SAFER BARNSLEY PARTNERSHIP

# Domestic Homicide Review

## Executive Summary

Anne
October 2016

Independent Author
30 June 2017

| | INDEX | Page |
|---|---|---|

## 1 Introduction

1.1 This is an executive summary of a Domestic Homicide Review commissioned by the Safer Barnsley Partnership in relation to the murder of 'Anne' on 8 October 2016.

1.2 This summary outlines the process undertaken by the Safer Barnsley Partnership domestic homicide review panel in reviewing the homicide of Anne, who was a resident in their area.

1.3 The following pseudonyms have been in used in this review for the victim and perpetrator to protect their identities and those of their family members:

| Name | Who | Age | Ethnicity |
|---|---|---|---|
| Anne | Victim | 35 | White British |
| John | Perpetrator | 29 | British |

1.4 Criminal proceedings were completed on 6 April 2017 and the perpetrator was sentenced to life imprisonment with a minimum tariff of twenty years.

1.5 Following Anne's death, and a referral by South Yorkshire Police, the case was considered by the Domestic Homicide Review/Safeguarding Adult Review Executive Sub Group of The Safer Barnsley Partnership [Community Safety Partnership] on 4 November 2016. The group concluded that the criteria for a Domestic Homicide Review were met and the Home Office was informed of the intention to conduct a Domestic Homicide review in November 2016.

1.6 All agencies that potentially had contact with Anne and John prior to the point of death were contacted and asked to confirm whether they had involvement with them. All twelve of the agencies contacted confirmed contact with Anne or John and were asked to secure their files.

2 **Contributors to the review**

South Yorkshire Police

Barnsley Council, Adult Social care

DISC ([formally Phoenix Futures] Drug and alcohol service

Barnsley Hospital NHS Foundation Trust

Doncaster and Bassetlaw Teaching Hospitals Foundation Trust

South West Yorkshire Partnership Foundation Trust

Pathways Family Support Centre

Victim Support

Yorkshire Ambulance Service

Barnsley Clinical Commissioning Group

South Yorkshire Community Rehabilitation Company

Rotherham General Hospital

3 **The Review Panel members**

Independent chair and author

Independent support to chair

Barnsley MBC Commissioning Manager, Healthier Communities Business Unit

South Yorkshire police, case and policy review officer

Barnsley MBC, Adult Social Care, mental health team manager

Barnsley Hospital NHS Foundation Trust - adult safeguarding

Doncaster and Bassetlaw Teaching Hospitals Foundation Trust - safeguarding adults

DISC [Formally Phoenix Futures] locality manager

Yorkshire Ambulance service, named professional safeguarding vulnerable groups

Barnsley CCG, designated nurse safeguarding adults.

Sodexo Justice – South Yorkshire Community Rehabilitation Company

## 4 Terms of reference

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 inform national and local policies and procedures as appropriate;

Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

Contribute to a better understanding of the nature of domestic violence and abuse; and

Highlight good practice.

[Multi Agency Statutory guidance for the conduct of Domestic Homicide Reviews 2016 section 2 paragraph 7]

### Timeframe under Review

The DHR covers the period 22 October 2011 to October 2016

**Case Specific Terms**

**Subjects of the DHR**

Victim: Anne 35 years old

Perpetrator: John 29 years old

a) How did your agency identify and assess the domestic abuse risk indicators in this case; was the historical domestic abuse taken into account when setting the risk levels and were those levels appropriate?

b) How did your agency manage those risks?

c) What did your agency do to keep the levels of risk under review?

d) What services did your agency provide for the victim and perpetrator and were they timely, proportionate and 'fit for purpose' in relation to the identified levels of risk?

e) How did your agency ascertain the wishes and feelings of the victim and perpetrator about their victimisation and offending and were their views taken into account when providing services or support?

f) What did your agency do to safeguard any children exposed to domestic abuse?

g) How effective was inter-agency information sharing and cooperation in response to the victim and perpetrator and was information shared with those agencies who needed it?

h) How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to the victim and perpetrator?

i) What did your agency do to establish the reasons for the perpetrator's abusive behaviour and how did it address them?

j) Was there sufficient focus on reducing the impact of the perpetrators abusive behaviour towards the victim by applying an appropriate mix of sanctions (arrest/charge) and treatment

interventions?

k) Were single and multi-agency policies and procedures, including the MARAC and MAPPA protocols, followed; are the procedures embedded in practice and were any gaps identified?

