Safer Communities Torbay

Domestic Homicide Review

Executive Summary

DHR01

Executive Summary into the death of Male R in December 2011

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Safer Communities Torbay is a statutory multi-agency partnership which includes:

Torbay Council, Devon and Cornwall Police, Dorset Devon and Cornwall Community Rehabilitation Company, National Probation Service, Devon and Somerset Fire and Rescue Service, and Torbay and Southern Devon Clinical Commissioning Group.

Safer Communities Torbay

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Background to the Review

This Domestic Homicide Review (DHR) was commissioned as a result of the killing of a 44 year old man (Male R) on 28th of December 2011 by his then partner, a 45 year old woman (Female K). Female K was found guilty of murder on 29th of May 2012 and was sentenced to a minimum of 13 years imprisonment.

A DHR is usually conducted within the local authority area where the death occurred. In this case, Male R resided and was killed in Dorset, while Female K resided in Torbay. The statutory agencies in both geographical areas assessed the level of agency contact with each resident and agreed a DHR should be led by the Community Safety Partnership (CSP) in Torbay, known as Safer Communities Torbay (SCT), with support from the Dorset Community Safety Partnership (DCSP).

This DHR uses the process agreed by SCT for such reviews. A core group of senior managers from relevant agencies and the SCT Chair alerted the agencies to the possibility of a review and the need to secure evidence. This core group confirmed that in light of the initial evidence, a DHR was justified to learn the lessons that can improve service provision. The SCT Chair initiated the DHR in accordance with S9 of the Domestic Violence, Crime and Victims Act 2004. This DHR was established on 3rd December 2012 but due to staffing issues was suspended in May 2013. The DHR recommenced on 5th of August 2014.

Purpose of this review

The purpose of a DHR, as set out in the Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews[1], is to:

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

DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for coroners and criminal courts, respectively, to determine as appropriate.

The specific terms of reference for this review were:

- Seek to establish the sequence of agency contact with Female K, and where relevant, her children focusing on the period 2006 to 2011 (unless for a specific reason the DHR panel is of the view that this timeframe should be altered in consultation with SCT). This includes identifying any recorded incidents of domestic violence between Female K and Male R.
- Invite the involvement of the family (and, if appropriate, friends) of Male R and Female K, to provide a robust analysis of events. This will be done on completion of criminal proceedings, with contact initially through the police Family Liaison Officer.

1 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/209020/DHR_Guidance_refresh_HO_final_WEB.pdf

- Consider whether, under the circumstances, agency intervention potentially could have, or would not have, prevented the victim's death, given the information that comes to light through the review.
- Provide a report which summarises the chronology of events, analyses and comments on the actions of the agencies involved, and makes any required recommendations for improving the way agencies, singly and together, respond to domestic abuse.
- Identify how and within what timescales any recommendations will be acted on, and what is expected to change as a result.

The review sought to:

- Identify which agencies and professionals should be asked to submit reports or otherwise contribute to the review including, where appropriate, agencies that have not come into contact with the victim or perpetrator but might have been expected to do so. For example, victims may come from within hard to reach communities and consideration should be given to how the community can improve engagement and access to such groups.
- Establish whether there was any evidence of risk of serious harm to Male R that was not recognised or identified by the agencies in contact with both Female K and Male R. If it was, to examine whether the information was shared with others and/or whether it was acted upon in accordance with recognised best professional practice.
- Establish if any of the agencies or professionals involved considered that their concerns (if communicated) were not taken sufficiently seriously or not acted on appropriately by the other parties involved.
- Establish if the homicide indicates that there have been failings in one or more aspects of the local operation of formal domestic violence procedures or other procedures for safeguarding adults, including homicides where it is believed that there was no contact with any agency?
- Establish if the victim was being managed by, or should have been referred to a Multi- Agency Risk Assessment Conference (MARAC).
- Establish if the homicide suggests that national or local procedures or protocols may need to change or are not adequately understood or followed.
- Identify what appear to be the most important issues to address in identifying the learning from this specific homicide and how the relevant information can best be obtained and analysed.
- Establish if Female K or Male R had any contact with a domestic violence organisation or helpline and if so to determine how that organisation should be involved and contribute to the process.
- Establish how friends, family members and other support networks (for example, co- workers and employers, neighbours etc.) and where appropriate, Female K contribute to the review, and who should be responsible for facilitating their involvement.
- Establish how matters concerning family and friends, the public and media be managed before, during and after the review and who should take responsibility for the relevant sharing of information without incurring significant delay in the review process.
- Clarify how the review process can take account of previous lessons learned i.e. from research and previous DHRs.

The review focused on events from 2006 to 2011. These dates provided for discussion the five years prior to the death of Male R. Consideration was given to the impact of the troubled early life of Female K, but the focus of the review was maintained on the five years prior to the murder, since this was the time in which agencies work had the potential to make a difference to the eventual outcome.

Definition of domestic violence and abuse

In March 2013, the Government introduced a new definition of domestic violence and abuse, which is designed to ensure a common approach to tackling domestic violence and abuse by different agencies. The new definition states that domestic violence and abuse is:

'Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

'Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. 'Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

This definition, which is not a legal definition, includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group[2].

Information relating to domestic violence and abuse along with details of local and national support services can be located on the AreYouOk website (created and managed by SCT) at www.areyouok.co.uk.

Subjects of this review

The subjects of this review are Male R, the victim and Female K, the perpetrator who were in a relationship at the time of the homicide.

Male R's family had no relevant involvement with Female K or with the incidents which led to this review. At the time of his death Male R was living alone in Portland, Dorset. He had a close relationship with his mother, who was divorced from his father. He had a younger sister. Although he lived alone, he was reported to be happy and well integrated. Male R's family were approached via Dorset Police but preferred not to participate.

[2] Source: Multi agency statutory guidance for the conduct of Domestic Homicide Reviews (revised 1 August 2013)

Information had been provided by Female K's family to the original police investigation, which was made available to this review. A visit was conducted with Female K in prison and her experience was useful in understanding the impact of her early years on subsequent behaviour.

Female K had spent much of her early life in care. She had four sons. At the time of the incident she was living alone in Torquay, but spending increasing amounts of time with Male R in Dorset.

The Review Process

The review panel consisted of:

Name	Title	Agency/Organisation
Bob Spencer	Independent Chair	Independent
Jim Connelly-Webster	Independent Overview Report Author	Independent
Kelly Warner	Project Officer	Torbay Council, Safer Communities Torbay (SCT)
David Parsons	Domestic Abuse and Sexual Violence Steering Group Chairman	Torbay Council, Community Safety Team
Lisa Jennings	Children's Services Quality Assurance Manager	Torbay Council, Children's Services
Charles Pitman	Public Protection Unit Manager	Devon & Cornwall Police
Amanda Jones	Quality Assurance & Development Manager	Devon & Cornwall Probation Service
Delia Gilbert	Patient Safeguarding and Patient Safety Lead	South Devon and Torbay Clinical Commissioning Group
Vanessa Ford	Interim Director of Nursing & Practice	Devon Partnership NHS Trust (DPT)
Maria Kasprzyk	Interim Safeguarding Development Lead	Devon Partnership NHS Trust (DPT)

Ensuring independence of the review

Home Office statutory guidance requires that:

The review panel should appoint an independent chair of the panel who is responsible for managing and co-ordinating the review process and for producing the final overview report based on individual management reviews and any other evidence the review panel decides is relevant.

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. Some areas may wish to develop a regional agreement where experienced individuals from neighbouring areas are exchanged or loaned to the review panel to help share good practice and promote the sharing of new information and learning.

Neither the Chair of the Panel nor the author of the overview report has any direct involvement with any of the professionals whose work was being reviewed. The Chair of the panel has over 30 years' experience in policing and since completing police service in 2009 has had experience as Independent Chair of several children's and adults safeguarding boards. The Overview Report Author has experience as a senior police officer and since completing police service in 2011 has had experience in the fields of education and health as well as conducting a variety of reviews.

