Safer Leicester Partnership
Working together for a safer City

DOMESTIC HOMICIDE REVIEW:

EXECUTIVE SUMMARY REPORT

INDEPENDENT OVERVIEW REPORT

INTO THE DEATH OF

'Janice'

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20 July 2016

INDEX

PART 1: DOMESTIC HOMICIDE REVIEW, BACKGROUND AND PROCESS

1.1 Purpose of the review:

The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.2 Who the report is about:

This DHR is about *'Janice'* [1], who was 46 when she died as a result of domestic violence perpetrated by her partner '*Ian*'. From her early 20's Janice had spent long periods living abroad, in the USA and Europe. At the time of her death she had 2 adult children who had remained resident in the USA. Other family members included 2 sisters living in the North West of England. Janice had a history of problems related to alcohol misuse and mental illness. She also had a reported history as a victim of domestic violence in previous relationships.

Janice moved to Leicester in November 2014. Initially she stayed with a friend who she had met abroad, before moving into the Dawn Centre (temporary homeless accommodation). Over the last 6 months of her life Janice had 2 brief periods of residence at the Dawn Centre:

- Around 4 weeks in November / December 2014
- One night in January 2015

Janice left the Dawn Centre voluntarily in December 2014, when she went to stay with her sister in Blackburn for a short period, before being re-admitted to the

[1] For reasons of confidentiality, pseudonyms of 'Janice' and 'Ian' (homicide victim and perpetrator, respectively) are used throughout the report. Other pseudonyms are used for family members, ex-partners, etc.

Dawn Centre in January. After staying for one night, Janice was asked to leave as she was suspected of supplying illicit substances to another resident.

From leaving the Dawn Centre until the homicide (around 15 weeks later) Janice had no secure or stable accommodation. On occasions she stayed at Ian's address, where there were a number of reported domestic violence incidents, including 6 occasions when the police were involved. There was also involvement by emergency medical services and other agencies. The full report includes a chronological summary and detailed analyses of these incidents.

1.3 Perpetrator background:

At the time of the homicide Ian was 44 years old. He was born in the Republic of Ireland and moved to Leicester around 1998. Police records show that he had a history as a perpetrator of domestic violence in previous relationships and had 8 previous criminal convictions for domestic violence related offences. Alcohol misuse was a common factor in these offences. On 2 occasions Ian had received 3-month prison sentences for assaulting previous partners. The last recorded offence had been in 2008.

1.4 Janice and Ian's relationship

Janice and Ian's relationship commenced at some time between late November 2014 and early January 2015. Agency IMRs indicate that none of the services involved with Janice or Ian had knowledge of the relationship until January 2015.

At this time, Ian was already well known to the services based in the Dawn Centre building, including the hostel itself and GP Practice 1 which provides primary health care services to hostel residents and other people in the locality affected by homelessness and complex needs. Ian had recently moved into his privately rented flat, with support from homelessness services and the Anchor Centre (city centre day service for street drinkers).

The collective evidence from agency IMRs suggests that a significant feature of the relationship was mutual binge drinking followed by verbal conflict, escalating to physical violence. When violent incidents were reported (to the police or other services) it often proved difficult to reliably ascertain whether Ian or Janice had been the primary instigator.

Throughout the period of the relationship, Ian was resident as the sole tenant of his privately rented flat. Apart from her 2 brief periods of residence at the Dawn Centre, she had no secure accommodation. She may on occasions have slept rough or stayed with other people, but this detail is unknown.

For some periods Janice stayed overnight in Ian's flat, but she would then leave - or be ejected by Ian – often following an alcohol fuelled conflict. During daytime periods Ian and Janice sometimes attended the Anchor Centre, either together or separately.

In summary:

- When the homicide happened Janice and Ian had known each other for around 6 months.
- It had been a highly volatile relationship between 2 people who each had a long history of alcohol misuse, street drinking and periods of homelessness.
- Ian had a history in previous relationships as a perpetrator of domestic violence, including some serious assaults resulting in prison sentences. This pattern of behaviour continued in his relationship with Janice.
- Janice had a history in previous relationships as a victim of domestic violence.

1.5 Outline summary of the homicide incident:

At around 7.30 am on a Saturday morning, Leicestershire Police received an anonymous telephone call stating that a woman had been murdered at Ian's address, which was a flat (situated in a block of flats) in Leicester. The male caller

rang off before any further detail could be obtained. Police officers attended at 7:50pm but were unable to gain entry to the block. The supervisory officer present concluded that the available information / intelligence did not justify the use of force to enter the flats and the incident was closed.

