ The Review has not been able to trace any record of this alleged abuse having been reported to the Police or any other agency at the time. At X's trial in 2014 it was confirmed that no report was made.

²² SAIVE is a charity providing support to survivors of sexual abuse. They only accept self-referrals.

- 16.11.5 Whilst at the hospital a Staff Nurse spoke with X regarding domestic abuse, completed a risk assessment and made a MARAC referral.
- 16.11.6 X was seen by the Police at the hospital but was uncooperative and unwilling to name or provide the location of her assailant.
- 16.11.7 Notwithstanding this, Y was arrested at 0611 hours. On arrest he stated that he and X had been arguing and in self-defence he had pushed her over causing her injuries.
- 16.11.8 X subsequently provided a statement to the Police in which she described a violent and sustained attack by Y. X stated that she was punched to the face which rendered her unconscious only then to regain consciousness and discover that Y had her in a headlock and was hitting her hard around her neck and on her back. X also described being choked by the headlock and again becoming unconscious.
- 16.11.9 X stated that when she regained consciousness the second time Y began to apologise to her for what he had done, soon after which he left the address. X described her injuries as being a swollen and cut right cheek, a sore neck and back, cuts and bruises including to her arms where she has been grabbed.
- 16.11.10 The Officer who obtained the statement from X recorded that she had injuries of a 1cm cut to the right cheek surrounded by bruising and swelling, numerous bruises to her left arm, abrasion and bruising to her lower left side of her back, large abrasion, bruising, swelling and reddening to her left back shoulder area and numerous other abrasions and areas of reddening to her back, neck and shoulders.
- 16.11.11 Whilst in custody Y was interviewed on two separate occasions regarding the allegation of assault on X. Throughout these interviews Y maintained that he was acting in self-defence. Y described how X initiated the violence by dragging him out of bed by his beard and how a struggle between them ensued. The incident was then concluded with Y pushing X away causing her to fall and strike her face on a speaker in the room, which caused the injury to her face.
- 16.11.12 Y detailed injuries that he had received as a result of the struggle as bruising and scratching to his arms and marks on his back. These injuries were recorded, as was a scratch to his face.
- 16.11.13 Y informed the Police that he had been in a relationship with X for about four years and that X had been aggressive to him in the past, stating that it would happen 'every six months'. When asked if any incidents had ever been reported to the Police he replied, "No, kept it between us".
- 16.11.14 *During the homicide investigation friends of Y, one of whom had been present in a pub when Y met X, confirmed the duration of the relationship and provided insight into its nature.*
- "During their subsequent relationship X did not move in permanently with Y. She kept her home in Silverdale and Y had his flat. She would often stay overnight with him but she did not actually move in."*
- "Y and X had not been going out together very long when he told me that she was 'crazy'. He went on to say that she would argue with him over small trivial matters which she would blow up out of all proportion."*
- 16.11.15 *Y's sister referred to Y mentioning X around the time that their relationship started but keeping her at a distance from his family. She described one occasion when X was brought*

to a family birthday party where she got drunk and became embarrassing. Y's sister got the impression that he was ashamed of X and her behaviour. Y's sister further described how X tended to control Y, constantly texting him and becoming very jealous if he had any contact with another woman. The relationship was described as working very much on X's terms, for example Y was very rarely allowed to visit X at her home and throughout the whole of the relationship only did so around 6 times.

- 16.11.16 *One friend of Y described X as carrying out a "frenzied attack" on himself whilst at Y's flat, after he had said something which he believed to be relatively innocuous. X took exception to the comment and attacked him with her hands. X was restrained with assistance from Y but during this struggle she bit Y on the arm. This friend said of X that she would "just flip like this sometimes" and that he kept on telling Y to leave X. He felt that Y was too embarrassed to tell him everything that was going on between him and X.*
- 16.11.17 *This incident was not reported to the Police at the time. Y did however discuss the incident with another friend and showed him the bite marks. Y went on to tell this friend that the relationship was getting volatile as X was kicking off at any given moment. The friend also advised Y to "get rid of her".*
- 16.11.18 *It is clear from the accounts of these friends that a number of domestic abuse incidents had taken place in which X is described as being the aggressor. This information was not however known to the Police, or any other agency, at the time.*
- 16.11.19 In accordance with advice from the CPS, Y was charged with assault on X and detained to appear in court.
- 16.11.20 *The investigation leading to this decision is analysed in detail at 20.5. It is concluded that had the investigation been less partial and account taken of X's previous history of violence Y would not have been charged.*
- 16.11.21 On 29 October 2011 Y appeared at court and was granted bail with conditions not to contact X directly or indirectly and not to visit X's address.
- 16.11.22 A 7 Step Plan²³ was initiated and an alarm was fitted by the Police at X's address.
- 16.11.23 A DIAL risk assessment scored X as at High risk (16). Referrals were made by the Police to Arch and for the case to be heard at a MARAC. The referrals included that Y was claiming self-defence. They also referred to domestic violence incident involving X in a previous relationship, but not to her having been a perpetrator convicted of assault. As X's children were not residing with her no referral to Children's Social Care was made.
- 16.11.24 A referral was also made to Victim Support who decided that X's situation did not fall within their remit²⁴ and that they would take no action.
- 16.11.25 *A friend of Y recalled to the homicide investigation team being told by him that he had been arrested for assaulting X and the case was going to court. He describes Y as being very upset about going to court as he said he acted in self-defence. Y told him that X had pulled*

²³ The 7 Step Plan outlines the means by which Staffordshire Police respond to victims of domestic abuse.

²⁴ Victim Support is not able to support high risk victims of domestic abuse unless it has a separately funded IDVA service in the area in which the victim lives (*Victim Service Operating Procedures v1_1 December 2013 and Victim Support's supporting victims of domestic violence: Service delivery operating instructions (June 2012)*). Victim Support's service thresholds in 2011 were similar to the current ones and Victim Support in Staffordshire and Stoke-on-Trent did not and does not manage any IDVA services.

him out of bed by his beard and then smashed a lamp over his head. He said she went for him again, he pushed her backwards and she lost her footing because she was drunk.

- 16.11.26 *Y also played his friend a recording which he had made on his mobile phone of an incident when X launched an aggressive verbal attack on him. The friend was so concerned about the violence towards Y that he advised him to contact Arch for support.*
- 16.11.27 *This recording must have been made prior to the incident in October 2011 but was not referred to by Y in his interview with the Police. There is no indication that it was brought to the attention of anyone other than the friend prior to Y's death. It cannot be known why Y did not utilise this relevant material in his defence of the assault charge.*
- 16.11.28 On 31 October 2011 Y contacted Arch and spoke with the male victims IDVA²⁵. Y was very concerned about the forthcoming court case. He disclosed that X was abusive towards him and described an incident in which she dragged him out of bed by his beard. A basic safety plan was discussed which identified that as Y was no longer in a relationship with X he was not at immediate risk. The IDVA advised Y to seek advice from a criminal law solicitor, agreed to send Y information about support available to him and did so. Further advice and support was offered in the accompanying letter should Y require this.
- 16.11.29 *Around this time another friend received a telephone call from Y when X turned outside his home demanding to be let in and saying that she would kill herself. The friend advised Y not to let her in and to keep a record of any further attempts to contact him. It is not known whether Y followed this advice. No record made by Y of attempted contact has been traced.*
- 16.11.30 On 7 November 2011 the Arch female IDVA contacted X and explained her role. Access to an outreach service was offered to cover a forthcoming absence of the IDVA on leave.
- 16.11.31 On 22 November 2011 X visited her GP surgery and reported visual disturbances. She stated that a 7 year long abusive relationship had ended three weeks previously after she had been punched in the face while asleep and that she was to go to court in January 2012²⁶, to prosecute her ex-partner. She stated that she did not want to start drinking again. She described obsessive behaviour at home with having everything in order, said she felt like ending things and had suicidal thoughts of cutting wrists and overdosing on tablets. X asked for a psychiatric referral. The GP arranged for the Crisis Resolution Team to visit X that day and obtained a promise from X that she would not do anything prior their arrival.
- 16.11.32 When the Crisis Resolution Team saw X she stated that she had been abstinent from alcohol for 4 years and was concerned regarding the pending court case. No evidence was found of severe mental illness and the view was taken that X's mood was a consequence of her current stressors. It was noted that X was being supported by her mother and friend. Contact details for a mental health helpline, domestic violence helpline and ADSIS were provided and X was discharged. When X next saw her GP, on 6 December 2011 she was offered group counselling support but declined this stating that she was arranging one-to-one counselling with ADSIS.
- 16.11.33 ADSIS have no record of ever being contacted by X.

²⁵ Information regarding Y's contact with Arch is from the recollection and personal records of the male IDVA as the organisation's original records were destroyed in a fire.

²⁶ The allegation by X that she had been punched in the face whilst asleep does not accord with her statement to the Police in October 2011 and was not repeated to anyone else, at that time or later. The basis of this statement is unknown.

16.12 MARAC in November 2011

- 16.12.1 In November 2011 the alleged assault on X was presented at a MARAC.
- 16.12.2 At the time of the MARAC hearing the safety measures that had already been initiated were commencement of a 7 Step Plan, installation of a Tunstall (panic) alarm at X's home address, placement of flags on the relevant Police systems and a referral to the IDVA. Following the hearing the subsequent actions were for the Police to continue with the 7 Step Plan and for the IDVA to continue to engage with X. It was decided that as X's children were not living with her and she only had supervised access to them no further action was required in respect of the children.
- 16.12.3 On 5 December 2011 the female IDVA conducted a risk assessment with X in accordance with the Arch risk assessment and management procedure apart from completing the scoring procedure to provide an actuarial indication of risk. In view of Y's bail conditions and the presence of an alarm at X's address this was followed up during a personal visit on 12 December 2011 during which support for X in the run up to and during the trial of Y was agreed. This included provision of information about the court process, an appointment for a pre-court visit, a request to Witness Care for special measures at the trial and that a request for a Restraining Order to be made. X was also provided with information about the Freedom Programme.