l) How effective was your agency's supervision and management of practitioners involved with the response to needs of the victim and perpetrator and did managers have effective oversight and control of the case?

m) Were there any issues in relation to capacity or resources within your agency or the Partnership that affected your ability to provide services to the victim and perpetrator or to work with other agencies?

n) Does your agency have any information in relation to the subject's early life experiences which may have contributed to their substance misuse and relationship difficulties?

o) If your agency has information relevant to the terms of reference that relates to events before the 22.10.2011 please include it in the Individual Management Review as a short narrative.

p)The review must take full account of issues raised by the victims' families and represent the voice of the victims and their families including children where appropriate in its narrative.

## 5 Summary Chronology

### Anne and John

5.1.1 During the period covered by the review, Anne had many contacts with a range of medical services. Yorkshire Ambulance Service assisted her on twenty five occasions and she was admitted to four different hospitals on multiple occasions. Most of Anne's medical episodes were as a result of her chronic long term misuse of alcohol.

5.1.2 Prior to her relationship with John, Anne had a significant relationship with another man and became pregnant. Following a fall, her baby was born prematurely at six months gestation and sadly only lived for six days. Her father thought that she began to

drink very heavily after this and when she became pregnant with a second child, the baby was born with foetal alcohol syndrome. Anne and her child's father split up and ultimately she lost custody of her child. When her father asked her why she was drinking so much she said it was "to try and forget things".

5.1.3 Anne and John had been in a relationship for approximately six years before Anne's death. Both of them maintained their own homes and did not formally live together. The first time that they came to the attention of agencies as a couple, was as a result of a domestic dispute between them in October 2011. This ended when John was struck over the head with a golf club by a third party.

5.1.4 Although they were known to be in a relationship by family members, Anne and John appear generally not to have been keen for this to be recognised by agencies. They often referred to themselves as single and did not acknowledge the relationship when asked about their relationship status. Neither Anne nor John were employed consistently during the period of the review. Anne for much of the time was ill as a result of her alcohol misuse. John worked sporadically in undeclared employment and received medical treatment for minor work related injuries.

5.1.5 On the occasions that their relationship came to the attention of agencies it was because of domestic abuse reported to the police or when John disclosed issues in their relationship to his offender manager. Their relationship was unknown to health professionals apart from one comment that Anne made in relation to her boyfriend wishing that she would give up alcohol.

5.1.6 Despite the lack of visibility of their relationship, the police recognised that Anne was at risk of domestic abuse from John following his arrest for assault on her mother's partner in October 2013. This resulted in a marker being placed on the police computer system in December 2013, which highlighted Anne as a high risk victim of domestic abuse. This assessment was proven to be correct when John assaulted Anne in September 2015.

5.1.7 What was known separately to agencies about the couple, was their issues in relation to substance misuse. Anne was admitted to hospital on many occasions for medical conditions caused by alcohol misuse. John was initially referred to drug and alcohol services by his GP and received support from October 2011 until he

declined further support in August 2014.

5.1.8 Although a range of professionals attempted to offer support to Anne, they were consistently unsuccessful. Anne lived a life that was largely unseen to professionals, unless she chose to engage with them. Even when she did engage, for example with drugs and alcohol services she frequently missed appointments and did not stay engaged consistently to the extent that any help offered could be effective. She did not return calls or respond to letters and cards that were posted when she had missed appointments.

## 5.2 Key events

5.2.1 On 20 October 2011, Anne and John were involved in an argument after both of them had been drinking. It was alleged that following a scuffle over Anne's mobile phone a third party appeared and hit John to the back of his head with a golf club. Anne was also accused of hitting John whilst he was on the floor. A suspect was arrested but there was insufficient evidence to proceed with the case.

5.2.2 On 25 October 2013, John was arrested for common assault following an incident where he assaulted Anne's mother's partner. Anne was present at the time. John later appeared at Barnsley Magistrates court [ 29 November 2013] and received a Community order with supervision, costs and a Drug Rehabilitation Requirement [DRR].

5.2.3 On 16 December 2013, two flags were created on the police dispatch system. The first recorded that Anne had previous disputes with her mother's partner. The second flag recorded Anne as a high risk victim of domestic abuse, naming John as the perpetrator.

5.2.4 On 16 December 2013 a basic OASys[1] assessment was completed by South Yorkshire Probation Trust, a full risk of harm assessment was not completed as there were no indicators of domestic abuse demonstrated in the information available at the time of the assessment.