The following day (Sunday), the incident was reviewed and further intelligence checks were completed. That process identified previous incidents involving Ian and Janice at this address. Entry was forced into the flat at 12:23pm when Janice's body was discovered.
A forensic pathologist's report was unable to specify the cause of death, but a guilty plea to manslaughter was accepted by the prosecution. Ian had admitted placing Janet in a choke hold, during an alcohol fuelled row. The Court were informed that he did not intend to kill his victim.

1.6 Involvement of family members and friends:

Janice's sister in Blackburn was invited to contribute to the DHR and it was hoped that she may also facilitate communication with Janice's (now adult) children who remain resident in the USA. This invitation was declined.

The female friend that Janice met in Spain and stayed with for a short period (in November 2014) in Leicester was also contacted, but she also chose not to take any part in the DHR.

1.7 Agency involvement:

The following agencies had significant involvement with Janice and Ian during the period under review and contributed Individual Management Reviews (IMRs):

Organisation	**Primary reason for contact With perpetrator (and/or) victim**
Leicestershire Police	Call outs to domestic incidents (P&V) & homicide response

Leicester City Council Homeless Prevention & Support Service	Periods of accommodation at Dawn Centre hostel (P&V separately)
Leicester City Council Housing Options Service	Housing applications (P&V separately)
SAFE Project	Domestic violence helpline contacts (V)
GP Practice 1	G.P. and other primary healthcare services (V & P)
University Hospitals of Leicester NHS Trust	Treatment at Emergency Department, Leicester Royal Infirmary (V)
George Eliot Hospitals NHS Trust[2]	Treatment at Urgent Care Centre, Leicester Royal Infirmary (V)
Anchor Centre	'Wet' day centre for street drinkers (V&P)
Nottingham University Hospitals NHS Trust	Treatment at Emergency Department, Queens Medical Centre (V)
Leicestershire Partnership NHS Trust	Community mental health services

1.8 Review timescales:

Home Office guidance suggests a target period of 6 months for the completion of DHRs. This DHR has taken nearly 12 months from outset to completion. This has been due to a number of factors, including the need to wait for completion of the criminal process so that DHR enquiries would not unduly interfere with the criminal case which concluded in autumn 2015.

[2] At the time these events occurred the Urgent Care Centre was managed by George Eliot Hospitals NHS Trust whilst the Emergency Department (on the same hospital site) was managed by UHL. The Urgent Care Centre has since been taken over by the UHL Trust. Separate IMRs were provided, in relation to events at Emergency Department and the Urgent Care Centre.

1.9 Confidentiality:

Pending Home Office approval for publication of the report, the DHR panel and Leicester CSP have managed all information about this case as highly confidential. Information sharing has been restricted to members of the DHR Panel, their line managers and senior managers of services which provided Individual Management Reviews.

1.10 DHR Panel

There was no Adult Services involvement in this case, allowing Adult Services Directorate senior managers to chair meetings with professional independence. The Panel Chairs were:

- Mr. Paul Kitney, Head of Service Adult Safeguarding, Leicester City Council (first 2 meetings).[3]
- Ms. Ruth Lake, Director Adult Social Care & Safeguarding Leicester City Council (subsequent meetings).

Independent Consultant Richard Corkhill[4] was appointed as Overview Report Author. Mr. Corkhill has been a self-employed consultant since 2004. His professional background includes practitioner and senior manager roles in the social care and supported housing sectors. In the last 4 years, he has worked as a DHR Chair / Author for a number of different Community Safety Partnerships. He has never been employed by any of the organisations which had involvement in this case.

In addition to the Chair and Report Author, the Panel included representation from the following organisations:

- Action Homeless

[3] Mr. Kitney left his employment with Leicester City Council during the course of the DHR and was replaced as DHR Panel Chair by Ms. Lake.

[4] Further information about the report author can be found at: **www.richardcorkhill.org.uk**

- Anchor Centre
- GP Practice 1
- Leicester City Clinical Commissioning Group
- Leicester City Council Domestic Violence Coordinator
- Leicester City Council Housing Options & Homelessness Services
- Leicestershire Partnership NHS Trust
- Leicestershire Police
- Living Without Abuse
- Nottingham City Council Domestic Violence service
- Nottingham University Hospitals NHS Trust
- SAFE (Non-statutory domestic violence service)
- University Hospitals of Leicester NHS Trust

Administrative support was provided by Leicester City Council.

