SOUTH WORCESTERSHIRE COMMUNITY SAFETY PARTNERSHIP

Overview Report

Domestic Homicide Review of the Circumstances Concerning

Case 2

A Worcestershire Woman

Died between 17th March and 12th April 2012

aged 48 years

Independent Chair and Author

Malcolm Ross M.Sc.

17th February 2013

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1. Introduction

1.1 For the purposes of this review report and in order to protect the identity of those involved a code will be used to identify each individual. The people referred to in this report will therefore be known as:

Victim - V1

Current partner and person charged with her murder - P1,

Father - Father

Mother - Mother

First husband - H1

Second Husband - H2

Children:

Oldest son - S1

Second son - S2

Third son (adopted) - S3

Oldest daughter - D1

Second daughter - D2

Third daughter (adopted) - D3

P = Partners

N = Neighbours

A = Associates

1.2 V1 lived manly in Worcester in council provided housing. She became estranged from her family and children and lived a chaotic lifestyle fuelled by alcohol. She associated with people of a similar lifestyle, mainly homeless people, many, like V1, with previous criminal convictions and would frequent homeless centres in and around Worcester City Centre. V1 was well known to the police, support agencies and homeless organisations.

1.3 V1 had experienced many years of domestic abuse from various partners and more than often declined to complain and follow through with police investigations. She often suffered injuries as a result of these incidents.

1.4 On Thursday 12th April 2012 Police were notified by staff at a Day Centre who knew her well, that V1 had not been seen for some days. On the same day neighbours around her flat reported that they had not seen V1 for some time and her washing was still on the line outside and curtains closed.

1.5 Police affected an entry and found V1 dead in her flat. It has not yet been ascertained how long she had been dead. She had suffered multiple injuries including fractures to facial bones, clavicle, ribs and jaw. Signs of her body indicated that she had been dead in excess of a week.

1.6 A murder investigation was launched by West Mercia Police and subsequently P1 was arrested in Dorset and charged with V1's murder. In December 2012, P1 appeared before the Crown Court and after a three week trial he was convicted of murder on 13th December and sentenced to life imprisonment, with a recommendation that he serves 17 years.

1.7 The Domestic Violence, Crimes and Victims Act 2004, establishes at Section 9(3), a statutory basis for a Domestic Homicide Review, which was implemented with due guidance[1] on 13th April 2011. Under this section a "domestic homicide review" means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—

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

(b) a member of the same house hold as himself, held with a view to identifying the lessons to be learnt from the death.

[1] Multi-Agency Statutory Guidance For The Conduct of Domestic Homicide Reviews - Home Office 2011 *www.homeoffice.gov.uk/publications/crime/DHR-guidance*

1.8 In compliance with Home Office Guidance [2], West Mercia Police notified the circumstances of the death in writing to South Worcestershire Community Safety Partnership (SWCSP) on 25th April 2012.

1.9 On 14th May 2012 members of the SWCSP met to consider the circumstances of this case and the Chair of the Partnership decided that the circumstances did meet the criteria for a Domestic Homicide Review (DHR), and as such a review should be conducted under Home Officer Guidance as well as guidance from Worcestershire Safer Communities Board[3]. On 15th May 2012 SWCP wrote to the Home Office informing it of the death and the intention to conduct a DHR.

1.10 The Review was Chaired and Authored by Mr Malcolm Ross, an Independent Consultant.

1.11 The administration and management of the Review process has been carried out by Gemma Davies, Worcestershire Forum Against Domestic Abuse until she left her post in November 2012.

1.12 Terms of Reference

Specific areas of concern for the DHR to focus upon

- Organisations' involvement in the case 6 months prior to the first referral to MARAC. (Multi-Agency Risk Assessment Conference)
- Organisations' involvement in the case during times preceding and following subsequent MARAC dates: 25/11/10 and 24/02/11.
- Risk Management Plans considered, implemented and outcomes
- Support Services engagement with deceased in Recovery Programmes

Panel Membership

[2] Home Office Guidance Page 8
[3] Domestic Homicide Review Protocol Worcestershire Safer Communities Board 2011

The Panel will comprise of individuals across a broad spectrum of both statutory and voluntary sector agencies. Representation should be at a sufficient level of seniority within their respective organizations to commit to the delivery of resulting recommendations. The Panel shall consist of core representation from the following agencies:

- West Mercia Police
- West Mercia Probation Trust
- Worcestershire NHS Trust
- West Mercia women's Aid
- Stonham (Housing Association)
- Crisis Reduction Initiatives (CRI) Pathways to Recovery
- Worcester Community Housing
- Health

Chair and Independent Author of the DHR Panel: Malcolm Ross

Independent Management Reviews (IMRs)

IMRs are to be requested from the following agencies:

- West Mercia Police
- West Mercia Probation Trust
- West Mercia health and Care NHS Trust
- West Mercia Women's Aid
- Worcester City Council Housing Department.
- Worcester Community Housing
- NHS Worcestershire
- Worcestershire Acute Hospital Trust
- Maggs Day Centre
- CRI Pathways to Recovery

Further agencies may be asked to submit IMRs in the light of the progress of the Review.

Family Liaison

This process is to be agreed following the completion of the criminal proceedings and will be actioned in consultation with the West Mercia Police Senior Investigating Officer and the Family Liaison Officer. A letter setting out the purpose for the review has been sent to one of V1's children with whom the

Police are liaising, and stating that the family will be invited to contribute to the review process in due course and after the trial.

How the DHR will link to any parallel investigations of practice
Not applicable

How the DHR will link to the criminal justice system, either a Police or Coroner's investigation:

Overview report to be published following trial of suspected offender

Start and completion dates for the DHR**:**

14th May 2012 to 11th November 2012

A strategy for the implementation of lessons learnt from the DHR:

The DHR Subgroup will develop an action plan, based on the recommendations of the Review. Organisations will be accountable to the DHR Subgroup and subsequently the Safer Communities Board and South Worcester CSP for completion of the recommended actions.

A strategy for the publication of the Overview and Executive Summary:

The overview and executive summary reports will not be published until after the trial of the suspected offender**.**

Media Strategy
All media enquiries will be handled by WCC Media Relations Officer
Legal Advice
The Panel will have access to Legal departments within WCC and West Mercia Police.

1.13 Liaison with the Police

The Chair/Author of the Review Panel will be responsible for ensuring appropriate liaison with the Crown Prosecution Service and the Police through the Disclosure Officer identified by the West Mercia Police. The Chair/Author

will have access to the Senior Investigating Officer (SIO), the officer from West Mercia Police in charge of the investigation.

1.14 Purpose of the Review

The purpose of having a Domestic Homicide Review is not to reinvestigate or to apportion blame, it 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;
- Prevent domestic violence homicides and improve service responses for all domestic violence victims and their children through improved intra and inter agency working.
- Ensure agencies are responding appropriately to victims of domestic violence by offering and putting in place appropriate support mechanisms, procedures, resources and interventions, responsive to the needs of the victim, with an aim to avoid future incidents of domestic homicide and violence.
- Assess whether agencies have sufficient and robust procedures and protocols in place, which were understood and adhered to by their staff

1.15 Review Time Period

The Review will consider the events of the V1's life from December 2009 to April 2012.

1.16 Panel membership

The Panel will comprise of individuals across a broad spectrum of both statutory and voluntary sector agencies. Representation should be at a sufficient level of seniority within their respective organizations to commit to the delivery of resulting recommendations. The Panel shall consist of core representation from the following agencies:

Louise Wall	Detective Sergeant West Mercia Police
Ernie Lock	Detective Chief Inspector West Mercia Police
Jan Francis	Chief Executive West Mercia Women's Aid
Michelle Coates	Senior Client Service Stonham
Jon Shorrock	Manager CRI Pathways to Recovery
Manjinder Purewal	Head of Service West Mercia Probation Trust Worcestershire
Bruce Mourby	Head of Neighbourhood Worcester Community Housing

Catherine Whitehouse Designated Nurse Safeguarding South Worcestershire, Redditch and Bromsgrove and Wyre Forest Clinical Commissioning Groups.

Martin Lakeman	Strategic Co-ordinator Worcestershire Forums Against Domestic Abuse and Sexual Violence

1.17 Independent Overview Report

Home Office Guidance[4] requires that;

"The Review Panel should appoint an independent Chair of the Panel who is responsible for managing and coordinating the review process and for producing the final Overview Report based on IMRS and any other evidence the Review Panel decides is relevant", and

"The Review Panel Chair should, where possible, be an experienced individual who is not directly associated with any of the agencies involved in the review."

[4] Home Office Guidance page 11

1.18 The SWCSP decided to appoint an Independent Chair and Author for the Domestic Homicide Review. Having sought expressions of interest in both posts, they appointed Mr Malcolm Ross.

1.19 Mr Malcolm Ross was appointed at an early stage, as Author. He is a former Senior Detective Officer with West Midlands Police and has many years' experience in writing Serious Case Reviews and Chairing that process and more recently, performing both functions in relation to Domestic Homicide Reviews. He has had no involvement either directly or indirectly with the members of the family concerned or the delivery or management of services by any of the agencies. He has attended the meetings of the panel, the members of which have contributed to the process of the preparation of the Report and have helpfully commented upon it.

1.20 **Individual Needs**

Home Office Guidance[5] requires consideration of individual needs and specifically:

"Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary?"

There is evidence that some professionals were insensitive to V1's need in their contact with her. There are occasions when each contact was dealt with in total isolation without any reference to previous contacts, thus preventing the holistic view of her needs to be seen.

1.21 Family Involvement

Home Office Guidance[6] requires that:

"Members of informal support networks, such as friends, family members and colleagues may have detailed knowledge about the victim's experiences. The Review Panel should carefully consider the potential benefits gained by

[5] Home Office Guidance page 25
[6] Home Office Guidance page 15

including such individuals from both the victim and perpetrator's networks in the review process. Members of these support networks should be given every opportunity to contribute unless there are exceptional circumstances",
and:
"Consideration should also be given at an early stage to working with family liaison officers and senior investigating officers (SIOs) involved in any related Police investigation to identify any existing advocates and the position of the family in relation to coming to terms with the homicide."

1.22 In this case the Overview Report Author made contact with the Senior Investigating Officer (SIO) from West Mercia Police at an early stage. The family members of V1 have been written to via D1 offering the family the opportunity to contribute to the Review and to receive its findings and recommendations.

2.0 Sequence of events

2.1 V1 was born on 9th September 1963 and was 48 years old at the time of her death. She was an alcoholic and her drinking meant that she relied heavily on other people, mainly men, who had a similar drink problem. She was well known to the police having been convicted on 96 occasions including 21 convictions for failing to surrender to custody, 10 offences of drunk and disorderly, 5 offences of threatening behaviour and 28 breaches of her anti-social behaviour order (most of which involved drunkenness). This has resulted in the Court sentencing her to terms of imprisonment on 22 separate occasions. She had been subject of an Anti-Social Behaviour Order between 2004 and 2009.

2.2 She associated with numerous male partners during the latter stages of her life, and she was frequently subjected to severe acts of violence and rape by these men, but only occasionally did she call the police and hardly ever made a complaint or statement in support of a prosecution of the offenders.

2.3 The timescale for this review is from December 2009 to April 2012.

December 2009 to December 2010

2.4 V1 was a regular attender at a Day Centre in Worcester and this was to become one of her central points of refuge when she needed support and advice. It was also the staff at the Day Centre that became concerned when she had not attended for some days which resulted in the police being notified and her body being found. She would often have daily meals at the Centre and members of the staff there were clearly fond of her.

2.5 V1 lived in a rented flat. She and her regular visitors to her flat were the cause of considerable anxiety for the neighbours alongside and beneath her flat. Calls to the police regarding noise, drunkenness and violence were made by neighbours on a regular basis. The menace from V1's flat caused neighbours to move from the area.

2.6 V1 was registered at Doctor's Practice No 1 from December 2009 until April 2011 when her notes were transferred to Worcestershire Strategic Health Authority. It is of interest to note that in the IMR from the GP there is an entry to the effect that on 4th December 2009 a letter from the Job centre was sent to her GP issues around the criteria for assessment of her capacity. The GP responded that she meets the eligibility criteria for employment and work related support allowance but proof of her disability may still be required for other organisations. So in December 2009 V1 was considered to have a disability.

2.7 At 6.50pm on 6th January 2010 police were called by N1 saying that V1 was harassing him and had thrown whiskey into his face. He told police that he had been experiencing problems with V1 and had invited her into his flat intending to sort the problems out but an argument started. Police did not attend and there is no record of how the situation was resolved other than an e mail being sent to the Local Policing Team.

2.8 Within 25 minutes N1 called the police again stating that as V1 had left his flat she had deliberately damaged a glass by smashing it and he wanted a police officer to attend. Officers did attend and both V1 and N1 were found to be under the influence of alcohol. No further action was deemed necessary, N1 did not want to make a formal complaint against V1.

2.9 10 days later at just after midnight on 16thJanuary 2010, N1 again called the police saying that P1 was banging his flat front door and threatening to smash the door down. Police attended immediately and P1 was found to be wanted by West Midlands Police for a serious assault. He was duly arrested. P1 has numerous previous convictions for such offences. There is nothing to suggest that either V1 or P1 were questioned about the anti-social behaviour shown towards N1.

2.10 At 01.35 on 3rd February 2010 N1 called the police complaining that V1 was at his door, half naked and stating that she had been assaulted by P3 who had refused to leave the flat. Both V1 and P3 were drunk. P3 was arrested for a breach of the peace after refusing to leave and a police referral was made to the Domestic Abuse Unit. There was no formal complaint made by V1, who declined to give the officers sufficient details of the incident for a Domestic Abuse Investigation Guide Booklet to be completed. No details of the incident were shared with other agencies. This incident is recorded as a Domestic Incident by the police.

2.11 At 14.26 on 9th March 2010 a call was received by the police from a Worcester Community Housing plumber who had attended at V1's flat in order to fix a leaking washing machine. It is alleged that the pipe to the washing machine had been disconnected, according to the plumber, deliberately, and had caused a flood in the flat below. The plumber reported that V1 had a black eye and she had been abusive to her neighbours as well as to the plumber. There were signs of violence in the flat. The plumber reported that on visiting the flat below to assess the damage, occupants stated that V1 and P1 had been fighting all night.