Contributors to the review

Summary of agency contact with Female K

Organisation	Status
Dorset Police	Not known to service prior to incident
South Devon Healthcare NHS Foundation Trust (Torbay Hospital)	Known to service
Devon Partnership NHS Trust	Known to service
Wellbeing and Access Team, Torbay	Known to service
South Devon Healthcare NHS Foundation Trust	Known to service
Torbay and Southern Devon Health and Care NHS Trust	Known to service
Housing Options Service Torbay Council	Known to service
Children's Social Care	Known to service
Torbay Supporting People Service	Known to service
Devon and Cornwall Police	Known to service
Dorset County Council (Adult Safeguarding)	Not known to service prior to incident
Devon and Cornwall Probation Service	Not known to service prior to incident
General Practitioner 2	Known to service
General Practitioner 1	Known to service

There is no relevant agency contact with Male R.

Usually a method of obtaining information from agencies and organisations for DHR's is through Individual Management Reviews (IMR's). An IMR is a process of review resulting in a document which the review panel can then consider.

The aim of an IMR is to:

- allow agencies to look openly and critically at individual and organisational practice and the context within which people were working to see whether the homicide indicates that changes could and should be made;
- identify how those changes will be brought about; and,
- identify examples of good practice within agencies.

An IMR template was produced to support those tasked with completing reviews and associated documentation. IMR's were requested from those agencies with significant involvement.

An Individual Management Report was received from Devon and Cornwall Constabulary. The Devon Partnership NHS Trust completed a Root Cause Analysis Investigation providing a chronology of their dealings with Female K. The Trust also provided a report detailing her treatment from their teams, produced from an examination of their electronic records. Housing Options, Torquay produced a brief chronology of their dealings with Female K covering the period from September 1999 to October 2009. The Paignton Community Team of the Torbay and Southern Devon Health and Care NHS Trust provided a chronology of their dealings with Female K, which amounted to a single incident in August of 2010, relating to her detention by police under S136 Mental Health Act 1983, after she threatened to walk into the sea to drown.

The South Devon Healthcare NHS Foundation Trust provided a brief chronology of their dealings with Female K covering the period from 1998 through to April 2005, this chronology covered attendances at the hospital

following an overdose in 2004 and a domestic assault in 2005. The Trust was also able to provide details of a number of past addresses she provided during previous attendances. The Safeguarding and Reviewing Service of Torbay Children's Services provided details from their electronic records system in respect of Female K and her children. They provided details from the Devon Social Services Child Abuse Register. Details were obtained from Female K's GP for the period 2005 to 2012. The Probation Service provided the most current assessment carried out with Female K while in prison.

Dorset Constabulary provided details of the brief facts of the murder by providing an extract from the case file. Dorset County Council indicated that they had no relevant information regarding Female K or Male R.

The overview report was based on the IMR received along with the RCA and related health documents. Interviews were carried out with Female K in prison.

The facts

Female K and Male R met via an online dating site. They had been in a relationship for 6 to 8 months prior to the murder of Male R. There was regular communication between them by means of texting, with some 4500 texts from or to Female K found on Male R's mobile phone. No texts were found which talked of violence to or from either party.

The first text contact found was on 3rd June 2011, but by 20th June that year the messages indicated that they had fallen out. Male R appeared to be attempting to end the relationship by text message. The text communications reveal a developing pattern in which she visited him, he then cooled the relationship, she would send insecure, emotional texts, he would get angry, she would apologise, they would make up and then she would visit again.

During November 2011 Male R regularly texted Female K stating he loved and missed her, however when she suggested renting a room in Portland to be near him, he replied accusing her of being a stalker and said he needed his own space. Prior to Christmas 2011 Female K had stayed with Male R for periods of a week or two and there were text conversations between them about her "overstaying her welcome".

On 10th of December 2011 she appeared to return to Portland and stay with him before leaving on 21st of December then returning on 23rd. She appeared to remain over the Christmas period.

The circumstances of Male R's Death

Over the Christmas period Female K and Male R appeared to be arguing frequently. During the evening of Tuesday 28th of December 2011 they were out together near Male R's home in the Easton area of Portland. At about 1:27am on Wednesday 29th December Female K called the police on the 999 system to say that she had stabbed Male R. She reported that it had happened some 20 minutes earlier. Police arrived and found her sitting astride Male R's body, holding a large knife. Male R was pronounced dead and Female K was arrested for his murder. Female K made significant statements at the scene, admitting that she had stabbed Male R. Male R had been killed by a single knife wound through the chest to the heart.

The account given by Female K

Female K was interviewed by the police; after initially stating that she could not remember the incidents, she eventually wrote an account of what had happened and gave it to the police officers. She described a violent struggle in the kitchen, that she was trying to slash her wrists and that he was trying to stop her. She described how in the struggle she had accidentally stabbed him in the chest with a kitchen knife. She described how, after the struggle Male R initially seemed to be alright, but quickly succumbed to his wound and died.

The trial

On 29th May 2012 Female K was sentenced to life imprisonment for the murder of Male R, who was described as a 'kind and gentle' man. She was told she would serve a minimum term of 13 years imprisonment.

The court was told that Female K had a history of self-harm and had a history of being in abusive relationships. Female K claimed that Male R was stabbed accidentally when he grabbed the kitchen knife that she said she was trying to kill herself with. The trial judge said; "The jury heard you give evidence and rejected your evidence. There is evidence of some violence and a struggle. On your own admission you pulled Male R's neck chain and he had scratches all over his face which suggests that violence was used. There was some kind of tussle. The court finds that you picked up the knife and used it. I do not accept the submission that you picked up the knife to use on yourself.

Female K's personal circumstances were taken into account when deciding her sentence. The trial judge said; "You have been in care since the age of six. You had to give your children away and you've been prescribed anti-psychotic medications. You have vulnerabilities and found it hard to keep up with the demands of real life. Meeting someone like Male R gave you hope, perhaps false hope, of a life of normality." A report by a consultant psychiatrist produced to the court described that Female K had borderline personality disorder, adjustment disorder, suffered from depression and there was evidence to suggest an emotional personality disorder.

Family Background

Female K was born in 1967 and was 45 at the time of the incident. She was originally from Burnley and had lived there and in a variety of locations, in Yorkshire, Lancashire and in Torbay, Devon. She had been brought up with her mother and father separately and a variety of care homes and foster homes since the age of 6. Since leaving school she had been in a number of relationships with men, many of them involving abuse of various types and degrees.

She had four children who themselves were given up to be put in care, either with foster parents or family members. She had been diagnosed with a borderline personality with a history of depression and chronic anxiety and had been on anti-psychotic medication. She had a recorded history of both mental health and domestic abuse incidents in Devon and Cornwall but a much longer history of abuse and violence as a child and young person in Yorkshire and Lancashire. She reported a history of emotional, physical and sexual abuse on a number of occasions and had several admissions to psychiatric hospitals. She also had a history of abuse of alcohol and cannabis.

She maintained contact with her children and they had continued to come into and out of her life. Her older children, when adults themselves, frequently being an additional cause of anxiety and incidents of domestic abuse.

A feature of her relationship with the Devon Partnership NHS Trust's mental health services was her frequent failure to attend appointments. On several occasions this resulted in her being discharged from services and subsequently re-referred by her GP.

Male R was born in 1967 and was aged 44 years at the time of his death. He lived alone in the Easton area of Portland, he was described as happy, helpful and friendly. Although he sometimes seemed lonely, he appeared to like his independence and space. He was employed locally as a laminator and had been so for about the past 15 years. He had been in several long term relationships before meeting Female K. He was known to over indulge in

alcohol but there is no indication that he became violent as a result, indeed he was described as becoming emotional and affectionate.

Agencies Involvement

There was little relevant involvement with Male R by any agency. He had a historic conviction for drink driving but other than that there was no contact with agencies in Dorset. Agencies there had no reason to know that Female K was visiting Dorset nor that she was involved with Male R. All of the data regarding relevant agency contact is related to Devon. The terms of reference for this review are to focus on events between 2006 and 2011, brief mention will be made of events prior to that period to set the context.

Agencies recorded history with Female K prior to 2006

Female K's life included a complex set of home movements, mental health needs, police involvement and child care arrangements. Her parents separated when she was 4 and she was placed in care herself at around the age of 6 and had suffered a wide range of physical, sexual and emotional abuse from several relatives, family contacts, partners and strangers.