[1] OASys is the abbreviated term for the Offender Assessment System, used in England and Wales by Her Majesty's Prison Service and the Probation service nationally from 2002 to measure the risks and needs of criminal offenders under their supervision.

5.2.5 On 30 January 2014, Anne was admitted to Rotherham General Hospital. She said that she had fallen whilst intoxicated, banging her head on a sink and hitting her arm on the bath. The Yorkshire Ambulance Service staff assisting her asked about domestic abuse and Anne denied that it was a factor in her injuries.

5.2.6 On 29 May 2014 Anne attended at a Phoenix Futures [drugs and alcohol service] 'walk in' clinic. A comprehensive assessment was carried out during which Anne stated that she was drinking a litre of vodka a day and taking prescription medication for depression. An AUDIT[2] Score of 40. A score of 8 or more indicates hazardous or harmful alcohol use. A score of 20+ indicates dependency. A risk assessment was completed during which Anne stated that she was single and responded "No" to a question on recent threats from others and/or domestic violence. Her case was allocated to a recovery navigator for further support. Following this Anne failed to attend two appointments and was then sent a discharge letter which contained information on how to obtain further support.

5.2.7 On 19 October 2014, Anne was admitted to Barnsley hospital after suffering from a series of falls. She had extensive bruising to her body and was unable to communicate effectively. Extensive tests concluded that she had suffered a subarachnoid haemorrhage[3] and she was transferred to another hospital. She was later transferred back to Barnsley hospital when it was decided that she did not require surgery. Anne stayed as an in-patient at Barnsley hospital until she was transferred to a Neurological Rehabilitation [stroke] Unit on 31 October 2014.

5.2.8 On 20 November 2014, following a period of rehabilitation, Anne was discharged from the Neurological Rehabilitation Unit. Whilst an inpatient, there had been no concern around domestic abuse and the only mention Anne made of a boyfriend was on one occasion, when she told staff that her boyfriend wanted her to give up drinking.

[2] Alcohol Use Disorders Identification Tool. A ten item screening tool developed by the World Health organisation to assess alcohol consumption, drinking behaviours and alcohol related problems.

[3] A subarachnoid haemorrhage is an uncommon type of stroke caused by bleeding on the surface of the brain. It's a very serious condition and can be fatal. Subarachnoid haemorrhages account for around 1 in every 20 strokes in the UK.

5.2.9 On 22 December 2014, Anne was admitted to Barnsley hospital with bruising to the chest and face, she said that she had been involved in a fight. She was also treated for medical issues arising from her misuse of alcohol. She declined to give further information in relation to the fight that she had been in and did not want any legal action to be taken. The matter was not reported to the police. When asked why she had started drinking again she said that it was because she was unable to have access to her child. Anne stayed in hospital on this occasion until 25 December 2014.

5.2.10 As a result of the incidents in October, November and December 2014, a series of referrals were made to Adult Social Care. Their assessment of Anne's case and response to it was ineffective. On the last of the referrals in December 2014, two unsuccessful attempts were made to contact Anne by telephone and nothing further was done.

5.2.11 On 26 September 2015, police received a third party report of an assault on Anne by John. The third party reporting the incident described Anne as having been kicked in the head and punched. On officer attendance Anne was found in the road with what appeared to be severe head injuries. She was taken to Doncaster Royal Infirmary, where CT scans revealed injuries to the face and head. She did not wish to speak to officers or answer risk factor questions. Despite this, John was arrested and charged with assault and given bail conditions not to contact Anne or go within fifty yards of her home address. The incident was assessed as high risk and referred to MARAC[4] with an action for IDVAs[5] to make contact with Anne. John later appeared at Barnsley Magistrates Court, however the case was discontinued when the Crown Prosecution Service decided that there was insufficient evidence to provide a realistic prospect of conviction.

5.2.13 On 21 October 2015, Anne's case was discussed at MARAC and three actions were agreed

1. Make Anne aware of the outcome of the discussions at MARAC
2. Check if Anne was known to Phoenix Futures for her alcohol

[4] A MARAC [Multi Agency Risk Assessment Conference] is a multi-agency meeting where information is shared on the highest risk domestic abuse cases.

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

issues
3. Ensure all agency files are tagged [to highlight a high risk]

All actions were marked as complete by 4 November 2015.