16.13 Acquittal of Y at Court

- 16.13.1 In January 2012 Y appeared North Staffordshire Magistrates Court and argued that he had been acting in self-defence. He was found not guilty of assaulting X.
- 16.13.2 *A friend of Y informed the Review that in the period prior to the trial Y was depressed, had reached "rock bottom" and had intended to plead guilty, viewing it as the easiest option. It was only after the friend examined the court papers, including her criminal record which contained the conviction for assault on Partner 3, and went with Y to see his solicitor that Y decided to defend the case.*
- 16.13.3 On 30 January 2012 X contacted the female IDVA for advice on a claim to the Criminal Injuries Compensation Scheme. In view of Y's acquittal the IDVA advised X to obtain advice on this from a Solicitor. The IDVA remained in contact with X until 13 February 2012 when, with X reporting no further contact from Y it was agreed to close the case. X was invited to re-access support from the IDVA if she needed it in the future.
- 16.13.4 On 13 February 2012 Y informed his GP that he was obtaining support from Brighter Futures²⁷ in relation to the break-up of his relationship with X. Y was in fact referring to support from a friend who works for Brighter Futures rather than receiving a service from that organisation.
- 16.13.5 *Y's sister, who had attended court to support her brother, told Y after the hearing that it would not be good for him to see X again. She was however aware that Y did resume the relationship; although he never specifically mentioned it, attributed by her to his embarrassment at having done so.*
- 16.13.6 *A friend of Y also informed the homicide investigation that within a short time after the court case the relationship between Y and X recommenced as did her abuse of him:*

²⁷ Brighter Futures is a 3rd sector organisation which provides support to those who require extra help to live independent and fulfilled lives in the North Staffordshire area

“To my utter disbelief shortly after the court case X and Y got back together and she told Y she would change her behaviour. She told Y she was going to stop drinking and when I was visiting the flat I saw she was drinking either coffee or tea so I thought that she was making an effort to change”

“However shortly after they had got together again Y told me that they had had a row again and X had tried to punch him but had punched the wall. Y told me that he was trying to record her actions on his phone but she had tried to grab his phone and it had ended up on the floor. Both of them tried to get the phone and as she did so she knocked the telly over.”

16.13.7 *This friend again advised Y to end the relationship but Y responded that he had to sort things out in his own head first before he made a decision’*

16.13.8 *The resumption of Y’s relationship with X is described by his sister and a friend as leading to friends “steering clear” when she was around, thereby making Y feel more isolated.*

16.14 X crisis and assault on hospital staff in January 2013

16.14.1 On the evening of 21 January 2013 Partner 1’s wife contacted Staffordshire Police and reported that X’s child (Z) had been visiting X when she had “gone berserk” and Z had run out of the house to a neighbour’s address.

16.14.2 The Police spoke with Z on her mobile phone. She stated that she had made a remark about X drinking and X had “kicked off, throwing things, slamming doors and had thrown a phone at her. X was reported to have then locked Z in the house although she had managed to escape and go to the neighbour’s house.

16.14.3 X’s sister also called the Police and reported that she had had a call from X who was at her home, intoxicated and threatening to harm herself.

16.14.4 Police Officers attended and arranged for Z to stay with X’s sister until her father could collect her. It was recorded that no assault had taken place and that Z refused to make a complaint about her mother’s actions.

16.14.5 Police Officers then visited X and found her intoxicated with a large bump on her forehead. She stated this was from falling off a chair. An ambulance was called but X refused to be assessed or taken to hospital. X was eventually persuaded to go to hospital and was taken there by ambulance with Police Officers following, arriving at 2235 hrs.

16.14.6 Around 2320 hours X left the UHNS Emergency Department and hospital staff contacted the Police who found X collapsed and returned her to the Emergency Department.

16.14.7 X was recorded by a Doctor who examined her as having been punched in the face earlier in the evening. This differed from the account given to ambulance staff and the triage Nurse that X had fallen and hit her head on a table²⁸. A facial x-ray was taken which revealed no abnormality. An alcohol audit was completed and X claimed to have not consumed any

²⁸ The triage nurse has been interviewed in connection with this Review but the doctor is not available for interview to clarify if an assailant was mentioned. It appears likely that the discrepancy arises from X giving differing accounts to the different professionals. The reason for this is unknown but it is speculated that this may have been an attempt to deflect culpability for any complaint that Z might make against her.

alcohol that evening, although there was evidence that she had been drinking. The audit suggested a high risk and an advice leaflet was provided to X.

- 16.14.8 In the early hours of 22 January 2013 X went into a public area of the Emergency Department and started shouting and swearing. Security staff attempted to calm her but she remained aggressive and it was decided to eject her from the Department. As this was taking place X spat in the face of one member of staff and assaulted another with her bag. Police Officers present on another matter intervened and arrested X for assault and a public order offence.
- 16.14.9 At the Police station X vomited in her cell and on the advice of a Police Surgeon, in view of the head injury which she had sustained, was taken back to the Emergency Department by ambulance. At the hospital she was given a scan which revealed nothing untoward and she was returned to Police custody.
- 16.14.10 On 22 January 2013 X was assessed in custody by the Criminal Justice Mental Health Team. She was asked about her facial injury but could not recall how it had happened; later stating that she "may have fallen down the stairs". She reported that she had previously been a victim of domestic abuse and that she misused alcohol in order to cope. X stated that she had been alcohol free for seven years and therefore this was no longer an issue. No mental illness was identified
- 16.14.11 Later that day X was interviewed and admitted the public order offence but denied assaulting hospital staff. She was charged with assaulting two hospital staff members and the public order offence and bailed to court.
- 16.14.12 On 22 January 2013 the Police informed Staffordshire Children's Social Care of the preceding events. Contact was made by Children's Social Care with Partner 1's wife for an update with regard to Z. They were advised that she and Partner 1 were leaving the Family Court to collect Z and that X had given up an ongoing application for custody of Z, who would therefore be residing full time with her and Partner 1 in the West Midlands. They were further advised that the court had adjourned to February 2013 when a Contact Order may be made in respect of X, but that at that time Z wanted no contact with X.
- 16.14.13 Staffordshire Children's Social Care advised Partner 1's wife that they would be sharing a full account of the situation to their counterparts in the West Midlands, for information only, and did so.

16.15 **Y change of GP**

- 16.15.1 On 23 January 2013 Y registered with a new GP Practice, his third during the period under review. His medication for depression, anxiety and insomnia was reviewed but the regimen remained largely unaltered thereafter.
- 16.15.2 The change of practice was accompanied by a more proactive approach to identifying and addressing underlying issues and seeking alternatives to continued prescription of medication for Y.

16.16 **Conviction of X and community sentence in July 2013**

- 16.16.1 In July 2013 X appeared at North Staffordshire Magistrates Court in relation to the incident on 21 January 2013 and pleaded guilty to all of the offences with which she was charged.

She was noted by probation service staff to be under the influence of alcohol, volatile and aggressive.

- 16.16.2 X was given an 18 month Community Order with supervision and sentence programme (including thinking skills and work on alcohol misuse) requirements.
- 16.16.3 The sentence was informed by a Pre-Sentence Report prepared by Staffordshire and West Midlands Probation Trust. The assessment of risk remained unchanged throughout the subsequent period of supervision; that X presented a medium risk of harm to the public overall and that this risk was most prominent in relation to her partners and staff. The particular risk was of aggression and violence which was identified as most likely to occur when X was intoxicated and had difficulty dealing with her emotions. During the OASys assessment which formed the basis of the report X made no mention of any ongoing relationship.
- 16.16.4 A Risk Management Plan was produced using the required tool. Objectives identified were to gain understanding of the views and perspectives of others, self-control, and for X (who reported no memory of them) to gain acceptance of her role within the index offences. The work actually undertaken went beyond the the written plan and included clearly focussed supervision sessions and a 1:1 Programme with a focus on thinking skills, problem solving and positive goal setting. A home visit was also undertaken.
- 16.16.5 This period of supervision on a Community Order remained incomplete when X was arrested for the murder of Y in December 2013.
- 16.16.6 *During the investigation into Y's death it was identified that during 2013 an uncle²⁹ of X's oldest child was a frequent visitor to X's home. Police enquiries identified that the visits to X were taking place during the months prior to the death of Y and it is likely that X was having a sexual relationship with both this man and Y during this period. It is not known if either man was aware of the other but text messages exchanged between Y and X suggest that Y suspected X was seeing someone other than himself.*
- 16.16.7 On 17 July 2013 there is a record of a substantial GP review of Y's treatment. This identifies that he reported living alone, estranged from his family, for example he had no cards or other contact on his recent birthday, struggling to get out of bed, having poor concentration and drinking 3 small bottles of cider per night for the last couple of months. He was recorded as unkempt, having poor eye contact and with flat speech. An offer of referral for alcohol misuse support was declined by Y.
- 16.16.8 The GP referred Y to Healthy Minds and an appointment was offered for 31 July 2013. In the referral the GP noted that Y had had mood problems since he was 15 years old but did not take any medication for this until 2002 (when aged 31). A risk assessment completed by the GP, indicating that Y posed no risk to himself or others accompanied the referral.
- 16.16.9 This appointment was cancelled by Y on 18 July. Y was contacted on 31 July 2013 to re-arrange the appointment but stated that it was not convenient to talk and it was agreed that Healthy Minds would write to him. Healthy Minds records indicate that Y was discharged after not replying to a letter sent to him on 1 August 2013.
- 16.16.10 Y was reviewed again by the same GP on 7 August 2013. Y reported that he had had no alcohol in the last few days as he could not afford it but was noted to smell of alcohol. He

²⁹ This man was traced and interviewed. He declined to elaborate on the nature of his relationship with X or make a written statement.

stated that his partner, who had not previously been mentioned, may have cervical cancer³⁰. The GP planned to conduct a further review one month later.

