Kirklees Partnership

Domestic Homicide Review
Overview Report

REPORT INTO THE DEATH OF ADULT A IN JUNE 2011

Report produced by Professor Pat Cantrill

Date: February 2013

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SECTION 1

1.0 INTRODUCTION AND BACKGROUND

1.1 Introduction

This Domestic Homicide Review (DHR) was commenced to examine the circumstances surrounding the sudden unexpected death of Adult A in Kirklees. West Yorkshire Police were called to a domestic incident on 9 June 2011, where Adult A was found to have been assaulted. Adult B was present at the scene and was arrested. Adult A was conveyed to hospital where she was pronounced dead as a result of multiple stab wounds.

Adult B was charged with the murder of his partner Adult A and subsequently pleaded guilty to murder at a hearing on the 3 October 2011. Adult B was sentenced to life imprisonment with a minimum 12 years on 4 October 2011.

1.2 Reasons for Conducting the Review

Domestic Homicide Reviews (DHR's) came into force on 13 April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Adults Act (2004). The act states that a DHR should be a review '*of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:*

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself, held with a view to identifying the lessons to be learned from the death'

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

- Identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

The guiding principles, which underpin this review are:

- **Urgency** – agencies should take immediate action and follow this through as quickly as possible

- **Impartiality** – those conducting the review should not have been directly involved with the victim or the family

- **Thoroughness** – all important factors should be considered

- **Openness** – there should be no suspicion of concealment

- **Confidentiality** – due regard should be paid to the balance of individual rights and the public interest

- **Co-operation** – the agreed procedure and statutory guidance contained within Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2011 should be followed

- **Resolution** – action should be taken to implement any recommendations that arise

1.3 **Process of the review**

The Kirklees Safer Stronger Communities Partnership Board convened a Domestic Homicide Review panel in June 2011 and made the decision that a single agency review was a proportionate response as there were lessons to be learned from the case in respect of Adult B's mental health history and services provided.

It was agreed that a single agency review should take place as Adult B had been discharged from South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) within the preceding 6 months of the incident dated 9 June 2011. Terms of Reference (TOR) were established and SWYPFT undertook a review and produced a report identifying the issues, lessons to be learned and recommendations.

The DHR panel was reformed in July 2012, following direction from the Home Office who advised that a full DHR should be undertaken as the case met the criteria set out in paragraph 3.8 of the guidance due to the escalation of Adult B's violence towards partners across three relationships.

A DHR was commissioned in August 2012 by Kirklees Safer Stronger Communities Partnership Board in line with expectations of Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2011. This guidance is issued as statutory guidance under section 9(3) of the Domestic Violence, Crime and Adults Act 2004.

The DHR panel met on the 21 August 2012 and set the terms of reference. These were shared with all health providers; NHS Kirklees, Calderdale and Huddersfield

NHS Foundation Trust (CHFT, Yorkshire Ambulance Service (YAS), South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) and they were also shared with West Yorkshire Police and West Yorkshire Probation Trust.

It was decided by the Kirklees Children's Safeguarding Board and the Kirklees Safeguarding Adults Board not to commission Serious Case Reviews as the criteria for these was not applicable in this case.

A Domestic Homicide Review Panel was established. Membership of the panel comprised of multi-agency senior representatives with strategic and operational responsibilities for domestic violence, adults and children's safeguarding, honour based violence, mental health, as well as alcohol and drug misuse.

The panel consisted of the following senior officers:

REPRESENTATIVE FOR:	NAME	POST
Kirklees Council	Rachel Tanner	Head of Safeguarding and Support
South West Yorkshire Partnership NHS Foundation Trust	Julie Fleetwood	Assistant Director Nursing Directorate of Nursing Clinical Governance and Safety
Calderdale and Huddersfield NHS Foundation Trust	Karen Hemsworth	Associate Director for Safeguarding Children & Adults
West Yorkshire Police	Ged McManus	Superintendent
West Yorkshire Probation Trust	Kathy Loney	Head of Kirklees and Wakefield Probation Trust
NHS Greater Huddersfield	Anne McPherson	Assistant Director of Quality Improvement Safeguarding Adults
Kirklees Council	Sarah Carlile	Safeguarding Partnership Manager
Voluntary Sector	Bridget Hughes	Lifeline Project
Housing *	Karen Oates	Kirklees Housing Commissioning Manager

*Whilst not a panel member the senior officer was consulted in relation to the housing aspects for the review purposes.

Professor Pat Cantrill was commissioned as the independent chair of the panel meetings and to be the author for the DHR.

At the meeting on 21 August 2012, the DHR Panel requested that the following agencies/bodies secured their records, identified whether they had any contact with Adult A or Adult B and commissioned an independent author of sufficient experience and seniority to undertake an Individual Management Review (IMR). This was requested from the following agencies:

- NHS Kirklees – GP's
- South West Yorkshire Partnership NHS Foundation Trust
- West Yorkshire Probation Trust
- West Yorkshire Police
- Kirklees Housing
- Calderdale and Huddersfield NHS Foundation Trust
- Yorkshire Ambulance Service NHS Trust

The agencies with no record of contact and IMR's not developed are:

- Community and Voluntary Sector organisations
- Kirklees Council- Adult and Children's services.

As stated above, expertise from each area was represented on the panel except Kirklees Housing as there was limited contact of significance in this case. However, whilst the agency was not represented on the panel a panel member was a named link and conversations were held with them. The report and the lessons learned were shared with them for consideration and comment.

Calderdale Council and Health Services were initially alerted to secure information but because consent to access records was denied by Adult B's previous partners, Adult C and Adult D, no further approach was made.

The authors of the Individual Management Reviews are independent in accordance with the guidance.

1.4 **Time Period**

The time period for the review is from the first known domestic abuse incident in January 2002 when Adult B was in a relationship with Adult C to the death of Adult A on 9 June 2011.

1.5 **Terms of Reference**

The purpose of the Domestic Homicide Review is to:

- Ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case.

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence including their dependant children.

- 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.

- Identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

- In addition the following areas will be addressed in the Individual Management Reviews and the Overview Report.

- Whether family, friends or colleagues were aware of any abusive behaviour from the alleged perpetrator to the victim, prior to the homicide.

- Whether there were any barriers experienced by Adult A or her family/ friends/colleagues in reporting any abuse in Kirklees or elsewhere, including whether she knew how to report domestic abuse should she have wanted to.

- Whether there were opportunities for professionals to 'routinely enquire' as to any domestic abuse experienced by the victim that were missed.

- Whether there were opportunities for agency intervention in relation to domestic abuse regarding Adult B, the perpetrator that was missed.

- The review should identify any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and/or services.

- The review will also give appropriate consideration to any equality and diversity issues that appear pertinent to the victim, perpetrator eg age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

The review will consider any other information that is found to be relevant.

1.6 Individual Management Review Authors

The DH Review Panel has received and considered the following Individual Management Review Reports (IMR):

Organisation	Author name	Author title
Calderdale and Huddersfield Hospitals NHS Foundation Trust	Hannah Smith	Designated Nurse - LAC
South West Yorkshire Partnership NHS Foundation Trust	Karen Batty	Practice Governance Lead Nursing, Clinical Governance & Safety
West Yorkshire Probation Trust	Caterina Fagg	Senior Probation Officer
Yorkshire Ambulance Service NHS Trust	Janine Waters	Named Professional for Safeguarding Adults
NHS Calderdale- General Practice	Gill Poyser Young	Designated Nurse
West Yorkshire Police	Joanna Burton Karen Boustead	Serious Case Review Officers Safeguarding Central Governance Unit

1.7 Development of Individual Management Reviews

The objective of the Individual Management Reviews (IMR's) which form the basis for the DHR is to give as accurate as possible an account of what originally transpired in an agency's response to Adult A and Adult B, to evaluate it fairly and, if necessary, to identify any improvements for future practice. IMR's also propose specific solutions, which are likely to provide a more effective response to a similar situation in the future. The IMR's have also assessed the changes that have taken place in service provision during the timescale of the review and considered if changes are required to better meet the needs of individuals at risk of or those experiencing, domestic abuse.

This report is based on IMR's commissioned from professionals who are independent from any involvement with the victim, her family or the perpetrator. The report author has indicated whether there is confidence in the findings of an IMR. The IMR's have been signed off by a responsible officer in each organisation. The DHR has been quality assured and signed off by Sue Richards – Assistant Director of Adult Services, on behalf of, the Kirklees Safer Stronger Communities Partnership Board.

The DHR has utilised the single agency review undertaken by South West Yorkshire Partnership Foundation NHS Trust (SWYPFT) in June 2011. SWYPFT have undertaken further work to build on the report to reflect the terms of reference of the

DHR and have produced a report identifying the issues, lessons to be learned and recommendations.

The Overview Report's conclusions represent the collective view of the DH Review Panel, which has the responsibility, through its representative agencies, for fully implementing the recommendations that arise from the review. There has been full and frank discussion of all the significant issues arising from the review.

In addition, a comprehensive integrated chronology has been compiled and analysed by the DH Review panel. This document records agency involvement and significant events from the period covered by the review.

In reporting the views of individuals who received services, the Review Panel is not endorsing those views as accurate or as a fair assessment of the services they were given.

They are the subjective views of the service user and should be considered with respect, in that they may offer lessons for the services involved.

Consent to access medical records

During the development of the DHR, a particular area of difficulty was access to the medical records of Adult B and the previous partners and child. Adult B, we were informed, is seeking legal advice. The authors continued with their IMR's in relation to Adult B in line with opinion of the General Medical Council who recently stated that:

> *We … feel that there is a strong parallel with Serious Case Reviews. Our 0-18 years guidance for doctors (paragraph 62) says that doctors "should participate fully" in Serious Case Reviews; it goes on to say "When the overall purpose of a review is to protect other children or young people from a risk of serious harm, you should share relevant information, even when a child or young person or their parents do not consent." We think it reasonable that this should be the principle that doctors should follow in cooperating with DHR's as well"* [1]

This action was further supported by recommendation in DoH document[2] '*Striking the Balance'* 2012. Adult B was informed that IMR authors would access only records that were of relevance to the review. A request for Adult B to meet with the report author was declined.

Adult B's family do not wish to be involved with the report. A letter has been sent to offer a copy of the report.

[1] Letter from GMC to Professor Pat Cantrill, Chair of Adult A DHR Sheffield, 6/10/11

[2] Striking The Balance' Practical Guidance on the application of Caldicott Guardian principles to Domestic Violence and MARACS. April 2012

Adult D was contacted in relation to participating in the review and accessing her records and Child E's, Adult D declined to participate or consent to these access requests. A legal opinion was sought, which concluded that the records of Adult D and Child E could not be accessed for these purposes without consent. Any assessment of the relationship between Adult D and Adult A has been made from Adult B's records. Adult D has been informed that the DHR will make anonymised reference to her relationship with Adult B based on his records.

Dissemination

Whilst key issues identified by the Review have been shared with organisations, the report will not be disseminated until clearance has been received from the Home Office Quality Assurance Group. The IMR's will not be published. The DHR report will be made public and the recommendations will be acted upon by all agencies, in order to ensure that the lessons of the review are learned.
The content of the Report and Executive Summary is anonymised in order to protect the identity of the victim, perpetrator, relevant family members, staff and others, and to comply with the Data Protection Act 1998. The Report will be produced in a form suitable for publication with any Home Office approved redaction before publication.

Adult A's father agrees with the content of the report and will receive a final copy after Home Office approval.

1.8 **Subjects of the review**

Deceased victim: Adult A

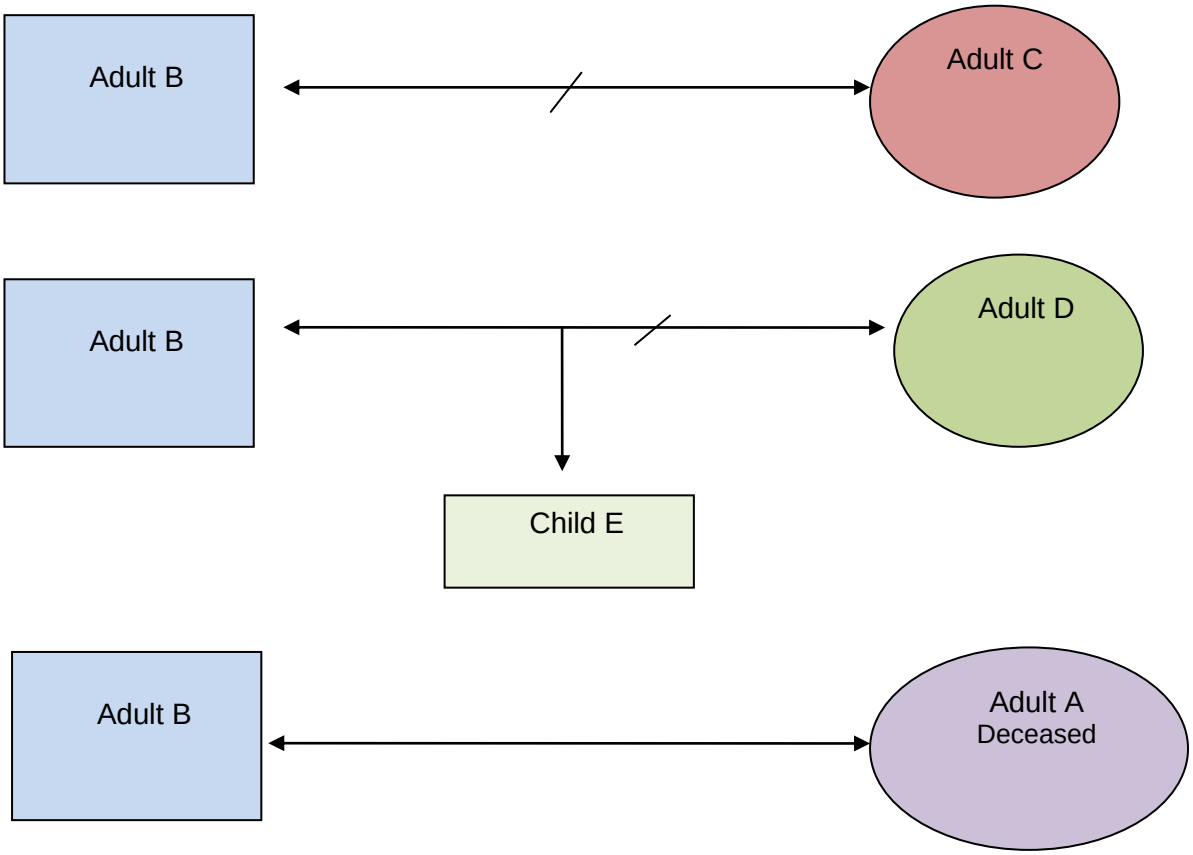
Perpetrator: Adult B

Adult B has one child by a previous partner who did not live with Adult A and Adult B and is not subject of this review.

Adult A was white British and Adult B is mixed white British and Asian ethnicity.

Adult B has two previous partners, Adult C and Adult D, who are said to have experienced domestic violence in their relationships with him.

1.9 **Family genogram**



1.10 **Involvement of the family**

In domestic violence homicides, members of informal support networks, such as friends, family members and colleagues may have detailed knowledge about the victim's experiences. The Review Panel considered carefully the potential benefits gained by including individuals from both the victim's and perpetrator's networks in the review process.

There were attempts by SWYPFT to engage with families in the original single agency review of their services and approaches were unsuccessful. Extensive efforts were made to meet with family members to ensure that the maximum learning was obtained from the case.

There is evidence that there was domestic violence in the relationship between Adult B and Adult C and between Adult B and Adult D. The delay in commissioning the DHR may have influenced the willingness of Adult C and Adult D to participate as they have moved on with their lives but these individuals also declined to contribute to Police investigations at the time of the incident and in the SWYPFT review.

SECTION 2

2.0 DOMESTIC HOMICIDE REVIEW PANEL CONCLUDING REPORT

2.1 Introduction

This DHR report is an anthology of information and facts from agencies, all of which were potential support agencies for Adult A and Adult B. This report examines agency responses to and support given to Adult A prior to the point of her death on 9 June 2011.

Essentially, seven agencies had records of contact with Adult B and Adult A prior to her death. They are:

- NHS Kirklees – General Practitioners
- Calderdale and Huddersfield Hospitals NHS Foundation Trust
- West Yorkshire Police
- Kirklees Housing
- West Yorkshire Probation
- South West Yorkshire Partnership NHS Foundation Trust
- Yorkshire Ambulance Service

As identified earlier, South West Yorkshire Partnership NHS Foundation Trust undertook an internal review during 2011 to identify the key issues and lessons to be learned from the Trust's contact with Adult B in December 2010. The findings of this review have been used to inform the IMR and the DHR.

2.1.1 Summary of the case

Adult A

Adult A worked as a care assistant. She had five siblings. The family were not told by Adult A that she was experiencing domestic abuse, although they were suspicious. There is evidence that Adult A provided care and support to Adult B during periods when he was receiving mental health services and that she attempted to get him the care he needed. Reading the individual reviews of services identifies that the support she needed was not always identified and addressed by services.

In 2008 Adult A began a relationship with Adult B. There is evidence that from the early stages of their relationship Adult A was experiencing verbal and physical abuse. In March 2008 Adult B was reported to have taken an accidental overdose of drugs and alcohol following a domestic incident with Adult A. There was no physical assault at this time but a verbal dispute. The Police responded and Adult B was arrested and Adult A was offered cocoon watch and support, which were declined.

[3] IDAP is an accredited group work programme consisting of 27 educational sessions focussing on domestic abuse and power and control issues.

On 2 March 2009, Adult B appeared before Calderdale Magistrates Court for a further offence of criminal damage. Contact was made with the Police Domestic Violence Unit and it was confirmed that the Police had been called to a dispute between Adult B and Adult A in January 2009, which was the day before Adult B committed the offence of criminal damage. In April 2009 Adult B appeared before Calderdale Magistrates Court charged with Common Assault against Adult A as a result of the offence that had occurred in January 2009. He pleaded not guilty and a trial date was set but this did not proceed. He also had a further offence of theft from a person. Adult B appeared at Bradford Crown Court in September 2009 in relation to the theft and was sentenced on the basis of an oral report provided by a WYPT court officer. Adult B was made subject to a further 12 months Community Order for the offence of the theft from person. He has been convicted at court on 4 occasions, the last being in September 2009 when he received a community penalty for theft from a person.

There is no record of Police contact with either Adult A or Adult B from March 2009 until early 2010 when a further incident of domestic violence was reported where Adult B physically assaulted Adult A by punching her in the face resulting in reddening and swelling. Adult A attended Accident and Emergency at Huddersfield Royal Infirmary, although she did not wait for treatment.