2.12 There was no officer available to attend at that time due to other more pressing duties and there was a delay until 20.17. When officers arrived they assisted in removing P1 from the address at the request of V1. There is nothing recorded about any injury being noted on V1, and the issue with the damaged caused by the water was not taken any further. V1 was advised about the removal of the pipe by Worcester Community Housing. This matter is recorded as an Anti-Social Behaviour incident by the police.

2.13 The next call to the address was made at 21.22 on 21st March 2010 by N3, who stated that there was a 'bad domestic' occurring at V1's flat. N3 could hear shouting and swearing and property being thrown about the flat. She had even turned up her television so mask the noise from V1's flat. Police attended immediately and on arrival there was a delay in V1 opening the door. Officers could see that there had been a disturbance in the flat but there were no signs of another person in the flat. It is not recorded if the flat was searched by the police and there is nothing to suggest that any injuries were noticed on V1. There is nothing to suggest that the person N3 referred to was ever identified.

2.14 N3 was seen and advised to contact the council about the noise and she was provided with the telephone number to do so. The incident was recorded by the police as a Domestic Incident, having originally been recorded as Domestic Abuse.

2.15 At 22.43 the following evening, 22nd March 2010 N3 again had to call the police. Noise from V1's flat was keeping N3's three young children awake. There was loud music, screaming and shouting coming fromV1's flat. N3 stated that V1 constantly had black eyes. Officer attended promptly but again V1 took some time to open the front door. Officers suspected that whoever the male person was that N3 had referred to, was hiding in the flat. V1 refused to allow police into her flat and did not appear to be drunk. Police said she did not appear to have any injuries but there is nothing to indicate to what extent V1 was 'examined'.

2.16 The report is endorsed by a supervisor that the noise was no more than a loud party, irrespective that there were three children affected by the noise.

2.17 At this time one of V1's ex partners, P2 was in prison. He had been sentenced to 4 years for pouring boiling water over V1 and he was due to be considered for parole. On 25th March 2010 the Victim Liaison Officer from the Probation Service were preparing to contact V1 regarding his release. An earlier opportunity to contact V1 in February 2009 regarding P2's release was thwarted due to the fact that a letter sent to V1 from Probation had not been delivered as at the time V1 was serving one of her periods in prison herself. A letter was sent to V1 by Probation offering an appointment but they received no reply.

Enquiries were made at the Day Centre but V1 was only making sporadic visits to the Centre at that time.

2.18 At 20.38 on 16th April 2010 N3 was being disturbed by the noise from V1's flat and she used the intercom button to ask V1 to keep the noise down. N3's children were also being disturbed and at that time N3 was six months pregnant. N3 called the police for assistance. N3 reported that V1 was at the back of the flat outside, shouting and threatening to assault N3. The police Call Taker advised N3 to dial 999 in the event of either V1 or her male companion, whose identity was subsequently discovered at P1, continued the threats. No officer was despatched to the answer the call and no explanation is recorded as to the rationale behind that decision. Between 20.38 when the first call was received and 21.20 the status of the call was changed by the Call Taker to 'active' and then back to 'not resourced'. At 21.20 the entry on the log is amended again to 'all officers committed.'

2.19 At 22.15 for some reason, the Call Taker contacted N3 but there is nothing recorded about the details of the conversation other than N3 was 'happy to wait up'. The note continues to say that the disturbance at V1's flat had continued and was still on going at the time of this latest call. Officers did eventually attend to V1's flat, albeit at 22.45, some 2 hours and 7 minutes after the initial call. There is nothing recorded as to who they spoke to or what the officers did at the flat. A Domestic Abuse Incident form (CO1) was submitted which indicates that N3 complained to V1 about the noise and V1 had threatened to 'smash her head in'. The form indicates that both V1 and P1 were heavily intoxicated, abusive and obstructive to the police. Initially V1 complained to the police that she had been assaulted by P1, but immediately retracted that allegation and became increasingly abusive when pressed for details by the officers. She showed no signs of injury. P1 denied any assault. He was told to leave the premises to prevent a breach of the peace. There was no referral made to any other agency irrespective that there appears to have been safeguarding issues with regard to N3's children and safeguarding issues also in respect of N3 herself.

2.20 On 1st May 2010 the Day Centre conducted a review of V1's situation and recorded that there was an Anti-Social Behaviour Order (ASBO) in place regarding V1 and that she had shown signs of injuries to her face and body allegedly caused by her ex-partner and other associates. She was not engaging regularly with the Day Centre and they had difficulty in monitoring her. The Day Centre was aware that there had been problems at the flat caused by V1's associates and V1 had recently been issued with a warning of tenancy termination due to the constant complaints.

2.21 During May V1 attended at the Day Centre on occasion for lunch.

2.22 On 14th May Probation contacted the police to verify V1's address as V1 had failed to keep a voluntary appointment. It was agreed that she should be subject of a Multi-Agency Risk Assessment Conference (MARAC) the following month. V1 was offered two alternative voluntary appointment with Probation during May, both of which she failed to attend.

2.23 On 19th May 2010 it was decided at a Multi-Agency Public Protection Panel (MAPPP) that P2 who was at that time in prison for scalding V1, should be regarded as a Level 1 Offender and this would be reviewed prior to his release from prison in September 2010.

2.24 On 4th June 2010 Probation made a MARAC referral to West Mercia Women's Aid regarding V1, which was passed to an Independent Domestic Violence Advisor (IDVA), who was given actions to convene a core group to discuss V1's case, and to engage V1 in some support. V1 failed to attend the arranged appointment, but despite this a decision was made to continue with the referral due to the high risk posed to V1 from P2. Further attempts were made to arrange a meeting but V1 again failed to attend so the case was closed in July 2010.

2.25 During June 2010 V1 maintained contact with the Day Centre on quite a regular basis and on 23rd June she told the Day Centre staff that she didn't want P2 to know that she was at the Day Centre should he call from prison. It appears that he would regularly call the Day Centre asking to speak to V1. It also appeared to the Day Centre staff that P2 was getting frustrated that he wasn't able to

speak to V1. In view of that another MARAC meeting was arranged to discuss V1's risk. P2 would not be released from prison without an address and it appeared that he wished to reside with V1.

2.26 The following day another MARAC meeting was held. V1 expressed the wish to continue with the support she was getting from the Day Centre, Probation and Women's Aid. She also wanted to maintain tenancy and re-settlement support regarding her accommodation. The meeting heard that P2 was due to be released in September 2010 and Probation was to set licence conditions upon his release. He was to report to the Probation Offices in Worcester, reside where directed, not commit any offences and behave, maintain contact with the Probation Service, undertake work as approved and not to travel outside the UK.

2.27 On 26th June 2010 the Day Centre held a review summary in respect of V1. She had been attending Freedom Programme and had been at the Day Centre on a regular basis. She was reported as having a good relationship with a female friend and she was being supported by the Day Centre. V1 was looking to move from the area as she was unhappy with her accommodation, but she was also reported to have frequent visitors to her flat who cause anti-social behaviour during drinking sessions.

2.28 On 29th June 2010 P1 was removed from the Day Centre by the police after intimidating staff. He was suspended from the Centre for 3 months.

2.29 On 1st July, 2010 N2 and N3, neighbours of V1, called Worcester Community Housing saying that there was water coming into their flat from V1's flat. They had got no reply when they had been to V1's flat. Housing officials attended and gained entry into V1's flat to rectify the leak on the following day.

2.30 On 8th July 2010 V1 had a discussion with a member of staff from the Day Centre. V1 expressed her concerns about her safety when P2 was released from Prison. She was told that a MARAC meeting had been held and the member of staff wished to work with V1, who stated that she would think about the offer.

2.31 On 15th July V1 failed to keep an appointment with West Mercia Women's Aid. V1 rang to say that she had overslept. Again on 21st July V1 failed to attend for a meeting with the Day Centre.

2.32 On 27th July Hospital records show that she had previously attended in April 2010 with a head injury, on two occasions in 2007 with burns to her chest wall and another minor head injury and once in 2008 when she collapsed.

2.33 On 22nd July V1 attended at the Accident and Emergency at Worcester Hospital. She was reported to have contusion to her chest wall, face and having a minor head injury. She was found on the tow path to the River Severn complaining that she had been kicked in the head. She had been drinking alcohol. She was admitted for observations. However police records regarding the latest admission on 22nd July 2010 indicates V1 was found unconscious in the road saying she had been assaulted by a man (P5) with whom she had been having a relationship for the past couple of months. She was intoxicated and could not recall exactly what happened. Whilst the police were at the scene P5 appeared and was arrested. He was detained overnight, interviewed and released without charge the following day. He denied assaulting V1.

2.34 V1 was detained in hospital overnight with a small cut to her eyelid, swollen nose and a cut ear. A note indicates that an Inspector filed the papers on 27th July 2010, indicating that there was 'no realistic prospects of a conviction' against the man.

2.35 Police were called again on 27th July to an address in the road where V1 lives, (P4's address). V1 was drunk and trying to break in through emergency doors. No police action was required.

2.36 6 Days later a Probation Liaison Officer expressed the wish to see V1 for her to consider any conditions that she would like to be imposed on P2 on his release. However, a member of the Day Centre staff informed Probation that V1 and P2 were in contact with each other by telephone and that V1 was being bullied by other man.

2.37 During the remainder of August V1 attended the Day Centre on an almost daily basis to either have breakfast or lunch. It is recorded however, on 17th August

that she was drinking heavily and was not committing to appointments. She was spending time with her associates including A1.

2.38 On 1st September 2010 Probation wrote to V1 informing her of the release of P2 and offering an appointment to discuss the conditions to his licence. V1 failed to keep the appointment.

2.39 For the next few days V1 attended at the Day Centre each day and on 8th September Probation considered the fact that P2 was expressing an intention to live with V1. Probation thought about banning the relationship but V1 wanted him home. Her wishes were to be confirmed.

2.40 Following consultation with MARAC co-ordinator, the police and V1's Probation Manager, it was decided that it would be in the best interests of both V1 and P2 to allow him to reside at V1's flat. It was considered that if this had not been allowed both V1 and P2 may have disappeared. By allowing him to reside with V1 he could be properly supervised.

2.41 However, on 12th September V1 called the police to say that P1 had slapped her and tried to throw coffee over her. He had locked her out of her flat. She called him a bully. On arrival of the police P1 had left the flat and V1 was described as being drunk. Arrangements were made with the police for V1 to be interviewed the following day but she did not attend or make a complaint. The police were unable to take any further action.

2.42 The following day V1 confirmed to Probation that P2 could go to her flat on his release from prison. Probation indicated that P2 would be released on 28th September 2010 and as V1 was agreeable he would use her address as his bail address. It was made clear to V1 that heP2 would be recalled if her broke any of his conditions of his bail conditions.

2.43 On 15th September 2010 the Probation Service requested the police to make a personal visit to V1 and confirm that she wished P2 to reside with her at her flat. That day, neighbours of V1 made a complaint to Worcestershire Community Housing about the noise and nuisance being caused at V1's flat.

2.44 On 20th September 2010 at a discussion between a Probation Officer and a Manager, it was decided that all agencies were happy for V1 and P2 to have contact as this was seen to be the safest option for V1.

2.45 On his date of release from Prison, 28th September 2010, P2 attended at his Probation Office with V1. Both were described as being intoxicated. P2 signed a compact agreement and was given future reporting conditions. A note states that standard licence conditions were in place. He had been imprisoned for pouring boiling water over V1.

2.46 On 4th October 2010 a decision was made by Probation to retain P2's case at level 1 MAPPA (Multi-Agency Public Protection Arrangements). On 8th October the Day Centre reported seeing P2 and V1 together.

2.47 On 12th October neighbour N2 called the police at 21.54, complaining that shouting, banging, singing and loud music could be heard from V1's flat, so much so that his 5 children aged between 5 and 17 weeks were all awake being disturbed by the noise. He explained that he was logging complaints for the council. He also stated that associates A1 and A2 has threatened his partner and he and his partner N3 feared for their safety and also feared for reprisals should the police disclose to the V1 and her associates their identity. The police recorded this incident as a level 2 call which required prompt or priority response.

2.48 The police Call Taker contacted the Anti-Social Behaviour Unit by e mail and a supervisor called N2 and informed him that he needed to contact the Environmental Health about the noise problems. When N2 stated that he thought the police were not doing anything to help, He was told that if it was possible, an officer would be sent, but the police could not promise such action.

2.49 N2 was told that the Local Policing Team would contact him but no officer contacted him and nothing was done regarding any Child Safeguarding issues.

2.50 Two days later, on 14th October 2010, P2 went to a neighbour's flat to apologise for a disagreement that had occurred earlier and indicated that he was going to V1's flat and kill her. It is known that later that evening he threatened to pour boiling water over V1 and held a knife to her throat threatening to cut her. P2

had been living with V1 for 2 to 3 weeks and domestic abuse had occurred between him and V1. The neighbours called the police regarding the threats to kill V1. They found V1 very drunk. Police conducted an investigation and a file was subsequently sent to Crown Prosecuting Solicitors (CPS), who decided that No Further Action should be taken with regard to this reported offence.

2.51 At 22.38 on 16th October 2010, neighbours again called the police to report that people in V1's flat were fighting. There were police records of previous domestic violence incidents at V1's house and notes indicating that V1 was subject to a risk management plan. Police were despatched to the address as an immediate response incident. The neighbours were seen as was V1. She complained that P2 had attempted to rape her when she refused to have sex with him. P2 was arrested and detained.

2.52 V1 was seen by specially trained officers. She stated that since P2 had been released from prison there had been domestic violence and he often held a knife to her throat, beat her and he had tried to throw her into a bath of water. She wanted him out of her flat. However, V1 refused to make a statement of complaint or allow a medical examination or provide samples for forensic examination.