- 16.16.11 On 21 August 2013 X informed her Probation Service Officer that Z was coming to stay with her after a dispute with Partner 1's wife. The Probation Service Officer challenged X about the incident involving Z in January 2013. X stated that this had not been an assault but only a confrontation. The Probation Service Officer arranged a home visit to check on the suitability of Z staying with X. At the home visit that X informed the Officer that Z had not in fact come to stay with her.
- 16.16.12 At the GP review of Y on 4 September 2013 he reported having had no alcohol for the last few weeks as he had no money and that his partner had had the all clear on the suspected cervical cancer. Y was described as clean with normal speech and reasonable eye contact, although a little low of mood.
- 16.16.13 On 11 October 2013 X informed her Probation Service Officer that Z had moved in with her and that she was arranging a school placement. The Probation Service Officer advised that he would contact Education Welfare regarding this and did so.
- 16.16.14 By 6 November 2013 Z was on the roll of a secondary school in Staffordshire and remained a pupil of that school until 31 January 2014; although the last date actually attended was 16 December 2013.
- 16.16.15 At Y's GP review on 5 November 2013 it was noted that he had still not seen Healthy Minds. He confirmed that he lived alone although his girlfriend "pops round" occasionally as she had a child to look after. He reported only drinking at weekends. Y was described as well kempt, calm but still talking quietly and still with a low mood.
- 16.16.16 On 11 November 2013 X missed an appointment with her Probation Service Officer and a warning letter was sent to her. Four other missed appointments around this time were attributed by X to back pain and this reason was considered acceptable by the Probation Service Officer.
- 16.16.17 *A friend of Y informed the homicide investigation that towards the end of November 2013 Y told him that X had argued with him about a text exchange with X's child who had asked Y if X was drinking vodka and he had replied that she was drinking cider. X accused Y of being a "grass" and Y had not seen her since that row.*
- 16.16.18 On 5 December a one to one session between X and her Probation Programme Tutor focussed on analysis of the previous offence (the one committed in 2006) as X stated that she could not remember any details of the current index offence. The records of this session reveal a rigid thinking pattern whereby X maintained that she could not have done anything differently.
- 16.16.19 On 10 December 2013, a further probation one to one session with X focussed on decision making. X stated that almost all of her decisions in the past are blocked out by alcohol misuse. The session did proceed but there was a clear theme of X avoiding responsibility and reporting a lack of recollection of offending behaviour.

16.17 Z as a Child Missing Education

³⁰ The partner was established by the Review to be X who was having abnormal cervical cells investigated at this time.

- 16.17.1 On 10 December 2013 non-attendance of Z at school since 29 November led to the school requesting follow up by an Education Welfare Worker. Persistent efforts were made by the Education Welfare Worker and Police to contact or trace Z over the succeeding days. When professional spoke with X she was uncooperative and would not reveal Z's whereabouts.
- 16.17.2 On 13 December 2013 the Education Welfare Worker made a referral to First Response requesting that Z's situation be stepped up to specialist services. It was agreed that a Child Social Work Assessment should be undertaken and the case was allocated to a Social Worker.
- 16.17.3 On 16 December 2013 Z returned to school and was spoken with by the school's Behaviour Support Manager. Z stated that things were better than they had been at home. Z knew that X was a recovering alcoholic and knew when she had had a drink. Z reported not being engaged by school and having been staying with a friend in the West Midlands.
- 16.17.4 Also on 16 December 2013 Y was reviewed by his GP. He stated that he had been in touch with Healthy Minds and had an appointment for the New Year.
- 16.17.5 On 17 December 2013 X attended a further one to one session with the Probation Programme Tutor. X stated that she had had another 'low week' and was feeling quite stressed. She stated that this was due to conflicts with Partner 1 and his wife over their child. The Probation Programme Tutor encouraged X to discuss what she could do to try and avoid arguments or deal with them without getting angry or upset and X stated that she would "like the situation to end altogether".
- 16.17.6 On 18 December 2013 the allocated Social Worker visited X's address and completed a missing person return interview with Z which also formed part of the Child Social Work Assessment (subsequently completed on 7 January 2014). At this visit Z stated that her desire to stay with X was the result of strict rules imposed by Partner 1 and his wife and them stopping contact with X, with which Z disagreed. Z reported being happier in the care of X, although there had been an argument leading to Z going to stay with a friend temporarily. Neither X nor Z would divulge the reason for the argument.
- 16.17.7 The Social Worker raised the issue of alcohol misuse with X who stated that historically she had issues with alcohol and depression. X said this was triggered by an older sibling of Z had been sexually abused. X stated that she really struggled to cope, and had allowed the children to be cared for by their father whilst she went into hospital for a detox and to deal with her breakdown. She said that when she came out of hospital, father (Partner 1) would not return the children to her care and would only allow contact every other weekend. X said this then stopped. She reported that the Family Court and had been involved in the custody dispute.
- 16.17.8 X gave her permission for checks to be undertaken to inform the assessment.
- 16.17.9 During the visit neither X nor Z referred to X having a partner or other significant relationship.

16.18 **Murder of Y**

- 16.18.1 Later in December 2013, in the afternoon, West Midlands Ambulance Service received a 999 call from X who reported that during an argument a male had fallen and hit his head. She stated that Y was unconscious and had been unconscious for 40 minutes. Four Ambulance resources were dispatched to the scene. At the address Y was found with severe swelling to both eyes, swelling and bruising to the face, bruising and marks to both hands and dried

blood on both hands. The Police were contacted. Y was confirmed dead at the scene 45 minutes after the 999 call.

16.18.2 X was arrested at the scene on suspicion of murder and a homicide investigation was commenced.

16.18.3 Z was not at X's address. The Police and Children's Social Care made arrangements for Z to stay with a friend and subsequently to return to the care of Partner 1 and his wife.

16.18.4 X was interviewed on two occasions, during which she denied that she had unlawfully killed Y and maintained that she and Y had had an argument during which she had pushed him away and he had banged his head on the TV. She stated that when Y had failed to regain consciousness she contacted one of her children and then phoned for an ambulance.

16.18.5 In relation to the injuries suffered by Y the pathologist's report states:

"Y had been subject to a substantial blunt force assault that has resulted in significant bruising of the head, torso and limbs, as well as significant head injury and injury to the thoracic wall.

"The pattern of injuries is of multiple blunt force impacts that could be compatible with punches, kicks, stomps or use of an implement. Tramline bruising was evident to the upper limbs and also likely to the abdominal region. Tramline bruising is seen secondary to blows by a rod, stick or comparably shaped object. Its presence indicates that the upper limbs at least have been struck repeatedly with an implement."

16.18.6 X was charged with the murder of Y and subsequently remanded into custody. In 2014 X was convicted and sentenced to life imprisonment.

ANALYSIS

17 Y Substance (including alcohol) Misuse and Mental Health

- 17.1 The investigation into the death of Y identified that he had cultivated cannabis for his own use. The use of cannabis had not previously come to the attention of any agency and there is no indication that it was a factor relevant to the events under review.
- 17.2 There is also no indication that alcohol misuse was a significant issue for Y or played any part in the nature of his relationship with X. He did disclose to his GP that he was regularly drinking a fairly high level of alcohol on two occasions, in May 2009 and July 2013, but on both occasions this was in response to a specific enquiry from the GP. On two further occasions in 2013 Y advised his GP that he had been abstinent but there were indications that that might not be the case. It was appropriate that access to alcohol misuse services was offered but there is no indication that Y declining this had any detrimental effect upon him. The Primary Care IMR concluded that there is nothing to suggest that more should have been offered in terms of support related to alcohol consumption.
- 17.3 Y had a diagnosis of anxiety and depression and during the period under review was prescribed anti-depressants, hypnotics, NSAID and benzodiazepines by his GP. While repeat prescriptions were used there is also evidence of medication review and offers of other treatment modalities for his condition. Expert advice was sought from the Stoke-on-Trent Clinical Commissioning Group (CCG) Lead Pharmacist who concluded that the prescribing and advice to Y were in accordance with relevant prescribing guidelines.
- 17.4 It is recorded that Y said he was receiving support from Brighter Futures in February 2012³¹. He was also referred to Healthy Minds during July 2013 although he missed his appointments and at the time of his death was awaiting a rearranged appointment for the beginning of 2014. The Review found no evidence to suggest that Y should have been offered more support in terms of his mental health.