In January 2011 Adult A attended A&E with a small knife wound, that she stated was, caused by accidentally falling onto a knife in the kitchen. There was a further attendance at A&E two weeks after this with a laceration to her elbow, that she stated was, caused by slipping onto a glass whilst out, Adult A denied self-harm or assault. Two weeks after this Adult A attended A&E again reporting dizzy spells. There were no other reports from any professionals having contact with Adult A until the incident when she died.

In the early hours of Thursday 9 June 2011, Police attended an address in Huddersfield where Adult A was found to have been assaulted. Adult B was present at the scene and was arrested. Adult A arrived by ambulance at Huddersfield Royal Infirmary (HRI) Accident & Emergency (A&E). Adult A had multiple stab wounds over neck, chest and abdomen, these injuries were not compatible with life and she was pronounced dead.

Adult B was arrested at the scene. Adult B pleaded guilty to murder and is now serving a prison sentence.

Adult B

Adult B has a criminal history which commenced in 1995 with 19 arrests recorded, of which 6 related to assault. One of these assaults was against Adult A in January 2009 and one on a former partner in January 2007. Adult B had 9 domestic incidents in total recorded with the Police against three partners.

Adult B and Adult D had a relationship for approximately 5 years and had a child together. Adult B had his first psychiatric inpatient stay during this relationship, in 2002, where he was experiencing paranoia and hallucinations.

Adult B has a history of receiving three episodes of care from SWYPFT, one in 2002, one in 2007, and one in December 2010 when he received both inpatient and primary care. He disclosed that he drank alcohol and took cannabis. His admissions to hospital were associated with angry and paranoid behaviour, auditory and visual hallucinations and attempted suicide. During the admission process, Adult B disclosed that he had been sexually abused by a relative when he was 7 years old and that 'no action was taken'. Adult B stated that he had first started to feel paranoid when he was 16 years old but did not seek medical help at this time. He started to complain of depression when he was 21 years old.

Shortly after his stay in hospital in 2002, Adult B superficially cut his wrists following an argument; this was then followed by a more significant incident where Adult B self-harmed cutting both wrists and was found to be holding their baby when Police arrived. Adult B was discharged to his mother's address and he reported that he had commenced attending a self-help group for alcohol and substance misuse.

Counselling and support was offered to Adult B and the effects of domestic abuse discussed with his partner Adult D.

Domestic violence was known to feature in this relationship and episodes of domestic violence are documented in records for the period of 2002 to 2007 when the relationship between Adult B and Adult D ended. The next incident of significance occurred in early 2007 when Adult B physically assaulted Adult D and resulted in a conviction. Adult B's alcohol intake was a factor in these offences. A probation pre sentence report proposed that Adult B be made subject to a community order with requirements for supervision and to complete the Integrated Domestic Abuse Programme (IDAP)[3]. However, he did not undertake this course as the Magistrate did not make this a part of conditions of the outcome of his trial.

A second pre sentence report was prepared in January 2008. At this time Adult B was once again charged with criminal damage and had been drinking prior to the offence. On this occasion he attended the home of Adult D and damaged the front door when she refused to allow him entry. This offence placed Adult B in breach of the Conditional Discharge and Bind Over. Adult B was assessed as medium risk of harm to known adults. The report proposal was for a three months curfew and was made on the basis that there had been two convictions for criminal damage and none for direct violence.

Adult B presented with housing needs during the period following the break up of the relationship with Adult D and commencing a relationship with Adult A. During this period he was housed in Calderdale and there were concerns about him sustaining a tenancy successfully following criminal damage issues resulting in him being evicted. Adult B appears to have stayed with friends and a family member of his current partner at the time. Adult B presented as homeless in Kirklees but as he was not identified as having any specific vulnerability, this resulted in an appropriate 'no

[3] IDAP is an accredited group work programme consisting of 27 educational sessions focussing on domestic abuse and power and control issues.

priority need' being placed upon his housing status. Advice and signposting was offered.

Adult B's last episode of care with mental health services took place in December 2010 following a referral from A&E, where he presented with symptoms of anxiety, agitation, hallucinations, paranoia and thoughts of self harm.

2.1.2 **The context of service involvement**

The purpose of this section is to provide an overview of the context in which the domestic homicide of Adult A happened and identify changes that have occurred in the provision of domestic abuse services during the timescales of this domestic homicide review. It will enable assessment of the provision of services to take place with an understanding of the environment in which practitioners worked: the policy frameworks, organisational structures and professional practice from 2002 to 2011. It also addresses some of the DHR terms of reference and an analysis of the performance of Kirklees domestic abuse services is made and action taken considered.

2.1.3 **Domestic abuse and domestic abuse services in Kirklees**

Kirklees has three distinct areas:

- North Kirklees, which includes the urban centres of Mirfield, Dewsbury, Batley and Cleckheaton along with the more rural Spen Valley.

- Huddersfield; the largest town in Kirklees with about 130,000 residents.

- The rural and semi-rural area south and west of Huddersfield, including small towns such as Holmfirth, Slaithwaite and Denby Dale.

According to the 2010 Index of Deprivation, Kirklees is the 67th most deprived district of 354 in England. The poorest areas are concentrated in inner urban Wards in Huddersfield, Dewsbury and Batley and on edge of town estates**.** Kirklees minority ethnic communities make up 16% of its resident population with the majority living in the District's urban centres. Kirklees Muslim population of 39,300 is one of the highest in the country.

Kirklees Safer Stronger Communities Partnership Board was established to reduce crime and disorder in Kirklees communities. The Partnership involves members of the Police, Council, NHS and a range of other public sector and voluntary agencies. Kirklees Safer Stronger Communities Partnership Board has identified domestic and sexual abuse as one of its key priorities.

The Kirklees Domestic Abuse Commissioning Strategy (2012-15) is based on national prevalence rates from the British Crime Survey (2010/11) applied to Kirklees population which estimates the following prevalence of domestic abuse in the district:

- Over 22,000 (17%) men and 37,000 (29.9%) women between the age of 16 and 59 years will have experienced one or more episodes of domestic abuse since the age of 16.

- Over 3,000 (2.5%) men and over 23,000 (18.6%) women between the age of 16 and 59 years will have experienced one or more episodes of sexual assault (including attempts) since the age of 16.

- In 2011/12, there were over 6,000 incidences of domestic abuse reported to the Police in Kirklees. This involved over 4,000 individual victims. Overall rates of Police reporting in the last 5 years remain constant with little variation.

Analysis of the 6,036 incidents of domestic abuse reported to West Yorkshire in 2011/12 for the region, it is possible to establish the main categories recorded were "verbal dispute" (50%), "crime" (30%) and "breach of the peace" (10%). Recorded incidents peaked between 9pm and midnight although there was a noticeable but smaller peak around 3pm. Incidents were more prevalent at the weekend with 50% occurring between 6pm on Friday and 5am Monday. Victims were on the whole (but not exclusively) women and the age profile of victims peaked in the early 20's, drops off in the mid 30's before increasing slightly in the early 40's and then tailing off with age.

Domestic abuse as in many other areas is a significant issue in Kirklees. It makes up 28% of total recorded violent crime in Kirklees, (4707 incidents of violent crime) with West Yorkshire Police recording 1317 incidents of domestic abuse in the year April 2011 to March 2012. Nationally, 44% of adult victims of domestic violence are involved in more than one incident whilst in Kirklees it is presently 32%.

Review of offenders identifies that they come from every group of society but women are a particularly vulnerable group. Women offenders make up approximately 1 in 10 of the statutory caseload in Kirklees and their offence related needs are often very different to mens[4]. Of the female prison population, over half said they have suffered domestic violence and one third said they have experienced sexual abuse. Women Centre Kirklees works with some of the most vulnerable female offenders. Of these[5]: 2 in 3 (68%) had experienced, or were experiencing, domestic violence.

Adult B, during the period of the review, had difficulties with excessive use of alcohol which frequently resulted in violent incidents. The Kirklees Alcohol Strategy has been recognised by the Department of Health as an effective local response to alcohol related issues. Alcohol interventions in Kirklees, both specialist, acute and in primary care, have expanded in scope and effectiveness since 2008 with 1,100 people in structured care in 2011/12 and 75% of treatment episodes successful. Locally Enhanced Services cover 75% of GP practices with 919 health and social care staff trained in 2011/12.

[4] West Yorkshire Probation Trust. *Kirklees OASys data, July-September 2012.*

[5] Women's Centre Kirklees (2009) Service user data

Alcohol related crime has changed in Kirklees from the worst to the second best Local Authority quartile. However, male drinking levels, liver disease and months of life lost are still considerably higher than regional and national averages, with female levels lower.

Concerted efforts to tackle violent crimes, particularly related to alcohol, has seen the number of offences fall by 44% from the peak in 2005/06. This has resulted in Kirklees' performance being significantly better than other comparable areas although decreases need to continue if this position is to be maintained. There needs to be a continued focus on alcohol related violent crime associated with the night time economy in particular the impact domestic violence during weekends and after 6pm. This focus needs to incorporate domestic abuse in its widest sense and the impact that this has on individuals, families and society more generally.[6]

Review of provision and development of a strategy to tackle domestic and sexual abuse in Kirklees

Kirklees Safer Stronger Communities Partnership has in place a clear structure of accountability and governance. It reports to Kirklees Safer and Stronger Communities Partnership Executive Board, Cabinet Members and the Assistant Director for Children's and Adult Services. It is also supported by a Strategic Delivery Board.

Kirklees Council Domestic Abuse Service is going through significant change, as a result of an internal assessment. There was recognition that the service needed to be improved. The aim is to build on those areas of the service that work well by addressing those that require further development over the next three years. Kirklees Safer Stronger Communities Partnership Board are utilising examples of best practice across the country to make the required changes.

The newly developed Kirklees Domestic Abuse Strategy recommends an integrated Domestic Abuse service that provides clear pathways into and out of appropriate support. The significant difference is that the new specification will drive the core ingredients of an integrated service that will work to address key outcomes. This specification sets out a service that will support the victims and survivors of domestic abuse. It includes the establishment of key outcome and performance management measures.

The primary aim of the changes are to address early intervention and to support the victims and survivors of domestic abuse to develop and use self-management skills so that people can live their lives to the full.

There are a range of voluntary and self help services in Kirklees who also come together through the Domestic Abuse forum that meets throughout the year. It is envisaged that the forum will play a key part in supporting the implementation of the vision and strategy and its further development going forward in 2013.

[6] Partnership Strategic Intelligence Assessment-Informing the Partnership Plan 2012 - 2015. Kirklees Partnership. October 2012.

Performance of Kirklees Domestic Abuse Partnership

Multi Agency Risk Assessment Conference (MARAC)

All domestic abuse incidents are risk assessed and high risk cases are referred to MARAC and IDVA service. All high risk victims receive a visit from a DV Officer. All medium risk victims are contacted by telephone and may be visited. After this contact, the case may be raised to high risk level. This provides a second opportunity to assess circumstances and, if necessary, to re-assess the risk level.

MARAC data identifies that the number of high risk cases heard has increased, however, still remains low. Referrals to the IDVA service have also increased mainly due to an increase from Police referrals. The chairing of the MARAC is the responsibility of West Yorkshire Police and the administration is supported by Kirklees Council, it operates to the agreed MARAC Operating Protocol and to CAADA guidance**.** The MARAC is generally well attended by a range of statutory and voluntary agencies. Referrals to MARAC are overwhelmingly from the Police. However, this reflects the higher level of reporting to the Police, as agencies often find that cases they are considering referring have already been reported to the Police and referred.

A recent review in 2011-12 of the MARAC undertaken by Co-ordinated Action Against Domestic Abuse **(**CAADA**)** [7] based on the 10 principles of an effective MARAC identified areas of good performance by Kirklees Safer Community Partnership and areas were performance should be improved. The CAADA report indicates that the Kirklees MARAC is operating in line with many of aspects but further work is required to address issues associated with the lower than anticipated volume of cases and repeat referrals, risk assessment and required action and the attendance by some agencies. The changes being made to the service should address many of these issues.

Supporting Victims in Kirklees

The next group of services are provided for victims. They provide both immediate and short term protection and longer term emotional support to enable the victim to recover from the effects of domestic abuse.

The estimated average number of referrals to a full time equivalent (FTE) IDVA is approximately 100 cases per annum. This is likely to translate into a caseload of 60-70 cases a year per FTE IDVA. The Independent Domestic Violence Advocacy and Independent Sexual Violence Advocacy IDVA and ISVA of 1 FTE is commissioned by Kirklees Safer Stronger Communities Partnership Board from Connect Housing. The CAADA review identifies that there needs to be an increased resource to meet present and increased activity. Kirklees Safer Stronger Communities Partnership Board is in the process of recruiting more IDVA's who will be based in the integrated hub.

[7] CAADA's MARAC Quality Assurance Programme -Kirklees MARAC

The CAADA review identified that there needed to be the development of a policy that indicates how the IDVA or the Domestic Violence (DV) team receives referrals, as the present MARAC Operating Protocol (MOP) does not reflect current practice and this is being addressed by Kirklees Safer Stronger Communities Partnership Board.

Education and Training

Kirklees Safer Stronger Communities Partnership Board has a number of task and finish groups advancing and leading strategic planning and they are developing a training plan for Domestic & Sexual Abuse for the period 2013–2015. During the period 2011 to 2012 a formal multi-agency training plan was not in place. However, domestic abuse training was captured through the children and adults multi-agency training strategies.

This Training Plan, in development, will provide guidance for employers and staff in Kirklees in planning and accessing domestic abuse related training and recognises that all people who work with adults, children and young people need to be trained in domestic and sexual abuse, in parallel with their responsibilities in relation to safeguarding children and vulnerable adults. Managers and supervisors will have the responsibility to discuss with individual staff members their training needs. This will be supported by additional agency guidance and consists of single and multi agency training.

It identifies the groups as:

- those who have occasional contact with adults and/or children and young people, who may identify concerns;

- those who work directly with adults and/or children and young people, who can contribute to assessing risk, intervening, and engaging people in safety planning, where there are concerns about domestic and sexual abuse;

- those who have specialist roles to work with children and young people;

- those with specialist roles as domestic abuse champions and MARAC representatives, and those who manage services and undertake Section 47 child protection or adult safeguarding enquiries, and/or Domestic Homicide Reviews.

Kirklees Safer Stronger Communities Partnership Board has overall responsibility for ensuring that single and multi-agency training is available to meet identified needs. The employer is responsible for the organisation and delivery of induction and basic in-house training and refresher training. Employers are responsible for releasing staff to attend the appropriate external training appropriate for different staff groups.

2.1.4 **National Health Service Context**

Organisational changes

Like many other public services the NHS has been through a considerable amount of change with Government initiatives influencing legislation, policy and structural changes. A major issue for partnership development and interagency planning, working and service delivery is the frequent reorganisation and mergers of organisations and in some instances resultant changes in functions and responsibilities and key personnel. The present Government is reorganising the NHS. The result of this, in Kirklees, has been a growth in the number of agencies across boundaries that form the Partnership that have to be worked with.

General Practitioner Services

General Practitioners are not directly employed by the NHS, they usually work in practices as part of a team where they are self-employed, but they have contractual arrangements with the NHS to provide services to their registered patients. General practitioners employ their own staff eg practice nurses, receptionists, practice managers.

As a result, Primary Care Trusts and their predecessor organisations have limited powers in relation to the management of performance of GP's and their practice staff as they are independent providers of services and not employees of the PCT. Involvement in safeguarding and domestic violence protection does not form part of the contract with GP's and, therefore, does not attract the same incentives as the provision of other areas of care.

Since April 2004, Primary Care Trusts have had a statutory duty to work with other local agencies to reduce crime (in Crime and Disorder Reduction Partnerships under the Crime and Disorder Act 1998). They are the organisation that has responsibility to assess compliance of GP's but this will change with the implementation of Clinical Commissioning Groups and the responsibilities of Care Quality Commission. By April 2013 GP's have a legal requirement to register with the Care Quality Commission and comply with the essential standards, which cover quality and safety. They will be expected to self assess their performance against key standards including safeguarding children and adults.

2.3 **Analyses of Individual Management Reviews**

The focus for this section of the report will be an analysis of the response of services involved with Adult A and Adult B, why decisions were made and actions taken or not taken. Any issues or concerns identified are a reflection of the evidence made available with the benefit of hindsight and the application of foresight.

First and importantly this DHR was commissioned as a result of the death of Adult A who was stabbed and killed by her partner Adult B.

It is important that the findings of the review are set in the context of the internal and external factors that were impacting on delivery of services and professional practice during the period January 2002 to the death of Adult A on 9 June 2011.

The IMR authors and the domestic homicide review (DHR) author have attempted to provide a valid analysis and to cross reference information to complete gaps. Where possible, triangulation of sources of evidence has been used to increase confidence in the findings. All of the agencies involved in this review have provided frank accounts of their involvement in order to learn lessons.

In order to manage an account of agencies' involvement the DHR author has described separate involvement of each agency. The accounts of involvement of services with Adult A and Adult B cover different periods of time prior to her death. Some of the accounts have more significance than others. All seven agencies responding with information indicating some level of involvement with them but most had limited knowledge of Adult A and of her relationship with Adult B.

As stated earlier, there has been difficulty gaining access to some information, which would have informed the review, significant information regarding Adult B's earlier relationship with Adult D and their child has not been able to be accessed as permission was not given by Adult D. The report has used material in Adult B's records to provide information regarding their relationship but the response of services from Adult D's and Child E's perspective has not been able to be fully reviewed.

The majority of the contact of services by Adult B was with Mental Health, Police and Probation services with limited contact with universal services. As identified earlier, appropriate information provided by Adult A's family has been incorporated into the DHR.

2.3.1 **Health Services**

Universal services have an important role to play in the prevention and early recognition of domestic abuse. All health professionals need to be aware of domestic abuse, the signs and symptoms, the co-occurrence of child protection issues, and how to identify and raise the subject with patients. Appropriate referral routes and pathways need to be clear. The need for improved multi-agency links with health agencies is supported by a recent report commissioned by the Department of Health (DoH) and the Department for Children Schools and Families (DCSF) entitled "Responding to Violence Against Women and Children" (Alberti 2010); as well as the Coordinated Action Against Domestic Abuse (CAADA)'s own analysis which indicates that hospitals are the most effective locations to place Independent Domestic Violence Advocates to identify high risk victims of domestic abuse who may not be visible via the criminal justice system.

The Royal College of General Practitioners (RCGP) has produced guidance for GPs: 'Domestic Violence: The Role of the GP' which recognises that in many cases general practice is the first formal agency to which victims of abuse present for help.