Her early years were spent in Lancashire. There were significant problems in her family from her early years. Her father and mother both had alcohol problems, her aunt suffered from paranoid schizophrenia and a cousin is described as having Munchausen's Syndrome and being mentally handicapped. There is a history of mental health problems and sexual abuse within her family.

She was seen by a psychiatrist in 1982 who reported that she was "an extremely retarded, immature and extremely anxious girl who had been sexually assaulted at some time". She left school with no qualifications and found employment in a rehabilitation centre in Preston as a packer.

In 1987 she had a moderate depressive episode. In 1988 she gave the two children she then had into the care of her mother. In 1992 she suffered from post natal depression and took an overdose.

In 1993 she disclosed allegations of sexual abuse against one of her children which occurred while living in Lancashire. This was investigated but did not lead to substantive action. She then moved from Burnley to Paignton in Devon. In 1995 she attended Torbay Social Services seeking help with the aggressive and demanding behaviours of one of her sons. In 1996 she again disclosed the allegation of abuse from Burnley with additional separate allegations of abuse that had occurred in Paignton. Her step father was cautioned for sexually abusing the three of her sons that had been living with her and was placed on the Sex Offenders Register. A Child Protection Meeting was planned and a package of care arranged for the children.

In 1994 she was admitted to a psychiatric unit, having been diagnosed with severe depression. The ward described her as having little control over her anger and becoming angry at people for no apparent reason. She described herself as suffering from anxiety. She discharged herself, but in 1996 was admitted to a further psychiatric hospital where she was diagnosed as having an anxious and dependent personality disorder and was prescribed a tranquiliser.

She had been provided accommodation in a residential hostel for people with mental health problems.

Her children were placed in foster care and, with her consent, plans were made to accommodate the children under a full care order. The children were placed on the Child Abuse Register and a child protection meeting was held. The children and Female K were seen by a Family Support Worker and a Specialist Assessment and Therapy Team. Following these events Female K felt unable to cope and admitted herself to the Edith Morgan Unit an acute psychiatric unit attached to Torbay Hospital.

By November 1997 Social Services in Torquay were working on permanent placements for the children. They remained with foster carers while this was done and were taken off the At Risk Register.

In 1997 she had a severe depressive episode with psychotic symptoms and was diagnosed as having a borderline personality disorder. Borderline personality disorders are regarded as being a severe form of personality disorder and among the most severe, bordering on psychosis rather than bordering on normality. Borderline personality disorder is very similar to an emotionally unstable borderline personality disorder which she was subsequently diagnosed with by another psychiatrist. While there is no specific treatment for personality disorders, when faced with a patient who is manifesting symptoms as a consequence of a personality disorder, psychiatrists will often prescribe both anti-psychotic medication and anti-depressants in the hope of offering relief from the symptoms.

In March 1997 Female K went to live in Blackpool leaving the children in care, but returned in May. There were reports of her being addicted to alcohol and using alcohol impulsively when depressed. In 1997 and 1998 she suffered several suicide attempts.

In 1998 it was noted that there was little point in prescribing an anti-depressant for her as she did not have clinical depression, rather personality problems and unhappiness at her lifestyle.

In 1999 a case conference was held regarding concerns about serious risk of physical assault and violence that her then husband, Male 4, was displaying towards her. She was provided with Bed and Breakfast accommodation and referred to Women's Aid. She was given details of a local housing association but did not pursue it.

The first entry in the case notes of the Devon Partnership NHS Trust was on the 7th of October 1999. There had been previous keyworker involvement, but no detail is retained. On that day there was a case conference regarding Female K and her then husband Male 4. She was assessed to be at serious risk of violence from Male 4. It was noted that she would tell him that she was gambling and sleeping with other men. There was a further diagnosis of borderline personality disorder.

By 2000 she was being treated with various forms of medication in the hope of stabilising her mood and mild paranoia. She had an out patients appointment in February 2001, referred because of paranoid thoughts. She was discharged through non-attendance. At this time she was binge drinking and using significant amounts of cannabis.

She was re-referred to the Devon Partnership NHS Trust by her GP in 2002, having returned to Torbay from Blackpool. She was assessed by a Community Psychiatric Nurse (CPN), but not taken onto the caseload as her symptoms were not considered to be in need of treatment.

In November 2002 she was reassessed following a further GP referral. She reported hearing an internal voice that was derogatory in nature. She disclosed to her doctor that she had stabbed a boy with a pair of scissors for bullying her, leading to an assessment of having poor temper control. She reported a long standing cannabis habit of up to 20 joints a day and a having taken an overdose at the age of 23. The voices she was hearing were assessed as pseudo hallucinations and she was given a diagnosis of personality disorder and schizoid-affective disorder.

In January 2003 a diagnosis was made of borderline personality disorder alongside a chronic cannabis habit. In April that year she was prosecuted for assaulting a police officer.

In March 2003 she had an electroencephalogram (EEG examination to rule out epilepsy), this was recorded as normal. In April that year she disclosed to the Devon Partnership NHS Trust that she had been convicted of assaulting a police officer and had received a conditional discharge. She did not attend a planned series of outpatient appointments.

In September 2003 she attended the Accident and Emergency Unit in Torquay. She was assessed by the on call doctor who reported that she talked about wanting to kill her mother's ex-partner for abusing her children. She was advised to attend the Community Mental Health services and reduce her cannabis use. It was noted that she had been drinking.

In October 2003 a safeguarding alert was raised by Rethink Accommodation because Female K had made an allegation of rape to them. She did not want to involve the police.

In April 2004 there was a series of missed outpatient's appointments and in the August of that year she was discharged from services.

In April 2004 Female K attended A&E having taken an overdose of pain killers after a domestic dispute. She reported that she had tried cutting her arms but had been restrained by her boyfriend, Male 5. She was assessed by the duty psychiatrist who noted that her relationship with her boyfriend was financially and emotionally abusive.

In November 2004 she had changed her GP and was re-referred to the Community Mental Health Team for help with anxiety. She did not attend a further planned series of medical appointments but was eventually seen by a consultant psychiatrist in May 2005. He noted paranoia but not that it was not delusional or psychotic. He referred her back to the Community Mental Health Team as she had changed GP again. She did not attend a proposed medical appointment in September 2005. By then she had moved to Paignton and changed GP. This GP in turn referred her back to the Mental Health and Recovery Team for help with paranoia and anxiety. She was allocated a care coordinator. Her new GP noted her long history of sexual and physical abuse and depression

It was reported that she spent some time in a local women's refuge and had both financial and social problems.

In December of 2004 Female K made a non-crime domestic abuse allegation against her partner, Male 5 regarding their relationship ending. The Domestic Violence Risk Assessment (DVRA) was assessed as a standard risk. She was recorded as being drunk and referred to her own mental health issues.

In January 2005 Female K reported that she had been assaulted by Male 5. In the April of that year Female K reported that an argument between her and Male 5 had resulted in him punching her on the back of the head, causing an injury requiring 4-6 stitches and a broken finger. Following this incident Male 5 was charged with assault. Female K sought to drop the charges, but the case went to court in any event and Male 5 was convicted of two counts of the assault.

In April 2005 Female K changed her GP's practice in Torquay and was examined by the new GP.

In May 2005 Female K reported another assault by Male 5. They had argued and he struck her in the face. Having reported the matter she subsequently tried to withdraw the case. The trial did go ahead, in conjunction with the assault that had occurred in April and he was convicted of both at the beginning of June that year.

Later in June 2005 there was a further domestic abuse incident in which Male 5 chased Female K through a street. It led to a DVRA of high. Female K reported that she had been in a women's refuge but had been thrown out. It was again reported that she had mental health issues.

In June 2005 she presented to the Waverly Community Mental Health Team in crisis. It was believed that her medication had worsened her condition in the past. It was noted that her crises were often precipitated by relationship or housing problems. It was felt that the Crisis Response Team would be a positive approach for such problems in the future.

She reported ongoing depression to her GP she was seeking anti-depressants but was advised that they had not been helpful to her in the past. She also reported that she was having ongoing mental cruelty from her boyfriend and sought a letter of support to the housing authority.