18 X Substance (including alcohol) Misuse and Mental Health

- 18.1 X had a significant history of long term alcohol abuse prior to the scope of this Review and had been prescribed medication to support her in withdrawing from alcohol. At her first GP attendance during the period under review, in March 2006, X reported that she had stopped taking this.
- 18.2 Between March and July 2006 X had 16 hospital attendances connected with her abuse of alcohol resulting in 11 admissions, one of which was for inpatient alcohol detoxification. On 11 occasions X's hospital attendance was also related to self-harm including taking overdoses of paracetamol and superficially cutting herself.
- 18.3 All assessments during this period and subsequently concluded that X's self-harming behaviour was a means of seeking attention and support, with no real intent to end her life. They also concluded that the main assistance that X required was for her alcohol addiction, which along with social stressors regarding contact with her children was a significant contributor to her low mood and self-harm, rather than in relation to her mental health.
- 18.4 In April 2006 X's then partner informed the hospital that she been using cocaine. This is the only time that any suggestion of illicit drug use by X is documented. All other hospital

³¹ He was in fact receiving support from a friend who worked for Brighter Futures rather than from that service.

attendances due to an overdose involved X ingesting over the counter / prescribed medication and / or alcohol. There is no evidence to corroborate that X had used cocaine on this occasion and no other information to suggest that she used illicit drugs at any time during the period under review.

- 18.5 The clinical investigations and treatment provided to X were appropriate and in line with national (NICE³²) guidance, as was the engagement of the NSCHT Crisis Resolution Team³³ and consequent referral to for specialist support from the Community Addiction Team, the Community Mental Health and Social Work Team and at the O'Connor Centre.
- 18.6 The referral route to the Community Addiction Team from UHNS in April and May 2006, which at that time included a requirement that this be made via the GP led to a delay in the Community Addiction Team assessing X. The NSCHT IMR identifies that the pathway has now changed and that all agencies are able to refer to a central referral point for addiction services.
- 18.7 Assessment of X by the Community Mental Health and Social Work Team commenced in June 2006, at which point she stated that she had been abstinent from alcohol for 4-5 weeks indicating that a chemical detox was no longer required. It was however identified that X would still benefit from a period of rehabilitation and the Community Addiction Team offered continued support to her. The assessment was completed in August 2006 and its conclusion, in line with those of earlier assessments, was that X did not have a mental illness but would benefit from services in relation to her alcohol abuse and mood.
- 18.8 X's engagement with specialist services in relation to her alcohol misuse, low mood and history of self-harming behaviour was at best sporadic and she was successively discharged by the services after not attending appointments.
- 18.9 The specialist alcohol and mental health assessments and services provided to X were appropriate and in accordance with national (NICE) guidance. Decisions to discharge X were made in accordance with the relevant NSCHT policies.
- 18.10 From June 2006 X had the first of a succession of appointments with her GP surgery at which she was prescribed anti-depressant and alcohol dependency medication, and which continued throughout the period under review. Between reviews the medication was subject of repeat prescriptions.
- 18.11 From October 2011, when X alleged that she had sustained a neck injury consequent to being assaulted (identified as primarily degenerative changes to her spine, although the potential for this to have been exacerbated by trauma could not be discounted), X reported that her pain relief was not working and requested stronger pain relief medication. This was well managed and documented by the GPs concerned, with clear rationale for prescribing or not recorded in the GP notes.
- 18.12 Expert advice was sought from the Stoke-on-Trent Clinical Commissioning Group (CCG) Lead Pharmacist who concluded that the prescribing and advice to X were all in accordance with relevant prescribing guidelines.
- 18.13 The NHS England IMR identifies that during the period under review X was seen by 18 different GPs and although individual consultations were dealt with effectively, there was no

³² National Institute for Health and Care Excellence

³³ The UHNS Emergency Department has a "Deliberate Self Harm Proforma" available to guide staff on whether a referral is required to Mental Health Services and if so whether that should be the Crisis Resolution Team or Liaison Psychiatry Clinic. This was completed and used to inform decision making when PERPETRATOR attended having self-harmed.

single lead professional responsible for taking an overarching view of X's case. NHS England made an appropriate recommendation for action to address this issue.

- 18.14 Although prescribing of medication for X's alcohol dependency continued throughout the period under review and X consistently maintained to the GPs who saw her that she had been abstinent since 2006 there are numerous occasions (in 2008, 2010, 2011 and 2012) when GPs noted evidence to the contrary. Information provided to the Review from a number of other sources also indicates that she continued to abuse alcohol throughout the period under review.
- 18.15 The NHS England IMR highlights that there is no evidence of this being challenged by the GPs reviewing X's medication and attributes the continued acceptance of X's abstinence to over-reliance on self-reported information. An alternative explanation may be that they were well aware of the continued alcohol use and decided that challenge and withdrawal of alcohol dependency medication would be counter-productive in maintaining engagement with X and might lead to X's alcohol intake increasing. If so it would have been good practice to record this.
- 18.16 X was seen by mental health professionals on two further occasions. First, in November 2011 when she sought a psychiatric referral from her GP, reporting suicide ideation consequent to the ending of her relationship with Y and the impending court case. She was seen by the Crisis Resolution Team who concluded that she did not have a mental illness, that her mood was the result of current stressors and that she was adequately supported by her mother and a friend. Second, in January 2013 by the Criminal Justice Mental Health Team whilst in custody for assault on staff at UHNS. Again no evidence of X having mental illness was found.
- 18.17 In both cases the NSCHT IMR concludes that the service provided was appropriate and that there is no indication that any further support should have been offered. The Review Panel concur with this view.

19 GP Engagement with Domestic Violence and Abuse Services

- 19.1 There is no evidence in Y's GP records of domestic violence and abuse being disclosed.
- 19.2 X's GP records include two references to her being a victim of domestic assaults, in October 2011 shortly after the alleged assault by Y and again in November 2011 when she referred to the same incident.
- 19.3 There is no indication that the GPs involved considered making a referral to MARAC or to other domestic violence and abuse support provision. While they would have been aware that other agencies were already involved, from the hospital discharge summary as well as information provided by X, it would have been good practice to explore what support was actually in place and whether any further action would be appropriate.
- 19.4 The Review Panel took the view that GP engagement in identifying and responding to domestic violence and abuse could be enhanced. Accordingly it is recommended 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 IRIS³⁴ would improve their contribution to keeping victims safe.

- 19.5 The Review Panel also heard that GPs are not directly represented at MARAC although they can refer in to the process and receive information on relevant cases heard at MARAC through an informal arrangement with North Staffordshire Combined Healthcare NHS Trust. The Review Panel took the view that formal links between primary care services and the MARAC arrangements would be more robust. Accordingly it is recommended that:

NHS England Shropshire and Staffordshire Area Team, as the commissioner of primary care services, and the Stoke-on-Trent Domestic Abuse Partnership should work together to review the pathway for information sharing between primary care services and MARAC and take any necessary actions.

20 The Effectiveness of Services Responding to Domestic Violence and Abuse

20.1 Incident involving Z and Partner 3 on 22 July 2006

- 20.1.1 On 22 July 2006 (see 16.6.28) the Police were called to X's address where an argument was taking place between her and Partner 3, who wished to collect his belongings and had been refused access. Later that day X called the Police and reported receiving calls and text messages from partner 3 threatening her, established by the Police to not be the case. The Police response, including conducting a risk assessment involving lateral checks with other agencies and sharing details of the events with X's Community Mental Health Team Social Worker was appropriate.

20.2 Partner 3 allegation of assault by X on 28 July 2006

- 20.2.1 On 28 July 2006 (see 16.6.28-9) the Police responding to a report by Partner 3 that he had been assaulted by X inappropriately recorded the incident as not involving a crime and left X at Partner 3's address. A contributory factor in this is likely to have been the omission of significant information regarding X from the risk assessment undertaken.
- 20.2.2 The Police IMR states that the information used in the risk assessment would reflect that provided by Partner 3 as the victim would be accepted unless there was reason to disbelieve him. There was an expectation that background information on Police systems regarding the parties involved in a domestic incident would be provided to officers at the time of their attendance but it has not been possible to establish what information was shared in this case.
- 20.2.3 Had more robust action been taken by the Police it is likely that the further (unreported) assaults on Partner 3 that day and on the following one (see 16.7.1 et seq.) would not have taken place. It may also have led to Partner 3 adopting a more resolute approach to ending the relationship and thereby impacted on the likelihood that the further events involving Partner 3 and X in July and August 2006 would have occurred.

³⁴ IRIS (Identification and Referral to Improve Safety) is a general practice-based domestic violence and abuse training support and referral programme that has been evaluated in a randomised controlled trial. Core areas of the programme are training and education, clinical enquiry, care pathways and an enhanced referral pathway to specialist domestic violence services.