2.3.2 **NHS Kirklees – General Practice**

The General Practitioner service is a universal service that provides primary medical care to families twenty-four hours a day both at the local practice where a family is registered and through the Out of Hours service. It provides holistic medical care (to include physical and psychological health care) for families from birth to death. GP's are the most common contact point for victims of domestic abuse [8].

Summary of Involvement of General Practice from 2002 to 2011

The first and most important point is that Adult A and Adult B had different GP's, which meant that there would not have been the ability for a GP to cross reference A&E, Police incidents and GP visits for the two of them.

Review of Adult A and Adult B's records has identified the following contact:

ADULT A

In September 2009: registered with her GP practice. The majority of the contact she had with the practice was associated with routine minor illness contact which is not significant in nature or prevalence for the DHR.

- In the December of 2009 the GP received a letter stating that Adult A had attended the A&E department of the local hospital with a sprained ankle.

- There are no further entries until a missed appointment in the July of 2010. The records do not state what this appointment was scheduled for or if any contact was made with Adult A to check why the appointment was missed.

- The next recorded entry in the records was when Adult A attended the GP in December 2010 requesting a sick note to enable her to stay at home to look after her partner Adult B who was being discharged from mental health in-patient care. The entry states that he had been detained under the mental health act and was now under the care of the crisis team. The GP provided Adult A with a letter for work in relation to her caring role but the entry does not go into detail of the support that would be required or if Adult A felt able to be her partner's carer.

- There are only three further entries in respect of Adult A within the GP records. One in February 2011 following an alleged fall onto a broken beer glass where she sustained a cut to the inner right elbow. Adult A had been seen in A&E where an X-ray was undertaken and 2 sutures applied to the wound. Adult A attended the GP surgery where the wound was noted to have healed well and the sutures removed. The second entry was two days later when she failed to attend a follow up appointment. There was nothing recorded to demonstrate that any contact was made to enquire why she had

[8] The report of the Taskforce on the Health Aspects of Violence Against Women and Children G Alberti 2010 DoH.

failed to attend. The final entry was to inform the practice of the death of Adult A.

ADULT B

There are a number of entries on the GP records of Adult B attending the GP surgery as a result of routine health issues or health issues related to alcohol consumption. Case relevant contacts include:

- Adult B consulted with the GP regarding alcohol and cannabis usage throughout 2002.

- There is nothing within the entry to show whether the GP had been consulted regarding Adult B and his capacity to parent Child E in light of his alcohol and substance misuse. The entry does state that Adult B was now attending substance misuse services.

- Adult B had many attendances at A&E departments throughout the review period following injuries sustained and the GP being informed by letter of the treatment provided.

- The records also demonstrate that the GP was fully informed of the convictions and prison terms served by Adult B.

- The GP records also have multiple entries in respect of his mental health issues with the GP providing care and also being notified of all admissions and contact with mental health services. Adult B had no contact with GP or other professionals following his discharge from hospital in December 2010 until the death of Adult A other than notification of attendance at A&E in March 2011 relating to Adult B being hit over the head with a pint glass and having sutures removed.

- The GP was aware of the investigation regarding child protection concerns. The GP was fully aware of the history of Adult B and mental health issues along with the incidents of domestic violence that had Police involvement.

Analysis of Service Involvement

There is no evidence in any of the GP records reviewed that either Adult A or Adult B indicated or disclosed domestic abuse to any of the practitioners involved in their care. However there is evidence to suggest that there were missed opportunities following Adult A and Adult B's A&E attendances that could have been explored further by the GP. The incidents were over a two year period 2009 – 2011.

Both Adult B and Adult A presented separately and together at the A&E department between 2009 and 2011 with a variety of injuries and a mental health episode.

However, domestic violence was not apparent as the reason for injuries sustained and were not recognised as such by CHFT and, consequently, not identified in GP correspondence. Therefore, there were no information sharing opportunities. There

is, within West Yorkshire, an information sharing protocol between all health agencies. As there was no evidence that any disclosures in respect of domestic violence or difficulties within the relationship between Adult A and Adult B took place, this issue did not arise.

The Royal College of General Practitioners (RCGP) has produced guidance for GP's: 'Domestic Violence: The Role of the GP'. This report aimed to raise awareness of this issue amongst GP's and encourages GP's to be proactive in raising the issue in certain situations. It recognises that in many cases of domestic violence, general practice is the first formal agency to which women present for help and that whilst they are unlikely to raise it directly, the contact with the GP can be '*used as a 'calling card': an apparently unimportant physical symptom to seek help indirectly*[9].

As the GP's for Adult A had not been notified of any incidents of domestic violence, it is difficult to ascertain if appropriate discussions or referrals would have been made. There is no evidence within the GP records available for Adult A that assessment of her included any relationship issues. The GP was aware that Adult A had a partner who suffered mental health issues and had been an in-patient following one acute incident but the records related only to a request for a sick note to be able to remain at home to care for him. The discussion did not identify how Adult A felt about this acute episode or the subsequent care he would require and any risks that it presented for her.

The DoH announced the introduction of routine enquiry regarding domestic violence in all health settings within an agreed framework in 2005 (DoH), suggesting all services should now be working towards this goal. Many professional and governmental bodies recommend 'routine enquiry' about domestic violence for all women; for example, the British Medical Association, the Royal College of Midwives, the Royal College of Obstetricians and Gynaecologists, and the Royal College of Psychiatrists (National Collaborating Centre for Women's and Children's Health, 2008). Screening would therefore be likely to increase the number of women identified as experiencing domestic violence and appropriate support and advice provided or signposted.

Current Department of Health guidelines state that the successful implementation of policy and guidelines for domestic abuse relies on a comprehensive education and training programme. All staff who have contact with patients should be trained in domestic abuse issues, this includes administrative and reception staff (DoH, 2005) [10].

The Home Office, in its guidance for health professionals, suggests that given the importance of domestic violence as a factor impacting on health, training about enquiry should be part of pre-registration curricula and post registration on-the-job training for all health professionals (Taket, 2004) [11].

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[9] Heath, Iona RCGP Policy: Royal College of General Practitioners - Domestic Violence-The GPs role

[10] Responding to domestic abuse: a handbook for health professionals. Department of Health. December 2005

[11] Should Health Professionals Screen All Women for Domestic Violence? Ann Taket, C. Nadine Wathen, Harriet MacMillan 2004

The RCGP curriculum[12] includes a statement on domestic violence which states that a GP should, at exit from GP specialty training, be able to:

'Recognise the prevalence of domestic violence and question sensitively where this may be an issue.'

This curriculum has been in use since 2007. Prior to 2007 a curriculum covering every area in depth did not exist, so GP's trained prior to this may not have covered the topic in training. The RCGP has recently appointed two Clinical Champions to increase awareness of the GP's role in identifying women who are experiencing domestic abuse and signposting them where appropriate to local services. To aid this, an online learning module for GP's has been produced[13]. This describes the HARKS screening questions which are suitable for use by staff in primary care.

In May 2012 CAADA produced guidance[14] for general practices to assist them to respond effectively to patients that are experiencing abuse. The guidance supports the:

- Identification of a designated person.
- Finding out what existing domestic violence services are available.
- Engaging with local domestic abuse services and the Domestic Violence Coordinator, to develop an effective working partnership.
- Commissioning training for the practice team.
- Establishing a simple care pathway for patients disclosing domestic abuse.
- Ensuring that the practice's response to disclosure always adheres to its information sharing protocols.

The IMR author has analysed the records of Adult A to establish if there were any indications that could have signalled underlying distress as described in the RCGP guidance. The GP records available demonstrate that the GP had not been notified of the incident in January 2011 where Adult A had attended A&E following a laceration to her chest but had this information been available when Adult A had attended the surgery for dressing following an alleged slip on broken glass in February 2011 this would have been an appropriate time to discuss if any domestic violence was being suffered by Adult A.

Adult A and Adult B were not subject to MARAC consideration. The GP records did not indicate whether there had been Police involvement with the couple. In a relationship where children are part of the family make-up health visitors receive notification of incidents of domestic violence and following this discussions are held between the health visitor and the GP to share this knowledge.

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[12] RCGP Curriculum 2011: http://www.rcgp-curriculum.org.uk/PDF/curr_10_1_Womens_Health.pdf
[13] Violence Against Women and Children, RCGP 2011 http://elearning.rcgp.org.uk/course/category.php?id=8

[14] Responding to domestic abuse: Guidance for general practices © 2012 CAADA and IRIS.

In this case there were no children within the relationship so if the Police had been involved it would not automatically follow that the GP would have been in receipt of this knowledge unless a disclosure had been made by either party.

The close link between domestic violence and abuse, mental and physical ill health and children's safety and wellbeing, plus the positive results of working in partnership, make it even more important that the NHS recognises and acts upon its responsibilities in this area. General practice, as part of the wider NHS, has a duty to respond to women and child survivors of domestic violence and abuse and to safeguard vulnerable adults and their children. This response can improve public health, improve health outcomes and support a patient-centred service and addresses not only the contemporary health burden but also that of future generations. GPs' response to women and children, who can be isolated and fearful as a result of their experiences, is critical to their patients' future emotional and physical health. The initial reaction of the person they tell and the follow-up within and beyond the NHS can have a profound effect on their ability to re-establish their life, health and wellbeing. The prevalence of domestic violence and abuse is substantially higher in a general practice population than that found in the wider population.

Eighty percent of women in a violent relationship seek help from health services, usually general practice, at least once, and this may be their first or only contact with professionals. There is extensive contact between women and primary care clinicians with 90% of all female patients consulting their GP over a five year period. This contrasts starkly with its virtual invisibility within general practice, where in fact the majority of women experiencing domestic violence and abuse and its associated effects are not identified.

General Practice is the main point of contact for all primary healthcare services. It can be expected that General Practitioners will have a holistic overview of their patients and their needs. The recognition of factors which, particularly in combination, may indicate that someone is experiencing or could potentially be harmed as a result of domestic violence is very important. As the contact time that GP's have with patients is limited it is important that they have a trigger list of indicators in the same way that they have for assessment of illness. These factors would include clinical matters eg disability, chronic health problems, mental health problems, stress, threatened suicide; and social issues eg recurrent non-attendance for appointments, not engaging with education services, recurrent injuries, frequent changes of address and/or GP.

It is recommended that NHS Kirklees and Clinical Commissioning Groups through their contractual arrangements with GP's recognise the important role of GP's in relation to victims of domestic abuse and their families and that appropriate training, guidance and support and care pathways are provided by commissioners and professional bodies, to include identifying the risk indicators associated with perpetrator behaviour. General Practitioners need to become more aware of the power of their role, and to use it to safeguard children and to support parents experiencing domestic violence.

It is vital that GP's undertake a complete assessment including asking questions about relationships and the home environment. Health professionals are well placed to refer perpetrators to appropriate services. The receipt of domestic violence notifications from the Police to health visitors and schools nurses in Kirklees has had a substantial impact on the identification and referral of domestic abuse victims in health settings, resulting in improved close partnership working between health and domestic abuse services.

However, the concern is that whilst this process is delivered in isolation to those victims who have children within the household, the impact on the wider victims of domestic violence will be limited. There needs to be acknowledgement of this as general practitioners remain unaware of victims within their caseloads unless self-disclosure is made.

The IMR author's view is that there is still a lack of knowledge of services and confidence in referring patients because of:

- a lack of knowledge and confidence in handling patients who disclose that they are experiencing or recognising the indicators of domestic violence. In line with many other parts of the country the issue of female abuse against male abuse would not be so readily considered. There should be a raising of awareness of guidance on Domestic Abuse and Services available for practice staff

- a lack of knowledge about MARAC referral process

- GP's are uncertain about what services were available if a patient disclosed domestic violence

- Significant Event Analysis in practices not identifying domestic violence as an area for training or to discus significant cases

- GP's not aware of RCGP advice to ask the question and the RCGP guidance on Domestic Abuse

- a reluctance regarding referral to MARAC without the patient's consent in known cases of domestic abuse, as it is felt this may lead to a deterioration in the Dr-patient relationship

The Department of Health have recently published a guide for health practitioners [15]which clarifies the application of Caldicott Guardian principles to Domestic Violence and MARACS.

By 2013 all GP's and other primary medical services have a legal requirement to register with Care Quality Commission and comply with the essential standards, which cover quality and safety. The standards include safeguarding children and

[15] Striking The Balance' Practical Guidance on the application of Caldicott Guardian principles to Domestic Violence and MARACS. April 2012

adults. This provides an opportunity for CCG's and NHS Kirklees to monitor and influence practice performance.

Conclusions

Women and men come into contact with the health system throughout their lives. This makes the health care setting an important place where individuals experiencing abuse can be identified, provided with support and referred if necessary to specialised services. Existing interventions in health care settings focus on training health care providers to identify and respond to abuse victims and drawing up guidelines for the proper management of abuse. On average, victims of partner violence experience more operative surgeries, visits to doctors and hospital stays throughout their lives than those without a history of abuse.[16]

2.3.3 South West Yorkshire Partnership NHS Foundation Trust (SWYPFT)

South West Yorkshire NHS Foundation Trust provides community mental health and learning disability services for over 1 million people of Barnsley, Calderdale, Kirklees and Wakefield. The Trust also provides some medium secure (forensic) services to the whole of Yorkshire and the Humber. The Trust, which was first established in 2002, now employs more than 4700 staff, in both clinical and non-clinical support services The Trust is represented on the Kirklees Domestic Abuse Strategy group and at the Multi Agency Risk Assessment Conferences (MARAC). The Trust Board is provided with assurance with respect to Domestic Abuse policies and procedures via the annual safeguarding adults and safeguarding children and young people reports.

Service provision and involvement of Mental Health services between January 2002 to the death of Adult A on 9 June 2011.

As outlined earlier in the report at 1.2, a single agency review was commissioned by Kirklees Safer Stronger Communities Partnership Board in June 2011 as Adult B had been discharged from South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) within the preceding 6 months of the death of Adult A. Terms of Reference (TOR) were established and SWYPFT undertook an extensive review and produced a report identifying the issues, lessons to be learned and recommendations. The IMR author has used the Single Agency Review Report to formulate the IMR but has revisited the findings and has cross referenced issues and lessons to be learned with the results of other IMR's.

There are only records of Adult B being a patient during the period of the DHR Review January 2002 to the death of Adult A on 9 June 2011.

The involvement of SWYPFT in the provision of services for Adult B outlined below provides a summary of the first two episodes of care which occurred prior to Adult B's relationship with Adult A and a more detailed assessment of episode three in December 2010.

[16] Intimate Partner Violence WHO 2002

Adult B received three episodes of care from SWYPFT in 2002, 2007, and in December 2010:

- In August 2002 Adult B was an inpatient for 8 days and was discharged back to the care of his GP in line with practice guidance having attended only 1 of 3 outpatient appointments. Adult B was admitted informally following him presenting at A&E in Huddersfield feeling angry, suicidal, paranoid, and experiencing auditory and visual hallucinations (hearing voices and seeing things that are not present). Adult B disclosed that in the previous few days he had attempted suicide. He also claimed to 'have been wrecking the house'. Adult B disclosed that he had been abusing alcohol and cannabis for the previous few months. His GP had commenced him on anti-depressants the previous month. Adult B stated that he had first started to feel paranoid when he was 16 years old but did not seek medical help at this time. He started to complain of depression when he was 21 years of age. In September 2002 he was discharged to his then girlfriend's mother's home. On the day of discharge he was offered an assessment by the drug and alcohol team, however, he declined. He was given the teams contact details and advised to reconsider contacting them. An outpatient appointment was given for two weeks, which he attended. He said he continued to binge drink at weekends and smoke cannabis several times a week. Contact details were given again for drug and alcohol services and Adult B was urged to attend. He was given a further two appointments which he did not keep. In line with practice guidance the GP was informed in writing and advised that no further appointments would be sent unless the GP requested one. A review of the documentation led the investigators to believe the care and treatment that Adult B received during this brief admission was of a good standard.

- In September 2007 Adult B was assessed by a Consultant Psychiatrist at the request of his GP and referred back to GP for primary care counselling. Adult B was referred to the Consultant Psychiatrist by his GP with a 7 month history of low mood, crying, anxiety, sleeplessness and feelings of paranoia. He was initially commenced on anti-depressants by his GP in February 2007 but refused a referral to psychiatry services at that time. In October 2007 Adult B was seen by Dr.4, Consultant Psychiatrist who felt that Adult B was depressed, but not psychotic and had good insight. Dr.4 advised the GP to refer Adult B for primary care counselling and did not arrange to see him again. This intervention was appropriate to Adult B's assessed needs and was in line with expected practice and Trust policy.

- In December 2010 Adult B was a hospital inpatient for 3 days. On discharge he was referred to the Crisis Resolution and Home Treatment Team but the team were unable to make contact with him. He was, therefore, discharged in line with practice guidance and his GP was informed. The IMR author has undertaken an extensive investigation in relation to this episode of care because it is the most relevant to the DHR as Adult B was now in a relationship with Adult A. Adult B's contact with services was very brief, just 4 days, 6 months before the death of Adult A. The investigation had to rely mainly on what was documented in the written records. If something was not recorded it had to be assumed by the IMR author that it was not done. So, for

example, Adult B should have been provided with information about drugs and alcohol services. There is no written record of this being done. Staff said it would usually have happened and would have been recorded, so it has to be assumed that in this case the required referral was not made.

Analysis of Service Involvement

Adult B presented at A&E accompanied by Adult A in December 2010 with symptoms of anxiety, agitation, hallucinations, paranoia and thoughts of self harm. He was seen and assessed in a timely way by CPN2 from the Crisis Resolution and Home Treatment Team (CRHTT). At interview CPN2 said, that A&E staff had not provided her with any information about Adult B or Adult A and she had not sought any information. CPN2 indicated that the CRHTT do not routinely ask for this information from A&E staff when assessing referrals. In this case this meant that a very important part of Adult B's past history, the A&E attending pattern, was in fact missed. It is not considered that this impacted on the outcome in this case, as CPN2 did admit Adult B to inpatient care. However, in another case it may have an impact, as this was an important opportunity to obtain information from a partner service. CPN2 stated that if Adult B had been returning home to the community, with input from CRHTT, more in depth assessment questions to inform care planning and to determine Adult B's level of risk in a community environment, including any risk to CRHTT would have been made.

The investigation team were informed that as part of history taking both CRHTT and ward staff would routinely ask service users if they are involved with other services. Initially, the information gained is largely determined by what the service users wish to share. On-going assessment would be utilised to clarify this information. In this case a full mental health assessment was undertaken at A&E on initial referral, and Adult B was asked about his involvement with other services. He did not give a full answer, so staff did not have a full picture. The ward admission was very short and it is unclear if Adult B was asked about this information again during his inpatient stay.