In July 2005 there was a further domestic abuse incident involving arguments between Female K and Male 5. At the time they were living in a holiday park. Female K declined to give details of the refuge that she had been staying at or make contact with the police Domestic Abuse Unit. The DVRA risk assessment was judged to be high.

In August of 2005 Female K reported an argument with Male 5, she was assisted by the police to leave her address and stay with her family. Further safety advice was given. It was reported that both she and Male 5 had mental health issues.

In September 2005 Male 5 reported that Female K had scratched him on the neck during an argument. Male 5 subsequently gave a statement denying that the incident had occurred.

In October 2005 Female K was arrested for being drunk and disorderly, she had been on a roof top, throwing stones and threatening to jump off. Police had negotiated with her to come down but then she had become abusive. She was not considered to be suicidal. She was eventually issued with a fixed penalty notice for her behaviour.

In September of 2005 she took a further overdose.

History Post 2006

On 1st of January 2006 Female K reported that Male 5 had returned home after drinking, had taken her house keys and gone into her flat, refusing to give the keys back.

On 18th of March 2006 Female K reported that she and Male 5 had been out drinking and on return to his flat they had argued and that he had assaulted her. Both of them had visible injuries and both were arrested for assault on each other. Female K stated that she had threatened to self-harm but that Male 5 had assaulted her. Male 5 described their relationship as being on and off over the previous two years but that they had finally separated due to Female K's volatile behaviour. Both were very drunk. Female K reported that the relationship ended after this incident. The DVRA was returned to standard.

On 11th May 2006, following a GP's referral, Female K was seen by the Community Mental Health Team and was supported by a care coordinator. She was reviewed by a consultant psychiatrist who noted that the paranoia she was expressing was in the context of her history of abuse as opposed to any psychotic process. There was no indication that she was a risk to herself or others. She was eventually discharged on the 26th of October for non-attendance.

During 2006 she applied for Disability Living Allowance.

On the 5th of March 2007 there was a further GP referral and Female K was reassessed by the Recovery and Independent Living Team. She was discharged back to the care of her GP.

On 16 March 2007 Male 5 reported that Female K had been drinking and was banging on his door shouting abuse. Male 5 was then described as her ex-partner.

On 14 April 2007 Female K reported that following an argument in a local pub Male 5, now described as her boyfriend, came to her flat door and was banging on it causing a disturbance. Police attended and the DVRA was set as Very High.

On 9 September 2007 Female K called police to report an argument with her adult son, which resulted in her asking him to leave. Both had been drinking.

On the 16 October 2007 her GP recorded that she had suicidal ideation.

On 23 December 2007 Female K reported an argument with her son who had been drinking. Her son reported that Female K was suffering from a mental breakdown.

On 18 January 2008 she was reassessed by a consultant psychiatrist following another GP referral. She was discharged and given advice about medication as she was not considered risky or presenting with any debilitating symptoms. During this period it was noted that she deteriorated in her mental state when her boyfriend moved out, but improved when they were together again.

In April 2009 Female K made contact with Housing Options due to a threat of eviction. She was seen and advised. She was referred to the Housing Referral Hub for floating support. This is assistance by a Supporting People worker,

without accommodation being part of the service[3]. In June 2009 she again made contact to see where she was on the waiting list.

In July 2009 Female K was referred to the Devon Partnership NHS Trust Mental Wellbeing and Access team because of mood swings and being "snappy". She was taken on to the case load of a Care Coordinator and was assessed in August 2009. No risks were identified. She was offered a range of services including a medication review, a referral to a Support Time and Recover (STR) worker and a stress course run by the Depression and Anxiety Service. She did not take up these services.

In September 2009 the Hub referral was closed due to lack of contact. In October that year Housing Options received contact from Female K's landlord advising of rent arrears.

On the 9 September 2009 she was seen in a mental health clinic.

On 15 September 2009 there was a follow up appointment to that held in August, Female K having complained of poor memory. She was seen by a consultant psychologist, it was noted that her memory problems were "most likely related to anxiety rather than organic in nature". It was recommended that she should engage with the psychological support already planned.

On the 5 October Male 5 reported that Female K's son had assaulted her. Male 5 described Female K as his partner. Female K and her son were found to be under the influence of drink and drugs. Police investigated and the incident appeared to be related to her son not liking Male 5 or wanting him present.

In November 2009 Female K completed a "mini mental examination" at her GP's surgery. She was assessed and scored 25/30, she was referred to the psychology department for a memory assessment. By then she had engaged with a STR worker, her presentation was stable and it was agreed that she would be discharged.

In 2009 the relationship with Male 5 ended.

On the 12 January 2010 Female K contacted her Care Coordinator with concerns about her rent arrears. The Care Coordinator contacted the STR worker who reported that Female K had disengaged from the team. The Care Coordinator advised Female K to contact the local Disability Information Service for help with benefits. The Care Coordinator wrote to Female K in March 2010 asking her to make contact but she did not respond. She was discharged from the services of the Devon Partnership NHS Trust on the 27th April 2010 following lack of contact. The Well Being and Access team wrote to her GP and to Female K about potential onward referrals. It appears that these referrals were not taken up.

On 25 January her GP recorded that she had been subject of an assault. On the 3 February 2010 she completed a mental health personal health plan.

On 10 July 2010 Female K reported to police that Male 5 had called her regarding a debt. There were risk factors recognised in that she reported she was depressed, suffering from a mental breakdown, at risk of self harm or suicide and had been through a separation in the last 4 months.

On 28 August 2010 Female K was detained under S136 of the Mental Health Act after threatening to walk into the sea to drown. She had been drinking. She was seen by a Forensic Medical Examiner. By then she was sober, she did not show any signs of suicidal ideation and wanted to go home. She reported that she had recently been to see her GP but had stopped taking her medication because they were making her feel drowsy. She was referred back to her GP and a referral was made to the Community Mental Health Team by the Social Service.

On 15 October 2010 she changed her GP's practice. It was noted that she was on Fluoxetine and Seroquel. It was recorded that she was not paranoid, but was anxious. She was not suffering from a full panic attack. She completed an alcohol screening survey (FAST) on which she scored 2, indicating only moderate drinking.

[3] http://www.torbay.gov.uk/sp-directory-section-two.pdf

On 11 January 2011 police received a report from Female K that there had been a drink fuelled argument between Female K and her son, Son 1. The DVRA was graded as low risk.

On 12 January 2011 her GP carried out a mental health review. It was recorded that she lived alone and had recently finished a relationship. It was recorded that she smoked, but no longer drank.

On 6 May 2011 her GP noted that there had been contact from the Disability Coalition Torbay, who were seeking advice on her stability prior to starting some short term counselling, addressing issues from her past. Her GP was not able to advise.

On 21 June 2011 Female K called police to allege that she had invited some homeless people into her home who had then stolen money from her. No suspects were identified.

On 8 July 2011 her GP noted that paranoia was returning. The GP felt that it may be necessary to re refer to the Mental Health and Recovery Team.

On 9 September 2011 a counsellor contacted the GP to report that Female K had been anxious and had not been taking her medication because it affected her libido.

On 12 September 2011 her GP noted that she reported to have been stressed over her son. She reported that she was now in a relationship and was eating well.

There were no further agency contacts until on 28 December 2011 when Female K was arrested for the murder of Male R.

Female K's Perspective

Whilst the panel was grateful for the contribution of Female K in this review, information received from the convicted perpetrator Female K, should be treated with caution. The panel recognise that Female K is the only person in the very unique position of being able to comment in a very intimate way about Male R, and that Male R is not able to dispute any comment made. The panel would like to provide reassurance in that Female K's discussions were led appropriately by an individual with extensive experience in interviewing perpetrators, and that the analysis of the discussions has been completed by the Review Panel (i.e. a multi-agency team of professionals).

Female K was seen in Prison in October 2014. She was able to give an account of her history and her views on some of the experiences she had been through. The conversation was not focussed on the offence for which she was convicted, rather her background and history. Her recollections are not precise as to dates but give an indication of her history from her own perspective. Her account has been summarised.
She was born in Burnley and recalls a history of sexual and physical abuse from family members, friends of family and carers. The first instance she recalls was when she was three and a half but there were frequent incidents throughout her early years.