- 20.2.4 At that time there was no support provision available for male victims of domestic abuse³⁵ and therefore no opportunity to further reduce the risk of further violence by referral of Partner 3 to specialist support provision.
- 20.2.5 One of the attending Officers has been interviewed by the Police IMR author. The Officer could not recall the incident but after reading the records acknowledged that the incident should have been resolved differently, and that the rationale for concluding a call regarding an assault as a non-crime domestic was lacking. The Officer also raised concerns regarding the decision to leave the two parties at the same address. The Officer stated that, if presented with the same situation today, X would have been arrested at the scene and a more thorough domestic abuse investigation would have been carried out.
- 20.2.6 The Police IMR observes that the views of this Officer reflect greater awareness of current domestic violence and abuse policies and recognition of the importance of responding robustly to all such incidents. It also points out that this accords with the HMIC³⁶ comment following their 2014 thematic inspection that “Tackling domestic abuse is a priority for the Force and staff demonstrated a high level of commitment and awareness”.
- 20.3 **X allegation of assault by Partner 3 and Partner 3 allegation of assault by X in August 2006**
- 20.3.1 The Police response to the allegations made by X on 1 August 2006 that she had been assaulted by Partner 3 (see 16.7.14 et seq.) was robust and appropriate to the circumstances reported.
- 20.3.2 The one exception to this was referral of X to Victim Support, which did not have a remit for supporting high risk victims of domestic violence and abuse in Staffordshire. The referral should have been made to the specialist domestic abuse support provision in place at the time. That this was not engaged is attributable to a lack of familiarity by front line Police staff with that support provision. Victim Support does not have any extant record of the referral and there is therefore no indication of whether passing the referral on for specialist support was considered.
- 20.3.3 MARAC arrangements were not available at the time. They were subsequently implemented in Staffordshire in 2007.
- 20.3.4 It is apparent that cognisance was taken of Partner 3’s claim to the Police that he had only acted in self-defence and this was reflected in the decision of the CPS that they required further lines of enquiry to be pursued before making a decision on whether Partner 3 should be charged.
- 20.3.5 The Police response to the report on 7 August 2006 (see 16.7.22 et seq.) that he had been assaulted by X was significantly less robust. There was a two day delay in obtaining a statement from Partner 3 and no recognition that this should be expedited so that X could be arrested and dealt with for the offences before she was released from her detention under the Mental Health Act, 1983, Section 136.
- 20.3.6 That this did not happen is primarily attributable to a lack of urgency exhibited by the Police Control Room in deploying resources to deal with Partner 3’s allegation, on which the notification by Partner 3 that he was concerned about X returning to his home had no impact.

³⁵ This was introduced in 2010.

³⁶ HM Inspectorate of Constabulary

- 20.3.7 There was also an opportunity, notwithstanding that their main focus would have been the welfare of X, for either the Officer who detained her under the Mental Health Act or the Custody Sergeant to have prompted a more urgent response but this did not occur. In this respect the Custody Sergeant has been contacted but does not recall this particular arrest. The Officer who detained X is no longer with Staffordshire Police and unavailable for interview.
- 20.3.8 The risks associated with this delay were exacerbated by a further three weeks delay in arresting X from 9 August 2006, when Partner 3 made a statement. This was disproportionate when contrasted with Partner 3 being arrested within 24 hours of X's allegation of assault by him.
- 20.3.9 The investigating Officer has been interviewed in relation to this but has no recollection of the case. The Officer acknowledged that three weeks was a disproportionate amount of time for the arrest to be made and stated that such an incident would be dealt with more expeditiously now.
- 20.3.10 In this regard the Police IMR highlights that any domestic incident investigations where the suspect is not arrested at the time of initial attendance are now placed on the 'rolling handover' filter. This ensures that the incident is continually investigated until its conclusion and does not stagnate should the investigating officer be away from his normal duties. Each incident in this filter is reviewed at a daily management meeting which is chaired by a senior Officer.
- 20.3.11 Notwithstanding the lack of urgency, the investigation was sufficiently thorough to provide the CPS with the evidence to prosecute and subsequently convict X.
- 20.3.12 Partner 3 cannot recall if he reiterated at this time his earlier claim that he had been assaulted by X on 28 July 2006. That this was not mentioned in his witness statement suggests that he did not. From the extant case papers it is not possible to establish whether there was any join up by the Police between this case and the ongoing investigation of X's complaint against Partner 3 and whether, regardless of Partner 3 not raising it, there was any consideration of whether X might have been questioned and possibly charged with that offence as well.
- 20.3.13 The decision not to prosecute Partner 3 for the alleged assault on X was eventually taken after submission of additional material to the CPS on 15 November 2006. The extant records do not indicate whether there was any join up within the CPS between this decision and the then ongoing prosecution of X, although in their submission to the Review that agency maintains that there should have been and it was likely that there was.
- 20.3.14 The Police IMR highlights that with the introduction of Domestic Homicide Reviews and the Domestic Violence Disclosure Scheme it would be appropriate to review the retention policy around all reports of domestic abuse regardless of whether a crime is involved or not. An appropriate recommendation is made by the Police regarding this. The Review concluded that retention by the CPS of at least those case papers which provide a record of their involvement and the rationale for decisions made would better serve the needs of Domestic Homicide Review processes as well as supporting good governance and improving overall accountability.
- 20.3.15 It is therefore recommended that:

The Crown Prosecution Service put in place arrangements for the retention of at least sufficient case papers to provide a record of their involvement and the rationale for

decisions made in domestic violence and abuse cases; and consider whether such arrangements should be extended to other crime categories.

20.3.16 No additional entry was placed on the Police intelligence system following conclusion of the investigation and the decision not to prosecute Partner 3, or following the conviction of X in March 2007. A 'case closure summary' would have provided a holistic perspective on the relationship and the allegations made by both parties; and put in context the entry made on 1 August 2006 stating that X was a victim of serious domestic violence and abuse, and in particular highlighted that the allegation was related to her assault on Partner 3. (See 20.6.26) for the potential impact of this on subsequent events involving Y).

20.3.17 It is recommended that:

Staffordshire Police put in place arrangements to ensure that staff investigating incidents of domestic violence and abuse are aware of and take into account the circumstances of any previous such incidents, involving either party, where claims of self-defence or counter-allegations have been made.

20.3.18 As in July 2006 there was no service available to support Partner 3 as a male victim of domestic violence and no opportunity for the case to be referred to a MARAC. Although not supported in doing so Partner 3 was successful in ending the relationship with X and having no further contact with her.

20.4 Community Sentence of X in March 2007

20.4.1 The Probation Trust IMR identifies that although there were strengths in the delivery of their Risk Management Plan following conviction of X in March 2007, including communication between the staff involved and a clear focus on victim awareness; the plan itself was insufficient to manage the risks presented and individual practice in the case was not as robust as it should have been.

20.4.2 A particular example was the acceptance that X would not engage with 'groupwork' programmes without identifying any alternative to meet the objectives of those parts of the sentence plan – specifically related to domestic abuse.

20.4.3 A further example concerns the disclosure by X in April 2007 that she was in a relationship with a man and was staying at his address. In view of the identified risk to future partners this should have prompted reconsideration of the risk assessment and contact with the Police to inform this. It did not do so. Failure to disclose an address was also a breach of the terms of the Community Order and an enforcement response to this should have been taken. Neither the case records nor the staff involved are able to explain why these actions were not taken.

20.4.4 In light of the practice deficiencies it is difficult to understand how the sentence objectives could be concluded as met.

20.4.5 Areas in which action is being taken by the Probation Trust (and its successor organisations) to improve practice are detailed at 20.7.12.

20.4.6 In addition to these measures the Panel concluded that if the sentence plan for X had reflected an accredited programme for work with female perpetrators of domestic violence and abuse there was likely to have been a more informed and robust approach to the management of her community sentence. It is recommended that:

The National Offender Management Service strengthens their approach to addressing domestic violence and abuse by adoption of an accredited programme for work with female perpetrators.

20.5 X allegation of assault by Y in October 2011

- 20.5.1 When X was taken by ambulance to the UHNS Emergency Department on 28 October 2011 proactive exploration of domestic violence with her by a Staff Nurse, leading to completion of a risk assessment and making a referral to MARAC was effective and robust practice.
- 20.5.2 The Police initial response to allegation of assault in commencing an investigation and arresting Y, notwithstanding that X was uncooperative with their actions, was expeditious and appropriate to the information available at the time.
- 20.5.3 The ensuing investigation which led to the prosecution of Y was however flawed in a number of respects.
- 20.5.4 First, on interview Y explained that the injuries to himself and to X resulted from a struggle between them during which they had both fallen over. The level of injuries to them both, which with the exception of the cut to X's face were comparatively the same, could be more readily explained by Y's account rather than the sustained violent attack described by X.
- 20.5.5 The interviewing officer acknowledged Y's explanation as to how he came about his injuries:

Y "No told you what happened, she grabbed me physically by the beard, dragged me around the room, well from the bed, I pushed palms out"

Officer "Yeah"

Y "To get her off me"

Officer "Yeah"

Y "During the struggle she's grabbed me"

Officer "Again"

Y "Round the wrist"

Officer "I" can see the marks"

Y "As you can see me marks"

Officer "Yeah"

Y "You can see all the marks there"

Officer "I can see them yeah"

Y "All that's happened in the process of knocking and getting her off me"

Officer "Yeah".

20.5.6 However, when Y offered the same explanation as to how X got her injuries; the explanation was not as readily accepted:

Officer "Can you come, can you come up for an explanation for all these bruises all over her"

Y "Well can you, you know can happen during the struggle can't it I don't know"

Officer "Okay. Her bruises, her injuries I'll tell you, she said injury wise she said that she sustained soreness to the right cheek which is now swollen and cut you've given an account for that you said that's possibly where she's struck the speaker"

Y "Hmmm mmm"

Officer "She's got neck and back pain that feel really sore, in fact her necks swollen at the moment"

Y "That will be where she fell over"

Officer "She's got cuts and bruises all over her"

Y "Part of the struggle"

Officer "Police Officer, (officers name) visited X today, he's obtained a statement from her and he's documented the injuries which are of a similar nature. Now just by you pushing her and her falling onto the speaker isn't, where's she going to get all these bruises all over her body from and this?"