Following the face to face assessment the required documents, ie Comprehensive Health and Social Care Assessment and Sainsbury's Risk Assessment (Level 1) and the Mental Health Clustering Tool were completed, again, in a timely manner by CPN2. The Sainsbury Risk Assessment and MHCT were fully completed, whilst the Comprehensive Health and Social Care Assessment was partially completed. CPN2 had completed sections on Adult B's history of the presenting condition, past psychiatric history, mental state examination, current treatment and treatment plan. In the section "Forensic History" the comment "did not disclose" was recorded.

On the basis of her assessment CPN2 took the decision that Adult B required admission, which Adult B agreed to. CPN2 suspected that the cause of his symptoms was due to his amphetamine use but otherwise restricted her assessment to the point of the decision to admit. Her view was that, although further information gathering was required, his mental state was too disturbed to undertake further assessment at this point, and since he was being admitted, the assessment and information gathering process which she had begun would be more usefully continued and completed by ward staff.

CPN2 undertook her assessment of Adult B in the presence of his girlfriend (Adult A). CPN2 described Adult A as being somewhat chaotic during the assessment. For example when it was suggested that Adult B would be admitted to hospital Adult A said she would have to leave her job to look after him. Although CPN2 advised that this was not necessary and if she required time off work she may be better visiting her GP to obtain a sick note she left the room to call work and returned saying she had left her job. CPN2 described Adult A as a concerned partner, who did not appear anxious or afraid but also felt that her reaction to Adult B's admission was disproportionate. CPN2 did not feel that there was a need to make enquiries with regards to domestic abuse. She stated that if she had had concerns then she would have asked appropriate questions and would have interviewed Adult A separately. She explained it was something she is always aware of, but did not have any concerns in this case.

As part of the required assessment documentation, CPN2 completed the Mental Health Clustering Tool and placed Adult B in Cluster 3, non-psychotic (moderate severity), with an associated low risk to self. CPN2 clarified at interview that this was a mistake, and that she had intended to place Adult B in Cluster 14, 'psychotic crisis'. The investigation team are of the view that placement in care cluster 3 was not detrimental to Adult B's care and didn't result in any negative consequences in this case, as there is no evidence to suggest that this information was referred to by the inpatient MDT. However, in another case this could be significant and it is important that the systems in place are not vulnerable to individual error in this way.

When CPN2 had completed her assessment and taken a decision to admit Adult B to hospital, she communicated her intention to her colleague at CRHTT who was responsible for identifying a hospital bed. CPN2 was informed that there was no bed available in the local 'home ward' area. CPN2 undertook a mental risk assessment to assess if Adult B would be safe remaining in A&E and made a decision that it was appropriate to leave Adult B at A&E with his girlfriend. CPN2 communicated her intention to the person in charge of A&E and gave advice on what to do should Adult B leave the A&E before CPN2 returning to base to complete the assessment documentation in preparation for the ward admission. The investigation team were informed that CPN2 did have access to a computer with Trust electronic records in A&E. CPN2 informed the investigation team that if she had determined Adult B to be 'at risk' she would have remained in the A&E department with him until he was transferred to a ward.

Adult B did leave the A&E department, the person in charge followed CPN2's advice. Adult B returned to the department with his girlfriend, he had been home to collect belongings that he needed for his stay in hospital. A bed was identified for Adult B. CPN2 communicated the content of Adult B's assessment verbally to the nurse in charge on the admitting ward and advised her of the assessments recorded on the electronic documentation record.

The investigation team considered the intervention by CPN2 on behalf of the CRHTT to have been generally of a good standard and that the decision making and rationale for her decision to admit Adult B to hospital as appropriate. However, there were 2 areas of practice where there were some concerns:

- A mistake in completion of the clustering tool meant that the service user was placed in the wrong cluster, with associated lower risks. It is always possible for individuals to make mistakes, and key systems and processes need to have checks and balances in place to identify and correct individual error. Although this was not seen as an issue in this case, in a different scenario it may have influenced the outcome. The CRHTT, or equivalent service, needs to ensure that there is a system by which the appropriateness of the cluster and other key decisions and recording following assessment are confirmed for people who have ongoing contact with the services - for example through the referral meeting, supervision, MDT review, the discharge meeting.

- Given that liaising with A&E staff at the time of the initial assessment is the only practical opportunity to get information about A&E presentation history, and that so far the best indicator of risk is past history, the investigation team were of the view that when an assessment is being conducted in A&E, CRHTT staff should routinely make this enquiry to ensure that as full a history and risk profile as possible is obtained.

On admission to the ward Adult B was prescribed anti-psychotic medication. Evidence from the electronic records and interview with Dr 6 indicate that Adult B responded to this within two days and a reduction in symptoms was recorded. Consequently incomplete parts of the comprehensive health and social care assessment initiated by CPN2, which routinely should be completed by the ward team, were not explored further and no care plan was formulated. An opportunity to take independent informant history was missed. In preparation for discharge a referral was made to the CRHTT within twenty four hours of admission, while Adult B was still experiencing paranoid ideas. There is no evidence, either documentary or from staff at interview, that Adult B's psychotic symptoms were explored any further.

There was evidence in the documentation that the nursing team had engaged Adult B in 1:1 sessions where it is recorded several times that Adult B appeared guarded in the interactions. It is recorded that Adult B was not a risk to himself or others in the documentation of these 1:1 sessions, which appears to be based on the discussion.

The above incident, and its subsequent management, needs to be considered in the context of Adult B's 2 previous contacts with mental health services, the first in 2002, when he was admitted to hospital for 8 days with similar symptoms to 2010, and the second in 2007 when his GP referred him due to symptoms of anxiety with paranoid thoughts. In 2007 the psychiatrist determined that Adult B was not psychotic and that his cognitive functions were intact, and suggested that the GP refer him for counselling. Both these previous episodes had been brief and it appears that in between there had been no clear evidence of psychotic symptoms at a level which required referral or treatment, even though in the initial interview assessment Adult B indicated to CPN 2 that he always experienced low level psychosis.

Further assessment of Adult B would have allowed the ward team to gain a wider perspective on Adult B's mental health issues and determine if the working diagnosis of drug induced psychosis was correct. Establishing an accurate diagnosis would influence discharge arrangements appropriate to the person's needs. As the

inpatient assessment didn't include a comprehensive past history, it was difficult to establish an accurate assessment of risk, and provide adequate follow-up.

Risk assessment is an integral part of the assessment and care planning process, and risk assessment requirements are described in both the Trust's CPA policy and procedure document and in the Clinical Risk Assessment Management and Training Policy. The principles of Trust policy are in keeping with national guidance including, the Care Programme Approach (CPA) (1991), and more latterly the document 'Refocusing the Care Programme Approach: Policy and Positive Practice Guidance' (DH, March 2008), and the DOH 2006 guidance on risk assessment. The Trust uses the Sainsbury Risk Assessment tool, which has a Level 1 and a Level 2 assessment.

Level 1 is an initial risk assessment tool to be completed at initial assessment and updated at timely intervals and at significant changes, such as prior to a period of leave or discharge, or when a significant event has occurred, such as self harming. Trust policy states that all service users in contact with the adult mental health services must have an individual Level 1 risk assessment as part of an initial and subsequent assessment of health and social care needs.

Level 2 is a multi-disciplinary risk assessment tool. The Trust's risk policy states that a Level 2 risk assessment should be completed for all service users who are on CPA and for someone who is an inpatient, although there is no timeframe for this being completed. Level 2 is a complex risk assessment which may take some time to complete. This could be difficult to achieve during a short admission and/or if the patient is highly disturbed.

In the case of Adult B, a Level 1 risk assessment was completed as part of the initial referral assessment by CRHTT CPN2. This risk assessment reflected the information she had at her disposal from her assessment. As stated earlier this would have been informed by seeking information from A&E at the point of assessment. In relation to the violence and aggression section of the Level 1 risk assessment, CPN2 indicated:

- 'yes' there was evidence of 'previous incidents of violence'
- 'yes' to 'misuse of drugs and alcohol'
- Some 'unknown risk' categories, particularly in relation to 'previously dangerous impulsive acts'
- In the 'other' category section 'risk to others' was 'unknown risk'
- Narrative text explaining that 'Adult B admitted that he has become violent in the past but he declined to divulge details of this'

When Adult B was first transferred to the ward it appears that no immediate attempt was made to complete the missing information from the Level 1 assessment begun by CPN2 at initial assessment, and no Level 2 assessment was completed or attempted.

A further level 1 risk assessment was completed at the point of Adult B's discharge from the ward by Ward Nurse 1 (WN1). WN1 was Adult B's Primary Nurse and Care Coordinator. In relation to the violence and aggression section of the risk assessment, WN1 indicated at this assessment that the 'previously dangerous impulsive acts' had changed to 'no risk' in the 3 days between 7 December 2010 to 10 December 2010. It is unclear what assessment evidence was used to inform this change in risk status.

At interview ward staff seemed unclear about the requirements relating to the Level 2 risk assessment; WN1 stated she was unclear about when a Level 2 risk assessment would need to be completed. Dr 6 stated that the risk assessment was a document that the ward nurses completed.

Risk assessment and management is an integral part of all patient care and treatment. In an inpatient environment observation, discussions with patients and carers/relatives, the care plan and the treatment provided are all used to obtain information and to inform risk assessment and management.

After the death of Adult A, Adult B's girlfriend, mental health services were made aware that Adult B in fact had an extensive criminal history which included a history of domestic violence. The investigation team concluded from reviewing the documentation and interviews with staff that Adult B's criminal history was not explored in any depth while Adult B was on the ward, and the limited information he provided was not followed up with any consultation with the Police or Adult B's GP. The information Adult B provided in this review meeting was taken at face value. There is evidence that risk issues were to some extent considered by the ward MDT, particularly in relation to Adult B's personal safety. The care plan, for example, addresses the level of observation and at a medical review by Dr 2 on 8 December 2010, Adult B was asked for information about his previous criminal history. At interview both Dr 6 and WN1 stated that they would not routinely follow up on criminal history, and given the presenting symptoms of Adult B this was not done in this case. The investigation team were also told that the Police were not always helpful and had on occasion declined to share information with ward staff, so the staff member hesitated to ask for information about Adult B. An information sharing agreement/protocol is in place which is signed up to by the Trust, West Yorkshire Police, Local Authorities, probation and other partners.

The investigation team undertook a simple Trust-wide survey/ interview of other adult acute medical staff, service managers, ward managers and CRHTT managers, to clarify their practice in relation to routinely requesting criminal information from the Police in relation to inpatients if the person had indicated during assessment that they had a criminal history and then declined to expand on this information. The outcome was a consensus of opinion that further exploration of criminal history would be undertaken, which included contacting the local Police and that there was a good relationship with their local Police and routinely asked for criminal information. None of the professionals interviewed or consulted would have contacted the GP for relevant criminal history information.

It is difficult to know whether, with additional information about Adult B's previous criminal history, the care and treatment provided or the assessments and decisions

made would have been in any way different. At interview Dr 6 was clear that her decision would not have been different as it did not change his presentation at the time of admission or discharge.

Given the length of time from discharge to the death of Adult A there is no evidence that this affected the outcome in this case, but in another scenario it could be significant. Trust policy does not give timeframes for completion of the Level 2 risk assessment, and completion may be difficult in a short timeframe, particularly when the patient is highly disturbed.

At interview staff who recollected the case all stated that although generally aware of and alert to domestic violence issues no concerns or alarms were triggered for them in this case during their interactions with either Adult A or Adult B. At interview both the CRHTT CPN's, CPN2 and CPN3, and Dr 6 explained that they were not aware of domestic abuse issues in this case, and if they had had any concerns would have explored this avenue. However, the staff did not meet with Adult A, Adult B's girlfriend, separately from Adult B either at the initial CRHTT assessment or while Adult B was on the ward, Adult A did not seek a separate interview or discussion with staff and the staff did not suggest this. Although CPN2 described Adult A as being quite chaotic at the time she said that there was no indication that Adult A was anxious or afraid, or that she would like to see her separately.

All staff interviewed said that Adult A did not appear unhappy, anxious or troubled in any way with regards to her relationship with Adult B or the decision for Adult B to go home. They all agreed that if any concerns had been raised they would have explored this with Adult A. The investigation team are of the opinion that staff were aware of domestic abuse issues and would have explored this if Adult A had raised the issue. However, individuals in an abusive relationship do not always volunteer this information for many reasons, and staff did not proactively give Adult A an opportunity to share any information or concerns she may have had. It is difficult to ascertain whether it would have made a difference to the care and treatment of Adult B, or to this case. If contact had been made with the Police staff would have had additional information about Adult B's criminal history of domestic violence. This would have enabled complete risk assessment to be made.

The investigation team learned that questions about domestic abuse are not a standard question in the mental health assessments that practitioners undertake. All staff said that although they would not always ask, if they had any suspicions they would explore this further with the individual and record their suspicions.

None of the staff members involved in Adult B's case had had any concerns or suspicions in this case. All practitioners also made reference to Adult B's girlfriend Adult A and had no concerns regarding her welfare. However, the research for domestic abuse demonstrates that it can be up to the 35th incident of domestic abuse before a victim discloses, and so it is not surprising in this instance that there was nothing forthcoming.

The Calderdale CRHTT CPN3, who assessed Adult B for home based treatment at the point of his discharge, stated that even if the assessment process had identified Adult B's previous domestic abuse episodes, it would not have changed her decision

regarding Adult B not requiring home based treatment. She also said that she would have expected this assessment information to have been considered by the ward team prior to a referral being made to home based treatment for the discharge assessment. It is only in retrospect that the information about Adult B's criminal and domestic abuse history has been identified. Adult B did not fully disclose this information to staff, and although there was some indication of a criminal history staff on the ward did not take action to obtain further information. Although, it is unclear whether this would have in fact changed the care and treatment or the outcome, other services in the Trust have indicated that in a similar situation they would probably have proactively sought more information from the Police.

Whilst on the ward, given Adult B's presentation, reasons for admission and stated problems it could be expected that he would have been provided with information about how to make contact with local drugs and alcohol services and encouraged to find help to address these issues. He may or may not have chosen to seek help from and engage with these services. It is possible that had the 7 day follow-up by the CRHTT been successful then this information would have been provided to Adult B as part of that process, but from the evidence obtained throughout the investigation it appears that Adult B may not have received this information.

Within 24 hours of Adult B's admission a reduction in symptoms had been noted, although Adult B was still experiencing symptoms at night time. Adult B himself was very keen to be discharged. In a 1:1 engagement session, Adult B shared that he felt much improved since admission.

As discussed earlier, there is no evidence that while Adult B was on the ward there was any further exploration of Adult B's psychotic symptoms, or any additional criminal information gathered from the assessment process to contribute to what was already known about his risk profile. Dr 6 was of the view that the decision regarding discharge was based on Adult B's presentation and so additional criminal information would not have changed this. The investigation team sought a wider Trust perspective from other adult acute inpatient psychiatrists and were informed that if the criminal history had a connection to a person's mental health issues then a different approach would have been adopted, otherwise the approach would have remained the same.

At the point of discharge Adult B was assessed by CPN3 from the Calderdale CRHTT. She explained at interview that although the decisions were all made with regard to Adult B being discharged and only requiring 7 day follow up she nevertheless undertook her own assessment, which involved taking account of past history, mental state, how the person had progressed since admission, mental illness present at the time of her assessment, what the person said and risk to the person and or others.

CPN3 interviewed Adult B in the presence of his girlfriend Adult A. Adult B was keen to go home, and Adult A was apparently supportive of this decision. The assessment record, documented by CPN3 states, "Adult B's girlfriend, Adult A, said he is back to his normal self and she is happy for him to be discharged home". Adult B and Adult A were in agreement with CPN 3 that home based treatment was not necessary. CRHT CPN3 gave Adult B and Adult A information on mental health services for

future reference. Adult B did not meet the criteria for Intensive Home Treatment, CMHT or Assertive Outreach follow up, and there was no indication that he required referral to psychological services. Considering the information available at the time, and the outcome of their risk assessment it was quite reasonable to discharge Adult B with 7 day follow-up.

The current Trust CPA (Care Programme Approach[17]) policy states that "all individuals admitted to in-patients services will be on CPA', and that, "all service users discharged from hospital will receive 7 day follow-up. This includes those service users who, following a review while receiving in-patient care, have been identified as requiring Standard Care". There is no explanation of 7 day follow up arrangements and the rationale for this process in any policy document.

In reviewing the CPA and 7 day follow process in relation to this case the investigation team found some confusion amongst the staff involved about whether or not Adult B was or should have been on CPA and when and how discharge from CPA is executed, when only 7 day follow up is required.

Following his discharge from the ward a referral was made to the Kirklees CRHTT for 7 day follow up. In fact the CRHTT had difficulties engaging with Adult B to undertake the agreed 7 day follow-up, and he was not seen by services after his discharge from the ward. After several attempts to make contact with Adult B, by CPN4, the Triage nurse, CPN5, a senior practitioner from the Kirklees CRHTT made the decision to discharge Adult B from the service after reviewing his documentation and assessment information. CPN5 informed the investigation team that she had reviewed the risk assessment, inpatient progress notes and admission assessment and deduced from the information recorded that there was 'nothing to suggest' that CRHT should be taking further action, for example, asking the Police to undertake a welfare visit. CPN 5 explained that her decision to discharge Adult B from the mental health service was a unilateral decision. CPN 5 communicated this decision to the GP by letter.

CPN 5 said at interview that she was of the understanding that Adult B was on CPA. The Trusts electronic record system, RIO indicated that a CPA discharge meeting had been arranged to discuss Adult B's discharge from service. CPN5 explained to the investigation team that to discharge a person from CPA on RIO, a multi disciplinary meeting is required to be arranged. CPN5 clarified that there had been no actual CPA meeting but she had recorded it in this way as it was a requirement of RIO.

Given that Adult B had been discharged from inpatient care and was on CPA at this time the investigation team do not think that the discharge decision should have been made by a single practitioner without reference to the multi-disciplinary team. This is not to suggest that the decision in this case to have been in its self unsound, or to have contributed to the outcome; it is the team process where an individual in

[17] Care Programme approach -CPA- is a term for describing the process of how mental health services assess a patient's needs, plan ways to meet them and check that they are being met. It includes the appointment of a care coordinator.

the team makes a discharge decision about someone on CPA which we consider to require review. Since this admission a new policy has been developed which addresses this issue[18].

Current Trust policies (specifically the CPA and Discharge Policies) lack clarity about the purpose and rationale for the 7 day follow-up process following an inpatient admission. These issues are of particular concern in cases like Adult B, where there has been only a very brief inpatient admission and where no ongoing care other than the 7 day follow up is planned, although the person is on CPA because they have been an inpatient admission. While the confusion regarding the CPA process did not appear to affect the care Adult B was in fact offered, since an appropriate referral for home based treatment was made and the CRHTT did action the referral, the investigation team consider this to be an area which requires clarification in both policy and procedure.