2.53 P2 was interviewed and denied responsibility. The following day police again attempted to convince V1 to complain about the rape incident but she again refused. She indicated that she wanted to renew the relationship with P2. CPS was contacted and advised that there would be no reasonable prospects of proving the offence due to V1's reluctance to complain, and no further action was taken.

2.54 On 17th October Police informed Probation and P2 was recalled to prison by Probation. The police again attempted to persuade V1 into complaining against P2. Again V1 would not reconsider changing her mind. The police even tried to put the officer who had dealt with her during the incident when P2 injured her with boiling water for which he was convicted, in touch with her, again in an attempt to get her to change her mind. Again this failed. In addition N2 and N3 were reluctant to make a statement to the police or give evidence whilst they remained neighbours of V1.

2.55 During the latter part of October, V1 maintained contact with the Day Centre, visiting almost every day.

2.56 On 3rd November 2010, Probation sent a letter to V1 advising of the recall of P2 and offering an appointment on 11th November 2010. She was advised that if she failed to keep the new appointment on 11th November, 2010, the Probation would consider a joint home visit. She failed to attend the appointment.

2.57 On 8th November V1 was removed by the police for causing problems at the Day Centre whilst drunk. On 15th November 2010 V1 signed a contract with the Day Centre to the effect that she would not attend if she had been drinking. However, two days later, on 17th November, she was drunk at the Day Centre, throwing cups around and being abusive to the staff. Again police attended and removed her. She was arrested, detained for 6 hours and released without charge.

2.58 There was a MARAC meeting on 25th November that reviewed V1's case. It was decided that V1 should continue to be supported by West Mercia Women's Aid Independent Domestic Violence Advisor (WMWA IDVA) who should maintain liaison with the Day Centre and inform V1 of the outcome of the review. Probation reported that V1 still wanted a relationship with P2 and she declined any support. The charges against P2 of rape and threats to kill V1 were dropped. Probation would not support a Parole Board release of P2. The IDVA was to continue to support her and the police were to consider a Violent Offenders Order (VOO) against P2. V1 was making excuses for the offences committed on her by P2 and she was stating that she still wanted him back. It was agreed that V1 and Probation should meet at the Day Centre to talk through these matters.

2.59 On 8th December V1's electricity provider threatened to cut off her supply. V1 sought advice about how to complain about her neighbours.

2.60 On 10th December the multi-agency meeting took place at the Day Centre and the Domestic Abuse Management Plan was downgraded from high to medium on the basis that P2 was in prison.

2.61 On 12th December 2010, police were called to V1's flat following a complaint from N2 and N3 about the noise. V1 had been asked by the neighbours to be quiet but this had resulted in more noise, abusive behaviour and constant ringing of the doorbell. Children were unable to sleep. On arrival of the police the occupants of V1's flat were identified as being, V1, A1, a brother of P2, and another unknown man. A1 was arrested for breach of a CRASBO Order for which he was imprisoned.

2.62 P2 tried to contact V1 through the Day Centre on two occasions, 14th and 15th December requesting v1 to write to him and provide money for him.

2.63 On 20th December neighbours called the police again to a fight outside the front door of the flats, involving V1 and several associated from her flat. Officers were unable to attend immediately due to other commitments, but eventually arrived to find everything in order. Those present smelled of alcohol but the officers reported that people were talking loudly as opposed to arguing and fighting. There were no signs of domestic violence in the flat and it was noted that V1 was subject of a Risk Management Plan.

2.64 Nine days later on 29th December 2010, the same neighbour again called the police to report that V1 and her friend were banging doors and had been threatening towards the complainant. Officers attended and found V1 to have a small cut to her toe and P1 to have scratch marks to his neck and chin. Neither of them would disclose how their respective injuries occurred or wished to pursue any complain about the other. P1 became aggressive towards V1 in the presence of the officers and was arrested to prevent a further Breach of the Peace. A note in the Police chronology correctly points out that it appears that the original complaint from the neighbour had not been addressed.

January 2011 to December 2011

2.65 On 2nd February 2011 Probation and the police had a discussion regarding the fact that due to V1's reluctance to pursue her allegations of rape and threats to kill by P2, the cases had been discontinued. There was a discussion about P2 being made subject of a Home Detention Curfew, but this never materialised.

2.66 The following day there was another complaint to housing, from neighbours about swearing by those frequenting V1's flat.

2.67 On 4th February there was a MAPPA level 2 meeting to discuss the release of P2.

2.68 At the Day Centre on 7th February 2011, V1 complained to staff that she had been raped by a man and was bleeding from her injuries. She was advised to go to the police and the Walk in Centre for medical attention. She did neither.

2.69 On 12th February 2011 N2 and N3 made a complaint to Worcester Community Housing on two consecutive days that a man at V1's address was hanging out of windows, drunk and swearing and banging on their windows.

2.70 On 14th February V1 went to the Probation Offices and reported that she had been threatened with eviction from her flat. She then announced that she had been in a relationship with P1 for 18 months and wanted to marry him. She agreed to have a joint meeting on 22nd February with the IDVA as per the MARAC recommendations. On that day V1 attended at the Probation Offices where she reiterated her intention to marry P1, but she expressed concern about what P2 would think of that idea and what his reaction would be.

2.71 On 24th February 2011it is noted that V1 refused to engage with a MARAC meeting. The meeting recorded that the Probation Victim Liaison Officer was to liaise with Stonham and would provide an update regarding P2's release.

2.72 On 1st March 2011 yet another compliant was made by neighbours of V1 to the effect that a man staying at her flat was causing a nuisance.

2.73 On 5th March V1 was barred for a day from the Day Centre again for her behaviour. The following day V1 attended Accident and Emergency at the hospital intoxicated.

2.74 On 7th March 2011 a MAPPA level 2 meeting was held with P2 being the centre of debate. It was decided that the case should be raised to level 3 and to include some protective factors within the licence for P2, in that he would not reside at V1's flat and any contact with her must be supervised. Worcester Community Housing considered suspending V1's tenancy. This meant that this was the last

chance for V1 from a housing point of view, but as the Probation chronology indicates, this issue was for MARAC and the MAPPA remit was for P2.

2.75 On 10th March 2011 V1 failed to attend at the Day Centre for an arranged meeting with Probation so she was unaware of the suspended tenancy arrangements. The following day she was seen at a multi-agency meeting. She was informed that she was not to be evicted at that stage, but she was served with a notice to seek possession. There is comment that there was a lot of agency involvement with V1 at this time and that there had been no recent complaints from her neighbours.

2.76 On 17th March, Worcester Community Housing decided to go ahead with the suspended tenancy for V1 but she failed to attend another arranged meeting, so again was unable to be told.

2.77 On 23rd March at a MAPPA meeting the best way forward regarding the housing conditions for P2 on his release was discussed. He was due for parole on 16th March, but he would not be released due to the risk he posed to V1. He was required to complete an anger management course before being released and a note states that V1 was happy with a 'no contact condition'.

2.78 On the same day Worcester Community Housing decided to install noise monitoring equipment around V1's flat as the disturbances had started again. The equipment was installed in May 2011.

2.79 On 24th March V1 attended at the Probation Offices for a meeting with the IDVA, Housing and Probation. It was a regular occurrence to use offices at Probation for meetings with V1 with the IDVA and other agencies and not particularly with a Probation Officer, as this was V1's venue of choice. V1 was not on any statutory requirement therefore any/all contact with Probation was voluntary. At this meeting she was told about the suspended tenancy possession and they discussed the option for her to move. She reported being threatened by a neighbour. She also stated that the wedding to P1 was off and that she had not seen him for some time and believed that he was in Birmingham. She was informed that the Parole Board had decided not to release P2 at the moment

and she expressed concerns that's he would be blamed for that by his associates. The Probation Officer informed the police of her concerns.

2.80 At a multi-agency meeting held on 8th April 2011, it was stated that P1 and P4 had been seen in V1's flat. P1 was subject to a CRABSO. Two days later P2 tried to contact V1 from prison by ringing the Day Centre. V1 had not been seen for a few days.

2.81 On 12th April 2011 V1 attended at the Walk in Centre surgery complaining of various ailments including rectal bleeding from which she suffers every two weeks after being raped some five years ago. There is nothing to indicate that she was examined. She also complained of breathlessness and having difficulty in breathing. She was given antibiotics and steroids. She was advised to see her registered GP but seemed reluctant to do so.

2.82 On that day, there was an indication that V1's situation was improving for a time. She told the IDVA and a Probation Officer that she was going away on holiday, she was undergoing an alcohol detox programme and she was willing to work with the IDVA after her holidays. She also stated that she had seen P1 and the wedding was back on and arranged for September.

2.83 On 15th April 2011, N3 reported to the police that she had been beaten up by V1's boyfriend who had just come out of prison (P1).Police had to effect entry to V1's flat as she would not open the door and police could hear a commotion inside. Both V1 and P1 were drunk and both had injuries. Neither would complain so both were arrested. P1 had teeth missing and blood in his mouth. V1 had a bruised face and a bloody bite mark on one of her toes. Neither would complain or have their injuries photographed. Police decided that a charge of assault would be difficult to sustain due to lack of complaints so both were bound over to keep the peace.

2.84 On 5th May 2011 the Walk in Centre surgery wrote to V1 stressing the importance of her attending a new patient health check which she had failed to do.

2.85 On 8th May V1 expressed concerns to the Day Centre staff that P4 was going to stay at her flat albeit he had assaulted her in the past. On 10th May V1 saw

a GP at the Walk in Centre who strongly advised her to decrease her alcohol intake and improve her lifestyle. She was seeking antidepressant medication.

2.86 On 14th May 2011 police attended at V1's flat after she alleged that her purse had been stolen by two men who had been at her flat. P4 was also there and gave various versions of events. V1 could not recall why she had called the police but stated that there was £100 in her purse. Police considered this a dubious call as V1 seem only interested in obtaining a crime number so she could claim a crisis loan from the DDS.

2.87 On 23rd May N4 called the police about a disturbance at V1's flat. Police took an hour to respond, during which time N4 called again. On arrival officers found V1, appearing sober, and stating she had had an argument with another woman. N4 was told to contact Worcester Community Housing should there be further disturbances and to log the events.

2.88 Two days later Worcester Community Housing received a report from N2 and N3 about threats of physical violence from people at V1's flat.

2.89 On 15th June 2011 MAPPA minutes indicate that V1 was now not happy with the 'no contact' decision regarding P2. She had been told that it was for her own good and that there were concerns that he could harm her. It was recoded that she was in a violent relationship presently with P1 but they still intended to marry. It was considered that a risk assessment would indicate that the chances of violence would increase in drink and there were no boundaries to the violence when drunk. The MAAPA level was to maintain at level 3. Parole would not be considered for P2 until February 2012, but the potential for violence between P1 and P2 once P2 was released was identified. On this day V1 failed to attend court regarding the breach of the peace events of 15th April. She said that she was afraid of the outcome of the court hearing and she was hiding from the police because she thought there would be a warrant for her arrest in existence.

2.90 On 26th June 2011 a risk assessment of V1 was carried out at the Day Centre, which concluded that V1 was at high risk from her ex-partner and other associates who she encourages into her flat to drink. When under the influence

of drink she is aggressive and abusive and even though P2 was still in prison, P2's brother posed a threat to the safety of V1 as did P1, P4 and A1 and A2.

2.91 During July there were several other incidents where neighbours called the police because of disturbances at V1's flat. One of the neighbours decided to move as he feared for the safety of his family.

2.92 There then followed an allegation by V1 that P3 had assaulted her. He had kept her in her flat, beaten her, forced her to have sex and at one point stated that she had been knocked unconscious by P3. However, as before, she refused to be medically examined and declined to report the sexual offence. P3 was eventually arrested for the assault but without a complaint no further action was taken. It is of interest to note that on the day of reporting these incidents, V1 was drunk and the police officers that attended arranged for her to attend at the police station 2 days later to make a statement. Their justification for doing so was that she was drunk and a coherent statement would not have been possible. The fact that V was nearly always drunk may have meant that she would never be able to make a coherent statement.

2.93 She was found the following day by Day Centre staff.

2.94 On 22nd July 2011 West Mercia Women's Aid (WMWA) IDVA saw V1 who disclosed that she had been abused by most of her partners and that she would like to move out of the area, later deciding on Evesham, Pershore or Malvern areas. She confirmed her reluctance to making a statement to the police about any assault or injury. She was assessed as being at high risk of harm. It was noted that there had been an escalation within the last three months of physical harm towards V1,

2.95 On 29th July 2011, a man, who himself appeared drunk, called the police telling them that there was a drunken woman being assaulted by a man. Officers attended at V1's flat but were not allowed in. They tried to contact V1 by phone but that was unsuccessful. Further attempts to make contact with V1 were made the following day and eventually she was traced and described as being safe and well.

2.96 On 17th August 2011 the Walk in Centre surgery sent another latter to V1 reminding her of the importance for her to have a health check. She failed to respond to the first letter.

2.97 2 weeks later another letter was sent reminder V1 that she had not responded to the previous letter.

2.98 On 20th September 2011 the Probation VLO was informed of a telephone call between P2 and V1 on 14th September during which he threatened to kill her. That information was passed to the police. There is nothing in the police IMR to indicate that the police received the information or if they had, did anything about it.

2.99 On 28th September the Walk in Centre surgery sent another letter to V1 reminding her of the need for a health check as she had ignored the previous two.

2.100 After several attempts to contact V1 in September, WMWA write to her arranging a meeting on 3rd October. V1 attended that meeting where her safety was discussed as well as a possible move from the area. V1 stated that she thought her drinking was out of control and she still wants to resume the relationship with P1. She declined to take part in the 'Freedom Programme' (This is designed to raise awareness of professionals around domestic abuse and allow them to sign post victims to the Freedom Programme.). V1 discussed what would happen when P2 was released from prison to which V1 replied, 'He will probably kill me'. She was sure that one of her associates would kill her. She said that she felt safe in her flat until all of the drinking associates were present. There is no suggestion that V1 was referred for any medical or mental treatment regarding her drinking.

2.101 On the same day V1 had a meeting at Probation offices with the IDVA and Probation and in contradiction to what she told WMWA, she told probation that she was no longer seeing P1.