5.2.14 Although attempts were made to contact her, in fact no contact was made and Anne was never made aware of the MARAC meeting. Anne had previously been known to Phoenix Futures but was not receiving a service at that time and they were not in contact with her. The action was in effect meaningless. Agency files were tagged to highlight the risks involved.

5.2.15 On 7 November 2015 John contacted the police reporting that Anne had been at his house kicking the door. When officers attended, the house was in darkness and attempts at contact in order to follow up the incident were unsuccessful.

5.2.16 On 18 November 2015, John reported to the police that Anne had kicked his door open and hit him in the face. Although he told the police about the incident he declined to provide a statement or support a prosecution. A DASH[6] risk assessment was completed which recorded a standard risk to John.

5.2.17 On 28 February 2016, John reported that following an argument with Anne he had removed her from his house and she had stayed outside kicking the door. Anne was advised by the police about her conduct. A DASH risk assessment was completed which recorded a standard risk to John.

5.2.18 On 2 May 2016, John attended at a local police station to report that he had been assaulted by Anne and sustained a cut lip. Anne was arrested and restrictive bail conditions were applied to prevent her from approaching John, but the case was discontinued following advice from the Crown Prosecution Service. CPS took the view that there was insufficient evidence to provide a realistic prospect of a conviction, given that both parties made allegations against the other and there were no independent witnesses. The reviewing lawyer was aware of the domestic abuse history in the case. A DASH risk assessment was completed which recorded a standard risk to John.

[6] The Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model was implemented across all police services in the UK from March 2009, having been accredited by ACPO Council, now known as National Police Chief Council [NPCC]

5.2.19 On 24 June 2016, Anne contacted the police and stated that she had been assaulted by John. Officers arrived within a few minutes and found Anne alone and heavily under the influence of alcohol. She told them that she didn't know why she had called and didn't want officers at her address. Anne refused to answer any risk questions. A DASH risk assessment was conducted which recorded the risk as standard. This was later changed on review to Medium risk and a referral was made to the IDVA service. The IDVA service was unable to contact Anne.

5.2.20 On 8 October 2016, police received an anonymous call in relation to Anne's welfare. They attended at her home within a few minutes and found her deceased.

## 6 Key issues arising from the review

- Anne's family were aware of and disapproved of her relationship with John. They found it very difficult to support her and reluctantly had little contact with her in the two years preceding her death.
- Anne was seriously ill and misused alcohol but had the mental capacity to make her own decisions.
- John misused drugs and whilst he claimed to be reducing his drug use he tested positive for drugs on many occasions.
- Both Anne and John did not acknowledge their relationship to professionals and often described themselves as single.
- Professionals found it difficult and sometimes impossible to engage Anne.
- Yorkshire Ambulance Service highlighted their concerns about Anne's welfare on a number of occasions.
- Adult Social Care's assessment of Anne and contact with her was ineffective
- Anne's case was referred to MARAC but the response was ineffective.
- A further six domestic abuse incidents were recorded between the couple. A further referral to MARAC would have been appropriate.

## 7 Conclusions

7.1 Anne was seriously ill for a number of years prior to her murder, as a result of alcohol misuse. She was admitted to hospital on many

occasions and was aware of the services available to her. She chose to engage with services occasionally but often then quickly disengaged, as was her right. Apart from one brief spell when she was recovering from a subarachnoid haemorrhage, Anne was always assessed as having the capacity to make her own decisions.

7.2 John also had issues with substance misuse. He received services for three years, firstly as a result of a referral from his GP and later when he was convicted of assault and given a Drugs Referral Requirement as part of his sentence. John consistently told drugs workers that he was reducing his reliance on drugs. Despite this on almost every occasion when tested as part of his DRR the test showed positive for at least one drug. John cooperated with drugs workers and attended appointments. Within the context of harm minimisation, he was not seen as a difficult case and his cooperation in attending appointments and tests was seen as positive.

7.3 Although their relationship was known to their families and others in the community both Anne and John often described themselves as single and did not disclose their relationship to services. This meant that for health agencies in particular it was impossible to provide support to Anne in relation to the risk of domestic abuse.

7.4 As so little was known about them, there were few opportunities for joined up partnership working in relation to the couple. The first significant opportunities were in October, November and December 2014 when Adult Social Care received referrals in relation to Anne. Adult safeguarding procedures should have been implemented which would have given an opportunity for joined up multi agency involvement. This did not happen and was a missed opportunity to fully understand Anne's life and the issues she was experiencing.