PART 2: SUMMARY OVERVIEW OF FINDINGS AND KEY LEARNING POINTS

This summary overview of findings is structured around the lines of enquiry which were set out in the DHR Terms of Reference. The detailed evidence bases for these findings are detailed in Part 2 of the full report.

1. To review whether practitioners involved with Ian and Janice were knowledgeable about potential indicators of domestic violence and aware of how to act on concerns about a victim or perpetrators

There is evidence that some practitioners were knowledgeable about indicators and how to act. For example, the responses by staff at Queens Medical Centre in assessing risks and then taking actions aimed reducing future risks have been identified as good practice. Similarly, the Outreach Alcohol Support Worker demonstrated a good understanding of the risks Janice was facing and acted appropriately. There are several other examples of good practice highlighted in Part 2 of the report.

There is also some evidence of lack of understanding of risk factors in some agencies, either at individual practice levels or at policy and procedure levels Examples include:

- Awareness of impact of homelessness as a DV risk factor.
- Closely associated with homelessness - isolation from informal social support apart from local street drinking networks.
- Awareness of significance of Ian's past history as a perpetrator in previous relationships as a risk factor in current relationship.
- Possible 'downgrading' of perceived risks and need for strategic multi-agency actions, where violence is believed to be mutual – failure to recognise that mutual violence may actually indicate *higher* risks.
- Insufficient recognition of power balance in the relationship.

2. To establish how professionals and agencies carried out risk

assessments, (including assessment of the victim's mental capacity to make decisions relating to risks) including

i) whether the risk management plans were reasonable response to these assessments.

ii) whether police DV risk assessments and management plans of Ian took account of his early forensic /criminal history, and assessments of risk made during this period.

iii) whether there were any warning signs of serious risk leading up to the incident in which the victim died that could reasonably have been identified, shared and acted upon by professionals

iv Whether risk assessments considered risk to individuals when services were withdrawn

Warning signs:

- There were clear and repeated warning signs. This included 6 police incidents in the months leading up to the homicide and 2 CAADA-DASH risk assessments which found Janice to be at high risk.

Risk assessments:

- There is clear evidence that police DV risk assessments did not take sufficient (if any) account of Ian's early forensic and criminal history.
- Risk assessments also did not sufficiently take into account a number of other factors, including those associated with Janice being homeless.
- There was no assessment of the increased domestic violence risks to Janice, when a decision was taken to evict her from the Dawn Centre hostel accommodation.
- There were many missed opportunities by housing, homeless, primary healthcare and alcohol services, when incidents of domestic violence were disclosed, but no formal risk assessment was carried out and no pro-active attempt made to engage Janice with specialist support. This appears to have been primarily due to a lack of staff training and awareness in relation

to domestic violence risk assessment processes and local multi-agency policies and procedures, including the MARAC protocol.

Risk management plans:

- Although two different agencies completed MARAC referrals (only one of which has been confirmed as received by the MARAC office) Janice's situation was not discussed at MARAC, due to a breach MARAC policy / procedure. As a result of this there was never any clear multi-agency risk management plan. This has been identified as a very significant missed opportunity.

Mental capacity:

- It is very probable that when heavily under the influence of alcohol Janice's ability to recognise risks and make informed decisions about possible DV risks posed by Ian was temporarily impaired. However, there is no evidence to suggest Janice's mental capacity was impaired or that there would have been any grounds to formally assess her mental capacity to make decisions about her relationship or about whether or not to drink excessively.

Information sharing:

- There was some sharing of information by some of the agencies involved and there were significant (but unsuccessful) attempts to support and encourage Janice to effectively engage with specialist DV services.
- On one occasion staff at the Dawn Centre refused to share information with Nottingham Womens Aid, without Janice's written consent. The DHR has concluded that, given the urgency of the situation (i.e. potential placement in a women's refuge) seeking verbal consent via a telephone call to the hospital where Janice was an in-patient would have sufficiently addressed concerns about confidentiality.

3. **To identify whether services that were involved with either Ian or Janice were aware of the circumstances of Janice's presence in the home and agencies involved with them. Whether connections were made and information shared between these services in order to establish a full picture of the vulnerability and risks arising from the relationship.**

Most services in regular contact with this couple were aware that Janice and Ian were in an intimate relationship; that this included occasions when Janice would stay at Ian's flat and that there were increasing concerns about violent incidents. Collectively, the agency IMRs also show that there was significant communication and information sharing between agencies. This included an intensive period of communication between GP Practice 1, CPN, Anchor, SAFE and Housing Options, in attempts to put an effective plan to reduce risk levels. Within these communications there are examples of good practice as well as some examples of communication breakdowns.