2.102 Another letter (4th) was sent to V1 on 4th October from the surgery, this time reminding her of the need for a flu vaccination. She did respond to this and was vaccinated on 11th October, but the following day another letter was sent by the

surgery as she had not attended for an asthma review. A second letter was sent from the surgery on the same day, 12th October reminder V1 of the need for the health check as she had ignored the previous 3 letters.

2.103 On 29th November 2011, V1 reported to staff at the Day Centre and also to the WMWA IDVA the VLO that she had been beaten by P4 twice in recent days. He had cut her back with a knife and there was blood over her furniture in the flat. She was advised to call the police but stated that it would make the situation worse and she would be beaten again. He had hit her around the head and she was confused. She could not recall the correct days of the week. Neither the Day Centre nor Probation called the police or arranged medical examination or care for V1.

2.104 The following day a MAPPA meeting was convened resulting in V1 being put in touch with the Police Domestic Violence Unit, but a note states that her engagement with the IDVA and the probation Victims Liaison Officer was erratic. The risk between P1 and P2 was discussed and it was noted that V1 was at risk from both men.

2.105 On 2nd December 2011 a 5th letter was sent form the surgery because V1 had ignored the previous 4, and on 3rd January 2012 a 6th letter was sent to her.

January 2012 to 12th April 2012

2.106 On 4th January 2012 at a MAPPA meeting Probation stated that they were not supporting parole for P2. V1 was refusing to engage with her care plan and support. The case was re listed for another MAPPA meeting in July 2012, six months away. A note indicates that there would be a MARAC referral at about the same time.

2.107 However, on 6th January 2012 an associate reported to the police that V1 had been raped by P4. She also reported that he had assaulted her. It was stated that V1 and P4 had been in a relationship for 18 months and the rape had taken place in P4's flat. Officer attended and investigated the allegation. V1 was reluctant to give any details of the offence but a written statement was taken

which contained very little information due to V1's unhelpful manner. Forensic evidence was taken, which later proved that P4 had had sexual contact with V1, but that result was not obtained until after her death. P4 was arrested and interviewed and said that there had been sexual contact which was consensual by both parties. He denied the separate complaint of assault. A MARAC meeting was called for the 13th January but V1 was still unwilling to complain and pursue the allegation. In those circumstances No Further Action was taken.

2.108 On 12th January 2012, V2 discussed the incidents with Day Centre staff and asked for support from a support worker from the Day Centre. The following day an IDVA from WMWA spoke to V2, who stated she was tired and wanted to give up drinking. She described the rape offence committed by P4 but stated that she didn't want to take the matter any further. The police were invited to the meeting and a detective Officer attended at the Day Centre. V2 confirmed she would not make a statement but did talk about her intention to move away from the area. She said that she had not heard from P2 from prison or any of his associates nor were there any complaints from the neighbours.

2.109 However, an arrangement was made for a member of staff from the Day Centre to meet V1 at the police station on 15th January to make a formal statement about the offences. V1 failed to turn up for the meeting.

2.110 Over the next few days the Day Centre staff and the IDVA worked with V1 in trying to find her a place to move to and also making sure that she had adequate security on the front door of her flat. The offer of a refuge was talked about but V1 was not keen to move into refuge.

2.111 On 24th February 2012, V1 was told that P2 was out of prison and staying in Wolverhampton or West Bromwich. She did not know if this was true but it clearly upset her. She was told that this would have to be checked and them a conversation took place about her moving into a refuge. She stated that she was reluctant to go as she would feel isolated.

2.112 On 1st February the Walk in Centre surgery sent the 7th letter reminding V1 to attend for a routine check-up as she had failed to attend on the previous 6 invitations.

2.113 On 2nd February V1 did attend at her GP's surgery and there is an extensive entry in the Health chronology regarding her ailments. She disclosed to the GP about being raped the previous month and that the police were involved. She was seen by 2 GPs, one being senior to the other, but neither of them considered contacting Woman's Aid or Pathways to see if she was not actually attending, nor did they consider a detailed discussion about the rape because the police were involved. They suggested that V1 should continue with the Support Worker at WMWA.

2.114 On 3rd February V1 attended at the Probation Offices to see the IDVA and a Probation Officer. She reported that she had had her purse stolen whilst she was at a friend's flat. There was a discussion about fitting an alarm to her flat but she declined saying that she would not use it and it would probably be stolen in any event. She stated that she intended to go to Hereford to look for somewhere else to live at some time in the future. She was scared of starting elsewhere again and when P2 came out of prison she would probably tell him where she lived. She was told that P2 would not be able to contact her once he was released as a condition of his licence as he posed such a high risk to her. V1's reply was that she would contact him and no-one could stop her doing that. When the dynamics of domestic violence was pointed out to her she stated that it was all that she had ever known. She told Probation that she wants to live with P2 when he was released and she was looking at Hereford and also Pembrokeshire. V1 was advised to contact Pathways for treatment for her alcohol problems but she said she had lost the telephone number.

2.115 On 6th February 2012, V1 reported to the police that it was A3 who had stolen her money but she refused to take the matter any further or even make a statement.

2.116 On 8th February blood tests results showed them to be normal but with excess alcohol content.

2.117 On 16th February the Walk in Centre surgery wrote to V1 for the 8th time.

2.118 On 29th February V1 attended at the Probation Offices and stated that she was still in contact with P2 and requested help with her drinking. There followed 3

more failed appointments with either the IDVA or the GPs for more blood results.

2.119 On 8th March 2012, N4 reported to the police that his friend had been assaulted by V1. On arrival the police were informed that there had not been an assault.

2.120 The following day at WMWA V1 disclosed that P1 was back on the scene and concern was expressed regarding the risk when P2 was released from prison. V1 stated that a move to Hereford was still possible.

2.121 At an appointment with her GP on 13th March V1 stated she was trying to control her drinking albeit she described a recent 'binge' when considerable amounts of alcohol had been consumed. She stated that she had an appointment with Pathways regarding her drinking but the GP did not confirm that with Pathways.

2.122 0n 14th March the GP wrote to V1 stating that she had been prescribed folic acid as her blood results needed improving and she was also advised to take vitamin B tablets.

2.123 On the same day a worker from the Day Centre called the police expressing concern about the welfare of V1 as P1 was back in Worcester and had a history of violence. A note states that the police did not seem too concerned about this. Police did make checks to see if P1 was barred from being in Worcester by an injunction but there was no such injunction is existence. P1 was, however, stopped and checked by police in Worcester City centre by patrolling officers.

2.124 On 22nd March and 28th March V1 failed to attend for appointments with WMWA and the Walk in Centre respectively. The Walk in Centre wrote to her stating that she could no longer pre-book appointments at that practice due to her failed appointments.

2.125 On 2nd April Probation queried when to list a MARAC meeting for V1 in view of P2's forthcoming release in September. June was arranged.

2.126 On 12th April WMWA considered that the V1 case should be closed due to her failing to attend appointments, albeit her case could be re-opened at any time. (Indeed the case was still open at the time of V1's death) A discussion took place about the risk of P1 being back in Worcester. On the same day the Day

Centre raised concerns with the police about V1, who had not been seen by staff at the Day Centre for 3 weeks. In addition a member of the public approached an officer with the same concerns.

2.127 The Fire and Rescue Service was contacted and forced V1's flat door to find her dead inside. A murder investigation was commenced by West Mercia Police and as a result, on 19th April P1 was traced to the south of England and arrested. He was subsequently charged with the murder of V1 and on 13th December 2012 he was convicted and sentenced to life imprisonment with a recommendation that he serves 17 years.

3. Analysis and recommendations

3.1 To put Domestic Violence into some context the British crime Survey (BCS) 2005-06 found that 1 in 20 of all reported crimes in England and Wales were domestic abused related, with 29 per cent of females and 18 per cent of male reporting domestic abuse. According to Women's Aid (2007) two women are murdered every week in England and Wales by their partner or ex-partner. In 80 per cent of all cases the victim was female, which rose to 89 per cent when four or more incidents were reported. In 33 per cent of all female homicides the woman was killed by her partner or ex-partner and in all crimes, domestic abuse has the highest revictimisation rate of 43 per cent of recurring abuse and 23 per cent of being revictimised three or more times[7].

3.2 V1 lived a chaotic lifestyle, fuelled by alcohol which encouraged problems with other people, mainly male, who lived a similar lifestyle. She was dependent upon the company of others and seems to be unable to live a separate existence from them. She was constantly subjected to the most humiliating physical and sexual behaviour at the hands of her male associates and although the police attended, either being called by V1 herself or more often than not, neighbours, she never cooperated with the police and did not support any complaints to the point of prosecution. V1 had many opportunities to

[7] Counselling Survivors of Domestic Abuse Christiane Sanderson JKP 2011 page 29

remove herself from this situation but always declined and chose to remain amongst the alcohol fuelled violence and sexual abuse.

3.3 This review pertains to a woman, so low in self-esteem that she can see no other way out. She remarked to a support worker that she expected that one of her associates would kill her one day. She lived with the inevitability that this would be the way her life would end, and still chose to do nothing about it. She was offered continuous help and assistance especially from the workers at the Day Centre who, it appears, were fond of V1 and tried to get her to appreciate that her quality of life would be better if only she were to move away from the men she associated with and made a clean break. But all of the advice went unheeded and she remained in the company of those who abused her. Indeed she was adamant that she was going to marry one of her abusers and persisted on maintaining a relationship with another who had poured boiling water over her in the past and had served a long prison sentence for doing so.

3.4 In examining the IMRs submitted by agencies in this case there are several issues that are worthy of mention, which indicate the service from some agencies could have been better, but also where services showed a caring attitude towards her. There are recommendations made within this section of the report that hopefully will go some way to prevent such an existence and final end to anyone else.

3.5 Actions of the police when called to incidents

The shared Association of Chief Police Officers ACPO, Crown Prosecution Service (CPS) and government definition of domestic violence is:
'any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults, aged 18 and over, who are or have been intimate partners or family members, regardless of gender and sexuality.'
(Family members are defined as mother, father, son, daughter, brother, sister and grandparents, whether directly related, in-laws or step-family.)

3.6 National Policing Improvement Agency (NPIA) issued guidance[8] in 2008 for all police officers attending incidents of domestic abuse.

3.7 The priorities of the Police Service in responding to domestic abuse are as follows:

- To protect the lives of both adults and children who are at risk as a result of domestic abuse;
- To investigate all reports of domestic abuse;
- To facilitate effective action against offenders so that they can be held accountable through the criminal justice system;
- To adopt a proactive multi-agency approach in preventing and reducing domestic abuse.

3.8 In particular, Section 3 of the guidance concerns the duty of positive Action' by officers in attendance and states:

'the Human Rights Act 1998 places positive obligations on the police to take reasonable action which is within their powers, to safeguard the following rights of victims and children:

- Right to life (Article 2 ECHR)
- Right not to be subjected to torture or to inhuman or degrading treatment (Article 3, ECHR)
- Right to and respect for private and family life (Article 8 ECHR)'

3.9 The guidance goes on to say that:

'Failure to make an arrest when there are grounds to do so may leave a victim at risk of further harm. It may also ,mean that the police force is vulnerable to legal challenge under both the Human Rights Act 1998 and the law relating to negligence.'

3.10 The Police IMR helpfully points out that;

'Patrolling Police officers are routinely trained in identifying signs of domestic abuse but are not expert neither do they receive the specialised training officers

[8] Guidance on Investigating Domestic Abuse NPIA 2008

from the Domestic Abuse Unit receive. In many of the cases examined in this report officers identified that there may be a domestic abuse issue and either acted in accordance with Force Policy by arresting the offender or removed the offender from the scene and ensured the Domestic Abuse Unit were aware of the incident. West Mercia Police maintain support for patrol officers dealing with such matters via specialist officers and units and specialist websites which are linked to external websites.'

3.11 It is clear therefore that officers attending ought to be aware of any previous incidents reported at the premises so they can make a valued judgement about the circumstances and the history of those involved. From this information officers can make an assessment of the risk that is involved in each individual case.

3.12 The police IMR goes on to say:

'However there appears to be a breakdown collectively between all aspects of policing in the provision of a collective response'.

3.13 The identification of risk is established within NPIA guidance and calls for attention to be given towards previous assault, which is one of the most established risk factors of future assault. Suspects with a history of violence against women present a particularly high risk. Guidance also states that previous sexual assaults by the suspect is a very high risk factor for future harm and homicide and should be regarded as sub–lethal violence. Escalation in the degree of violence is often an important feature of risk of future harm and the suspects previous criminality or breach of civil and criminal court orders or bail conditions are equally important features to consider when determining risk.

3.14 However officers have to be cautious that:

'Risk assessment and management processes must NOT be used to decide whether or not to conduct an effective investigation or in place of an effective investigation.'[9]

3.15 Response varies by virtue of the circumstances of the call. Level one response is an emergency or immediate response; level two is a priority response or prompt response; level three is where an immediate or prompt response is not required but police attendance is required through a scheduled appointment; level four is resolution without deployment.

3.16 When complaints of anti- social behaviour are identified the Call Taker should refer to a list of questions that include:

- What exactly is happening?
- Has this happened before?
- Do you know who is involved, their names and where they live?
- Do you know if any other agencies (i.e. Counsellor or Social Services) have been notified of these problems?

3.17 The Call Taker also has the capacity to view any previous incidents involving the person(s) and /or addresses. These are referred to as various previous incidents (VPI).

3.18 In this review there are varying responses by the police for calls of assistance by either V1 or her neighbours.

3.19 The manner in which the police dealt with the calls N1 made to the police on 6th January 2010 regarding the behaviour of V1 and her associates in her flat, left a lot to be desired. The first call at 18.49 was not responded to but a message was left by e mail to the local policing team. The second call at 19.12 the same day stated that the incident had escalated and V1 had caused damage to glass in N1's flat. The call is graded as a level 2 response requiring

[9] Guidance on Identifying , Assessing and Management Risk in the context of Policing Domestic Violence ACPO 2005 page 3

a priority or prompt response. N1 called again at 19.24 and this call is labelled as a repeat of the 19.12 call. Officers attended at 19.52 and they stayed with N1 for over an hour, leaving at 21.06, which according to the Police IMR is: **‘**considered a lengthy period in relation to how the incident was concluded. ‘

3.20 The matters were resolved by the officers leaving a message for the local policing team but there is nothing to indicate that the LPT received the information or acted upon it. In essence nothing was done about this complaint.