The investigation team also had some concerns about how the 7 day follow-up process and discharge was conducted by the CRHTT after discharge from inpatient care, given that Adult B had been in inpatient care and was, therefore, technically still on CPA. The investigation team were informed that there are occasions, this being one of them, where staff feel the 7 day follow up intervention is more of a 'process' to be followed, rather than a useful intervention for the person.

All staff who were interviewed had attended safeguarding training which also raises awareness of domestic violence and were aware of domestic abuse and what interventions to take if they suspected it was occurring.

The Trust has domestic abuse policies in place relating to both staff and service users. These policies focus on the risks of domestic violence to a staff member or service user as a victim of domestic abuse. There is no guidance for staff on what action to take should they suspect a service user is a perpetrator of domestic abuse.

Conclusion

Overall, the investigation team were of the view that each part of service functioned adequately, and within agreed pathways of care, but the defect was that they were not joined together in a more complementary fashion in relation to assessment processes. The additional assessment made by the IMR author endorsed the view of the investigation team. The Care Programme Approach (CPA) was introduced in 1999 to ensure the effective coordination and delivery of mental health care. Risk assessment and risk management were introduced as being central to effective mental health practice within the CPA process. In the case of Adult B although it was Trust policy for patients like Adult B to be put onto CPA this did not take place.

However, although some recommendations for improvement have been made which includes CPA there is no clear evidence to suggest the care concerns identified in

[18] The Trust's policy, 'Did Not Attend and No Access Visits', section i., 'Clinic appointments and cancellation of clinic appointments procedure', and section ii. 'Routine/scheduled community/home visits'.

this report had a direct impact on the outcome of the incident under review. Domestic violence is a major public health problem because it is common and associated with physical and mental health morbidity. It is more common in psychiatric patients and is under detected by mental health professionals. Routine enquiry increases detection but needs to be introduced in the context of comprehensive training, and only where referral and care pathways have been developed. High-risk patients should be referred to multi-agency risk assessment conferences for multidisciplinary assessment and safe management.

2.3.4 **Calderdale and Huddersfield NHS Foundation Trust (CHFT)**

Calderdale and Huddersfield NHS Foundation Trust consists of two main hospitals in Huddersfield and Halifax. The hospitals are Huddersfield Royal Infirmary and Calderdale Royal Hospital they also provide outreach services in the local communities. The Trust provides healthcare for more than 435,000 people across Calderdale and Kirklees. In 2009/10 more than 110,000 men, women and children were cared for as inpatients and almost 380,000 attended outpatient clinics. The two accident and emergency departments cared for approximately 130,000 people

Service provision and involvement with Adult B and Adult A

The IMR author examined records for Adult B and Adult A during the period January 2002 to the death of Adult A on 9 June 2011. For the purposes of the IMR, the records have been carefully reviewed by the IMR author and the following contact established. The involvement of CHFT in the provision of services for Adult B and Adult A outlined below contains only contact that is relevant to the DHR.

ADULT B

- In October 2002, Adult B attended the Accident and Emergency Department (A&E) having taken overdose of tablets and alcohol. He had blood on his hands and face as a result of breaking Adult D's mobile phone. He was aggressive in department and slashed his arm, abdomen after admission on the ward. He was admitted for psychiatric assessment. The Police were aware of the incident. The following day Adult B requested to be discharged against advice. He left the ward but went straight back to A&E. The Police were informed and his GP made aware of his discharge against medical advice.

- In May 2009 Adult B attended A&E following a self harming incident having slashed both forearms with broken glass. The A&E records state that he was a known schizophrenic. There is, however, no evidence in any hospital records that Adult B had a diagnosis of Schizophrenia. Adult B did not wait for treatment. There is no record of the GP being informed of this episode.

- In December 2010, Adult B attended A&E with Adult A. He had a history of hearing familiar voices for last two days, voices coming through wall, telling him they are going to kill him and he stated that he felt he needed to get a gun to protect himself. Adult B was visibly distressed. Adult A informed the staff that she thought he is making it all up and believed it was a result of him

taking speed a few nights ago. He was seen by crisis mental health team who agreed his admission to psychiatric unit. The records show that staff had been alerted to inform the Police if Adult B left the department because of the risk of Adult B self harming whilst psychotic. Adult B and Adult A did leave the department and the crisis team and Police were informed. Adult B and Adult A returned later stating that they had been home to get Adult B's coat. At this point a security officer was called to department to sit with Adult B until he was transferred to a Mental Health unit at CRH.

- In April 2011 Adult B attended A&E following an assault. The history from Adult B was that a pint glass was smashed over his forehead which resulted in multiple lacerations which required sutures. Verbal head injury instructions were given before discharge. Adult A was present.

ADULT A

- In July 2009 Adult A attended A&E with a history of being assaulted by two males. She said that she had lost consciousness and she had bruising to her face and laceration to her lip. She was admitted to Clinical decision Unit (CDU) for head injury observations. Adult A insisted on being discharged against medical advice and was advised to see own GP for follow up the following day. Adult A assured CDU staff that it wasn't her boyfriend, but his friend who assaulted her. She reassured the staff she will be safe with him and he was telephoned and a taxi arranged for her to be taken to his address. There is no mention in either A&E record or CDU record of alcohol or drugs, therefore, the IMR author has not been able to identify what this concern was. There is no mention of Police involvement or the need to inform Police of incident.

- In February 2010 Adult A attended A&E following an alleged assault by Adult B. She had been punched in face. She is said to have smelt of alcohol and did not wait for treatment.

- In January 2011 Adult A attended A&E with laceration to her chest. The history she gave in the Triage area was that she was holding a knife and slipped on the floor. The Triage nurse recorded that Adult A was very tearful. She was seen by a doctor and the history remained the same. The injury was recorded as a surface wound. Adult A was asked by the doctor whether the injury was due to self harm or assault and Adult A denied both.

- In February 2011 Adult A attended A&E with a glass injury to her right arm near her elbow. She stated that she was out having a meal and slipped on the way home. In minor injuries this history changed to she was pouring drinks into glasses which were on the floor. She slipped on the wet floor and fell onto the glasses breaking them. The wound was full dermal thickness, 1.5cm deep, muscle visible but intact. The wound was closed with 2 sutures.

Analysis of Service Involvement

This section analyses CHFT involvement with Adult A and Adult B. The IMR author identifies that there is no evidence within any of the health records scrutinised that either Adult A or Adult B indicated or disclosed domestic abuse to any of the health professionals involved in their care. However, what is clear is that there were missed opportunities in A&E attendances that should have been explored further by staff involved. Both Adult B and Adult A presented separately and together at the department between 2009, 2010 and 2011 with a variety of injuries and a mental health episode. The incidents analysed are four incidents related to Adult A described above were over a two year period 2009 – 2011 and the seven for Adult B from 2002 to 2011. There would not have been any cross referencing of Adult A and Adult B's attendance records in A&E. This is normal practice.

During the period of the review and currently, staff within the Trust work to the guidance stipulated within the National Domestic Violence Guidance, relating to input with individual domestic abuse cases, routine questioning within midwifery services and care of children living in families where domestic abuse is a factor. *(Responding to Domestic Abuse: A Handbook for Health Professionals* DoH, Dec 2005).

ADULT A

In July 2009 it appears that CDU staff did all that they could to dissuade Adult A from taking her own discharge and appropriate information and advice was given in respect of head injury. However, Adult A was discharged to her boyfriends address when it was known that one of the assailants was a friend of Adult B her boyfriend. Whilst there are no issues from a clinical management perspective given the history of an assault warranting admission the expectation is that the Police are notified by the A&E staff. This was a serious assault which raised the issue of public protection. There appears to have been a lack of curiosity and asking key questions about the domestic abuse. Adult A's declaration that Adult B was not an assailant was accepted and she returned to boyfriend's address, but given that one of her assailants was supposedly a friend of Adult B, it would be reasonable to anticipate that there may possibly be further risk of assault if the assailant attended the address or if Adult B was involved. An effective risk assessment was not completed. There was no pathway in place to support staff in decision making.

Disclosing information to outside agencies without consent can be concerning to practitioners, who often worry about breaching confidentiality. In certain circumstances, where there are public protection issues, such as this assault the Crime and Disorder Act 1998 should be applied.

As stated in the chronology and in the IMR the record identifies a tick against inclusion criteria (for CDU management) signifying that there was another source of concern such as drug or alcohol intoxication or cerebrospinal fluid leak. There is no mention in either A&E records or CDU records of Adult A having alcohol or drug issues, therefore, it is not possible to identify what the issue was. To have ensured continuity of appropriate care this should have been completed. It is an example of inadequate record keeping.

On the 25 January 2011, Adult A attended A&E with a laceration to her chest. The explanation of the injury she gave to the nurse in triage was that whilst holding a knife, she slipped on the floor and sustained a chest laceration. The triage record notes identify that Adult A was very tearful. Adult A was seen by the A&E doctor an hour and a half later, who recorded that Adult A was carrying a knife and slipped onto the floor. It was at this point that Adult A was asked whether the injury was the result of self harm or assault, Adult A denied both and no further enquiry was made. This is a disappointing response from the A&E practitioners involved. Adult A presented with a knife injury to her chest, this is not a common injury and should have immediately alerted practitioners to the possibility of assault. The story given by Adult A as the cause of the injury was not plausible; the injury Adult A sustained was on the right side of her chest which suggests penetration. Adult A was reported to be very tearful in triage this was not explored by the triage nurse. A&E staff raised no concerns about inconsistencies. This would have provided an opportunity to sensitively question Adult A about the injury and her distress and if she was experiencing domestic abuse.

There is an expectation that, as a senior staff member, the triage nurse would have questioned Adult A carefully and sensitively about this injury and how it happened. Further assessment should have been of additional injuries or bruising as a result of falling to the floor. There is no evidence in the records that Adult A was asked about other injuries. Given the size of the wound, her tearfulness was disproportionate to the injury and therefore should have prompted additional consideration. In interview the triage nurse confirmed that she did not ask about self harm or assault, which should have been considered. The Triage nurse stated that she did not explore Adult A's tearfulness as she assumed that it was because Adult A was in pain. The doctor did ask about self harm and assault. Adult A's denial was accepted.

There is no evidence in records or following interview that Adult A’s wishes and feelings were ascertained, and this in the IMR authors opinion comes back to the lack of recognition by practitioners in A&E to the possibility of domestic violence.

This was an opportunity to gauge Adult A’s wishes and feelings, the assessing practitioner accepted Adult A’s version of how the injury occurred, and put the tearfulness of Adult A down to discomfort due to injury. This was a missed opportunity.

Fifteen days later, in February 2011, Adult A again attended A&E, she presented at triage with a laceration to her right arm by the elbow. History recorded by Triage ENurse 4 is that Adult A was out for a meal and slipped on the way home and sustained a glass injury to her right arm near her elbow, exposing a layer of fat. In minor injuries, the history from Adult A given to EN3 was that she was pouring drinks into glasses on the floor, slipped on the wet floor and fell onto the glasses breaking them.

There is a difference in the history given by Adult A to how this injury occurred. In triage the location is outside and a fall onto a broken glass, one would expect that other injuries may have been sustained, but this question was not asked of Adult A. In minor injuries, the story changes and infers that the injury was sustained in the home, with a fall and by the glass breaking on impact. However, there appears to be

just one laceration that is 1.5cm deep. On interviewing EN4, she could not remember Adult A but stated that she would have documented if she thought the injury did not fit the story. Therefore, EN4 assumes she was satisfied with Adult A's account, EN4 confirmed there was nothing to indicate domestic abuse. EN3 was interviewed, she did not remember the case, EN3 did not read the Triage entry, therefore, was not aware of the change in history given by Adult A. EN3 accepted the story given by Adult A when in the minor injuries area. It was acknowledged that had she read the triage record, she would have clarified the history with Adult A. EN3 did not remember Adult A from her previous attendance fifteen days earlier, although Adult A had been so distressed. Because of the nature of the previous injury, the change in history given and the short duration of time between attendances, EN3 should have viewed this episode as concerning.

It is a point of concern that practitioners did not read triage entries as standard practice. It could be argued that this was a minor injury and the department may well have been busy that day. However, the context of the attendance changed because of the discrepancies, and this attendance followed on from another trauma injury in a relatively short space of time.

ADULT B

In December 2010, Adult B attended A&E. Adult A accompanied him. Adult B was hallucinating, and there was a disclosure of substance misuse by Adult B from Adult A, two members of staff were interviewed in relation to this attendance.

The priority of the clinical staff was said to have been Adult B's safety, as he presented as vulnerable and was recorded to have been crying in the doctor's office. There were no indicators of domestic violence in the records and no concerns expressed about Adult B and Adult A's relationship. An acute episode of psychosis where the client is verbalising that he feels threatened and is seeking means to protect himself should have prompted assessment of risk to Adult A and A&E staff whilst Adult B was in the department. Adult A was not seen on her own to ask whether she felt at risk or had been harmed prior to attendance at A&E. This was a missed opportunity.

Adult B was the focus of this episode, and given his psychotic presentation that was appropriate. Clinical care in respect of his mental health was appropriate and communication and referral pathways were robust. There does not appear to have been concern as to whether Adult B had contact with children and the potential risk. Adult B was the focus and Adult A was seen as an accompanying adult and not as his partner who had raised doubt about the authenticity of Adult B's behaviour in relation to drug use. No opportunity was taken to speak to Adult A alone to establish her wishes and feelings in respect of this episode and the impact it may have had on this relationship.

The final A&E attendance considered was on the April 2011, when Adult B accompanied by Adult A attended A&E following an assault that resulted in a large laceration to his forehead requiring 10 sutures. There is very little recorded in the triage record about what appears to be an assault resulting in a significant head injury. The A&E doctor, who saw Adult B 3 hours later, recorded that Adult B

appears to be intoxicated and a bit 'high'. Adult A is described as being 'sober'. Adult A was with Adult B and may well have been present when the assault took place. It is suggested by the A&E doctor that Adult B was intoxicated and a bit 'high'. There is a strong evidence base that alcohol and drug use significantly increase the risk of domestic violence. Staff should have considered the risk to Adult A on discharge. There is no indication in the record that consideration was given to Adult A returning to a house with Adult B who had been involved in a violent affray, nor was there any consideration of whether there were any children in this relationship. The assault was seen in isolation of wider safeguarding considerations.

Whilst the clinical practice of staff was appropriate and services were in place to respond to outcomes of assessment, the issues associated with domestic abuse and effective assessment and relevant enquiries were not made for the A&E attendances that have been highlighted. Practitioners were too accepting of the accounts being given to them by Adult A and Adult B. This was a particular concern in respect of Adult A's last two attendances, where a more rigorous line of enquiry should have clarified the accounts given by Adult A in respect of presenting with laceration injuries. If rigorous enquiry had taken place, the responses given may have led to the referral of Adult A to appropriate domestic violence services. Adult A was not identified by health care professionals as a victim of domestic violence. Therefore, there was no signposting to other agencies or options/choices offered.

The report of the Taskforce on the Health Aspects of Violence Against Women and Children recommended the following:

> *'There should be specific training for all 'first contact' practitioners, with an emphasis on asking patients about violence and abuse, and an appropriate initial response, including signposting and referral to other services such as expert advocacy'*(Responding to violence against women and children – the role of the NHS 2010)

UK emergency departments should conduct screening on the basis of an index of suspicion (selective enquiry), they only ask about domestic abuse if the health care professional identifies factors that are suggestive of domestic abuse. However, routine screening of patients within a set criteria (eg over 16 and female) has been shown to significantly increase detection rates (Olive, 2007).

A&E is expected to respond to allegations of domestic abuse from men as well as women and children. They are taught, and expected, to question people if it is suspected that the injury/reason for attendance at A&E is related to domestic abuse. They are expected to provide information and signposting to relevant support services and to safeguard children and vulnerable adults according to Local Safeguarding Children and Safeguarding Adults procedures.

There is evidence from staff that they have received training in relation to domestic abuse although in some cases it was not recent. Some staff had undertaken recent MARAC training and level 2 training related to safeguarding children and adults. There are issues associated with staff's knowledge regarding assessment tools and supervision. The Trust needs to have in place a strategy for ongoing domestic abuse training.

Accessing safeguarding supervision was of concern, none of the practitioners interviewed were aware of opportunities offered through the Trusts safeguarding team to participate in safeguarding supervision. Practitioners are expected to attend one session a year. Safeguarding supervision is offered by CHFT in response to recommendation from the Munro report.

Staff interviewed saw the changes required to improve care for domestic violence patients as:

- flagging up previous attendance in A&E
- having a dedicated environment for consultation
- awareness raising for all staff
- domestic violence leads who practitioners could consult with

All A&E practitioners interviewed were positive about the management support they receive. They had undertaken safeguarding training in line with the CHFT safeguarding training strategy.

A&E practitioners stated that the environment and time restrictions in A&E are not conducive to exploring the issue of domestic violence with patients and this was seen as a potential barrier.

The Trust is represented at the MARAC (Multi-Agency Risk Assessment Conference) within Kirklees and has a named contact for MARAC within Calderdale and Huddersfield Hospitals NHS Foundation Trust has signed up to the Information Sharing Protocol. This ensures that relevant information is shared between the Trust and other organisations within the MARAC process in order to protect and maintain the safety of victims of domestic abuse and their families.

Additionally, the Trust has representation at the local MAPPA (Multi-Agency Public Protection Association) meetings and is committed to information sharing with this forum as required.

Conclusion

The IMR author's opinion is that from information contained within the health records and from a review of expected policy and procedure at that time that the clinical care received by Adult A and Adult B was in line with regional and national expectations. Issues that arise relate to staff recognising the indicators of domestic violence, asking key questions and having curiosity and tenacity to follow through. Discussion has already taken place with the consultant nurse for A&E services to agree measures to increase practitioner awareness of the issues of domestic violence attendances in A&E and to develop a pathway for practitioners to follow when caring for patients they believe to be involved in domestic violence.

2.3.5 **West Yorkshire Police**

West Yorkshire Police serve approximately 2.2 million people living in one of the five metropolitan districts of Bradford, Calderdale, Kirklees, Leeds and Wakefield. The physical area, of some 2000 square kilometers or 780 square miles, contains the West Yorkshire conurbation and a network of motorway and trunk roads which allow easy access to and from other population centres.

Service provision and involvement between January 2002 to the death of Adult A on 9 June 2011.