7.5 Domestic abuse in the relationship was highlighted to all agencies following John's assault on Anne in September 2015. This presented the second significant opportunity for partnership working when the case was referred to MARAC. Two of the three actions from the meeting were superficial and were concluded within two weeks, Anne was not engaged by any agency. The third action may have provided some protective factors by highlighting agency records to alert workers to the high risk of domestic abuse.

7.6 There were six further reports of domestic abuse to the police after the MARAC meeting until the last report in June 2016. On five of

those occasions John reported Anne as the aggressor, indeed she was arrested and briefly placed on restrictive bail conditions in an attempt to prevent further harm arising. Given the couples history and the volume of incidents a further referral to MARAC should have been considered.

## 8 Lessons to be learned

### 8.1 Narrative

Anne's illnesses brought her into contact with many services. She engaged and sometimes disengaged with them as was her right. This made it challenging for any one service to have a holistic view of the issues affecting her.

**Lesson**

People with multiple needs may find it particularly difficult to engage with services. A coordinated case management approach may help to support service users who for whatever reason engage in risky behaviours.

Note: The Vulnerable Adult Risk Management policy introduced in Barnsley from April 2017 is designed to provide a comprehensive risk assessment and multi-agency management plan for individuals who are making unwise decisions leading to self-neglect.

### 8.2 Narrative

Anne declined support in relation to domestic abuse when it was offered and did not support John's prosecution.

**Lesson**

Victims of long term domestic abuse do not find it easy to seek help for a number of reasons including lack of self-confidence, fear, intimidation, financial dependence and guilt. Some of these indicators were apparent in the relationship between Anne and John and a more assertive approach to supporting victims who do not easily engage is required. Anne had many periods of time when she was in a safe environment in hospital and opportunities did therefore exist to engage with her.

### 8.3 Narrative

Anne was a victim of domestic abuse and John was a perpetrator.

Their relationship was not easy for others to understand and at times John highlighted risks to agencies and reported domestic abuse to the police on a number of occasions.

**Lesson**

The defining line between victim and perpetrator is not always clear and straightforward. A holistic view of the risks that each party in a relationship pose to each other is required in order to form a coherent risk management plan.

## 9 Recommendations from the review

### Panel Recommendations

9.1 The Safer Barnsley Partnership should ensure that the service specification for the Independent Domestic Violence Advocate service in Barnsley contains measures to ensure that its engagement with victims of domestic abuse is robust, persistent and seeks to involve partners in assisting with engagement where progress is slow.

9.2
a) The Safer Barnsley Partnership should put in place processes by which it can gain assurance that MARAC actions are meaningful and contribute to the safety of the victim.
b) Agencies are held to account for the delivery of agreed actions.

9.3 The Safer Barnsley Partnership should review its policy in relation to referrals to MARAC. Following the first referral there were six further domestic abuse incidents between the couple. Safe Lives[7] guidance is that three domestic abuse incidents resulting in a standard risk assessment in twelve months should result in a referral to MARAC.

[7] A national charity dedicated to ending domestic abuse. www.**safelives**.org

**Single agency recommendations**

**Barnsley Hospital NHS Foundation Trust**

9.4 Strive to ensure staff understand the indicators of possible domestic abuse and how to ask about domestic abuse in a sensitive way and manage any disclosure made.

9.5 To ensure staff ask about children and other dependents when patients attend the Emergency Department

**South West Yorkshire Partnership NHS Foundation Trust**

9.6 For identified services within SWYPFT to receive Domestic Abuse training.

9.7 For appropriate staff to access the Mental Capacity Act/Deprivation of Liberty Safeguards training as per Trust Mandatory Training Policy.

B**arnsley Adult Social Care**

9.8 Adult Social Care to complete an audit on the application of Adult Safeguarding Policy and Procedures and the application of the Mental Capacity Act 2005.

9.9 Development required on the ERICA system to improve and promote effective recording of assessment/risk assessment and interventions throughout the safeguarding episode. This should clearly capture links with domestic abuse and self-neglect.

9.10 Training for all assessment and care management staff to assist them in identifying domestic abuse and the appropriate use of the DASH tool.

**Yorkshire Ambulance Service**

9.11 YAS to explore with all Fire and Rescue Services across the Yorkshire region whether patients could receive relevant information about fire prevention where risks in the home are identified.