3.21 The next call to the address was on 16th January 2010, when N1 said he could hear V1 banging on his door and threatening N1. He could also hear V1 shouting at a man to ‘stop it’ but the man was not listening to her. The police Call Taker could hear the commotion in the background. Officers attended and arrested P1 who was wanted on warrant in the West Midlands Police area. There was nothing to indicate that either V1 or P1 were interviewed or indeed spoken to regarding their threats to N1. There is nothing to suggest that N1 was spoken to or that he was re-assured about the police action.

3.23 On 9th March 2010 at 14.26 a plumber who attended to fix a deliberately disconnected washing machine was abused. The plumber told the police that he could see injuries to V1. The police log is endorsed that the local officer was not on duty and this was not a case where a Community Police Support Officer could attend. An entry on the log at 19.32 indicates there were no officers available until 20.17, when officers attended and assisted in the removal of P1. There is nothing to indicate that the officers noted bruises or injuries to V1 and the damage caused by the disconnected washing machine pipe was not enquired into.

3.24 The attendance on 21st March 2010 followed a complaint from neighbours of a ‘bad domestic’ at V1’s flat. Officers attended within a few minutes and could see signs of a disturbance in V1’s flat, but no one other than V1 appeared to be present. Officers spoke to the neighbour advising her to call the council about the noise and gave her the number to call. A message was left for the LPT but nothing to indicate that this was followed up or the council or indeed any other agency informed.

3.25 The next call on 22nd March 2010 at 22.43 involved a neighbour complaining that the noise from V1's flat was preventing 4 young children from sleeping. Officers attended and stated that they could not hear any noise. They spoke to V1 who did not appear drunk and did not have any visible injuries. She would not let the officers into her flat. The matter was resolved by a referral to Worcester Domestic Abuse Unit. There is nothing to indicate that there was any cognisance of the effect this behaviour was having on the children of N2 and N3.

3.26 The Children and Adoption Act 2002 extended the parameters of 'significant harm' to include children being able to hear harm being caused to another even though the children were unable to actually see it. This took account of children in bed hearing domestic incidents such as those between parents in another room. This was the case here with N3's children being frequently so troubled by disturbances in V1's flat that they were unable to sleep.

3.27 Again on 16th April 2010 at 20.38 N3 called the police after V1 had banged on her door and threatened her. This was in response to N3 using the intercom buzzer to ask V1 to keep the noise down. N3 was at this time with 2 children and pregnant with a third. The police Call Taker told her to ring 999 if the noise persisted. The Call Taker noted that there had been lots of calls to V1's flat. No officer went at that time. Another entry was made on the log at 21.20 saying all officers were committed and at 22.15 the Call Taker rang N3 but there is no direct evidence of what was said other than a summary to the effect that N3 was happy to wait up. She indicated that the noise was still on going.

3.28 Officers eventually attended, 2 hours and 7 minutes later. A Public Protection Investigation Booklet was submitted in line with force policy. However, the police IMR points out;

'Although there was undoubtedly a domestic dispute between V1 and P1 the fact that they have made threats of violence over an extended period to N3 appears to have been ignored and not addressed at all'.

and:

‘Furthermore and of a more serious nature no regard appears to have been paid by the Call Takers, supervisors or officers attending that N3’s very young children were party to this behaviour. Safeguarding issues and welfare of the children have not been considered. ‘

3.29 The response from the Call Taker was less than expected and clearly did nothing to re-assure N3 or give a positive light on the police action.

3.30 V1 was found apparently unconscious with cuts to her eyelid, a swollen nose and cuts to her lip on 22nd July 2010. She complained that she had been assaulted by P5. As the officers were dealing with her P5 walked past the scene and was arrested. He denied the assault and blamed V1 for being aggressive. The log is marked that V1 did not know whether she wished to make a complaint and she couldn’t recall what had happened. She also stated that she was willing to go to court, but did not know who had assaulted her. The paperwork was finalised by an Inspector as ‘no realistic prospect of conviction’. This is perhaps the closest that V1 came to show a willingness to attend court albeit she declared that she did not know who was responsible but the papers were closed before any investigation had taken place. There is nothing to indicate that there was a search for witnesses or indeed that any further enquiries were conducted other than P5 denying the assault. It may well have ended in V1 not attending court but there was the initial willingness to do so which opportunity was lost.

3.31 V1 complained on 12th September that P1 had slapped her face and she called the police saying that she wanted P1 out of her house. On arrival P1 had left the flat and V1 was found to be drunk. Officers did not take the complaint any further but made arrangements for V1 to make a statement of complaint the following day, because she was drunk at the time. Inevitably V1 failed to attend and nothing more was done about the allegation. There is nothing to indicate that the officers noted any injury or pursued the complaint verbally with V1, asking her what happened and recording that conversation. The complaint was not followed up and 2 days later the log was finalised by the entry:

‘she has been given the opportunity to report this and believe that she is not going to make a complaint’.

3.32 NPIA guidance states:

- ‘Make accurate records of everything said by the suspect, victim and witnesses
- Record the demeanour of the suspect, victim and witness
- Obtain an overview of what has occurred, taking into account the established risk factors associated with domestic abuse (page 28)

and

- Obtain a first account as soon as practicable after the event, when the witness may be most able to recall the incident. (page 32)
- Previous withdrawals of support for prosecution should not adversely influence decision making in whether to arrest for an offence (page33)

and

- A domestic abuse officer should, where possible, take a statement which states and describes any reasons for the victim withdrawing their support for the prosecution process. If withdrawal statements are taken with care, they might still be used as evidence in current or future criminal proceedings or as evidence within the family court system. Any withdrawal of support for a prosecution should prompt a revised risk assessment process and safety planning. (page 51)’

3.33 The Police IMR comments:

‘When V1 and P1 were arrested for assaulting each other following a domestic abuse incident for example, both had injuries and both refused to have photographs taken of their injuries. There is nothing to prevent police from collecting such evidence in the course of an investigation’ and;

‘It is suggested that police had authority to take photographs of those injuries and should have done so which could have supported other future action such as an ASBO for example’.

3.34 It is considered that there was an opportunity lost here to even attempt to pursue a prosecution of a man, who, at the time of this allegation, had been released from prison and was on licence, irrespective that he went on to be charged with V1’s murder.

3.35 Another occasion when the police failed to deal with V1 adequately was on 17th September 2010 when she called regarding anti-social behaviour by local youths, who were throwing stones at her windows. She, at that time, was subject to a Domestic Abuse Risk Management Plan, designed to closely monitor everything relative to her and it could be expected that in these circumstances officer should have been deployed. Albeit the log is endorsed as a level 2 (prompt response) call, no officer attended and there is nothing to suggest that the LPT were made aware of the incident or that there was any liaison between the police or the Environmental Health over the constant nuisance at V1's address.

3.36 On 12th December police attended at V1 flat as a result of a call from the neighbour saying that her children were being disturbed by the noise. Occupants of V1 flat threatened the neighbour N2. One person present at V1's flat was arrested for breaching his CRASBO and that was the totality of the police action taken. No consideration was given to the safeguarding of the children of the neighbour.

3.37 On 15th December, the Police IMR points out that due to her anti-social behaviour V1 was issued with a Level 2 ASBO warning letter, The IMR goes on to say that an ASBO application would have had a greater effect.

3.38 At 20.20 20th December 2010 police were called to V1's flat where a fight was reported between V1 and some men in her flat. There was a clear breakdown in police communication and record examination as there was nothing recorded in the anti-social behaviour files about V1. In fact V1 had been issued with an anti-social behaviour order warning notice. Those present gave differing accounts of the event of that night and the police action was to give one of the men, P1, a lift to the Day Centre. Again no consideration of the effect such behaviour was having on the neighbour's children.

3.39 On 15th April 2001 police were called to V1's flat where there was a fight. V1 and P1 both had injuries from the fight and evidence of the fight could have

been obtained from the neighbour who reported that she was 'at the end of her tether'. Neither V1 nor P1 would make a complaint about each other or assist the police, so no further action was taken against them. Their conduct clearly constituted an offence of affray and perhaps more positive action by the police could have proved a substantive offence with evidence from the neighbours.

3.40 Lack of positive police action must have had a demoralising effect on the neighbours who had to live with this constant nuisance and drunken behaviour and relied on the police to bring the nuisance to an end.

3.41 Many of those incidents illustrated above and others that followed after April 2011 resulted in messages and e mails being left for the local community police officers to deal with but there is little evidence that the local police actually did deal with the complaints.

3.42 Positive action by the police in domestic violence/abuse cases has been recommended by guidance and Home Office Circulars since 1990. The first Home Office Circular [10] being HOC 60/90 followed by 15/2000, both of which stated that officers that attend to domestic violence incidents, should act positively, arrest the offenders, speak to the offenders and victims separately and seek charges for substantive offences. Withdrawal statement should only be taken by properly training domestic violence officers after the consequences of the withdrawal of complaints has been spelled out to the victim.

3.43 These circulars were confirmed by the NPIA guidance already referred to in this report. There is nothing to indicate that action as outlined in any of these documents was considered in the examples quoted.

Recommendation No 1

West Mercia Police should ensure that all front line officers are aware of their responsibilities for positive robust action when attending incidents of domestic abuse irrespective that there may have been repeated calls

[10] Home Office Circular 60/90 and Home Office Circular 15/2000

to the same address or people concerned, and compliance to NPIA guidance is ensured.

3.44 It has been mentioned that on at least one occasion, behaviour from those at V1's address, including V1 herself, may have constituted an offence of affray. There are other possible outcomes that could have been considered as outlined in the helpful police IMR, which states:

'The public is entitled to expect the police to take reasonable action to keep risk to a minimum when offences are brought to their attention. Failure to deal effectively with domestic abuse, whether by an ineffective investigation, failure to arrest a suspect or complete other police action (as would be considered reasonably appropriate to the circumstances) may leave a victim or others at risk.' (page 24)

and

'Courts have found that failing to ascertain possible eye witnesses; question suspects at an early stage; search for corroborating evidence; follow up proper complaints; as well as ignoring obvious evidence; may constitute a breach of duty to conduct an effective investigation by Police.' (Page 25)

3.45 Domestic Violence Protection Notices and Orders

On 30 June 2012, the Home Office announced that:

'the Domestic Violence Protection Order (DVPO) provisions operating in the West Mercia, Wiltshire and Greater Manchester police force areas were extended for another year.'

3.46 The Domestic Violence Protection Order (DVPO) pilot closed on Saturday 30 June 2012, but all three police forces will continue the scheme for a further year while the Home Office evaluates the pilot to assess whether or not a change in the law is needed.

3.47 Under the scheme the police and Magistrates can protect a victim when they are at their most vulnerable, in the immediate aftermath of an attack, by preventing the perpetrator from contacting the victim or returning to their home

for up to 28 days. This helps victims who may otherwise have had to flee their home and gives them the space and time to access the support they need and to consider their options.

3.48 Previously, there had been a gap in protection for victims of domestic violence due to either the police being unable to charge the perpetrator due to lack of evidence (meaning that the protection available to a victim through strict bail conditions could not be applied) or the process for granting longer-term injunctions taking several days or weeks to apply for. DVPOs are designed to bridge this gap by empowering the police and Magistrates to issue an immediate order to ban the perpetrator from returning home or making contact with the victim for up to 28 days.

3.49 The process involves the issuing of a Domestic Violence Protection Notice (DVPN) under Sections 24 to 33 Crime and Security Act 2010, to a perpetrator. This is designed to protect a person from domestic violence until a hearing in the Magistrates' Court within 48hrs. The intention is to allow the police to take short-term action to protect a person from domestic violence, where the person might be unwilling or unable to take steps to protect themselves. The duration of the DVPO is intended to afford the person protection by providing the opportunity to consult solicitors with a view to bringing an application under Part IV of the Family Law Act 1996 introducing Non-Molestation Orders and Occupation Orders. These can prevent a person from molesting another person associated with the respondent; can prohibit particular actions and behaviour or molestation in general; and sets out who has occupation rights in the home, including the exclusion of the respondent from it or an area around it.

3.50 This process was in force during the latter period of time that this review is considering and there were two occasions that police attended to calls from neighbours that would have qualified for the issue of a DVPO against those involved. It is considered that there were two missed opportunities to take this positive action.

3.51 Since this incident the DVPO has now been extended from a pilot to cover the whole force area as from 1st December 2012, so all officers should now be aware of the process. Indeed during the implementation of this process, all front line officers had face to face training with regard to the new process and together with national media awareness there should be a greater understanding of the value of issuing DVPOs.

3.52 The Police IMR points out that:
'Anti-Social Behaviour Order s (ASBO) are made against people who have engaged in anti-social behaviour which, in the United Kingdom is defined as 'conduct which caused or was likely to cause alarm, harassment, or distress to one or more persons not of the same household as him or herself and where an ASBO is seen as necessary to protect relevant persons from further anti-social acts by the defendant'. The ASBO provides restrictions on an individual's behaviour which, if breached can lead to prosecution'.

3.53 A Breach of an ASBO is an offence for which a person can be arrested and taken back before the court.

3.54 Some of the men associating with V1 and present when calls were made to the police by neighbours were subject to ASBOs and no action was taken in respect of their breach, which could have been proved by evidence from the neighbours that called the police, sometimes out of desperation and concern for their children.

3.55 The Police IMR also explains what an Anti-Social Behaviour Risk Assessment Conferences (ASBRAC) is. It is very similar to MARAC in that it is a multi-agency information sharing and risk management forum that is used to assess the threat/risk/harm of vulnerable high risk victims of anti-social behaviour. This process is currently being operated within Telford and Hereford.

Recommendation No 2
West Mercia Police to assess the impact of the pilot schemes of Anti-Social Behaviour Risk Assessment Conferences in the Telford and

Hereford Divisions and consider implementing the concept force wide as soon as possible.