Police systems identify that Adult B had a history of domestic violence with two previous partners. As Adult's C and D have refused access to their records it is not possible to analyse the learning from the situations apart from the information that is available on Adult B's Police records. The focus of the IMR is, therefore, on Adult A and Adult B.

As stated earlier, Adult B has a criminal history which commenced in 1995 with 19 arrests recorded of which 6 related to assault. One of these assaults was against Adult A in January 2009 and one on a former partner in January 2007. Adult B had 9 domestic incidents in total recorded with the police against three partners. The incidents involving Adult A and Adult B include:

- In April 2008, the first reported incident involving Adult A and Adult B was recorded. Adult B was arrested at the scene of the incident for breach of the peace. It is documented that Adult A disclosed that Adult B had mental health issues to the attending Police Officer. However, it is not documented whether the appropriate referral was made to health services to inform them of this incident or if Adult B's mental health issues were taken into account when completing the risk assessment which was risk assessed as standard risk. A Cocoon Watch [19]request was sent to the Neighbourhood Policing Team (NPT). However, Adult A declined to participate.

- A second domestic violence incident was reported in January 2009. Adult B had assaulted Adult A by punching her in the face causing a cut over her eyebrow. Adult B was arrested. The Crown Prosecution Service advised no further action in relation to the assault as there was insufficient evidence to proceed as Adult A refused to provide a statement. It is documented that Adult A was re-visited in order to attempt to gain her co-operation in proceeding with a prosecution. Adult B was charged with criminal damage and was convicted at Calderdale Magistrates Court in March 2009.

[19] "Cocoon Watch" scheme, in which friends and neighbours are asked to keep an eye on them and call police if their attackers appeared. It involves three levels of possible police action.

Analysis of Service Involvement

For the purpose of the analysis both incidents will be reviewed together. The IMR author identifies that the Internal Management Review has not identified any negative factors relating to the Police response or interaction with Adult A resulting from the reported domestic violence. The domestic violence incidents were correctly identified and the response and action taken was compliant with Force policy at that time.

There have been significant changes in how West Yorkshire Police handle domestic violence incidents since 2009. These would now influence the actions taken by Police in the response to the situation between Adult A and Adult B.

The domestic violence/abuse incidents and crimes related to Adult B have all been correctly recorded on Vulnerable Victims Database (VIVID), Crime Information System (CIS) and Record Management System (NICHE). However, in relation to the domestic violence/abuse incidents reported between Adult A and Adult B in April 2008 and January 2009, it is not documented whether the appropriate notifications were made by the Domestic Co-ordinator to local inter-agency services to notify of the domestic violence incidents. The needs of Adult B, as a perpetrator of domestic violence, also included mental health and drug and alcohol dependencies. It is notable that there was no consideration recorded by the Police to notify either Adult Social Care or the Mental Health Services regarding the information provided by Adult B when received into Police custody. The information provided for the purpose of the custody risk assessment was information concerning previous self harm incidents (hanging and overdose). There are depression warning markers on his Niche record and on a previous arrest record in October 2008 it is documented by the Custody Staff that Adult B had mental health issues of psychosis and depression. It would have been reasonable to expect notifications of the domestic violence incidents to Mental Health and Adult Social Care to have been made or consideration of doing so.

There was a lack of professional curiosity into Adult B's mental health issues which, had they been considered, could have resulted in notifications to other agencies that were able to address these needs. Had referrals been made, the opportunity to address and manage the mental health needs of Adult B may have been provided. Work is currently being undertaken by the Force to raise awareness of all frontline Police Officers and Staff regarding their responsibilities, particularly when dealing with people who are suffering from apparent mental health issues, to refer that person on or signpost them on to the appropriate safeguarding agency

The current Force Domestic Abuse Policy stipulates that Safeguarding Units "must consider proactive measures to manage the potential abuser". This would include offender management, for example referrals to Drug Intervention Programmes and referrals to other agencies. The current practice in the Safeguarding Units is to make referrals to Mental Health Services and Adult Social Care where a domestic abuse offender or victim has been identified as either needing support from Mental Health Services or has established mental health needs or suspected mental health needs. All staff within the Safeguarding Units now receive additional training by attending

the specialist safeguarding course delivered by staff at the Force Training and Development Centre. Mental Health the referral process and the signposting of individuals to the appropriate services are specifically included within the course.

It is documented on VIVID's, after Police attended the domestic violence incidents reported in April 2008 and January 2009, that Adult A's wishes were for no further Police action and no action. On both occasions, Adult B was arrested for breach of the peace in April 2008 and for assaulting Adult A in January 2009. It is documented that following the incident reported in January 2009 that Adult A stated that she "didn't want to press charges". Adult A also refused to give any information about the cut that was seen above her eye. The Domestic Violence Co-ordinator re-visited Adult A in order to attempt to gain her co-operation for a statement and prosecution. Adult A declined to provide a statement and CPS, subsequently, advised that there was insufficient evidence to proceed with a charge.

The current Force domestic abuse policy in place since June 2011 clearly stipulates that positive action must be taken at all domestic incidents by attending Police Officers or any Police Officer or Police staff who deal with a domestic abuse incident. In the current Force policy, it is clearly stated that "the decision, whether or not to arrest a suspect rests with the Police Officer and victims, should not, therefore be asked whether they require an arrest to be made". Safeguarding Unit staff are specifically required to review domestic abuse occurrences on a daily basis to ensure that the risk assessment has been properly completed and is accurate, the additional information they may hold regarding the victim or abusers antecedent history.

The two reported domestic violence incidents involving Adult A and Adult B presented opportunities for the case to be risk assessed. From 2004 and to May 2010, West Yorkshire Police utilised the SPECSS model of risk assessment for domestic violence incidents. At initial attendance of domestic abuse incidents, the Response Officers conducted a risk assessment and considered if any of the initial risk indicators are present ie Separation, Pregnancy, Escalation, Cultural Awareness/Isolation, Stalking or Sexual Assault. The Officers then agreed a risk category standard risk for the incident reported in April 2008 and medium risk for the incident reported in January 2009. The risk assessment were ratified by the Supervisor. The Attending Officer then submitted a VIVID report to the Police Safeguarding Unit, endorsing this with the agreed risk assessment by his/her Supervisor which was then reviewed and more comprehensively assessed by the Safeguarding Unit.

The risk level was used to inform the decision of what action/intervention would have been appropriate. Both the standard risk and medium risk resulted in Level B action which was to send a letter containing information on domestic violence to Adult A and offer/organise Cocoon Watch for Adult A. In relation to the domestic incident reported in January 2009, Adult B also received a letter informing him of West Yorkshire Police's policy to address domestic violence. The risk assessments and decision making process documented complied with Force policy and expected standards of practice. The reluctance of Adult A to provide a statement was identified by the Evidential Review Officer and a decision made that the Domestic Violence

Co-ordinator would be tasked to re-visit Adult A to attempt to gain her co-operation in proceeding with a prosecution.

As part of the SPECCS risk assessment the Domestic Violence Co-ordinator would review the Victim Risk Assessment and the Suspect's history and risk assessment to determine the level of intervention required. Multiple domestic violence offending with a different partner/partners could result in the SPECCS intervention level being upgraded.

Since May 2010, West Yorkshire Police have replaced SPECCS with the DASH (Domestic Abuse, Stalking, Harassment and Honour Based Violence) risk assessment tool. This is a three part process of risk identification, risk assessment and risk management facilitated by a meaningful interview with the victim undertaken by the first Officers who attend at the incident. It is a process that ensures that those victims who are most at risk of harm are prioritised and that the Police response and appropriate Safeguarding measures are promptly put into place. DASH contains explicit guidance on previous offending history and not only at the point of undertaking a DASH risk assessment.

Communications Staff are required to follow a deployment checklist when deploying a Police Officer/Police Officers to a Domestic Abuse incident, this would include researching PNC, CORVUS and other systems to establish the domestic abuse history of all parties, particularly the presence of MARAC or IDAP flags, criminal offending history of all parties, particularly violent and sexual offending, relevant intelligence and CP history in relation to any children at the address. This information must be passed to the attending Officer prior to them attending at the scene. The divisional duty Inspector is also informed if this is a repeat domestic incident.

The DASH risk assessment is undertaken by the attending Officer and the attending Officer is expected to use professional judgement when completing the DASH risk assessment. The DASH risk assessment also includes questions about previous DV history. The DASH risk assessment must be endorsed by a Supervisor, thereby providing the opportunity to escalate the risk assessment. The SGU will review all NICHE domestic abuse occurrences and ensure that the DASH risk assessment has been properly completed and review its accuracy in the light of any additional information they may hold regarding the victim or abusers antecedent history. This could result in DASH risk assessment level being escalated.

The assessment of level of risk is important because it also influences referral to Multi-Agency Risk Assessment Conference (MARAC). The MARAC referral process for Calderdale and Kirklees divisions has been in existence since the end of 2004. There are no documented referrals to MARAC for Adult A. The domestic violence policies that were in place at the time of the reported domestic violence incidents involving Adult A and Adult B did not contain specific guidance relating to referrals to MARAC. If the SPECSS risk assessment resulted in a high risk grading or medium risk level C response for a victim, then the domestic violence guidance at the time directed that Multi-Agency Public Protection Arrangements (MAPPA) and MARAC should be considered. The domestic violence incidents reported for Adult A were assessed as standard risk in April 2008 and medium risk in January 2009, both with a level B response. As a result MAPPA and MARAC was not considered. The

current Force domestic violence policy contains specific guidance relating to MARAC referrals. The policy stipulates that “where a victim is assessed as high risk under the DASH assessment model there will be a presumption that the case will be referred to MARAC”. A MARAC referral would also now be considered where there were repeated domestic violence/abuse incidents in cases where the risk was not assessed as high risk and would, therefore, apply to Adult A.

The Police report that the implementation of the Divisional Safeguarding Units in April 2012 have provided robust supervision and improved management oversight concerning all aspects of safeguarding throughout the Force. A supervision and management process is contained in the current DASH risk assessment process, which requires the initial DASH risk assessment to be agreed and endorsed by the supervision of the attending Police Officers, eg an occurrence is created on Niche and the DASH risk assessment scanned onto the occurrence and sent to the Safeguarding Unit who will review the incident. A domestic abuse incident can only be finalised by a Supervisor in the Safeguarding Unit.

Probationary Police Officers receive training on domestic abuse and Safeguarding as part of the initial training they are required to complete. The Sergeants within the Divisional Safeguarding Units receive advanced training and input on domestic abuse and safeguarding.

Conclusions

The IMR author identifies that Police attendance at the domestic incidents in 2008 and 2009 between Adult A and Adult B was in line with expected practice at that time. Each report was dealt with in the correct manner. Adult A was offered support with regard to domestic violence issues as was practice using the outcome form SPECCS risk assessment. The Police should have been more proactive in relation to multi agency working by contact with Mental Health Services. There were no racial, cultural, linguistic or religious issues apparent in any of the reports. What is clear from statistics and information available is that the required policy, process and practice is in place now and should result in a different outcome to that in 2008 and 2009.

2.3.6 **West Yorkshire Probation Trust (WYPT)**

West Yorkshire Probation Trust’s local delivery unit (LDU), in Kirklees, is the third largest of 5 Probation LDU’s in the county. Kirklees is a high performing Probation team. It’s success in reducing re-offending exceeds the local and national average performance, achieving 16% above the predicted rate in the last quarter. Kirklees Probation has a strong reputation for its work with partners in the district and it currently manages in the region of 2000 offenders.

The West Yorkshire Probation Trust was inspected by Her Majesty’s Inspectorate of Prisons and Probation (HMI), in 2012. Some of the work, of Kirklees practitioners, within the inspection was cited as “best national practice”. HMI assessed Probation’s performance against the 2011 National Standards. The outcomes for “Assessment and sentence planning” and “Implementation of interventions” were scores of 79% and 80% respectively; above average when compared to national results.

In 42 out of 70 cases with a history of domestic abuse there had been no further Police callouts. However, in a further 13 cases there was no record of the offender manager checking with Police regarding further incidents. Where there was an identifiable victim or potential victim, there was evidence that the risk of harm to them was managed effectively in 72% of cases. The Director of Operations has developed an action plan following HMI to address the necessary changes required.

Service provision and involvement with Adult B

WYPT had four contacts with Adult B from 2007 to 2010:

- Adult B first came in to contact with WYPT when an assessment and pre sentence report was completed for a court hearing at Magistrate's Court in March 2007. The report was prepared for offences of assault and criminal damage. The assault was against his then ex partner Adult D. Adult B was under the influence of alcohol at the time of the offences. The pre sentence report proposed that Adult B should be made subject to a community order with requirements for supervision and to complete the Integrated Domestic Abuse Programme[20] (IDAP). However, he did not undertake this course as the Magistrate did not make this a part of conditions of the outcome of his trial. An E OASys[21] assessment was undertaken and identified that Adult B did not condone violence between men and women having witnessed violence against his mother from her partner. It is noted that Adult B had some understanding of the power imbalance between men and women in conflict situations. Adult B was assessed as medium risk of harm to known adults. Sentencing did not take place until June 2007 when 12 months Conditional Discharge was imposed for the offence of criminal damage and combined with a Bind Over for 12 months.

- A second pre sentence report was prepared in January 2008 and a further E OASys assessment completed. At this time Adult B was once again charged with criminal damage and he had been drinking prior to the offence. On this occasion, he attended the home of Adult D and damaged the front door when she refused to allow him entry. Adult D stated that their son was in the house at the time although Adult B denied the child being present. This offence placed Adult B in breach of the Conditional Discharge and Bind Over. Adult B was assessed as medium risk of harm to known adults. The report proposal was for a three months curfew and was made on the basis that there had been two convictions for criminal damage and none for direct violence. During interview Adult B had been able to demonstrate that he was fully aware of the impact of his offending on his victim and it was on this basis that supervision

[20] Integrated Domestic Abuse Programme: IDAP is an accredited groupwork programme consisting of 27 educational sessions focussing on domestic abuse and power and control issues. It challenges the behaviour of male perpetrators of domestic abuse. The involvement of Women's Safety Workers is integral to the programme.

[21] Offender Assessment System/electronic Offender Assessment System: The nationally designed and prescribed framework for both Probation and Prisons to assess offenders. It makes use of both static and dynamic factors.

was considered as being not required at this point in time. A punitive sentencing proposal was deemed to be more appropriate. Adult B was sentenced to three months period of curfew whereby he was confined to his home during the evenings. This sentence was subsequently completed.

- In March 2009 Adult B appeared before Magistrates Court for a further offence of criminal damage. On this occasion the offence related to damage committed at his flat in January 2009. Adult B was under the influence of alcohol when he committed the offence and indicated that his actions were in response to disputes with the caretaker and neighbours. Adult B was sentenced following a fast delivery report prepared at court and made subject to a Community Order with 12 months supervision and 150 hours Unpaid Work now known as Community Payback. At this point Adult B had been convicted of three offences of criminal damage all influenced by alcohol. The first two offences were directly related to domestic abuse towards his ex partner Adult D. During supervision, Adult B indicated that, in part, the most recent offence was related to his partner Adult A as they had been arguing beforehand. Contact was made with the Police Domestic Violence Unit and it was confirmed that the Police had been called to a dispute between Adult B and Adult A in January 2009, which was the day before Adult B committed the offence of criminal damage. Adult B was charged with an assault against Adult A for this offence. However, the matter did not proceed to court and conviction.

  As part of supervision for the order made in March 2009, a further assessment was undertaken to inform the focus of this work. Adult B admitted previous cannabis and amphetamine use. He also informed the service that he was prescribed anti depressants from his General Practitioner. Objectives were agreed and identified as: to find stable accommodation, examine offending behaviour and impact of such upon others, employment/training/education and constructive use of time. Whilst the risk screening in the assessment identified Adult B as having threatened/assaulted others in the past the offender manager did not complete a full risk of harm assessment due to the most recent offence deemed as not being linked to behaviour related to serious harm. The absence of a full assessment of risk meant that aspects of Adult B's offending behaviour were not fully addressed.

  Adult B was supervised in accordance with National Standards 2007. Interventions were planned by the offender manager to focus on Adult B's lack of stable accommodation through referrals and applications to housing agencies. In July 2009 Adult B went to reside with the father of Adult A on a temporary basis. As a result of not having a stable address, Adult B was also supported to register with a new General Practitioner. Offence focussed work examined anger management. It would appear that Adult B was not entirely open about his alcohol use and denied this being a problem. Community payback hours were carried out in accordance with National standards. There were some missed appointments but these were accepted and evidence was provided to support periods of ill health.

- In April 2009 Adult B appeared before Magistrate's Court charged with Common Assault against Adult A this was the offence that had occurred in January 2009. He pleaded not guilty and a trial date was set. He also had a further offence of theft from person. Adult B, in the company of two co accused, approached a group of youths and demanded a silver chain from one of them. Adult B pleaded not guilty and elected trial at crown court. The assault charge mentioned previously against Adult A was subsequently dismissed at Magistrate's court on 24 September 2009. No E OASys review was undertaken due to the not guilty plea. Adult B appeared at Crown Court in September 2009 and was sentenced on the basis of an oral report provided by a WYPT court officer. Adult B was made subject to a further 12 months Community Order for the offence of the theft from person including 12 months supervision and 90 hours community payback to run concurrently with the existing Order. Adult B had not been charged and convicted of robbery on the basis that no weapon or threat of violence had been involved in the offence. The E OASys assessment was reviewed by the offender manager and the objectives remained as before and the risk assessment concluded that Adult B continued to present a low risk of harm. Adult B had been living in temporary accommodation in Huddersfield and in August 2009 he reported to his offender manager that he would like to remain in the area. Work commenced to secure permanent accommodation in Kirklees. On the 6 October 2009 Adult B's case was transferred to Kirklees and he secured tenancy of the rented property in Huddersfield.

  Adult B completed his community payback hours within nine months of the most recent order being imposed with very positive reports. There were absences but these were a result of a back problem supported by medical evidence and Adult B was unable to work on these occasions. In supervision Adult B engaged with his offender manager on offence focussed work examining anger management and consequential thinking. There is clear evidence in the case records that the offender manager challenged him about his thinking and behaviour. A review was completed in February 2010 and included a full risk of harm assessment, which concluded that Adult B presented a medium risk to known adults; these were his partners. The community order expired on 13 October 2010. West Yorkshire Probation Trust had no further involvement with Adult B until the offence of murder committed on 9 June 2011.

Analysis of Service Involvement

The IMR author assesses that in completing the first pre sentence report in March 2007, it is clear the probation officer had taken full account of the seriousness of the situation of domestic abuse committed by Adult B against his ex partner. The report was completed in line with WYPT Domestic Abuse Practice Guidelines. The report proposal was an effective recommendation based on a robust risk assessment. Given the outcome at court the long term potential harm was not reflected in the sentence imposed. The offence was assessed by the court as less serious than considered by the pre sentence report author. "WYPT staff had undertaken an assessment, of the risk of potential harm to women with whom Adult B had a relationship, which should have been taken into account by the Court when

sentencing".