Her parents separated when she was about four, she was eventually taken into foster care, then permanent care in a series of locations. She experienced incidents of bullying in several homes and particularly recalls being disbelieved when she disclosed what was happening. This had a significant effect on her future thinking. She experienced incidents of abuse at various times throughout her life in care.

When she was thirteen she started seeing her mother and sister again, first at weekends then full time. She experienced further incidents of sexual abuse in her neighbourhood. She was also sexually abused by her step father but once again was not believed when she disclosed what had happened.

She attempted suicide and was being seen by a psychiatrist who prescribed her Valium. She believed the intention was to admit her to a mental health hospital. At about fourteen she moved with her mother to

Lancashire. She went to a special school, but again was bullied there. After her school days she moved with her mother to Fleetwood near Blackpool.

Before she turned sixteen her mother remarried and she was sent back to live with her father, even though he had physically abused her when she was young. During this period, she began to hear what she believed was the voice of a young girl who had died, the voices seemed to come from over her head and scared her. At about the age of sixteen, having been with her father for a few months she tried to kill herself. She returned to live with her mother and her mother's new husband.

While living with her mother, she met Male 1 who became her boyfriend and she became pregnant with her first child. She found bed and breakfast accommodation and when she was about six months pregnant, Male 1 moved in with her.

Male 1 physically abused her and took any money she had and spent it. She eventually left, took her son and returned to her mother. Eventually Female K did re-enter a relationship with Male 1 and moved into a flat with him. She became pregnant with her second son. She began to suffer from malnutrition because Male 1 was taking and spending all their money. They split up when her second son was two weeks old. She moved back again to her mother.

She then moved to live in a caravan park in Yorkshire with her two small children. Male 1 reported her living conditions to the social services as unfit for the children. He sought custody of her first child but not her second. By this time she was twenty one, she described herself as confused, upset and unable to care for her children. She gave them up to her mother and step father to care for. She entered another abusive relationship with an older man on the caravan site. This ended in violence against her and she left the area.

She moved to a flat but was sexually abused by the landlord. She reported the incidents to the police but eventually was too scared to go to court. During this time she slept with different men in order to have somewhere to stay and fell pregnant with her third child.

She stayed with a friend, but was attacked by her friend's boyfriend and left.

About a year after her third son's birth, she was seeing another man, Male 3, and was some six months pregnant by him with her 4th son. This relationship lasted from about 1990 to 1994 when he ended the relationship. She was so upset that she kicked her foot through a glass door leading to a serious injury and subsequent infection. There were further incidents of bullying and abuse, some serious which led her to leaving her home.

Once again, Female K moved back in with her father. He had physically abused her when she was a child, but now she had nowhere else to go. Her father started picking on her oldest son and beat her up when he came in drunk. She moved out into a flat with her children.

Male 3 the father of her 4th son moved nearby with his girlfriend. They subjected Female K to further abuse, both physical and mental, but Female K stayed at that flat for several years.

Once again Female K gave three of her children up to her mother and her youngest son to her sister to care for. She had lost her children and was very depressed, she had a spell in a psychiatric hospital.

She went to see her mother who was by then living in Devon. She decided to remain there. She was not abused for a long time while in Devon.

Eventually she met Male 4 in a mental health care centre. He was psychopathic and schizophrenic. She knew him for about a year before marrying him. He significantly physically abused her and social services refused to let her children come to live with them.

By this time her children, who were living with her mother and her mother's new husband, had been sexually abused by him. Female K had suffered from a mental breakdown and could not have the children back but was able to see them with the support of social services.

Eventually, after 5 years she was able to leave him. Her mother was by then living back in Blackpool and helped her to get back to come and live with her. Female K soon went back to Devon, this time to Paignton.

About 2 years later she met a new partner, Male 5, who was an alcoholic. She stayed with him because she loved him, even though he told her he cheated on her. It was an unstable relationship, sometimes he would finish with her, but she would beg him by letter to take her back. She moved in with him, but he was stealing all her money. Male 5 tried to separate her from her children and family. He would make her tell her children to go away. He frequently assaulted her, breaking her finger and giving her a serious head injury. He was due to go to court for these matters, but she felt guilty at the thought of him going to prison. She told the authorities that she had provoked him into the assaults and the case did not go ahead.

On one occasion, following an assault she called the police, but he called them at the same time and made a counter allegation. She declined to go to court and the charges were dropped. She felt that she loved him and could not bear seeing him go to prison.

She was provided with a place in a women's domestic violence refuge but inadvertently let Male 5 know the location. Given the security needs of the refuge and its rules, she was evicted and once again had nowhere to go. Eventually she found accommodation.

After Female K and Male 5 ended their relationship, she was still receiving physical and emotional abuse from her two elder sons. They blamed her for the sexual abuse that had happened to them when they were in the care of her mother and her mother's ex-partner. Female K was very insecure after her relationship with Male 5. She started seeing a counsellor. She felt very suicidal and described herself as a "nervous wreck". This had been going on for two years when she met Male R.

She described herself as desperate for love; needy, lonely. She started internet dating and adopting risky behaviours. She took no safety precautions and was just keen to meet someone. Male R contacted Female K through the agency and asked her to go to his home for the weekend. She was willing to go, she did not care about the risk; she just wanted a relationship.

While he said that he was only using the dating site for fun, she was interested in developing a genuine relationship. She began to visit his home in Dorset, initially every two or three weeks, but soon almost every weekend.

A pattern emerged which involved the relationship being broken off and restarted by text or in person. Male R was jealous of relationships that Female K had, whether with her family or friends. Male R was never violent with Female K but would be verbally abusive in telephone calls.

Male R told Female K that he had been seeing another woman. Female K told Male R she loved him and felt she couldn't leave him. Female K described the relationship with Male R as unstable. He was cheating on her and told her that he was. She was scared of losing him. When she was with him the relationship seemed good but when they were apart it was not.

The week before his death they had a difficult telephone call, Male R was shouting down the phone at Female K. In the end she put the phone down on him, but afterwards when she did call back, he told her that if she ever put the phone down on him again, their relationship would be over. Female K felt desperate and didn't want to lose Male R. They later talked and agreed to meet at the weekend.

They argued intensely that weekend and Female K was going to cut her wrists, during the ensuing struggle Male R was stabbed and died.

Analysis

Was there was any evidence of risk of serious harm to Male R that was not recognised or identified by the agencies in contact with both Female K and Male R. If it was, to examine whether the information was shared with others and/or whether it was acted upon in accordance with recognised best professional practice.

This issue can be divided into two sections, firstly was Female K a predictable risk to any person? Secondly, was Female K was a predictable risk to Male R? Consideration should also be given to what extent Female K was a predictable risk to herself.

Female K had a history that involved mental health issues, alcohol and drug abuse and domestic abuse, both as victim and perpetrator. Her history of involvement with health agencies and police in Devon extended from 1996, but had included troubled times since her earliest years. She had received diagnoses that included borderline personality disorder, depression, anxiety and psychotic episodes. She had been assessed through the Domestic Violence Risk Assessment process as a victim of domestic abuse and had been graded at various times as standard or high risk. Some domestic abuse counter allegations were made against her and she was herself arrested for offences of domestic assault, she was also arrested for drunkenness.

The considerations of the agencies, in respect of domestic abuse, were focussed on the risk posed to her, rather than by her. This was consistent with the range and type of incidents that she had been suffering from. There were allegations that she had assaulted Male 5 and in 2002 a disclosure that she had stabbed a boy with a pair of scissors, however, the pattern of information that emerges does not portray Female K as a risk to others in general nor to any particular person. While there were some accounts of violence by her, these were within the context of some bullying or other abuse directed towards her. Her life appears to have been chaotic and difficult, involving significant violence directed towards her, from her childhood through to her difficult adult life.

The relationship with Male R was troubled, with frequent break ups and resolutions however there was no history of violence, indeed prior to the fatal incident, there were no reports of violence between them. There would have been no grounds for any agency to suspect that Female K posed a risk to Male R or any other partner. There would have been no grounds for any agency to know that Female K and Male R were in a relationship. If any agency had known of this or any other relationship, there would have been no basis for any intervention. This relationship appears to be with one of the few boyfriends in her life that did not contain physical abuse.