Y "Well where did I get all my bruises"

Officer "Well you've said that's because she's grabbed you by the beard"

Y "Well it's during; it's during the struggle isn't it"

Officer "Then she's grabbed your wrists. Well when you've pushed her away"

Y "Yeah"

Officer "You've given an account for yours, said that she was lashing out at you"

Y "Well yeah"

Officer "But how has she got hers"

Y "Well it's happened during the struggle int it"

Officer "How"

Y "I don't know"

Officer “She's fallen over you've said she's cut her head but you can't account for any of the other injuries”.

- 20.5.7 The Officer's approach to the interview and interpretation of Y's account did not take account of the disparity between X's allegation and the level of her injuries, or the more proportionate explanation provided by Y. It cannot therefore be seen as contributing to effective exploration of the accounts given by the two protagonists, which is essential where one party in an assault makes a counter allegation or raises a defence of self-defence.
- 20.5.8 Following a medical examination there was no medical evidence to support X's account that she had been put in a headlock and beaten to the point that rendered her unconscious on two separate occasions.
- 20.5.9 Second, the interview did not elicit that a witness, who subsequently gave defence evidence which was recorded by the CPS as contributing to Y's acquittal, had been present with Y and X shortly before the assault was alleged to have occurred. The evidence of this witness was not therefore obtained until given at the trial of Y.
- 20.5.10 Third, at the end of the interview, Y's Solicitor made a request to the investigating officer for Y's injuries to be photographed. These photographs were not taken. Fortunately, Y's solicitor took photographs of the injuries on his own phone whilst with Y in custody and these are later used as evidence in court.
- 20.5.11 Fourth, the case summary presented to the CPS contained opinion and presumption rather than a more balanced interpretation of the facts. The Officer's partial interpretation was again evident in the request made to the CPS for Y to be remanded in custody, which made little of him raising self-defence as an issue for consideration:
- “he demonstrated no remorse and even suggested that he had acted in self-defence”.
- “and only for the grace of god that the injured party has not sustained more serious injuries”.
- “I do not believe that it is an exaggeration to suggest that the injured party during this violent attack could have been killed”.
- 20.5.12 Fifth, the file presented to CPS did not disclose the previous convictions of X or the domestic incidents and investigations that X had been involved in.
- 20.5.13 The previous convictions of X were subsequently provided to the CPS (and consequently to Y's Solicitor). The domestic incidents and investigations that X had been involved in, and in particular that she had made an allegation of being assaulted by Partner 3 in the context of her having assaulted him was not. That material relevant to the previous history of X was not disclosed by the investigating officer or subsequently requested by the CPS was questioned by the Review Panel.
- 20.5.14 The Police suggested that for cases heard in the Magistrates Courts a proportionate approach to identifying material that should be disclosed under the Criminal Procedure and Investigations Act, 1996, would be less rigorous than for more serious Crown Court cases. Taken together with the absence of a closure summary on the police intelligence system regarding those investigations (see 20.3.16) this is likely to have undermined the probability that the material would be disclosed. This could however have been mitigated by application of the “thinking approach” to disclosure issues which is now emphasised within the 2013 revision of the Attorney General's guidelines on disclosure.

- 20.5.15 The investigating Officer was interviewed as part of this Review. He could not recall the case in any detail. The Review identified a number of organisational factors which are likely to have contributed to the approach taken to Y.
- 20.5.16 Staffordshire Police policy directs Officers to be victim focussed, which the Officer in this case was clearly trying to be. However it is also clear that this clouded the judgement of the investigator and insufficient weight and consideration was given to Y's claim of self-defence. In this connection the current CPS Guidance around self-defence and counter allegations³⁷ is relevant but was not complied with.
- 20.5.17 Further, the Police IMR identified that in 2011 the Police were under pressure to take 'positive action' on domestic violence, to secure prosecutions and to have perpetrators held in custody wherever possible. This itself, the consequent constraints on the time available to complete investigations before the alleged perpetrator must be charged or released and resultant reduced opportunity to collect further evidence or examine the previous history of the parties, are likely to have contributed to the approach taken by the investigating Officer.
- 20.5.18 Finally, the Review Panel was informed that Police procedures around interviewing, investigating and presenting a case to the CPS, involve a number of different Officers and teams, from call-out to prosecution. The call to the incident was dealt with by an attending Officer, the interview with Y was carried out by the Custody Interview Team, and any further enquiries/evidence gathering would be dealt with by a different team. The Custody Interview Team Officer would be the named case Officer, and have nominal ownership of the case but would not personally undertake any further investigative enquiries. The fragmented nature of this arrangement must undermine the likelihood of a coherent and balanced perspective being obtained in cases where self-defence and counter-allegations are present.

³⁷ **CPS Guidance on Self-defence and Counter Allegations**

http://www.cps.gov.uk/legal/d_to_g/domestic_violence_aide-memoire/#a21

In domestic violence cases, we should be alert to the fact that there may be sharply conflicting accounts of what has taken place, with each party claiming to be the victim. The defendant may make a counter-allegation or argue that s/he acted in self defence. In cases where a counter allegation has been made, police officers are instructed to conduct immediate further investigation at the scene (or as soon as is practicable) to attempt to establish the primary aggressor and to assess whether the victim may have been justified in using a reasonable level of force.

When there are counter allegations, police officers should have noted and recorded the following information:

- the comparative severity of any injuries inflicted by the parties;
- whether either party has made threats of future harm to others (including children, other families, or other members of the household);
- any prior history of violence by either party;
- any previous counter allegations by either party and the results of those allegations; and
- whether either party acted defensively to protect himself or herself or a third party from injury.

It may also be useful to ask the police for the views of the first officer at the scene and the investigating officer.

Where self-defence is raised, we should request from the police as much of this information as is appropriate, especially if considering discontinuing the case because of insufficient evidence.

Counter allegations may give rise to difficulties in prosecutions, particularly as instances where the defendant alleges that the victim is the abuser may end up being used as the basis of bad character applications against the victim (section 100 of the Criminal Justice Act 2003 allows for the bad character of any witness to be admitted, subject to certain conditions). As noted above, there will need to be a thorough investigation of such claims to ensure that factually incorrect or misleading information is not put before the courts.

- 20.5.19 The Police IMR concludes that had the investigation been less partial and the previous history of X been disclosed, Y would not have been charged³⁸. This perspective accords with the view of the prosecutor for the homicide of Y that the actions of Y were a clear cut case of self-defence. The Review Panel also concur with this view.
- 20.5.20 On the basis of the position adopted by the Police, that X was the victim of an assault by Y, and the associated risk assessment, referral of the case to MARAC and of X to Arch for IDVA support was appropriate. The absence from the referrals of information regarding X's conviction as a perpetrator of domestic abuse, and more significantly that having she had at that time reported that it was she who was a victim of domestic violence and abuse, made it unlikely that Y's claim of self-defence would be seen as credible and consideration given to the possibility that X was the perpetrator in the current case.
- 20.5.21 The Review was informed that current domestic abuse processes within the MASH require all relevant agencies to complete lateral checks on the persons involved and to share the resulting information. This process now provides a better overview of the domestic situation within the household and negates domestic abuse incidents being looked at in isolation.
- 20.5.22 As with the referral to Victim Support in July 2006 (see 16.7.17), referral of X to that organisation suggests a lack of familiarity amongst front line Police staff regarding the support framework available to victims of domestic violence and abuse.

20.6 The effectiveness of MARAC held in November 2011

- 20.6.1 The MARAC in November 2011 was appropriately chaired by the Case Conference Strategic Coordinator. X was the 6th case to be heard that day out of a total of twenty five; which is the maximum number of MARAC cases that will be heard in any one day and was allocated the locally agreed fifteen minute discussion period.
- 20.6.2 The Arch IDVA for X was unavailable for the MARAC and had submitted a report. Although it is not ideal to have representatives from a relevant organisation missing this is sometimes unavoidable and it would not be appropriate to delay the consideration of a case at a MARAC.
- 20.6.3 The IDVA report did not identify that Y had also been in contact with Arch as it is the organisation's practice to take victim's accounts at face value and not cross check with other records.
- 20.6.4 There was no reason for the male IDVA to be made aware of the MARAC in respect of X and thereby prompted to share information regarding his contact with Y, although the information provided by him that he was being prosecuted should have at least suggested that this was a possibility. With no extant records and having to rely on the memory of the male IDVA it has not been established whether consideration was given to this.
- 20.6.5 Arch have advised the Review Panel that their database has since been enhanced to include markers on whether a client is known as a victim and / or alleged offender to make join-up of linked contacts more likely.
- 20.6.6 Neither of the GP practices attended by X and Y were engaged by the MARAC.

³⁸ A letter dated 24 November 2014 to the Review Panel Chair from the Legal Advisor to the CPS West Midland Chief Crown Prosecutor maintains that on the evidence provided by the Police at the time, the decision to charge Y was the correct one. As this reflected the flawed investigation that had taken place and did not provide some crucial the basis of this opinion is different to that available to the Review Panel.