Reminders of Best Practice No 1
West Mercia Police to remind officers that a breach of an ABSO is an arrestable offence and positive action should be taken against those where evidence exists proving a breach.

3.56 Attendances of V1 at her GP and Hospital

V1 was registered at a GP surgery but often attended at a Walk in Centre for medical advice. Here she could engage with GP and receive prescription and some treatment.

3.57 The sequence of events indicates V1 was required to undergo periodic health checks, asthma checks and flu vaccinations, and communication between the surgery and V1 was usually by letter. However, it can be seen that the surgery wrote 8 times to V1 urging her to attend for a new patient health check to which there was no reply until after the last letter. Whilst it is appreciated that the letter may well be produced by computer, it must have been noted in the surgery by someone that V1 had ignored the previous batch of letters.

3.58 The surgery was aware that V1 had problems with alcohol misuse and that she was engaging with a Day Centre. The surgery also knew that she was taking prescribed anti-depressants. When V1 eventually attended at the surgery there was no discussion about why she had failed to attend on so many times. The GP IMR states:
'If this had been explored V1 may (or may not) have disclosed any issue of domestic abuse'

3.59 There is nothing to indicate that these missed appointments were followed up by the surgery. However, GPs at the surgery informed the IMR author that they have some 2,000 non-attendees per year and it would be difficult to follow up in all cases.

3.60 The surgery was also aware of V1 attending Accident and Emergency Department at Hospital, on one occasion as a result of an injury and another regarding ingestion of food problems. There is nothing to indicate that the reason for these attendances, especially the injury were followed up by the GP.

3.61 In February 2012, V1 reported to her GP that she had been raped during the previous month. (This was the occasion that V1 stated P4 had raped her). She told the GP that the police were involved and she was engaging with a counselor at Women's Aid. V1 was careful not to let anyone know that she was being supported by Women's Aid.

3.62 There is nothing to indicate that the GP explored the circumstances of the rape any further with V1. There was no confirmation of the fact that she was receiving support from Women's Aid or an assessment made as to how the event had affected V1 physically or emotionally. There was no opportunity given to V1 to discuss the matter further and perhaps giving her a chance to disclose more about the rape in general and her lifestyle in particular. She also expressed the fact that she had felt suicidal the previous week but not at the time of attending at her GP.

3.63 The GP IMR states:
'She does not appear to have been considered by the GPs as a safeguarding or Adult Protection concern. GP4 told the IMR author on 11.9.12 that she did not consider V1 to be vulnerable at the time'

3.64 Had information that she was being supported by Women's Aid been shared with the GP, it would have given the GP another contact point for V1.

3.65 The surgery was well aware that V1 led a chaotic lifestyle, had problems with alcohol, had been prescribed anti-depressants and she was reporting that she had been raped. It was also clear that she was reluctant to attend at the surgery for regular appointments.

3.66 The IMR author spoke with GP4 from Walk in Centre, who, during the review process who stated:

> 'due to the 'walk in' nature of the GP Practice, [Walk in Centre] they have a higher than average number of vulnerable adults and therefore, it may not be apparent when someone is vulnerable (as V1 was). GP 4 states that when she worked at a previous GP Practice she was more aware of patients who were potentially vulnerable as there were fewer vulnerable patients in the Practice'.

3.67 Do these comments indicate that there is a degree of complacency at this particular Walk in Centre or with this particular GP, who fails to recognise the vulnerable because there are so many of them? V1 was undoubtedly vulnerable and efforts should have been made to ensure her safety. There was a reliance by the GPs that she was being cared for by other agencies, Women's Aid, the Day Centre and in the case of the allegation of rape, the police, but there were no indications that the GP checked to see if what V1 was saying was correct and that she did actually have the support she claimed she was getting. Neither the GPs nor the hospital asked a direct question to V1 about domestic abuse and consequently there were no referrals made to Adult Social Care or partner agencies for support or assessment of risk.

3.68 Checks were made by the IMR author regarding the GPs Practice policies on Domestic Violence and it was found that there was not such a policy in existence. There is a natural assumption made here that any patient reporting being subjected to domestic violence will not receive the appropriate advice and guidance towards supporting agencies.

3.69 As far as training is concerned, Acute Trust staff have mandatory training regarding Safeguarding Adults and for clinical staff internal training on domestic abuse. GPs have training on Adult Safeguarding and Child Safeguarding but no specific specialist training on domestic abuse.

3.70 In June 2012 the RCGP issued guidance[11] for GPs in relation to domestic abuse to the effect that each surgery should have a designated person responsible for coordinating domestic abuse support services and referrals, establishing a more assertive approach and positive actions regarding domestic abuse, a clear care pathway including sharing information with other agencies, identifying the signs and symptoms of such abuse and requiring training for both health and non-health staff including GPs.

3.71 Research[12] has shown that GPs and nurses who have received specialist training to ask their patients about domestic violence as well as an easy way to refer them to advocacy organisations are 22 times more likely to document referral of women suffering domestic abuse compared to those without training.

3.72 The researchers explain:

"The substantial difference in referrals is strong evidence that the intervention improves the response of clinicians to women experiencing domestic violence and enables access to domestic violence advocacy that can reduce re-victimization and improve quality of life and possibly mental health outcomes".

3.73 Throughout the GP IMR reference is made to the fact that V1 did not present or was not considered as a vulnerable adult.

3.74 Vulnerable Adult is defined by 'No Secrets[13]' as a person:

"who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation".

[11] Responding to domestic abuse: Guidance for General Practices. Royal College of General Practitioners, CAADA et al. June 2012

[12]. "Training Primary Care Center On Domestic Violence Raises Referrals To Advocacy Groups." Grace Rattue *Medical News Today*. MediLexicon, Intl., 17 Oct. 2011. Web. 31 Dec. 2012. <http://www.medicalnewstoday.com/articles/236084.php>

[13] *No secrets:* Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse. Department of Health Home Office March 2002

3.75 It may have been considered that V1 did not fall into the definition of a Vulnerable Adult as per 'No secrets' but she was certainly in need of community care, (Day Centre, Women's Aid) through mental or other disability, (alcohol abuse) and was certainly unable to protect herself against significant harm or exploitation. Because a person does not fit a precise definition of vulnerable person, it does not prevent that person being considered to have a degree of vulnerability and due consideration being made to offer that person the support that Adult Safeguarding can.

3.76 V1's GPs failed to consider the risk she was constantly subjected to by her associates, her alcohol abuse and her general lifestyle. There is ample evidence to suggest that drinking increases ones risk of abuse. Nicolson[14] points out that drinking and other substance abuse by either or both parties is a common pattern in long- to medium- term abusive relationships.

3.77 The GP IMR points out:

'There is **no** evidence to suggest that health professionals at GP practices (during the defined period) had considered that V1 was a victim of domestic abuse. There is one reference on 2.2.12 to V1 being raped but no further discussion seems to have taken place and it is documented that this was being dealt with by the police.'

And the IMR further states:

'No GP discussion appears to have taken place with V1 regarding her disclosure about being raped (on 2.2.12). If GP 3 and/or GP 4 had explored the rape in more detail, V1 may or may not have disclosed more information to them. However, she appears not to have been given this opportunity.'

Recommendation No 3

South Worcestershire Community Partnership to request assurance from Clinical Commissioning Groups in Worcestershire that the guidance

[14] Domestic Violence and Psychology – A Critical Perspective Paula Nicolson 2010 page 92

'Responding to Domestic Abuse' (Royal College General Practitioners June 2012) has been implemented across all general practices.

3.78 V1's mental capacity was only formally assessed once when a hospital doctor carried out an assessment but that was only in order to establish if she could take her own discharge from the Emergency Department of Hospital. At her surgery, GP3 did not suspect that V1 was being subjected to domestic violence and GP4 said that V1 appeared to have the mental capacity to make decisions and GPs would have needed consent to discuss matters with other agencies. GPs did not think it was necessary to speak to other agencies at that time.

3.79 There is no evidence that any agency considered how years of alcohol abuse may have affected V1's mental condition and more importantly her capacity to arrive at reasonable, sound judgement and decisions.

3.80 V1 constantly made decisions not to follow through complaints of offences being committed against her, rape and assaults etc. She frequently expressed her intention to move away from the Worcester area to get away from her associates, but never did. She made decisions about her relationships with P1 and P2. She had ample opportunity to break off those relationships from both men, but despite calls to the police on a number of occasions asking for assistance to remove them from her flat, she persistently encouraged them to live and associate with her. A judgement had to be made by professionals about whether those decisions were correct and in her best interests. Her lifestyle was such, by associating with the same men who had offended against her, caused her serious injuries and constantly abused her, it was inevitable and predictable that the men would re-offend against her once they were at liberty to do so.

3.81 The IMR for NHS Worcestershire, covering both the Acute Hospitals Trust and West Midlands Ambulance Trust points out:

'There was little assessment of V1s level of vulnerability or mental capacity on presentation at the Emergency Department or any indication that she was

considered as a victim of domestic abuse. A narrow focus was adopted which concentrated on providing immediate medical treatment without focusing on the wider issues in relation to her social history and support within the community'

3.82 The IMR goes on to say that Health Professionals did not identify V1's level of vulnerability and therefore missed the opportunity to share information with partner agencies and her key worker.

3.83 The Composite Health report states:

'In this case health professionals did not view JH as a vulnerable adult and therefore did not raise any concern with senior staff or the Safeguarding Vulnerable Adult Lead. The view adopted seemed to be that as an adult JH was able to make her own choices even if her lifestyle and behaviour included a high level of risk and further injury.'

3.84 Having not been directly asked about domestic violence, opportunities were missed to make referrals to supporting agencies or adult social care.

3.85 An interesting comment was made in the Serious Case Review Report into the Death of Steven Hoskin[15] which states:

'If clear thresholds are set out, such as for example: any more than three presentations to A&E/Minor Injury Unit (MIU) services by a vulnerable adult within a period of three months; or any vulnerable adult who presents to A&E/MIU service having been assaulted/having taken an excess of drugs and/or alcohol, then the vulnerable adult concerned should always be referred to Adult Protection Services and the department of Adult Social Care'.

3.86 The Health IMR points out that there was no indication that V1 was viewed by Health Professionals as meeting the criteria of a vulnerable adult, which meant that:

' her future safety and wellbeing were never fully risk assessed or discussed

[15] Serious Case Review into the Death of Steven Hoskin Flynn M (2007) Cornwall Adult Protection Committee

with adult social care or the police'.

3.87 With regard to follow up appointments for V1 there was nothing to suggest that enquiries were made with her to ascertain if she was able to attend appointments and had the 'where with all' to do so in terms of funding transport etc.

3.88 Most assessments carried out by Health Professionals concentrated on her immediate medical needs in isolation together with attention being paid to her alcohol dependence and what the Health IMR called 'risk behaviour' rather than exploring the possibility of her being the victim of domestic abuse. This meant that there was no meaningful communication between the hospital and primary care or community services aimed at providing a co-ordinated response to her needs.

3.89 The Health IMR makes an interesting point when it states:

'There was no contact between Health Professionals and any extended family. On all attendances at the Emergency Department V1 attended alone or accompanied by police or her support worker'.

3.90 V1's history of injuries and assaults caused by her various partners should have raised concerns with Health Professionals who should have shared their concerns with other agencies, police, Adult Social Care and domestic violence support agencies. V1 was viewed as an adult who was able to make decisions on her own even if that meant living the kind of lifestyle that would make her vulnerable to abuse through either her alcohol abuse, or her associates, or both.

3.91 The Health IMR comments:

> 'Health Professionals shared minimal information between acute and community services and primary care in relation to the management of V1 as a head to reach patient. In view of her alcohol dependence and frequent injuries she had significant health needs which were difficult to review or monitor'.

3.92 The Health IMR suggests recommendations that adequately cover the

comments made in this review and other than the recommendation below, no further recommendations regarding Health are deemed necessary.

Recommendation No 4

Worcestershire Acute Hospital Trust to ensure that all Emergency Department staff obtain full details and antecedent information of patients who frequently present with alcohol and/or drug related injuries and share this information with other agencies such as the police and Adult Social Care.

3.93 Adult Safeguarding

Mention has already been made about the fact that V1 did not actually meet the criteria to be classed as a 'vulnerable adult' as per 'No Secrets'. There is a new bill before Parliament suggesting amendments to the Adult Safeguarding legislation which may make it easier to accommodate people in such circumstances as V1. A summary of the suggest legislation was set out in the Queens Speech in June 2012 and is aimed to modernise adult care and support in England, setting out what support people could expect from government and what action the government would take to help people plan, prepare and make informed choices about their care.

3.94 The main elements of the draft Bill will be:

- modernising the legal framework for care and support, to support the vision of the forthcoming White Paper on care and support
- responding to the recommendations of the Law Commission, which conducted a three-year review into social care law
- establishing Health Education England as a non-departmental public body
- establishing the Health Research Authority as a non-departmental public body
- carrying out engagement and pre-legislative scrutiny on the draft Bill, as many in the social care sector have called for, to enable government

to listen to people with experience and expertise, to make the most of this unique opportunity to reform the law

3.95 The main benefits of the draft Bill would be:

- modernising care and support law to ensure local authorities fit their service around the needs, outcomes and experience of people, rather than expecting them to adapt to what is available locally
- putting people in control of their care and giving them greater choice, building on progress with personal budgets
- consolidating the existing law by replacing provisions in at least a dozen Acts with a single statute, supported by new regulations and statutory guidance
- simplifying the system and processes, to provide the freedom and flexibility needed by local authorities and social workers to allow them to innovate and achieve better results for people
- giving people a better understanding of what is on offer, to help them plan for the future and ensure they know where to go for help when they need it

3.96 Hopefully the new legislation will provide the flexibility as outlined in the paragraph above in italics for professionals and local authorities to consider people like V1 as vulnerable all be it not meeting the criteria as set out in 'No Secrets' and thereby enabling her case to be referred to Adult Safeguarding and qualifying for all the support mechanisms that the Adult Safeguarding Board and procedures could provide for her.