During this review consideration was given to her risk status at the time the Domestic Violence Risk Assessments were conducted and whether the same data, if applied now, through the DASH, or other models would have led to any different outcome. It is difficult to make this comparison because of subsequent different training, approaches and recording methods. That being said, an examination carried out for this review indicated that the cases that had been brought to the attention of police would have merited a medium risk grading. These processes are designed to look at risk posed to the victim, not posed by the victim.

By far the greatest risk evident from the material available to the statutory agencies was a risk to her herself, either of self harm or of further abuse by any potential partner. While there had been some incidents of violence with her as perpetrator in her past, these were in the context of assaults or abuse applied to her.

Did any of the agencies or professionals involved consider that their concerns (if communicated) were not taken sufficiently seriously or not acted on appropriately by the other parties involved?

No agency had grounds for concerns about Female K as a potential significant perpetrator during the time parameters of the review, 2006 to 2011. There was no inter agency communication regarding her case. There are no apparent grounds that would have triggered inter agency communication regarding Female K as a potential perpetrator.

While no agency had concerns to share regarding Female K as perpetrator, there was data during her difficult history that, if shared, would have given all the agencies concerned a clearer and more holistic picture of her difficult and challenging life. If this fuller picture had been formed there would have been the possibility of support being offered to try to prevent the intergenerational nature of the chronic problems faced within the wider family. Female K had suffered abuse as a child, her children had suffered abuse in turn. The pattern of

abuse persisting through generations could be tackled, if not for the benefit of the current generation, then for those that follow.

Does the homicide indicate that there have been failings in one or more aspects of the local operation of formal domestic violence procedures or other procedures for safeguarding adults, including homicides where it is believed that there was no contact with any agency?

The domestic violence procedures and policies that now guide the relevant agencies are: D34 of Devon and Cornwall police and Paragraph 13 of Policy C19 of the Devon Partnership NHS Trust. These policies have a focus on the needs of the victim. The Devon Partnership NHS Trust policy deals with safeguarding adults in general and does not provide clear guidance for staff on referring patients who disclose domestic abuse.

While Female K was identified as a perpetrator on occasion her acts were in the context of the abusive relationships she was in. There was no basis, on the facts available, to see Female K as a perpetrator who posed a risk to an individual in particular or society in general.

While the homicide does not reveal any failing in the operation of domestic violence procedures, or safeguarding adults' procedures, in respect of the homicide itself, it does reveal some of the weaknesses in the systems for dealing with domestic violence allegations for those with complex needs. In particular, the process that had the best prospect of bringing together all the data on Female K was MARAC. The changes that have been brought into this system would provide a better service now than before 2006, when it was established and before 2010 since when high risk non-crime incidents as well as crimes have been considered.

If Female K had been brought to the MARAC process and if all available data had been brought to the MARAC it is possible that her complex needs may have been better recognised. If that were the case a further mental health diagnosis and plan may have been developed. Even if all that chain of possibilities had occurred, there are still no grounds for believing that the outcome of the homicide would have been influenced.

Was the victim being managed by, or should have been referred to a Multi- Agency Risk Assessment Conference (MARAC).

MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors. After sharing all relevant information they have about a victim, the representatives discuss options for increasing the safety of the victim and turn these into a co-ordinated action plan. The primary focus of the MARAC is to safeguard the victim. The MARAC will also make links with other bodies to safeguard children and manage the behaviour of the perpetrator. At the heart of a MARAC is the working assumption that no single agency or individual can see the complete picture of the life of a victim, but all may have insights that are crucial to their safety. The victim does not attend the meeting but is represented by an IDVA who speaks on their behalf.

Female K was not referred to the MARAC. The MARAC structure was set up in Torbay in 2006. At the time of its establishment the Torbay MARAC took notifications regarding crimes, not incident, graded as high risk through the DVRA process. There was one non-crime incident involving Female K subsequent to 2006, in April 2007, that was graded as very high risk. This involved her then partner, Male 5 banging on her door.

Since February 2010 MARACs in Devon & Cornwall have adopted the DASH (Domestic Abuse, Stalking and Honour Based Violence Risk Identification, Assessment and Management Model) 2009 risk assessment process and take notice of both crime and non-crime incidents.

Given that the 2007 incident could have caused a referral into MARAC, the details from it have been reconsidered against the DASH model. This indicates that on the data available to an officer at the time, it would have been scored as a medium risk. So while the non-crime element of the incident could have caused a referral to MARAC, the details of that incident would not have reached the "high risk" threshold for such a referral.

There was no basis for her case to have been within the MARAC process either as victim or perpetrator at the time of the death of Male R.

Does the homicide suggest that national or local procedures or protocols need to change or are not adequately understood or followed?

Protocols and Policies: The national and local procedures that were followed in this case relate to the MARAC and the Domestic Violence Risk Assessment process, which subsequently became the Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model. Both processes were followed correctly and dealt with the information available at the time.

Subsequent to this case, in February 2014 NICE Guidance note PH50[4] was published. This document sets out recommendations for healthcare professionals and others relating to domestic abuse. It is clear and helpful including recommendations on data sharing and referrals.

There is a need for improved training for police officers and mental health professionals in the management of chronic and complex domestic violence, seeing the whole picture, rather than simply the current incident.

GP services: It would be difficult to predict the behaviour of someone who has the combination of alcohol abuse, probable Bipolar Disorder and inconsistent compliance with medications. The care provided by her GPs appears appropriate with a number of referrals to DPT, which frequently resulted in her being discharged for non-attendance at appointments. There is no record of her considering harm to another person, there is only a record of her being a victim, either from a male partner or member of her family. There is frequent reference of inconsistent compliance with the medicine Quetiapin which could affect her mood.

Domestic Abuse services: From 2009 specialist Domestic Abuse support services were commissioned by Torbay council which took the form of Domestic Abuse Support Services (DASS) provided by West Country Housing Association. The service was for women and children only and included 7 units of refuge and 50 units of floating support.

Prior to this time refuge had been provided by Women's Aid but there was no specialist floating support or outreach service. There was a floating support service provided by the Council's Supporting People commissioned service, who would help some people who had experienced Domestic Abuse, but this was not a specialist service.

From 2008 to 2014 Torbay had supportive programmes (Pattern Changing then Recovery Toolkit) available to women and children, by several providers over this time. This function has since been included in the contract with the new provider for Domestic Abuse services.

The Domestic Abuse Support Service (DASS) was the local service provider until 1st September 2014, after this Sanctuary Supported Living took the contract for future service provision of Domestic Abuse services on 2nd September. They provide refuge accommodation and safe houses, floating support for high and medium risk cases including the provision of IDVAs, telephone support for low level cases, a recovery programme, a community based perpetrator programme and programme of support for children. The service is now known as Torbay Domestic Abuse Service (TDAS). The service is aimed at all, being able to assist all persons without exclusions. There will also be a survivors group.

Prior to TDAS the IDVAs had been paid for and managed by Torbay Council, who worked from the Safer Communities team. They then transferred to the new service. The first MARAC IDVA was appointed in 2008 with another post created in 2012. The Specialist Domestic Violence Court (SDVC) was established in 2008, in which year an SDVC IDVA was also appointed; this post has been provided by Victim Support since 2011.

[4] https://www.nice.org.uk/guidance/ph50/chapter/2-who-should-take-action

2006 to 2011 was a period of development for Domestic Abuse services in Torbay. Since then TDAS seeks to bring many areas of domestic abuse service provision under one roof to provide greater consistency. This work is supported by the Domestic Abuse/Sexual Violence Steering Group who has responsibility to deliver the relevant strategy for Torbay. Since its inception MARAC has received continued support. There have been ongoing efforts to get information into GPs surgeries and promote routine enquiry.

What appear to be the most important issues to address in identifying the learning from this specific homicide and how can the relevant information best be obtained and analysed.