In the second pre sentence report the proposal for a curfew was commensurate with the offence committed but full account was not considered in relation to the domestic abuse underlying the criminal damage. The risk of harm was appropriately addressed but had only focussed on convictions to date. Domestic abuse is often cumulative and takes many forms. This needs to be considered in the context of assessing risk of harm. The IMR author states that circumstances were compounded by the sentence for the last offence when the assault matter was not addressed. The pre sentence report author focussed on the classification of offences. In addition, there seems to have been an over reliance on the information provided by Adult B who was plausible and presented a convincing level of appreciation of domestic abuse within male and female relationships.

In March 2009 when the third offence of criminal damage took place sentence was imposed following a fast delivery report. On the surface this was appropriate given that the offence details at court would clearly indicate no connection with domestic violence and therefore a fast delivery report was a reasonable option for both the court and the report author. The subsequent E OASys assessment at the start of the community order did not fully address Adult B's behaviour. The focus on criminal damage neglected to consider all aspects of Adult B's behaviour and there was insufficient consideration given to Police domestic callouts and previous offending relating to domestic abuse. This assessment was prepared by a probation service officer and countersigned by a team manager. The endorsement of the assessment was correct based on the information supplied to the manager by the officer.

Supervision by the offender manager in Calderdale during the community orders correctly focussed on Adult B being homeless. The achievement of stable accommodation would assist with more in depth offence focussed work. Work also included some anger management interventions. Following the move to the Huddersfield area work continued to focus on anger management, thinking and behaviour. Further assessment took place and increased the risk of harm to medium. This was reasonable given that there was nothing to suggest imminent risk of harm at the time. The assessment of medium risk provided an improved analysis of Adult B’s overall offending behaviour.

When discussing offences relating to domestic violence Adult B was able to confidently verbalise that he recognised the impact of his behaviour on victims and awareness of power and control within relationship conflict. For the most part he tended to discuss more general anger management problems to which staff responded with relevant interventions. WYPT staff adopted an investigative approach to supervision and records are clear and comprehensive.

Reviews were completed in line with National Standards 2007. On the whole, probation staff worked constructively with Adult B in the light of information which was available and presented. A balance was achieved between challenging his behaviour and opportunities for therapeutic interventions. Police call out information was checked by probation staff on a regular basis and the last incident recorded was in January 2009. This was used by staff as a measure of progress in relation to domestic violence.

Alcohol was a factor in all three criminal damage offences. Adult B minimised alcohol use during assessment and it would appear that he was not open about his level of use. Alcohol was therefore not identified as a priority supervision objective. The offences all contain reference the impact of alcohol on violent incidents. It is, therefore, surprising that this was not addressed and there was not more curiosity.

During one and possibly two of the offences Adult B's young son was present. There is no suggestion that he was resident with Adult B or that Adult B had long term contact with children during supervision. Safeguarding issues were not fully acknowledged in assessments and there is no evidence of contact with Kirklees Children's Safeguarding services. Case records contain very little information regarding Adult B's mental health problems other than that he was prescribed anti depressants. Community payback hours were completed in accordance with policy and procedures. Adult B received positive reports for the work undertaken. A home visit was not undertaken which would have aided assessment and supervision. The case was not high risk, therefore, there was no requirement to undertake a home visit.

A crucial issue in this case is the first sentence imposed at court. The assault charge does not seem to have been pursued and the lack of a conviction for this offence seems to have been significant in how Adult B's behaviour was subsequently interpreted by probation staff. Criminal damage tends to be viewed as low level offending. However, it is clear that in this case these offences were masking a pattern of domestic violence.

Conclusion

In undertaking some of the assessments there could have been more vigilance to recognising the complexity of domestic abuse. Abuse of this nature is often disputed and victims are often placed under pressure by the perpetrator to withdraw charges. This, in turn, makes prosecution difficult if there is an unwilling witness. Probation staff need to remain objective whilst using all evidence available and this should be reflected in assessments. Police domestic violence call out information is, therefore, crucial to the process.

Magistrates need to have a good understanding of issues associated with domestic violence. In Adult B's first court appearance the recommendation from WYPT was for him to be subject to a community order with requirements for supervision and to complete the Integrated Domestic Abuse Programme22 (IDAP). However as identified earlier the Magistrate did not make this a part of conditions of the outcome of his trial.

This case did highlight indicators of domestic abuse for WYPT and overall these were sufficiently managed through supervision by ensuring regular domestic

[22] Integrated Domestic Abuse Programme: IDAP is an accredited groupwork programme consisting of 27 educational sessions focussing on domestic abuse and power and control issues. It challenges the behaviour of male perpetrators of domestic abuse. The involvement of Women's Safety Workers is integral to the programme.

violence call out checks. Even with enhanced assessment the offence of murder could not have been predicted. The severity of the leap from the type of offending for which Adult B was subject to supervision to the death of Adult A was significant. Adult B was not subject to WYPT supervision at the time the offence was committed.

2.3.7 **Kirklees Housing**

Kirklees Housing Services is part of the Place Directorate within Kirklees Council. The service has responsibility for housing strategy, policy (including the Council Housing Allocations Policy) and commissioning. The service has a clear focus on preventing and tackling homelessness and enabling and supporting people to meet their housing needs through the provision of information, advice, support and enforcement.

The Council's Housing Allocations Policy is based upon the Council's statutory duties as set out in legislation, and ensures that reasonable preference is given to those applicants who are in the greatest housing need.

Service provision and involvement with Adult A and Adult B

During the period of the review Adult B presented with housing needs following the break up of his relationship with Adult D and him commencing a relationship with Adult A. During this period he was housed in Calderdale. With hindsight, the records raise concerns about Adult B's ability to sustain a tenancy successfully following criminal damage issues resulting in him being evicted when resident in Calderdale. However at the time of application, this information was not available to the Housing Service. Adult B appears to have stayed with friends and a family member of his current partner at the time.

Adult B presented as homeless in Kirklees but as he was not assessed as having any specific vulnerability, in turn this resulted in an appropriate 'no priority need' being placed upon his housing status. This meant that Kirklees Housing did not have a statutory duty to house Adult B. However they did provide advice, signposting and support with housing applications to access housing from private rented, housing associations etc.

Analysis of Service Involvement

The actions taken by Kirklees Housing were in accordance with policies and procedures. The support offered was taken up by Adult A and Adult B who made a joint housing application through an interview with a Housing officer. Housing officers are skilled at assessing whether there are any issues which could raise concern or identify vulnerabilities, during this interview there were no vulnerability or domestic abuse indicators evident. Kirklees Housing were not aware that Adult B had been evicted from his previous residence. Where domestic violence indicators are identified or a victim is fleeing domestic violence, officers will firstly explore if measures can be put in place which enable the victim to remain living safely within their own home, rather than becoming homeless and having to move to other accommodation. Where it is not possible to prevent homelessness, this automatically places the priority rating to a high Band B for priority housing, by accessing this

housing there is also floating housing support, sanctuary and target hardening schemes. These were not accessed in this case as there was no presenting need.

Housing options do not receive information on past criminal history and would have had no reason to contact Calderdale Police in these circumstances as there were no signs for concern. Consent would have had to have been acquired to obtain these records. In hindsight even if this information was made available to them this would not have altered Adult B's housing status/priority.

Housing Officers are trained in safeguarding and domestic abuse to identify Domestic violence indicators. The application was appropriately allocated a Band C Low/Medium rating. Adult A and Adult B did not take up this application in the long term and it was cancelled following no response. Adult A and Adult B made their own arrangements for accommodation and took up residence in private rented accommodation which was the residence where they lived at the time of the incident, the service would not have been formally aware of this as there was no ongoing contact.

2.3.8 **Yorkshire Ambulance Service NHS Trust (YAS)**

Yorkshire Ambulance Service NHS Trust (YAS) was established on 1 July 2006 when the county's three former services (WYMAS NHS Trust, TENYAS NHS Trust & SYAS NHS Trust) merged. It covers the whole of Yorkshire; almost 6,000 square miles of varied terrain from isolated moors and dales to urban areas, coastline to inner cities. YAS employs 4,463 staff who, together with over 3,517 volunteers, provide 24-hour emergency and healthcare services to a population of more than five million.

Service provision and involvement between January 2002 to the death of ADULT A on 9 June 2011

The IMR author searched 16 addresses, within the dates provided and found one incident related to a 999 call for Adult A on 9 June 2011 at an address in Huddersfield.

In total 3 YAS clinicians attended the 999 incident for Adult A on 9 June 2011 made to YAS, by West Yorkshire Police. The female was identified as Adult A. The call was coded as a 'Red' incident. The performance standard for the Red code, in June 2011, was 75% of calls should receive a response at the scene within 8 minutes. A double manned ambulance (DMA) and a rapid response vehicle (RRV) (single-handed) attended. 2 Qualified Ambulance Technicians attended Adult A and as a result of Adult A's presenting condition a Paramedic back-up was requested. Adult A was clinically assessed and found to be in cardiac arrest with evidence of multiple stab wounds. Primary observations, taken identified that Adult A did not have a pulse and was not breathing. A Paramedic (RRV 1) was also in attendance.

As documented in the Patient Report Forms, a pre-alert call was made to the Emergency Department (ED) at Huddersfield Royal Infirmary (HRI) and Adult A was transported to HRI under emergency conditions (blue lights and sirens). Throughout

the journey to hospital basic life support was continued. Handover to ED staff took place on arrival at HRI.

Analysis of Service Involvement

Audit of the 999 call has demonstrated compliance with YAS protocols. From the auditor's report, *'The Call-taker obtained all of the relevant information and ascertained if Police responders were en route to address the potential scene safety issues. From the information provided in response to the interrogation, the correct Advanced Medical Priority Dispatch System code (27-D-01-S) was applied. A further request was also made that we be updated once the Police responders had actually arrived on scene.'*

The DMA was on scene within 2 minutes of the 999 call being made; this was within the expected performance standard. The attending practitioners performed CPR (basic life support) on Adult A, from arriving on scene to handover at hospital. As no further treatment could be given at scene, other than basic life support, a decision was made by RRV 1 to transfer Adult A to the A&E at Huddersfield Royal Infirmary. The hospital was only 2 minutes away, so this was appropriate.

The attending practitioners followed and implemented, where possible (given the exception of advanced life support), both national guidance (JRCALC Guidelines 2006 – Joint Royal Colleges Ambulance Liaison Committee) and YAS policies and procedures.

YAS produced and implemented 'Guidance for the Management of Domestic Abuse' and 'Policy for the Management of Domestic Abuse' in March 2011.

YAS also has guidance, policies and procedures for safeguarding:

- Guidance for the Management of Safeguarding Vulnerable Adults
- Policy for the Management of Safeguarding Vulnerable Adults
- Safeguarding Children and Young People Policy and Procedure

The current compliance with safeguarding training at YAS is as follows:

Safeguarding Training	YAS Compliance
Level 1 Children	97.2%
Level 2 Children	87.5%
Adults	95.9%

The above safeguarding training incorporates domestic abuse.

YAS is a 999 service for emergency and urgent health care and, as such, responds to calls for service on a needs-led basis. Generally, YAS do not hold any long-term therapeutic relationships (nor care records) with clients; needs are assessed and appropriate interventions made by attending staff at each separate call to service.

SECTION 3

3.0 CONCLUSION AND LESSONS TO BE LEARNED

3.1 Conclusion

The content of this section will address the terms of reference identified in the statutory guidance and the case specific terms of reference identified as part of the review. The terms of reference are identified in bold. To reduce repetition in answering the issues raised some terms of reference have been combined.

Developing the DHR provides an opportunity to analyse information across agencies, family members, colleagues and friends of the subjects of the review. However, there is a danger, in reviewing this with hindsight, of forming conclusions that were not possible for the participants to see at the time.

The DHR has:

- Been conducted according to best practice, with effective analysis and conclusions of the information related to the case.

- Established what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence including their dependant children.

- Identified 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

- Applied these lessons to service responses including changes to policies and procedures as appropriate, and

- Will assist in preventing domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

In line with the terms of reference, the DHR has covered in detail the period between January 2002 and 9 June 2011.

The IMR and the DHR authors have analysed information available and identified the lessons to be learned from the case, which are identified in detail at 3.2. An analysis of the issues has been influenced by the difficulty in gaining access to some information. The fact that Adult B's previous partners would not contribute to the review and refused access to records has influenced the ability of the panel to establish the performance of all services for example it is not possible to analyse health visiting or school records to establish if there were any disclosures made to these services about domestic violence and the action taken. Discussions with family members have not enabled us to establish the position in relation to all of these issues either.

The conclusions and lessons to be learned have informed the development of recommendations, which indicate the areas of change required to reduce the risk of a domestic homicide incident like this occurring again.

Overall Conclusions

The first and most important conclusion from the review is that the actions of Adult B which led to the death of Adult A could not have been predicted by any agency. However, there is evidence provided in the West Yorkshire Police and West Yorkshire Probation Trust IMRs of knowledge of domestic violence between Adult B and Adult A dating back to 2009 and that there were missed opportunities by other services to intervene to work with them to address their violent relationship and some of the issues that are felt to have exacerbated it such as alcohol and drug use. No coordinated response to the domestic abuse was triggered by any incident or involvement of services.

Kirklees Safer Stronger Communities Partnership Board provides a mechanism to enable a broad range of statutory and voluntary partners to work together to improve strategy, this leadership role is vital to ensuring that strategy evolves in line with changing needs of adults and developments continue to be implemented and assessed. There is a requirement for Kirklees Safer Stronger Communities Partnership Board to keep their vision clear and to maintain the determination to achieve the culture and key targets required. The impact of financial constraints and reconfiguration of services could influence the implementation of the required changes and it is important that Kirklees Safer Stronger Communities Partnership Board is supported by all partnership organisations to meet the required level and quality of safeguarding services.

It is, therefore, important that the strategic element of the partnership continues to be developed. Commissioning is a central feature of local government and public service reform. Councils have been challenged to shift away from narrow service delivery functions and adopt a more strategic commissioning role. This means stepping back from traditional service delivery and focusing on understanding the needs of the community and leading activity to secure improved outcomes. It means being open to using the best way of securing service outcomes and thinking creatively about how to get the most from available resources.

There is a strong commitment to the MARAC process locally. This is illustrated by the clear operational and governance structure where the performance of the MARAC is examined on a regular basis. Agencies are invested in the process, with the majority confident in identifying cases, as well as completing their actions within the target times. However, there are a number of areas for development at the MARAC, notably in regards to engaging with the victim, some aspects of action planning, volume and the identification of repeat cases

The changes identified in the Domestic Abuse Service Strategic plan 2012-2015 should result in an integrated service when fully implemented but they are in the early stages of development. Once fully embedded the result should be a coordinated and more effective response to domestic abuse in Kirklees.

Local policies and procedures generally reflected National Guidance. The picture is mixed in relation to organisations applying them and working effectively with other agencies. A major issue appears to have been embedding policies into practice and leading and managing change.

The Family

- **Whether family, friends or colleagues were aware of any abusive behaviour from the alleged perpetrator to the victim, prior to the homicide.**

- **Whether there were any barriers experienced by Adult A or her family/ friends/colleagues in reporting any abuse in Kirklees or elsewhere, including whether she knew how to report domestic abuse should they have wanted to.**

As stated earlier, the family were not told by Adult A that she was experiencing domestic abuse, although they were suspicious. Adult A's father asked her and she denied that she was. He had not thought about contacting anyone to discuss his concerns and feels that the family would have dealt with the situation without involving anyone else. He stated that he does not feel that there is anything any services could have done because of the control that Adult B had over her. He praised the response of the Police since the death of his daughter and that the family had received considerable support.

- **Whether there were opportunities for professionals to 'routinely enquire' as to any domestic abuse experienced by the victim that were missed.**

There is evidence of a lack of multi agency working. The management of information within and between agencies and by individual professionals is crucial to ensuring the planning of care and involvement of services to safeguarding individuals experiencing domestic abuse. Agencies failed to share information and as a result there was not the required level of shared analysis, planning and interagency practice. The quality of record keeping was also raised as an issue in some of the Individual Management Reviews although there is evidence of improvement in information systems and processes.

Kirklees as identified earlier have taken a high risk approach to domestic violence which as a result makes it more difficult to intervene earlier in cases. It would be preferable for there to be a single point of referral that provides a multi agency consistent systematic risk assessment determined by need to promote earlier intervention and a common basis for action. The implementation of a multi-agency co-located team would represent a significant step forward in Kirklees' response to domestic abuse and continue to transform outcomes for domestic abuse victims.

If Adult A had survived then the IDVA service was likely to have become involved and the level of intervention that had been required since 2008 provided. There are many factors that will cause a case to be categorised as high risk. On occasions these factors may be present in isolation and in other cases multiple factors may be

present. Each case must be taken on an individual basis and its own context assessed.

Robust assessment and decision-making to safeguard Adult A depended on good internal and cross-agency planning and practice drawing appropriately on the most up-to-date knowledge to enable the system to function as a whole. The lack of strategic multi agency meeting to discuss Adult A and Adult B and any service that agencies might be able to reduce risk to her resulted in there being no opportunity to consider the potential impact of the relationship between Adult A and Adult B. There were further missed opportunities to share and analyse information at the point of the allegations of Domestic Abuse in April 2008 and January 2009. What is clear is that a MARAC would have provided an opportunity to analyse information across agencies, family members, colleagues, and friends. There is a danger, in reviewing this with hindsight, of forming conclusions that were not possible for the participants to see at the time. However, if during the six months prior to the death of Adult A the indicators that Adult B's violent and threatening behaviour was escalating could have been pulled together and risk assessed then at least some concern would have been expressed.

There were opportunities for agencies to **'**routinely enquire' about the injuries that Adult A had particularly CHFT. The fact that this only happened on one occasion does not meet the requirements in the 2005 framework which suggested all Trusts should now be working towards this goal. Many professional and governmental bodies recommend 'routine enquiry' about domestic violence for all women; for example, the British Medical Association, the Royal College of Midwives, the Royal College of Obstetricians and Gynaecologists, and the Royal College of Psychiatrists (National Collaborating Centre for Women's and Children's Health, 2008). Screening is likely to increase the number of women identified as experiencing domestic violence. The fact that there was not the level of curiosity required when Adult A attended A&E on four occasions in 2009, 2010 and twice in 2011 resulted in referral information to Adult A's GP providing no alert for the GP to follow up any concerns. Adult A's attendance at A&E provided an opportunity to ask her about her injuries and the fact that the histories she gave for their cause conflicted. The fact that health professionals did not read previous records resulted in them not being able to identify patterns and differences in information provided. An environment was not created for Adult A to disclose the violence she was experiencing. She was asked by one Doctor but this was not developed. Since October 12th 2009 Doctors in the UK are now required to inform the Police whenever they treat a suspected victim of serious gun or knife crime. The guidance from the General Medical Council (GMC) extends the previous policy of mandatory reporting of gunshot wounds. Accidental knife injuries or those related to self-harm are not required to be reported, except in minors, when child protection issues are raised. Therefore Adult A's attendance at A&E as a result of what she declared as an accidental knife injury would not be required to be reported.