3.97 However, in June 2012 Worcestershire County Council recognised this 'gap' in services to people who do not meet the criteria and introduced a draft 'Protocol for Referral to the Community Intervention Team[16]'. This document sets out the purpose of the protocol as:

> '…. to establish a team of Social Care Workers who would focus on achieving a positive change for service users that do not meet the criteria for assessment for any service area. This team has now been

[16] Protocol for Referral to the Community Intervention Team Draft – Worcestershire County Council June 2012

established and is known as the Community Intervention Team.'

3.98 The protocol is aiming to achieve the following to:

- Maximise the independence of vulnerable adults
- Ensure people are signposted to low level services/activities that meet their needs in their own communities if appropriate
- Provide support to adults to access the most appropriate assessment
- Ensure all vulnerable adults receive a timely assessment that supports them to identify their health and social care needs and the outcomes they wish to achieve
- Ensure that support plans are implemented
- Ensure carers of vulnerable adults receive timely information, support and carers assessments

and the conditions of the draft protocol are to include:

1) Where a professional or a member of the public identify that someone is in need of health and social care or are in need of support to live independently or because they are at risk then the Access Centre should be the first point of contact to discuss the referral.

3.99 Once a referral has been made the Access Team will apply the following principles:

- People with presenting drug/alcohol conditions aged 65 and under will normally be referred to mental health services. If they have high-level physical care needs due to their substance dependency, and their physical health is the primary reason for referral, then this will go to the Area Community Social Work Teams.

- People who have received specialist education or appear to have severe or significant developmental delays will be referred to the Learning Disability Teams

- People who are under the age of 65 and have intermediate care needs will be referred to Promoting Independence or the Rapid Response Social Work Team.

This draft protocol would now be suitable to cater for V1.

Recommendation No 5

South Worcestershire Community Safety Partnership endorses the draft Protocol for Referral to the Community Intervention Team and seeks its implementation as soon as possible, as is the Adult Social Care Community Intervention Team contained within the Adult Social Care Bill.

3.100 Pathways to Recovery

Mention has been made of the amount of times V1 was referred to Pathways to Recovery for treatment and support regarding her alcohol dependency. Her attendance at Pathways was spasmodic, so much so that there were very little details taken from her regarding her personal circumstances on the occasions that she did attend. On her first assessment appointment she attended under the influence of alcohol and this limited the amount of information that could be obtained and also the amount of work with her that was possible.

3.101 That had a knock on effect, in that there was so little information gathered her position as a vulnerable adult was never considered, neither was her mental capacity assessed. The Pathways to Recovery IMR sets out recommendations aimed at the organisation improving contact with external agencies and adopting a more robust information gathering process on clients especially those that are referred from MARAC, as was the case with V1. It is considered that these IMR recommendations adequately cover the issues raised with Pathways to Recovery.

3.102 West Mercia Probation Trust decision making

V1 had considerable dealing with the Probation Service throughout the time parameters of this review.

3.103 The Probation IMR sets out the criteria for the contact that pertains to V1:

'[V1] was current to the Probation Service as a victim, receiving service from Probation Victims Liaison Officer (VLO) at Worcester. This was as a result

of a serious assault committed on her by her partner P2 who was in custody at DOD (Date of Death) and is still detained in prison. Following conviction of an offender to 12 months custody or longer for a violent or sexual offence probation have responsibility to offer the victim, Victim Contact Services via a victim liaison officer (VLO) whose responsibility it is to keep them informed about the progress of the offender at each stage through the custody and post release stages including licence conditions etc. This right is conferred by way of the Victims Charter and Criminal Justice and Court Services Act 2000. National Probation Circular 11/2008 refers'.

'The standard laid down is that following sentence the Victims Liaison Unit will write to victim within 8 x weeks. If no contact following 2 x letters then the case will be closed assuming the victim does not want probation victim's contact. If contact is accepted then the victim will be kept updated at significant stages throughout sentence and post sentence and the VLO will maintain a point of contact, maintain liaison with other agencies and support the victim as required. During this case of V1 whilst contact was not initially made following sentence due to a miscommunication, VLO contact was made prior to initial release of P2 and extensively sustained throughout the remaining period until death of V1'.

3.104 It is noteworthy that V1was also known to the Probation Service in her own right as being a previous offender, but she had not been known in that capacity for many years. The more recent contact had been voluntary as a victim. During this period Probation had no statutory contact with V1 what so ever.

3.105 P2 was subject of the MAPPA process and as such V1 was subject of the MARAC process. Both processes demand the sharing of information amongst agencies in order to appropriately manage the offender on one hand and the victim on the other. In both of these processes Probation have an important role to play. In discussing the vulnerability of V1 with regard to P2 it became apparent as information was exchanged and shared, that she was also vulnerable with respect to P1.

3.106 The Probation Service has helpfully included details of a Pre-Sentence report regarding V1 from 2008 and whilst this is outside the time parameters of this

review, there is an interesting comment made whilst considering if V1 should receive a non-custodial sentence for an offence in 2008. The comment is:

> 'To release V1 into the community at this point presents serious concerns in terms of risk of harm to herself with regard to the status of P2 and while he himself does not present risk to the defendant (V1), such is his influence with his likeminded associates that the high risk of harm to V1 remains high'.

3.107 The Pre-Sentence report goes on to acknowledge that V1 had a history of depression, mental breakdown, self-harm, although, when sober, she was able to appreciate the risks she was susceptible to but was unable to supply solutions.

3.108 So in 2008 it was recognised that her lifestyle posed a risk of serious harm to herself exacerbated by her association with P2.

3.109 The Probation IMR takes account of a MARAC meeting held in September 2010, where a discussion took place regarding the forthcoming release of P2 from prison and the risk he posed to V1. P2 had been categorised as a Level 3 MAPPA, meaning the highest level of risk that required the least intrusive supervision. He had been imprisoned for pouring boiling water over V1. The MARAC meeting came to the decision that:

> 'It was in the best interest of V1 to allow P2 to have contact and reside with V1 following his release. This was on the basis that V1 and P2 wanted contact, and professional opinions that whatever efforts were made to keep them apart they would meet and in the event that P2 would not have been allowed contact, it was likely that they could disappear together where there would be no support mechanisms or monitoring in place for V1 who would be at high risk of harm. On balance at that time it was felt by all agencies consulted that it was advisable to keep V1 and P2 monitored in Worcester where close supervision could be afforded by agencies who were aware of them.'

3.110 It was considered that this judgement was balanced but may have been regarded differently in light of the assault that followed on 16th October 2010.

3.111 It is the view of the Author that there was sufficient information at hand (from 2008) at the time of making the decision that V1 and P2 could associate and live together, that there was a risk to V1. Whilst it is appreciated that the decision was made difficult due to V1's insistence that she was going to have contact with P2, licence conditions for P2 not to have contact with V1 may have prevented the further assault he inflicted upon V1 in October. Negotiations were already underway with V1 about moving to Hereford but again due to her reluctance to make the decision. Such a move was never followed through.'

3.112 Mention is made in the IMR of this decision that V1 was at the time, receiving support from the Day Centre as well as Women's Aid and that appeared to have some influence on the decision making. It is stated that the wishes of V1 were taken into account and care not to disempower her was taken. The question that had to be asked is, 'Was she capable of making such a decision and was it reasonable?' It is known that during his time in prison, P2 constantly called the Day Centre to speak to V1, who, on occasions declined to speak to him and even told the Day Centre staff to tell P2 that she had not been to the Centre. She also made a remark to the effect that his (P2's) associates were constantly with her and knew what she was doing. It appears that although P2 was in prison, he had a hold over V1, which may have affected the way she thought and the way she came to make decisions that on first view appear unrealistic.

3.113 The Probation IMR makes the important comment that whilst Probation was aware that V1 was associating with various men during the time P2 was in prison and most if not all of the men had previous convictions, none of them were under the supervision of the Probation Service during that time and therefore no restrictions could be placed on them with regard to their association with V1. The Probation IMR also makes recommendations which adequately address the issues raised within this part of the report.

3.114 V1 had considerable support from the Probation Victim Liaison Officer (VLO) who despite V1's initial reluctance to engage persevered and eventually V1 recognised the risk posed to her from her associates. The VLO was also responsible for arranging meeting between V1 and the IDVA.

3.115 MAPPA and MARAC Meetings

MAPPA Guidance[17] sets out the purpose of MAPPA meetings:

> 'The purpose of the meeting is for agencies to share information which:
> Is pertinent to undertaking a multi-agency risk assessment.
> Identifies the likelihood of re-offending.
> Identifies serious risk of harm issues and their imminence.
> Is critical to delivering an effective MAPPA Risk Management Plan which addresses all the risks identified in the risk assessment.'

3.116 The previous MAPAA Guidance[18] states:

> 'The importance of holding effective Multi-agency Public Protection (MAPP) meetings at level 2 and 3 to share information on MAPPA offenders to support multi-agency risk assessments and formulate MAPPA Risk Management Plan (MAPPA RMPs), in order to protect victims and communities, cannot be over emphasised'.

3.117 The guidance[19] also includes the purpose of the MARAC meetings as:

- Share information to increase the safety, health and well-being of victims/survivors - adults and their children;
- Determine whether the alleged perpetrator poses a significant risk to any particular individual or to the general community;
- Construct jointly and implement a risk management plan that provides professional support to all those at risk and that reduces the risk of harm;

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[17] MAPPA Guidance 2012 version 4 Produced by the National MAPPA Team National Offender Management Service, Offender Management and Public Protection Group page 71
[18] MAPPA Guidance 2009 version 3.0 Produced by the National MAPPA Team National Offender Management Service Public Protection Unit page 97
[1919] MAPPA Guidance 2012 version 4.0 Produced by the National MAPPA Team National Offender Management Service Public Protection Unit page 44

- Reduce repeat victimisation;
- Improve agency accountability; and
- Improve support for staff involved in high-risk domestic abuse cases.

3.118 The Probation IMR illustrates that RMPs were in place with MAPPA in respect of P2 and liaison had taken place between MARAC and housing, Pathways to Recovery, the Day Centre, IDVA and the local police with regard to V1. Arrangements were in the early stages to get V1 moved to a refuge in Hereford. However, the IMR points out, these efforts to support and assist V1 were frustrated by V1's insistence that she was to associate with P2 on his release from prison.

3.119 It is also noted that whilst MAPPA and MARAC worked together assessing the risk P2 posed to V1, the risk other men in V1's life (including P1) posed to her went un-noticed.

3.120 The Probation IMR points out:

> 'There was no reference in the case papers reviewed of any consideration of mental capacity in relation to V1 or referring to Adult Safeguarding measures other than in the context of MAPPA or MARAC where multi-agency support was being provided/considered. Any references to V1 appear to consider that despite alcohol problems she appeared capable of making her own decisions and acting on her own behalf.'

and;

> 'However, assessment and support of V1 may have been better informed if a request or consideration of mental assessment had of been considered by MARAC on the basis that her chronic alcohol abuse may over the years have affected her cognitive ability.'

3.121 In his conclusion the Probation IMR author states:

> 'The issue of Adult Safeguarding and mental capacity assessments for MARAC is one that perhaps should be more readily considered and high

profile in instances where someone like V1 is failing to respond/engage with agencies and may be incapable of making rational decisions to protect themselves. I have discussed this aspect with the MARAC chair who feels it is a valuable point to consider in the future.'

Recommendation No 6

The Responsible Authorities within the Community Safety Partnership to explore the possibility of the introduction of a contractual obligation on providers to ensure that client information is passed on to other relevant agencies at the end of the contract.

3.122 Had the above recommendation been current it may have been the case that as V1 disengaged from the service, there would have been a more assertive follow up of her case as there would have been in high risk clients.

3.123 As far as the Acute Trust is concerned a flagging system linked to MARAC exists in the Accident and Emergency Department and is available to all staff thus enabling staff to assess any injury, examine the data base and consider whether there should be a further referral to the Police or Adult Social Care. There is also the facility to notify the GP electronically within 24 hours of the presentation at A&E, where domestic abuse should be flagged on both the victim's and any related child records**.**

3.124 Following the rape on V1 by P4 there was a referral by the MARAC Co-ordinator who arranged for a meeting on 13th January 2012. Another meeting took place on 2nd April 2012 and it was decided that a further meeting should be held in June. Between January and June there were a number of appointments that V1 failed to attend with WMWA and concern was also raised by a worker from the Day Centre about the welfare of V1 as P1 was back in Worcester. Given the history of V1 a delay in a MARAC meeting over a period when P1 was out of prison and P2 was about to be released from prison seems to be unreasonable,

3.125 There were no more MARAC meetings held. Whilst it is appreciated that that MARAC process doesn't work if the victim fails to engage it is considered that

MARAC should have a process which is designed to engage reluctant and hard to reach groups of society.

3.126 The risk assessment carried out on V1 indicated that she was vulnerable with regard to her safety from all of her associates, including and especially, P2. It was well known that despite all of the advice given that she would ignore the warnings and continued to associate with P2. There was only so much agencies could do to try to dissuade her from her unwise decisions and in such cases it is considered that 'an Osman[20]' warning should have been given to her in writing from the MAPPA / MARAC process which would have had the effect of making it clear to her that she was in danger and that agencies had advised her against taking such action irrespective that she decided to ignore the warning. As it was, the MARAC process for V1 suddenly stopped without consideration of what structure would continue with regard to her risk assessments.

3.127 West Mercia Women's Aid

V1 had considerable contact with the IDVA from WMWA following referrals from Probation, initially in June 2010 and again in November 2010. However, the WMWA suffered from the same problem of V1's reluctance to engage. Between February 2011 and April 2012 there were sporadic engagement with V1 but as stated above most appointments were arranged at the Probation Office. The IDVA appropriately advised V1 about her personal safety and helped her seek opportunities for re-housing but this never materialised as V1 never pursued it. V1 mentioned in passing to WMWA and to Housing, that she was from a travelling community but that is the only mention of any cultural issues that she may have had. Nothing was done with this information and this review can not draw any inferences from the comment. She also mentioned that some of her associates were from a similar community and hence her reluctance to be seen to seek support as she was of the opinion this would increase her risk amongst those she associated with. The IMR points out:

'It would appear that most of the agencies involved concentrated

[20] Osman V UK (1998) 29 EHRR245,reports 1998 - VIII

primarily on the threat to V1 from her initial perpetrator (P2) and the immediate threat from her current associates seemed to be a secondary consideration.'