This is a tragic case, arising from a very troubled life. Female K had been the victim of physical and sexual abuse since her very earliest years. She had been abused and betrayed by some of the people closest to her. Her own account of her life reveals a person seeking a loving relationship but frequently making choices that ended up harming herself.

She did receive agency services; for her physical and mental health and from the police in respect of domestic abuse, but these services were fragmented, with no one agency seeing the full picture of her life. Agencies need to maintain a focus on the chronic situations of abusers and victims, to seek to understand what is happening beyond the simple description of the current incidents.

She appeared to find a degree of happiness in the relationship with Male R. There would have been no basis for any agency to intervene in that relationship.

This case demonstrates the importance of providing a secure childhood. Especially for vulnerable children within the care system and the potential impact of childhood abuse on the subsequent development of some adults.

Her history, while tragic is not unique or even extreme in domestic abuse cases. The risk to challenged families, extending over generations and the need for support for them to break patterns of behaviour has been recognised and is reinforced by this case.

Findings and learning

Understanding domestic abuse as a multi-faceted complex issue to better deliver services

Victims of chronic domestic abuse will not usually present with simple, easily resolvable problems; they will often be disorderly, complex, and hard to engage with. Single agencies will find it difficult to deal with or understand the needs of such people from their own perspective and standard means of delivering services. Sharing information to build a holistic 'picture' of circumstances and plans will allow different agencies to understand the whole situation. Seeking to meet the needs of such victims will require bespoke planning and often more pro-active attempts to engage the individual. NICE guidance PH50 is very useful in this.

There is a balance to be struck between understanding clients rights for autonomous decision making yet being assertively supportive, pursuing the service offer when clients do not attend or do not engage. Staff can perceive their interventions as negative, even as abusive, if clients appear to decline the service, however when clients are suffering under the impact of a range of complex issues, they may not be in the best situation to make an informed decision to reject the service offer.

This review highlights that training and awareness raising of the needs of people with complex needs and how best to work with them, is currently an unmet area of need in Torbay. This is being developed following work on serious self neglect following learning from safeguarding processes and from previous SCRs. There are processes for safeguarding training and domestic abuse awareness, but these are generally around roles and responsibilities of professionals knowing how and where to refer people for help, rather than looking specifically at complexities and working with them.

Awareness and training for healthcare professionals

Most statutory agencies are now well aware of the importance of domestic abuse and the risks associated with it. However, in complex, chronic cases, no one agency can resolve the situation, indeed with such intractable problems and resource constraints, agencies can seek a simple quick solution when one does not exist.

Female K was given a diagnosis of borderline personality disorder. Despite being offered a range of interventions to address her mental health issues there is no reference to her being offered specific therapy such as Dialectic Behaviour Therapy (DBT) or any treatment in relation to her diagnosis. Whilst a referral to DBT may have been useful it was felt that due to her poor record of attendance and her noncompliance this may not have been accepted. However these behaviours would not necessarily preclude a referral as they could be addressed in the pre-treatment phase and contracting. The learning from this review reinforces the need to carefully review what non-compliance and non-engagement means for clients with a mental health background.

The same issues were raised in relation to her possible attendance at a group for women who had been sexually abused. It was considered that in addition to poor attendance and compliance issues Female K may not have had the ability to engage with the group processes for example reflection due to her stress and anxiety, poor memory and low cognitive abilities.

Risk assessment

The DASH process considers the risk to a victim but it does not consider the risk of the victim becoming a perpetrator. The revised DASH process as of 2010 takes into account non-crime incidents as well as those that are clearly crimes. This is a positive improvement. Domestic Abuse will often show up through non-crime incidents before there are identified crimes. An effective multi agency approach at this point can make a positive difference.

The learning (if not a question) from this review however and another local DHR is, how is it possible to assess risk when individuals are not within the service system? If there is no recorded abuse or violence previously within an intimate relationship that has been raised with an organisation (as in this case), what more can we do at a local, regional and national level to prevent such homicides?

The victim in this case was not receiving support for domestic abuse and was therefore not deemed to be at risk by agencies. The perpetrator in this case, whilst experiencing a history of abuse herself, was not deemed by any organisation to pose a risk of becoming a perpetrator.

These are complex questions for which the panel does not have the answers but need to be raised for local and national consideration (and are likely to have been raised via other DHRs across the country).

ViST (Vulnerability Screening Tool)

Since this case occurred a project has been established in Torbay to assess vulnerable adults and children. This new Risk Assessment tool has been utilised by Police Officers and Staff to assess vulnerability and replaces the existing child data sharing tool, form 121A. The ViST tool is designed as an aide memoire and is intended to improve identification of vulnerability and management of any risk. It is also designed to improve the knowledge of front line officers and encourage them to take responsibility at the earliest stage and signpost concerns to other agencies and services as required.

Officers conducting the assessment grade the forms as Red, Amber or Green and these are telephoned in to the police Central Data Input Bureau (CDIB) for direct input onto the Unifi electronic records management system. Further risk assessment and research is conducted by the police Crime Standards Team.

In the first 6 months of the pilot 2000 ViST forms, which is approximately 11 per day,) have been completed with some notable successes where, under previous way of working, the vulnerability may not have been identified or acted upon so swiftly.

Learning from this review and the introduction of the ViST both reiterate that risk is dynamic and as such processes and skills have to develop and adapt dynamically too. 'Having a risk assessment' and not revisiting it is not enough. There is a need to continually ask ourselves 'are these assessments fit for purpose?', 'are we asking the right questions at the right time, in the right way, by the right people?' and 'do our assessments reflect new social and environmental factors?'.

Central Safeguarding Team (CST)

The Central Safeguarding Team is a new function of Devon and Cornwall Police that performs a number of functions designed to improve processes for the assessment and management of risk and vulnerability, along with the sharing of information to partners. Chief amongst these is the processing of the ViST forms. This involves the assessment of risk after research on police systems has been conducted to identify cases requiring further multi-agency assessment and intervention.

In addition to the processing of the ViST the CST:

- Receive and assess referrals from partner agencies.
- Create a Dedicated Decision Maker role for CST Sergeants.
- Provides an enhanced service given to vulnerable people and partners
- Allocates referrals/enquires based on risk to the most appropriate officer
- Prepares child protection and adult safeguarding conference reports
- Provides assessment and desktop investigation of missing person enquiries in relation to children and adults completed by the new role of the Missing Persons Safeguarding Officer
- Initial assessment and research
- Services disclosure and information sharing requests from partner agencies
- Acts as a point of information and advice for operational Police Officers and Staff

The establishment of the CST in Torbay has resulted in a number of substantial outcomes and benefits to safeguarding such as;

- Increased capability of all staff to recognise and assess vulnerability
- 45% Reduction in allocated child enquires
- 48% Reduction in safeguarding adult work allocated
- Corporate Risk Assessment applied on all VIST's & Referrals
- Child VIST's; Information shared with partners within 12hrs of incident in all cases
- Adult VIST process has established a new referral pathway for adults suffering with mental health, drug & alcohol problems
- Child At Risk Alert (CARA) process

Awareness of the safeguarding needs of children

The panel was of the view that in reviewing historic information relating to this case, recognising and taking action based on the needs of children experiencing/exposed to domestic abuse was crucial. The panel was mindful of the "toxic trio" of mental health problems, substance abuse and domestic abuse and considered that in general terms, whilst there is a natural focus on the immediate needs of the victim within any domestic abuse

case, the learning from this review reiterated that both the short and long terms impact on any children present in the household must always be taking into consideration.

Complex cases

Female K presented to different agencies with different aspects of her overall situation. Her story was difficult and hard for any one agency to make a difference to her. Her frequent changes of accommodation and her changes of partner also made engagement with her difficult. Her story also involved at least three generations. Her case, overall, was no single agencies responsibility. Failing to attend appointments could be seen as evidence of a lack of willingness to engage, but could also be seen as evidence of being unable to cope with the complexity of her current situation. MARAC, post 2010, will help, but all agencies need to understand the complex situation that the victim is in.

The learning from this review is a reminder of how incredibly complex domestic abuse can be, the long lasting impact it can have on individuals and families and the need for organisations to consider cases in a holistic way to build an entire picture of circumstances and barriers to help and support.