- 20.6.7 Notwithstanding the overall desirability of engaging GPs it is unlikely that in this case X's GP would have been able to add anything significant to the process or that being aware of the actions agreed by the MARAC would have changed the approach taken in subsequent contact with X who had discussed the alleged assault on her on the day of the MARAC.
- 20.6.8 It is also unlikely that input from Y's GP would have added value as at that stage no information had been provided to the GP practice by Y about his relationship with X or the impending court case.
- 20.6.9 At the time of the MARAC hearing the safety measures that had already been initiated were commencement of a 7 Step Plan, Installation of a Tunstall (panic) alarm at X's home address, flags had been placed on the relevant Police systems and a referral had been made to the IDVA.
- 20.6.10 Reflecting the referral to MARAC (see 16.11.23) information was shared regarding domestic violence in a previous relationship of X but it was not identified that she had been the perpetrator in that case or that she had alleged she was the victim of domestic violence and abuse. Further no information regarding Y's claim of self-defence was shared. The potential for X to be the perpetrator in the current case was not therefore explored at the MARAC.
- 20.6.11 Following the hearing the subsequent actions were for the Police to continue with the 7 Step Plan and for the IDVA to continue to engage with X.
- 20.6.12 The Police IMR identified that although the actions agreed in this case were completed the arrangements for managing and reviewing action agreed at MARAC could be more robust and makes a recommendation in this regard.
- 20.6.13 The measures agreed by the MARAC were appropriate for promoting the safety of X but this was under the misconception of who the actual victim was in the relationship.
- 20.6.14 Coordinated Action Against Domestic Abuse (CAADA), who provide a national lead on MARACs, recognise that dealing with counter allegations is complicated and in 2012 addressed this by producing a guidance paper on the issue. Had this guidance been available at the time of the MARAC in 2011 the case may have been explored in more depth and, particularly if informed by a more comprehensive gathering of information held by agencies, a more holistic approach taken to the relationship between Y and X, with consideration given to measures which would promote Y's safety.
- 20.6.15 Respect³⁹ identify that men and women can be both victim and perpetrator in an intimate relationship and all agencies whose work involves domestic violence need to develop their awareness and approaches to these complex situations.
- 20.6.16 In October 2013, HMIC conducted a review of how Staffordshire Police deal with domestic abuse. The subsequent HMIC report 'Staffordshire Police's approach to tackling domestic abuse' published in March 2014, while recognising that it is a national issue, made specific reference to counter allegations in domestic abuse cases, stating:

"Where someone initially identified as the perpetrator makes an allegation against the victim. If counter-allegations are not identified and resolved, agencies may be providing services to the perpetrator and inadvertently helping them isolate and control the

³⁹ Respect is a membership organisation for work with domestic violence perpetrators, male victims and young people.

victim. The victim may not get access to the services they need because they are labelled “the perpetrator”.

- 20.6.17 In the absence of identification that Y was a victim of domestic violence and abuse by X he was not referred to specialist support services. On the advice of a friend (see 16.11.26) he did however seek advice from a male victims IDVA at Arch. Advice and an offer of further support were provided. At that time the male IDVA was not funded to work with male victims in Stoke-on-Trent. Providing this service to Y and an offer of further support, outside of the workers remit, was accordingly to be commended.
- 20.6.18 The HMIC observation accords with the position of Respect; that it is important to identify whether a purported victim of domestic violence and abuse is in fact a perpetrator, highlighting that if this is not done:
- The perpetrator may be referred to victims’ services, which is inappropriate, unsafe and a waste of resources
 - The perpetrator/abuser may feel that they can do what they like to the victim without a fear of consequences and this in turn may result in an increase in severity and frequency of physical or other attacks
 - The perpetrator will not have access to services which can help them change.
- 20.6.19 In the current case X was provided with IDVA services. In this connection the plans put in place were appropriate to the presenting circumstances, notwithstanding that the IDVA’s assessment of risk was not informed by an actuarial scoring process as it should have been
- 20.6.20 Following Arch’s involvement in a Serious Case Review in May 2012 all Arch domestic violence staff now participate in assessment/risk/support planning training at least annually and Arch has introduced an improved internal quality, monitoring and reporting system.
- 20.6.21 Stoke-on-Trent City Council, through their Safer City Partnership have an established perpetrator programme which seeks to engage perpetrators of domestic violence and abuse, offering them the opportunity to recognise, acknowledge and change their behaviour. This provision does not however extend to female perpetrators of abuse. The Arch IMR makes an appropriate recommendation for this to be addressed.
- 20.6.22 The Review Panel was informed that male victims of domestic violence and abuse are routinely screened by Arch to identify if they may actually be perpetrators, in line with the Respect guidelines and using tools provided by that organisation., Female victims are not routinely screened in the same manner, and it is left to the professional judgement of agencies involved to decide whether this would be appropriate on a case-by-case basis.
- 20.6.23 Had such screening been used in respect of X it is likely that consideration at least of her as a perpetrator of violence would have been prompted, and that a consequent deeper exploration of the circumstances may have led to a more appropriate response.
- 20.6.24 The view of the Review Panel is that the current arrangement is inequitable and potentially dangerous. It is therefore recommended that:
- The Stoke-on-Trent Domestic Abuse Partnership oversees the introduction of routine perpetrator screening arrangements by all providers of services to victims of domestic violence and abuse.**
- 20.6.25 In January 2012 Y appeared North Staffordshire Magistrates Court and argued that he had been acting in self-defence. He was found not guilty of assaulting X.

- 20.6.26 The acquittal of Y at court for the alleged assault on X does not negate the impact that the Police approach and consequent prosecution is likely to have had on him. The prosecution effectively colluded in the abuse of Y, clearly had an impact on his mental state and self-confidence (see 16.11.25-28 & 16.13.2-4) and is highly likely to have impacted on whether he sought assistance from the Police or domestic violence and abuse support services in the following period leading up to his murder.
- 20.6.27 It is clear that, to an even greater extent that with Partner 3 in 2006, abuse of Y went unreported. The Review Panel explored the relevance of the victim's gender to the likelihood of abuse being reported and the response provided.
- 20.6.28 The Review noted that between March 2013 and February 2014, the number of male victims referred to MARAC increased by 23%, compared to the previous year's figures. This suggests that a current multi-agency approach to raising awareness of and encouraging the reporting of domestic violence and abuse by male victims may be having some success.
- 20.6.29 It is clear however that the perceived stigma attached to being a male victim of domestic abuse has not yet been eradicated as reflected in the following (2014) extract from a Police incident recording:
- “I don't know how to report this being a male that has been hit by my female partner, it's so embarrassing, but it's happened before and I can't take it anymore.”
- 20.6.30 A further extract from a 2014 Police incident record also suggests that even when reported there is still some way to go in ensuring the that abuse of male victims is taken as seriously as that of female victims:
- “He initially said that he wanted to forget the matter. Asked him why and he has gone on to say he feels let down by the Police. He said if a female had gone into the station with injuries and said she had been assaulted by her partner the Police would have dealt with it straight away and the male would be arrested. He feels that as he was a male who had been a victim of domestic assault he has been treated differently. He cannot believe that he walked into a Police Station with facial injuries and was told to come back in two days time.”
- 20.6.31 A wide range of domestic violence and abuse services are available in Stoke-on-Trent (see section 13) and considerable effort is being made to ensure that these are effective. Without undoing the significant developments in responding to female victims more work is however needed to ensure that this positive approach is balanced, impartial and devoid of stereotypical views towards male victims of domestic violence and abuse.
- 20.6.32 The Police and Arch make a number of recommendations for improvements to their services in this regard. These are appropriate but must be mirrored across all service provision in the City. Accordingly it is recommended that:
- The Stoke-on-Trent Domestic Abuse Partnership develop proposals to address gender bias and stereotyping in the culture of agencies and professional groups dealing with domestic violence and gender based social and psychological barriers to victims accessing services.**
- 20.6.33 In this connection a friend of Y highlighted that there is currently no refuge or safe place to meet for male victims in Stoke-on-Trent. Such provision should form part of the consideration given to the recommendation.

20.7 **X conviction and community sentence in July 2013**

- 20.7.1 Although not the result of domestic violence the conviction of X in July 2013, having pleaded guilty to all of the offences with which she was charged in relation to the incident on 21 January 2013 (see 16.14) is relevant to the Review. Her sentence of an 18 month Community Order with supervision and sentence programme (including thinking skills and work on alcohol misuse) requirements was current when X was arrested for the murder of Y in December 2013.
- 20.7.2 Neither the pre-sentence risk assessment nor subsequent reviews were informed by the records of X's previous period of supervision or by contact with the Police. They were also not updated to reflect significant new information such as X's child coming to live with her in October 2013. Although a risk to staff was identified this did not result in it being flagged on the electronic case management system.
- 20.7.3 On interview the Offender Manager stated that he had relied on X's account and that it was not his usual practice to consult records of previous involvement with an offender. He also showed a lack of awareness about the need to flag risks so that other staff would be alerted to this
- 20.7.4 A Risk Management Plan was produced using the required tool. Objectives identified were to gain understanding of the views and perspectives of others, self-control, and for X (who reported no memory of them) to gain acceptance of her role within the index offences.
- 20.7.5 The Probation Trust IMR identifies that the sentence plan developed was insufficient to manage the risks presented or deliver the objectives of the sentence. The Offender Manager, while recognising the insufficiency of the written plan, was unable to explain the reason for this.
- 20.7.6 Regardless of the written plan's inadequacy the work actually undertaken was of a satisfactory standard and there is evidence of progress on all of the sentence objectives. This included clearly focussed supervision sessions and a 1:1 Programme with a focus on thinking skills, problem solving and positive goal setting..
- 20.7.7 The disconnect between the written plan and the service delivery is attributable to allocation of the case being split between an Offender Manager (with overall responsibility for Risk Assessment, risk management planning and the core functions of the 'responsible officer' role as defined within the Criminal Justice Act 2003) and a Probation Service Officer (with responsibility for direct delivery of the plans). Within this arrangement direct contact with X was completely delegated by the Offender Manager to the Probation Service Officer and a One to One Programme Tutor. It is clear that the Probation Trust position statement (dated May 2012) on joint working of cases was, fortuitously, not complied with.
- 20.7.8 The Staffordshire and West Midlands Probation Trust IMR highlights that consequent to their 'Further Serious Offence' internal review, which examined both of X's community sentences, there are action plans in place to address deficiencies identified in their practice during both this supervision episode and the earlier one..
- 20.7.9 Areas identified where improvements should be made are:
- Exchange of information with other agencies (in this case particularly Police) to inform assessments and management of the individual.
 - Accessing previous records for the purposes of risk assessment, risk management and engagement of the individual.