Some practitioners lacked the ability to critically analyse data and information to identify indications and patterns of safeguarding issues. This was a crucial issue in relation to making an effective assessment of the relationship between Adult A and Adult B. Contemporary practice calls for the ability to use assessment tools and techniques, objective measures and a systematic approach and to constantly strive

to advance practice to have; well developed observational skills, the ability to identify patterns and predict outcomes, identify escalating risk and ensure that reflexive practice is at heart of assessment. There were missed opportunities to work with and protect Adult A. As assessments were not effective they did not lead to an effective plan of care which resulted in a lack of leadership, coordination and recognition of her real level of vulnerability. Practice is the authority, understanding, knowledge and skills which the practitioner needs to bring to bear on the situation. It is necessary and important to follow the agency's procedures but it is responding with the appropriate practice that is also crucial. If they are not to trap themselves into inaction, practitioners must be prepared to work only with 'reasonable inference'. Reasonable inference is when agencies; follow and take full account of the facts and make a proportional response to them without prejudice to the service user.

- **Whether there were opportunities for agency intervention in relation to domestic abuse regarding Adult B, the alleged perpetrator that were missed.**

There is little evidence of direct one to one work with Adult B using assessment and therapeutic tools and techniques, objective measures and a systematic approach to identify patterns and predict outcomes, identify escalating risk. Evidence links Adult B's abuse of alcohol and drugs with violent incidents but very little work was undertaken with him to address these issues. In 2002 Adult B disclosed the sexual abuse he had experienced as a child and SWYFT did not follow this up and provide signposting to an appropriate service. As identified in the West Yorkshire Probation Service IMR the pre sentence report proposed in March 2007 that Adult B should be made subject to a community order with requirements for supervision and to complete the Integrated Domestic Abuse Programme[23]. The report proposal was an effective recommendation based on a robust risk assessment. A crucial issue in this case is the first sentence imposed at court. The assault charge does not seem to have been pursued and the lack of a conviction for this offence seems to have been significant in how Adult B's behaviour was subsequently interpreted by probation staff. Criminal damage tends to be viewed as low level offending. However it is clear that in this case these offences were masking a pattern of domestic violence. Given the outcome at court the long term potential harm was not reflected in the sentence imposed. The offence was assessed by the court as less serious than considered by the pre sentence report author. West Yorkshire Probation Service are reviewing the use of Oral and Fast delivery reports for domestic abuse offences.

In undertaking some of the assessments there could have been more vigilance to recognising the complexity of domestic abuse.

The Care Programme Approach (CPA) was introduced in 1999 to ensure the effective coordination and delivery of mental health care. Risk assessment and risk management were introduced as being central to effective mental health practice within the CPA process. It is unfortunate that a decision was made not to progress a

[23] Integrated Domestic Abuse Programme: IDAP is an accredited groupwork programme consisting of educational sessions focussing on domestic abuse and power and control issues. It challenges the behaviour of male perpetrators of domestic abuse. The involvement of Women's Safety Workers is integral to the programme.

CPA approach to the care of Adult B. It would have enabled a coordinated approach to meeting his needs with a key worker.

- **The review will also give appropriate consideration to any equality and diversity issues that appear pertinent to the victim, perpetrator eg age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation**

Adult A was white British and Adult B mixed race white British and Asian ethnicity. All of the IMRs considered issues associated with equality and diversity, religion and sex. There were no significant issues raised in relation to Adult A but indications in the records of Adult B that at least one violent incident between him and another man was triggered by racial comments.

- **The review should identify any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and / or services.**

There is evidence to suggest that there are issues associated with staff, particularly in the health and probation services, not receiving the required domestic violence training. As identified in Section 2.3 of the DHR, Kirklees Council and NHS Kirklees are developed a training strategy. There are also indications that partner organisations need to review the position in their own organisations and some IMR authors have identified this and made recommendations to address the issues.

In 2008 and 2009, the West Yorkshire Police MARAC Co-ordinator CE3, after consultation with the Head of the NHS for Calderdale, delivered a training programme to new Consultants and A&E health staff in the Calderdale and Huddersfield area to raise awareness of domestic violence, domestic violence victims and MARAC referrals. This training resulted from CE3 identifying a problem with a lack of domestic violence referrals from these sources. During the interview, CE3 stated that at that time, hospital staff were unsure of what to do when dealing with a domestic violence victim or incident and were concerned that disclosing information to the Police would breach the confidentiality of the victim. The training provided by CE3 sought to remedy this misconception and encourage hospital staff to take positive action in reporting domestic violence incidents and concerns.

3.2 **Lessons to be learned**

- **Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence including their dependant children.**

- **Identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working**.

1. Kirklees Safer and Stronger Community Partnership provides a mechanism to enable a broad range of statutory and voluntary partners to work together to improve strategy, this leadership role is vital to ensuring that strategy evolves in line with changing needs of adults and developments continue to be implemented and assessed. There is a requirement for Kirklees Safer and Stronger Community Partnership to keep their vision clear and to maintain the determination to achieve the culture and key targets required. It is, therefore, important that the strategic element of the partnership continues to be developed. Domestic violence structures will need to re-configure with changes in both commissioning and provider structures taking place in Kirklees. Difficult decisions will need to be made if services are to continue to develop, funding used wisely and integrated pathways developed. The fundamental elements of commissioning domestic violence services are to; analyse need, to have a clear strategic vision, specify what is required and to carry out an options appraisal regarding how best to achieve the required objective and to be clear about how performance is going to be managed and assessed. The development and implementation of the new Domestic Abuse Strategy 2012-2015 should address many of the structural and multiagency issues identified by this Review in relation to multiagency working, the education and training of staff resulting in increased understanding of issues related to domestic abuse and referral to specialist domestic violence services.

2. The Government's action plan 'Call to End Violence against Women and Girls 2011' identifies the importance of prevention and early intervention. Whilst the focus is on women and girls, the issue equally applies to male victims of domestic violence. The action plan identifies four key outcomes:

   - *Society believes violence against women and girls is unacceptable and is empowered to challenge violent behaviour.*
   - *Fewer victims of sexual and domestic violence*
   - *Frontline professionals (eg teachers, doctors, Police and prosecutors) are able to identify and deal with violence against women and girls*
   - *Employers recognise and support victims of domestic and sexual violence*

   There has been considerable advancement in services for people experiencing domestic violence with an emphasis being placed on people who are assessed as high risk. Undertaking this review has enabled agencies to review the services they provide from the perspective of prevention and early intervention. In the case of Adult A, it may have been possible to intervene earlier if she had been supported to disclose the domestic violence she was experiencing. As in many other areas of the country, this is different from the high risk focus in Kirklees. This is addressed in the newly developed Kirklees Strategy where there is an increased emphasis on prevention and early intervention.

3. There was opportunity in the case of Adult A and Adult B to evaluate their situation more effectively by referral of the case to MARAC. All professionals need to recognise the responsibility and accountability that comes with the role they undertake whether they are a Police officer, GP or psychiatrist. They

need professional maturity, the ability to respectfully challenge and an enquiring mind and the tenacity to see things through. No one called a strategy meeting or MARAC to enable multi agency conversations and planning to take place. What is clear is that a MARAC would have provided an opportunity to analyse information across agencies, family members, colleagues, and friends. It would also have provided the allocation of an IDVA who would have given additional support for Adult A.

The involvement of an IDVA would have enabled appropriate assessment and case management processes being developed that more accurately met the cause of the violence, the context, and the consequences. This should have resulted in better decision making, coordinated and appropriate interventions and treatment programmes tailored to the different characteristics of the violent behaviour of Adult B, for example the role of alcohol.

4. British Crime Survey data for 2008/09 shows that 38% of domestic violence incidents (ie more than one in three) were alcohol related. There is a clear (albeit complex) association between the misuse of alcohol and many cases of violence against women and children. This was the situation in the case of Adult B. Agencies in Kirklees need to ensure that their strategies relating to alcohol, including the communication aspects of those strategies, also factor in issues of violence and abuse, drawing on the evidence which shows the role of excessive alcohol consumption in dis-inhibiting perpetrators, and on the evidence of how excessive alcohol consumption can lead to a greater vulnerability to violence[24].

5. Domestic violence involves patterns of violent and abusive behaviour over time rather than individual acts. However, the criminal justice system is primarily concerned with specific incidents and it can, therefore, be difficult to apply criminal justice approaches in relation to domestic violence. Domestic violence situations vary greatly, and the criminal justice system appears more effective in dealing with the less entrenched situations. Court outcomes did not stop Adult B repeat offending by continuing his violence and harassment. A more systematic approach to domestic violence perpetrators is needed throughout the criminal justice system that directly links levels of risk and repeat behaviour with outcomes. Criminal justice agencies working with offenders who have committed non-domestic violence crimes need to be aware that domestic violence may also be an issue of concern. Domestic violence, although now considered a crime, still needs to be taken as seriously as criminal offences committed in other contexts.

6. There were problems associated with the ability of practitioners to critically analyse data and information to identify indications and patterns of safeguarding issues particularly in the mental health care of Adult B and A&E care of Adult A. Contemporary practice calls for the ability to use assessment tools and techniques, observational skills, objective measures and a systematic approach and constantly striving to advance practice and ensure that reflective practice is at heart of assessment. Assessment must be one of

[24] Responding to violence against women and children – the role of the NHS 2010

the cornerstones of working with children and young people and adults. All assessments must be underpinned by a sound understanding of people's developmental needs.

7. The NHS often provides the one setting where adults or children feel able to disclose, and it is, therefore, imperative that the services are aware of the need to provide safe spaces for this to happen. This applies just as much to services that do not specialise in treating adults and children who have experienced violence and abuse (eg primary care) as to those that do. It was raised by practitioners in the A&E that there is no suitable safe space to have a confidential conversation with patients and their partners or families. Commissioners and providers of healthcare need to build in the time and the space for disclosure across services, paying particular attention to the privacy and safety of the relevant parts of their premises, including the need to see people who may wish to disclose violence or abuse alone. There also needs to be coordinated action by all the Trusts to ensure that all staff are able to access the appropriate level of domestic abuse training. To enable robust early identification and prevention of domestic abuse there needs to be a focus on the perpetrators of domestic abuse. Health professionals are well placed to refer perpetrators to appropriate services, there needs to be acknowledgement of this in the planned development of the Health Based Domestic Abuse Services in Primary Care. The proposed restructuring of the NHS presents further challenges. During and following the transition process it is imperative that Domestic Abuse commissioning remains a priority issue within the NHS.

8. Raising public awareness of domestic violence is an ongoing issue. Kirklees is well aware of this and they need to not only increase awareness for victims but also to establish collective community responsibility. There is evidence that Adult A did not share the fact that she was experiencing domestic violence with her family but that they were suspicious. They would not have discussed this with any agency. The role that partner organisations, both statutory and voluntary, can play is crucial and the professionals that work in them need to act as champions to provide information to individuals and communities. Changing social attitudes challenging the norm of abuse is fundamental to prevention Evidence suggests that campaigns that targets how people feel they should act are most effective. Social media also offers opportunities to campaign cost effectively.

SECTION 4

4.0 RECOMMENDATIONS

- **Apply these lessons to service responses including changes to policies and procedures as appropriate**.

Kirklees Safer Stronger Communities Partnership Board

1. Kirklees Safer Stronger Communities Partnership Board needs to ensure that the priorities and changes identified in the Domestic Abuse Strategy 2012-2015 are commissioned, implemented and performance managed.

2. Kirklees Safer Stronger Communities Partnership Board should develop a communications strategy to provide information to the public and professionals about the appropriate action to take if they have concern about the risk of domestic violence against an individual.

3. Kirklees Safer Stronger Communities Partnership Board to raise with the Home Office the possibility of them holding discussions with the Judicial College regarding the training of magistrates to ensure that they have the required knowledge and understanding of domestic abuse and are able to identify cases where offences are masking a pattern of domestic violence.

Calderdale and Huddersfield Foundation NHS Trust

4. The Trust, with support from the safeguarding team, will develop a domestic violence pathway for practitioners in A&E to follow when they suspect domestic violence.

5. The EDIS system will be developed to record all A&E attendances and ensure that this information will be visible on all screens.

6. The organisation will ensure that they scope the feasibility of flagging MARAC cases on the EDIS system as an alert.

7. The Trust will scope existing premises/facilities within A&E departments for identification of area that can be used for private/sensitive assessment of patients.

8. All A&E practitioners will have annual safeguarding supervision.

South West Yorkshire Partnership NHS Foundation Trust

SWYFT developed the recommendations below following their initial single agency review in June 2011. It was not felt necessary to include further recommendations as a result of the DHR but their action plan has been reviewed and performance added to the overall action plan.

9. The CRHTT, or equivalent service, needs to ensure that for people who have ongoing contact with the services there is a system by which following assessment the appropriateness of cluster of the patient and other key decisions are audited and confirmed.

10. The CRHTT, or equivalent staff, should make routine enquiries with A&E staff at the time of the initial assessment to ensure that as full a history and risk profile as possible is obtained.

11. The Inpatient Service Manager should ensure that the ward MDT understands the requirements for formally completing the required risk assessments and that there are appropriate systems in place to facilitate this.

12. Staff at each interface or transfer to a new service throughout the patient journey will review the existing assessment and finish the parts not completed previously. This applies to both risk assessment and other parts of the assessment process.

13. Ward staff should routinely seek further criminal information from the Police in relation to inpatients if the person had indicated during assessment that they had a criminal history.

14. CRHTT should obtain contact and other key information about patients prior to discharge.

15. Ward staff should provide information on treatment and support options to people who experience drug and alcohol problems as a routine intervention and a system should be in place to support this.

16. All carers of people on inpatient wards should be given the opportunity to have a discussion with members the MDT in the absence of the patient.

17. CPA and discharge policies should be reviewed to clarify:

    - CPA status and discharge arrangements for inpatients who have had a brief admission to hospital

    - The 7 day follow-up process including the rationale for this and how it should be implemented.

18. Trust policy requirement to complete a Level 2 risk assessment for all inpatients should be reviewed with specific reference to short admissions.

19. Trust policy should be amended to include ‘Domestic Abuse Policy – service users’ guidance for staff in relation to service users as perpetrators of domestic abuse.

20. Information relating to domestic abuse and support should be readily available on the wards – for service users and for carers.

NHS Kirklees and Clinical Commissioning Groups

21. The CCG should review current provision and knowledge and initiate appropriate training for primary care professionals to raise awareness of domestic abuse and the current NHS Kirklees policy on risk assessment, referral and MARAC. This should incorporate the latest guidance on domestic abuse from RCGP ISIS and CAADA.

22. CCG should monitor and influence practice performance of all GP's and other primary medical services in relation to Care Quality Commission essential standards covering quality and safety and safeguarding children and adults.

23. CCG should work with GP practices to support safeguarding practices, including domestic abuse through local clinical governance mechanisms.

24. The CCG should develop with GP's, a care pathway for people who are the victims of domestic abuse. This should ensure that staff are aware of the issue of domestic violence, how to identify and assess people at risk and what services are available locally.

25. The CCG should scope the feasibility of developing systems to enable the flagging of identified victims of domestic abuse.

26. Information about the services available to victims of domestic abuse should be included in CCG websites and other ways of disseminating this to GP's explored.

27. NHS Kirklees should ensure that the learning from this DHR is shared with the appropriate receiver organisations from April 2013. This will include Greater Huddersfield CCG, North Kirklees CCG and the National Commissioning Board West Yorkshire Area Team.

West Yorkshire Police

28. Where mental health issues are identified as an area of concern when attending incidents of domestic abuse, the Police should, where possible, identify which services are involved and make appropriate referrals.

West Yorkshire Probation Trust

29. Review Domestic Abuse Awareness Training.

30. Review aspects of risk of harm training and guidance for assessment and case management of service users.

31. Ensure systems are in place to ensure timely and accurate screening of the individual's risk of harm to others is completed and where appropriate leads to a full analysis which is reviewed at appropriate intervals and following any significant change.

32. Review use of Oral and Fast Delivery reports for domestic abuse offences.

Kirklees Housing

There are no recommendations made.

Yorkshire Ambulance Service

There are no recommendations made.

Appendix 3 Glossary

A&E Accident & Emergency

ACPO Association of Chief Police Officers

BCS British Crime Survey

CAADA Coordinated Action Against Domestic Abuse. CAADA is a national charity supporting a strong multi-agency response to domestic abuse. Our work focuses on saving lives and saving public money. CAADA provides practical tools, training, guidance, quality assurance, policy and data insight to support professionals and organisations working with domestic abuse victims. The aim is to protect the highest risk victims and their children – those at risk of murder or serious harm.

"Cocoon Watch" scheme, in which friends and neighbours are asked to keep an eye on them and call police if their attackers appeared. Under the scheme, police had three possible levels of action:

- Level one involved issuing the offender an official warning and possible criminal charges at a magistrates' court.

- Level two, for a woman attacked more than once recently, involved more warnings, a police bid to block bail if the man was charged, and extra protection for the woman's home.

- The highest level, for the most serious cases, could provide the victim with a panic button or mobile phone to call police if she was attacked again

CPD Continuing Professional Development

CPS Crown Prosecution Service

DV Domestic Violence

DWP Department for Work and Pensions

IDVA Independent Domestic Violence Adviser

MAPPA Multi-Agency Public Protection Arrangements is the name given to arrangements in England and Wales for the "responsible authorities" tasked with the management of registered sex offenders, violent and other types of sexual offenders, and offenders who pose a serious risk of harm to the public. The "responsible authorities" of the MAPPA include the National Probation Directorate, HM Prison Service and England and Wales Police Forces. MAPPA is coordinated and supported nationally by the Public Protection Unit within the National Offender Management Service. MAPPA was introduced by the Criminal Justice and Courts Services Act 2000 and was strengthened under the Criminal Justice Act 2003.

MARAC Multi-Agency Risk Assessment Conference A MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors.

NHS National Health Service

Ofsted Office for Standards in Education, Children's Services and Skills

PCT Primary Care Trust