Equality and Diversity

The Equality Act 2010 legislates against discrimination for a range of protected characteristics relating to Equality and Diversity. Two of these characteristics may have been considered as relevant in this case, particularly 'Disability' and 'Sex'. A person is considered to have a disability if s/he has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities. Taking this definition and applying it to this case leads to the question of whether or not the perpetrator would have received (or been able to access) services in a different way, whilst herself experiencing domestic abuse. While the perpetrator was at times throughout her life recognised as a person with mental health needs and as a person suffering domestic abuse, her overall needs and vulnerability were not recognised.

Whilst the victim in this case did not approach (or experience) domestic abuse services, if he had done so with the behaviours exhibited at the time it is likely that the case would have been assessed as 'low risk' whereas many services are equipped to work with high to medium risk victims leaving a gap for 'prevention'. He would have been able to access general, publically available, domestic abuse literature. There is though no evidence to suggest he thought himself to be at risk.

Conclusions

This review has considered the way in which a variety of agencies worked with Female K. She was acknowledged as a repeated victim of domestic abuse. She was not identified as a potentially dangerous offender and having considered the available documentation that appears appropriate. Although she had complex needs these were as a victim rather than a perpetrator of domestic violence.

There is no evidence that the police or other agencies in Dorset should have known about Female K's presence there, nor if they had done, that it should have raised any concerns. There is no evidence that agencies in Devon should have had any concerns about Female K as a perpetrator of domestic abuse in Dorset or elsewhere. There may have been concerns that any relationship she formed could become abusive against her, but there was no realistic monitoring process that could, or should, have been invoked. Her most recent high risk domestic abuse incident was reported to the police in 2007.

Female K did merit attention via the MARAC process once it had been established in 2006. At that time though non-crime incidents, even those scored as high risk did not attract MARAC attention. This was changed in February 2010 and since that time high risk incidents, whether crime or non-crime have been considered by MARAC allowing for multiagency data sharing. However a rescoring now of the factors evident during 2006/7 reveal that her case would have been graded as medium risk and would not have been considered at MARAC even taking into account the crime and non-crime matters.

Female K did not present as a person who was a specific immediate risk, or who was at specific immediate risk herself, but she was in a chronic situation of risk. Each element of her mental health care and her domestic abuse situation, when approached separately did not attract in depth scrutiny. Her overall situation did merit multi agency, multi incident, holistic review. The DASH risk identification process does allow for this, but under the category of overall professional judgement rather than a specific direct approach to ensure that chronic situations as well as single incidents are considered. The "toxic trio", of mental illness, substance misuse and domestic abuse, played a significant part in this case as in many Serious Case Reviews.

There is no evidence that mental health practitioners followed up assessments that included disclosures of domestic abuse with any internal or multiagency data sharing process. There is a strong culture of patient confidentiality, but the DPT confidentiality policy does allow for the release of confidential information, under specific control, when it is in the clients best interests, with or without patient consent.

Female K had been through a series of experiences, with her birth family, with foster carers, in institutional care homes and in the wider community that left her without many of the life skills and secure start in life that people need to thrive. She grew up at a time when many of the safeguards now in place for young people in care did not exist.

Such cases are difficult and sit outside the performance regimes of major agencies; understanding their background and engaging with such ingrained problems takes up considerable practitioner time. A strong leadership culture that demonstrates the importance given to domestic abuse is required.

Considerations could arise regarding the mental capacity act 2005 and “capacity to consent”; there is though nothing in this case to suggest that Female K’s capacity to consent to her own treatment was so impaired that there should have been any agency intervention to impose treatment upon her.

The homicide that led to this review occurred in 2011 and the incidents that led ultimately to that homicide may possibly be considered as a factor, in part, to Female K’s very difficult early life. There have since been significant developments in domestic abuse working in Torbay, but even with these improvements it is unlikely that the pattern of events that led to Male R’s death could have been predicted or prevented.

Since the homicide occurred in 2011 there have been both single agency and partnership developments in Torbay which have improved the response provided to victims of domestic abuse.

Recommendations

Understanding domestic abuse as a multi-faceted complex issue to better deliver services

1. The constituent agencies of Safer Communities Torbay should each have explicit domestic abuse policies that include how and when to report incidents of domestic abuse, whether linked to that agencies service provision or not. Agencies within Safer Communities Torbay should promote these policies and procedures to their staff who may receive disclosures of domestic or sexual abuse in the course of their other duties.

2. The TSAB and TSCB should develop a process for the referral and management of disclosure of historical cases of sexual or domestic abuse.

3. That SCT continue to raise public awareness of domestic abuse (specifically controlling behaviours and the complexities of abusive relationship) and attempt to signpost victims to help and support at an early stage.

Awareness and training for healthcare professionals

4. When healthcare staff receive information that could indicate that a patient is a victim or potential perpetrator of domestic abuse they should seek specialist advice about the most appropriate action to

take. Evidence of this consultation and decision making must be recorded on the appropriate patient record and with consideration of NICE PH50 guidelines.

5. Domestic abuse training should be provided for all front line staff within the SCT constituent agencies. This should include front line A&E department staff. All training on domestic abuse should include the complete 2013 domestic abuse definition and with consideration of NICE PH50 guidelines.

Risk Assessment

6. With consideration of NICE PH50 guidelines service providers should review their risk assessment processes to ensure they are robust, with dip sampling to ensure quality control.

7. Patients with complex needs are liable to exhibit a high rate of "Did Not Attends", this should be seen as evidence of complexity rather than evidence of lack of willingness to engage.

8. Clinicians should follow up referrals made to other services if a reply has not been received within three weeks of the referral.

9. The SCT constituent agencies should review, amend and make robust use of their domestic abuse risk assessment frameworks.

Information sharing and multi agency working

10. The Adults & Children's Safeguarding Boards have many different information sharing protocols. There is a particularly effective mental health data sharing protocol, allowing for the sharing of risk data when working with patients with mental health problems. These processes appear well known to small groups of professional leads, but not more widely known. There are different protocols for different professional areas. The Adults & Children's Safeguarding Boards should require an audit to be carried out and if possible devise a generic information sharing protocol.

Awareness of the safeguarding needs of children

11. The importance of notifying partners of the risk to children seen in homes where domestic abuse is occurring should be included in any Domestic Abuse policies that are developed and should be promoted to staff.

12. Torbay is developing a Multi-Agency Safeguarding Hub (MASH) process, this should be developed as the basis for multi-agency safeguarding for both children and adults.
13. The panel recommend that the Community Safety Partnership make arrangements to enable the learning from this review (DHR01) to be disseminated to the local MARAC and the Torbay Adult Safeguarding Board and Torbay Children's Safeguarding Board;

    And that the Community Safety Partnership monitors the recommendations and associated actions from the DHR via appropriate means;

    And that DHRs feature as a standing item on the Community Safety Partnership's meeting agendas.

Terminology

CAADA	Coordinated Action Against Domestic Abuse
CARA	Child At Risk Alert
CPN	Community Psychiatric Nurse
CSP	Community Safety Partnership
CST	Central Safeguarding Team
DA	Domestic Abuse
DASH	Domestic Abuse, Stalking & Harassment
DASS	Domestic Abuse Support Service
DBT	Dialectic Behaviour Therapy
DHR	Domestic Homicide Review
DPT	Devon Partnership NHS Trust
DV	Domestic Violence
DVRA	Domestic Violence Risk Assessment
EEG	Electroencephalogram
GP	General Practitioner
IDVA	Independent Domestic Violence Advisor
IMR	Individual Management Review
MARAC	Multi Agency Risk Assessment Conference
MASH	Multi Agency Safeguarding Hub
NICE	National Institute of Clinical Excellence
PCSO	Police Community Support Officer
RCA	Root Cause Analysis
SCT	Safer Communities Torbay
SDHCT	Southern Devon Health Care Trust
SDVC	Specialist Domestic Violence Court
TDAS	Torbay Domestic Abuse Services

TSAB	Torbay Safeguarding Adults Board
TSCB	Torbay Safeguarding Children Board
TSDHCT	Torbay & Southern Devon Health Care Trust
ViST	Vulnerability Screening Tool

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