- Responding to significant new information, to include review of assessments and plans. In this case this is relevant to potential disclosures of a new or existing partner and also that X's child had come to live with her.
- Informing assessment by use of the approved risk assessment tools (SARA – Spousal Abuse Risk Assessments).
- Having clear systems for the archiving and retrieval of previous records. This is relevant as for the second period of Supervision the paper record from the previous period could not be found.

20.7.10 On 17 December 2013 X informed her Probation Programme Tutor that she had had another 'low week' and was feeling quite stressed. She stated that this was due to conflicts with Partner 1 and his wife over their child. X stated that she would like "the situation to end altogether".

20.7.11 The Probation Trust IMR author interviewed the Programme Tutor and discussed at length the reference to "the situation to end all together". The Programme Tutor explained that she had a very clear memory of this session with X and that the context of the discussion was the ongoing animosity between X, her ex-partner and his wife which was resulting in acrimonious telephone calls, messages and inappropriate disclosures to the children. The Programme Tutor stated that X stated that she wanted this situation to end and all parties to "stop arguing and be civil towards each other".

20.8 X contact with Children's Social Care in December 2013

20.8.1 On 18 December 2013 X had her last contact with any professional prior to the murder of Y when she was visited by a Social Worker conducting an assessment consequent to Z having been a missing child. X made no reference to having a partner or other significant relationship and gave no indication of any impending crisis.

21 Safeguarding Children

21.1 When, in March 2006, Partner 1 learned that X was in crisis through her alcohol dependency and was self-harming he removed his two children to live with him. The action taken by local agencies to establish that the children were safe and well was appropriate. Staffordshire Children's Social Care note that as Partner 1 had parental responsibility for the children and there were no concerns expressed by the Police regarding them being in his care, leaving the children with Partner 1 was an appropriate and proportionate response.

21.2 While there were attempts by X to regain custody of the children during the period under review they all remained living with Partner 1 and contact arrangements were closely managed by him with the support of the family court until late in 2013.

21.3 The welfare of the children was appropriately considered by the Police, Children's Social Care and the Housing Association in their contacts with X during 2006. Signposting of X to the authorities in the area that the children were living when she sought advice in May 2006 was also appropriate.

21.4 The decision of the MARAC in November 2011 not to make a referral to Children's Social Care as X's children were not living with her and that she only had supervised contact was appropriate.

- 21.5 When, on the evening of 21 January 2013 it was reported to the Police that during a visit to her by Z X had “gone berserk” causing Z to seek sanctuary with a neighbour, the action taken to keep Z safe and in the care of Partner 1 was appropriate. Sharing details of the incident with Children’s Social Care and the consequent sharing of this with their counterparts in the West Midlands was also appropriate and proportionate, taking into account the ongoing involvement of the family court and Z’s expressed intention of wanting no contact with X.
- 21.6 The response of the Probation Service Officer in August 2013 when informed that Z was coming to stay with X; challenging her regarding the incident in January 2013 and following this up with a home visit, was appropriate and robust practice. The Probation Service Officer also responded appropriately in October 2013 by confirming that a school place had been obtained when informed that Z had come to stay with X. It would however have been good practice to also contact Children’s Social Care regarding this development.
- 21.7 The Police and Staffordshire County Council IMRs describe in detail the measures taken in response to Z being reported missing in December 2013 and have confirmed that this was in accordance with all relevant policies, procedures and practice standards, involved effective communication between the agencies and creditable persistence by the school’s Education Welfare Officer to tracing Z. The Review Panel concur with this.
- 21.8 Children’s Social Care did identify that recording of their contact with the family should have been better, in that incidents and the child’s relationship with all significant adults should have been recorded on the individual files of each sibling; an issue identified by a previous review process in Staffordshire and also the subject of guidance from the Department for Education. An appropriate recommendation is made by that agency in this respect.

22 Ethnicity of Y

- 22.1 Y was of Asian heritage but by the time of his birth, his parents were westernised and Y more so. Y himself retained no traits of his Sikh religion and was completely integrated into his local community. There is no record of Y having been a victim of any BME related crime and no indication that his ethnic origin was ever a factor in his relationship with X.
- 22.2 The Review Panel explicitly considered this issue and concluded that Y’s ethnicity was not a relevant factor in his murder, the abuse that he was subjected to, or the provision of services to him.

23 Good Practice

- 23.1 The Review identified a number of examples effective and commendable practice:
- 23.2 A Police Community Beat Officer proactively visited X in May 2006 to check on her welfare.
- 23.3 In October 2011 a hospital Emergency Department Staff Nurse, proactively explored domestic violence with X leading to completion of a risk assessment and a referral to MARAC.
- 23.4 The male IDVA contacted by Y in October 2011 was not at that time funded to work with male victims in Stoke-on-Trent. Providing this service to Y and an offer of further support, outside of the workers remit, is accordingly to be commended.

- 23.5 Completion of an alcohol audit by a hospital Emergency Department triage nurse when X attended the department in January 2013.
- 23.6 When Z went missing in December 2013 the school Education Welfare Officer demonstrated commendable persistence in attempting to trace the child.

CONCLUSION

- 24.1 From information provided to the Review it is clear that violence and abuse of Y by X was occurring throughout their relationship and was known to his friends and family. With the exception of his reference to X being the aggressor when interviewed by the Police in October 2011 this was not however reported to any professional or agency. Y did not give any indication in the period immediately prior to his murder that there was any escalation of the violence or that he felt at greater risk
- 24.2 In the period immediately prior to Y's murder X had contact with staff from the Probation Trust, as well as with the Police and Children's Social Care in connection with her child going missing. She gave no indication that there was any impending crisis and in fact made no reference to being in a relationship.
- 24.3 On this basis the Review concluded that the murder of Y was not predictable. Accordingly there was no action which any professional or agency might have taken which would have directly prevented it.
- 24.4 While it cannot be concluded that they would have prevented it, there were areas in which different actions by agencies may have led to a reduction in the likelihood of Y being killed by X.
- 24.5 The most significant of these was the response to X's allegation of assault in October 2011, in which a number of factors, discussed in detail in sections 20.5 & 20.6, conspired to reduce the likelihood that Y would seek assistance regarding ongoing abuse and to potentially empower X as an abuser.
- 24.6 Second, there were two occasions when the Probation Trust had opportunities to ensure that X engaged in work to address her aggression, identified in both periods of supervision as being a particular risk to her partners. On neither occasion was aggression in the context of domestic violence and abuse specifically addressed in the sentence plan or the service provided.

RECOMMENDATIONS

- 25.1 The Review Panel make the following recommendations:
- 25.2 **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 IRIS⁴⁰ would improve their contribution to keeping victims safe.**
- 25.3 **NHS England Shropshire and Staffordshire Area Team, as the commissioner of primary care services, and the Stoke-on-Trent Domestic Abuse Partnership should work together to review the pathway for information sharing between primary care services and MARAC and take any necessary actions.**
- 25.4 **The Crown Prosecution Service put in place arrangements for the retention of at least sufficient case papers to provide a record of their involvement and the rationale for decisions made in domestic violence and abuse cases; and consider whether such arrangements should be extended to other crime categories.**
- 25.5 **Staffordshire Police put in place arrangements to ensure that staff investigating incidents of domestic violence and abuse are aware of and take into account the circumstances of any previous such incidents, involving either party, where claims of self-defence or counter-allegations have been made.**
- 25.6 **The National Offender Management Service strengthens their approach to addressing domestic violence and abuse by adoption of an accredited programme for work with female perpetrators.**
- 25.7 **The Stoke-on-Trent Domestic Abuse Partnership oversees the introduction of perpetrator screening arrangements in all providers of services to victims of domestic violence and abuse.**
- 25.8 **The Stoke-on-Trent Domestic Abuse Partnership develop proposals to address gender bias and stereotyping in the culture of agencies and professional groups dealing with domestic violence and gender based social and psychological barriers to victims accessing services.**
- 25.9 The Review was informed that the Association of Directors of Public Health (ADsPH) are currently developing initiatives to ensure compliance with NICE Public Health Guidance 50 (on responses to Domestic Violence and Abuse) across the West Midlands. That guidance accords with many of the recommendations above. It would therefore be fitting for the bodies charged with implementing these recommendations to take cognisance of the ADsPH initiative and ensure that the work is properly coordinated.
- 25.10 Recommendations for action to improve their services were also made by the agencies which contributed to this Review. These recommendations, along with the associated Action Plans are provided at Appendix B.
- 25.11 Implementation of action plans arising from recommendations of the Review Panel and the contributing agencies will be monitored under arrangements agreed by the Stoke-on-Trent

⁴⁰ IRIS (Identification and Referral to Improve Safety) is a general practice-based domestic violence and abuse (DVA) training support and referral programme that has been evaluated in a randomised controlled trial. Core areas of the programme are training and education, clinical enquiry, care pathways and an enhanced referral pathway to specialist domestic violence services.

Responsible Authorities Group. The Responsible Authorities Group will also implement a communications plan which ensures that learning from the Review is effectively disseminated.