3.128 The WMWA's IMR mentions that the IDVA did not liaise fully with the Day Centre or a local hostel who knew of V1 but states she actually never stayed there. A possible solution to the problem of V1 not attending WMWA appointments could have been for the IDVA to have made arrangements to see V1 at the Day Centre where she was more likely to frequent .

3.129 It is clear that the MARAC process attempted to enhance V1's self-esteem and rightly concentrated on being victim focused and the increase of safety for her. However this process also suffered from her apparent reluctance to engage likewise, but it is interesting to note that sometimes the IDVA meetings were held at the Probation Offices as opposed to the IDVA offices, which may have had the effect that V1 as being seen by others that she was seeking support from Probation, rather than seeking support from a support agency.

Recommendation No 7

When dealing with clients who are reluctant to engage at nominated agency premises, consideration should be given by West Mercia Women's Aid to seek alternative premises where the client is comfortable where formal meetings could take place.

Recommendation No 8

When dealing with clients who are reluctant to engage, West Mercia Women's Aid should ensure that there is a positive assumption that the risk is or remains high and the IDVA will refer on to the appropriate source such as the original referrer and MARAC as and when necessary, particularly where the history of abuse appears to be historic.

3.130 Part of the input that WMWA had with V1 was to try and encourage her to curtail her drinking habits but this did not come to fruition. Although she occasionally liaised with Pathways to Recovery there is nothing to suggest that WMWA

referred her to any specialist medical treatment regarding her drinking habits. There was a suggestion made that V1 should go to a hostel which specialises in dealing with people with drink related problems but the only one available was in Birmingham, which V1 refused to consider.

3.131 The IMR points out that the WMWA Risk Review Procedure was not followed by the IDVA as the review should have been conducted every three to six weeks. It is appreciated that this calendar of reviews would have been frustrated by V1's chaotic and difficult to manage lifestyle. The WMWA's IMR make suitable recommendations in relation to that issue.

3.132 The Day Centre

As can be seen from the sequence of events V1 was a regular attender at the Day Centre in Worcester and it became a central point of refuge for her when she needed support and advice. There were times when she attended on a daily basis mainly to obtain a midday meal but there were other times when she failed to attend, sometimes for days at a time. On other occasions she attended in a drunken state she was rude to staff, causing damage and frequently had to be evicted with the aid of the police, but reading the Day Centre IMR, it is clear that the staff there were quite fond of V1 and indeed they raised the alarm when she hadn't been seen for some time and the police found her dead.

3.133 The Day Centre was the focal point of contact between P2 whilst he was in prison and V1 and it is clear in her more sober moments, she befriended and confided in female staff at the Centre. The Centre appeared to know all of the details of her associates, the abuse inflicted upon her and indeed when she disclosed she had been raped they were the first to try and get her to seek medical advice.

3.134 The Day Centre was in the communication chain between MAPPA and MARAC. However between July 2010 and August 2011 that communication chain broke down as a result of a SP Review (Supporting People Review) and serious default notices being served on the Centre which suspended the Centre and staff were transferred elsewhere. Post August 2011, the Centre reopened

and is now within the communication chain. However, during that time of suspension significant events occurred involving V1. P2 was released from prison, other associates were inflicting violence upon V1 and her neighbours were constantly calling the police to disturbances as outlined in the sequence of events. It was unfortunate that the Centre ceased operating in that period of time as that important support for V1 was lost.

3.135 Worcester Community Housing

The connection between Worcester Community Housing (WCH) and V1 dated far before the timescale set out in the terms of reference for this review and representatives of the WCH knew V1 and her associates and their lifestyle extremely well.

3.136 WCH were always made aware of issues arising in relation to the antisocial behaviour emanating from V1's flat and had significant dealings with the neighbours who complained on a regular basis. Promises were made to the neighbours to install noise monitoring equipment as a way of obtaining independent evidence of the antisocial behaviour in V1's flat. However despite the promise this did not happen which is most unfortunate as the police were constantly called to the premises by neighbours who, for all obvious and completely understandable reasons, were reluctant to give written evidence which would help in prosecutions. Noise monitoring equipment may very well have covertly provided the evidence required.

3.137 The antisocial behaviour became so serious that V1 was issued with a notice stating WCH's intention to evict V1 and only through negotiation with WCH and the IDVA was that notice rescinded on the basis that such action would have rendered her homeless and therefore increased her vulnerability.

3.138 WCH failed to act on promises made to the family and also failed to take any positive action regarding the child protection issues for the neighbours of V1, whose children were affected by the behaviour and constant disruption of V1 and her associates. WCH failed to consider any safeguarding needs of the children and their families. Section 11 Children Act 2004 places a responsibility on agencies to take action when safeguarding of children is an issue.

Recommendation No 9

Worcester Community Housing should review the processes for dealing with situations where tenants are living with frequent disruptions and threats from other residents and their visitors, and make sure that robust systems are in place to ensure effective and timely action in order to safeguard families and children.

3.139 Working with reluctant clients

It is clear that throughout their dealings with V1 and her associates, there must have been an element of concern amongst the professionals involved about the threat and risk of assault, intimidation and disorder that V1 and her male associates posed to them. Whilst there is no direct evidence that any of the professionals felt intimidated, in that there are no records of how individuals felt entering her home under the circumstances as outlined throughout this review, it cannot be over looked that such 'families' and individual's lifestyles and the way they behave towards authority when under the influence of alcohol and/or drugs, can be extremely daunting for even the most experienced of professional when working in close proximity and within their home.

3.140 In this regard Herefordshire Safeguarding Children Board issued guidance[21] to staff in August 2011, that goes some way to identifying any escalation in animosity towards them and what steps can be taken to reduce tensions between professionals and such people. More importantly the guidance goes on to point out the expectations of management in these circumstances and recommends encouraging a culture among staff from all agencies of openness and support between workers, who should feel comfortable in admitting their concerns, and management who must ensure their staff feel safe in seeking support. Similar guidance is contained in Worcestershire Safeguarding Children Board Child Protection Procedures.

3.141 In addition to the Hereford Guidance, in December 2012 the Government

[21] Practice Guidance – Working with Resistant, Violent and Aggressive Families Herefordshire Safeguarding Children Board August 2011

Guidance[22] was issued with regard to this issue but in relation to Child Protection cases in particular. However there are several points raised in that document that pertain to cases such as V1's, where the principles of dealing with troubles families in Child Protection cases are transferable to adults, such as the five key components:

1. A dedicated worker, dedicated to the family
2. Practical 'hands on' support
3. A persistent, assertive and challenging approach
4. Considering the family as a whole – gathering the intelligence
5. Common purpose and agreed action

3.142 It may be prudent for the agencies involved in this case to study the new guidance and ensure that it is included in any future training.

Recommendation No 10

South Worcestershire Community Safety Partnership to ensure that all agencies attention is drawn to the guidance as issued by:

- **Herefordshire Safeguarding Children Board regarding working with resistant, violent and aggressive families;**
- **Worcestershire Safeguarding Children Board regarding Resistant, Violent and Aggressive Families within Inter-Agency Child Protection Procedures, and**
- **guidance issues by the Government in December 2012. Agencies should ensure that this best practice is included in future training and policy documents.**

3.143 Identified Issues of Good Practice

Mention has already been made about the strong bond that V1 had with workers at the Day Centre where she could seek support and advice and it

[22] Working with Troubled Families – Department for Communities and Local Government – December 2012

appears that she listened to those workers more so than any other person she came into contact with.

3.144 In a similar way the Victim Liaison Officer for the Probation Service persisted in making contact with V1 even though V1 was reluctant to engage with her. Rather than writing letters arranging contact the VLO went out of her way to make face to face contact with V1. The Probation IMR describes the VLO's record keeping as exemplary and precise and the rationale behind her actions and decisions was quite clear. The IMR goes on to point out that the VLO's actions in referring Domestic Abuse Index offences-victims to MARAC several months before release from custody has been recognised as good practice.

3.145 WCH were quick to respond when the washing machine water supply was deliberately disconnected causing a flood.

3.146 Training

Mention has been made throughout this review report about the Freedom Programme, a 12 week recovery programme for domestic violence victims. It is intended to hold Freedom Programme Training days for professionals from all agencies commencing in April 2013, which will be overseen by the Worcestershire Forum for Domestic Violence. Similar training is planned for the MARAC referral process. Both training courses are designed for members of all agencies and:

Recommendation No 11

The Responsible Authorities within Community Safety Partnership to encourage all agencies to partake in Freedom Programme Training and MARAC referral training as from May 2013

3.147 All agencies that have contributed to this Overview Report process have made recommendations within their own individual management reviews and it is incumbent upon South Worcestershire Safety Community Partnership to ensure that these recommendations are enforced in due form.

Recommendation No 12

South Worcestershire Safety Community Partnership to ensure that Individual Management Report recommendations as set out in the in action plans contained within this report are completed within the timescales indicated and that agencies report to South Worcestershire Safety Community Partnership confirming this within 6 months of the date this report is accepted by the CSP Board.

4 Conclusions

4.1 Home Office Guidance[23] indicates the purpose of a DHR is to

- Establish what lessons are to be learnt 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 upon, 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

4.2 The purpose of a domestic homicide review is to establish whether or not the death of the victim was predictable and / or preventable.

4.3 This is a tragic case of the victim V1, a 48 year old woman, dependent upon alcohol but also dependent upon the need to have associations with men in particular. Those men, by their very nature were of a similar disposition to V1, alcoholics that could be classed as street drinkers, men with previous convictions for alcohol related offences, and men who showed no compunction in causing distress and annoyance to neighbours and members of the public whilst under the influence of drink. It is clear that V1 and her associates made

[23] Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office 2011

the lives of her immediate neighbours unbearable and none of them showed any compassion or consideration to their neighbours and especially their neighbour's children.

4.4 There is no doubt that the whole block of flats where V1 lived were terrorised by the behaviour of V1 and her male associates. V1 persisted on having a relationship with the man who seriously injured her by scalding once he had been released from prison, despite extensive efforts by statutory and voluntary agencies to persuade her otherwise. She was given on-going support and advice which she was unable to use in a way to keep herself safe. Police were regular attenders at her flat to respond to the nuisance she caused. There were occasions when more assertive and robust action by the police should have been taken but in reality any such action would have been only a short term remedy because there is no doubt that her and her friends would have been together again once the police had dealt with them.

4.5 Given V1's difficulties in disassociating herself from these men and from evidence gained from the numerous attendances at the Emergency Department at the local hospital, it was inevitable that when V1 and the men were together, drunkenness and violence would ensue and on occasions serious sexual offenses committed on V1. Given these circumstances at least serious injury and possibly her death were predictable.

4.6 Throughout this review it is clear agencies were unable to provide appropriate services for V1 that would have assisted her and would have provided support to break the pattern of alcohol abuse, abusive relationships and association with undesirable men, all of which put her at significant risk.

4.7 Risk assessments were carried out in relation to P2, whilst P1 is the person charged and awaiting trial for her murder. She intended to marry P1 and albeit he was of the same drinking culture as the other men, it would be reasonable to assume that if P1 and V1 intended to marry that their relationship was perhaps somewhat different to the relationship she had had with other men. It transpires that that was not the case. The degree of violence shown towards V1 by P1 was minimal compared to the violence demonstrated by P2 and other men in her circle of 'friends'. It is considered therefore, that given all of the

circumstances her death was not preventable.

List of Recommendations

Recommendation No 1 Page 47

West Mercia Police should ensure that all front line officers are aware of their responsibilities for positive robust action when attending incidents of domestic abuse irrespective that there may have been repeated calls to the same address or people con concerned, and compliance to NPIA guidance is ensured.

Recommendation No 2 Page 50

West Mercia Police to assess the impact of the pilot schemes of Anti-Social Behaviour Risk Assessment Conferences in the Telford and Hereford Divisions and consider implementing the concept force wide as soon as possible.

Recommendation No 3 Page 55

South Worcestershire Community Partnership to request assurance from Clinical Commissioning Groups in Worcestershire that the guidance ‘Responding to Domestic

Abuse (Royal College General Practitioners June 2012) has been implemented across all general practices.

Recommendation No 4 Page 58

Worcestershire Acute Hospital Trust to ensure that all Emergency Department staff obtain full details and antecedent information of patients who frequently present with alcohol and/or drug related injuries and share this information with other agencies such as the police and Adult Social Care.

Recommendation No 5 Page 61

South Worcestershire Community Safety Partnership endorses the draft Protocol for Referral to the Community Intervention Team and seeks its implementation as soon as possible, as is the Adult Social Care Community Intervention Team contained within the Adult Social Care Bill.

Recommendation No 6 Page 68

The Responsible Authorities within the Community Safety Partnership to explore the possibility of the introduction of a contractual obligation on providers to ensure that client information is passed on to other relevant agencies at the end of the contract.

Recommendation No 7 Page 70

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When dealing with clients who are reluctant to engage, West Mercia Women's Aid should ensure that there is a positive assumption that the risk is or remains high and the IDVA will refer on to the appropriate source such as the original referrer and MARAC as and when necessary, particularly where the history of abuse appears to be historic.

Recommendation No 9 Page 73

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Recommendation No 10 Page 74

South Worcestershire Community Safety Partnership to ensure that all agencies attention is drawn to the guidance as issued by:

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- guidance issues by the Government in December 2012.

Agencies should ensure that this best practice is included in future training and policy documents.

Recommendation No 11 Page 76

South Worcestershire Community Safety Partnership to encourage all agencies to partake in Freedom Programme Training and MARAC referral training as from May 2013

Recommendation No 12 Page 76

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ACTION PLAN WITH OVERVIEW RECOMMENDATIONS AND IMR RECOMMENDATIONS GOES HERE ONCE THE RECOMMENDATIONS OF THE OVERVIEW REPORT HAVE BEEN AGREED BY THE PANEL.