In summary, it appears that most services did recognise that there were significant domestic violence risks and attempts were made to share information, refer for specialist DV support from SAFE to establish a risk management plan. However, it is not clear that the *'full picture of vulnerability and risks arising from the relationship*' was established. A full picture would have included:

- Sharing of police records which would have highlighted Ian's past history as a serious DV perpetrator and recognition of the significance of that history in assessing current risk levels
- Wider recognition of Janice's homelessness as a major risk factor, because she stayed in Ian's flat when she had no other options.

Multi-agency weaknesses in respect of the above points was a major factor in the circumstances leading up to the homicide.

4. Did agencies involved make routine enquiry about domestic violence when working with these adults and if so were any opportunities missed.

There is evidence that some agencies frequently engaged with both Janice and Ian

about domestic violence issues. A number of agencies took opportunities to advise both Ian and Janice to end the relationship as it was widely recognised that there were significant domestic violence risks when the Janice and Ian were drinking excessively. However, there were many missed opportunities when the level of risk that Janice was under could have been more effectively and accurately assessed, followed by more proactive signposting and referral for specialist support. Advising Janice to end the relationship was a simplistic response which failed to recognise that the process of separation from an abusive relationship can often lead to a period of significantly higher risk.

5. To establish whether agencies responded to alcohol and drug dependence and offer appropriate services and support to Ian and Janice.

As noted above, when the couple were together and drinking excessively, this was widely recognised as a major risk factor for potential domestic violence. The couple were offered support to bring their drinking under control. Both Ian and Janice had access to support and harm reduction approaches at the Anchor Centre. Janice also had contact with an alcohol outreach worker.

In summary, the evidence is that alcohol was recognised as a highly significant issue and both Ian and Janice were actively encouraged to access relevant services. The Anchor Centre provided a 'wet house' which helped reduce immediate risks associated with street drinking. Unfortunately, it appears that neither Janice or Ian were able to engage with longer term treatment for alcohol dependency / misuse issues. This has highlighted the need for substance misuse services to develop more flexible and opportunistic responses to people who are homeless and have a range of complex needs.

6. At each point of contact with emergency health services for assaults, self-harm and injuries –were enquiries made about domestic violence and procedures followed?

The level and quality of response from emergency health services was variable:

- Responses from the Urgent Care Centre tended to make assumptions that any active follow up to domestic violence concerns was the responsibility of other agencies.
- At Janice's first contact with Leicester Royal Infirmary following a reported domestic violence incident, no CAADA-DASH assessment was completed, which is breach of local policy and procedure. At her second contact an assessment was completed, resulting in a MARAC referral which according to hospital records was emailed to the MARAC office. However, there is no record of it being received by the MARAC office. Due to weaknesses (since resolved) in the hospital's email systems it is not possible to be certain whether or not the email was in fact sent to the correct email address.
- Queens Medical Centre (Nottingham) followed multi-agency policy and procedure, completed a CAADA-DASH assessment and made a MARAC referral. QMC's overall response has been identified as good practice.

7. To establish whether mental health needs of the adults subject to this review were supported and managed appropriately by local agencies

Although Janice spoke of having a bi-polar disorder which she said was diagnosed when she lived in the USA, the IMR from GP Practice 1 indicates no known history or medical record of such a diagnosis. It also indicates that, during the period under review, Janice's mental health was assessed by the GP service, but she was found to show no symptoms of psychosis or of risk of suicide.

However, Janice was referred to the Homeless Mental Health Service, which provided her with support from a Mental Health Nurse. Janice also had an appointment with a CPN, who made a verbal referral to the SAFE project.

In summary, it appears that Janice's mental health needs were adequately supported.

There is no evidence to indicate that Ian had significant mental health needs.

8. To establish if any agency or professionals considered any concerns were not taken seriously or acted upon by others.

The alcohol outreach worker raised concerns in an email in February 2015 with Housing Options about the DV risks resulting from Janice being homeless and reliant on an abusive boyfriend for overnight accommodation. It is unclear what Housing Options did with this information.

9. To establish if there were any barriers experienced by Ian, Janice or family / friends that prevented them from accessing help to manage domestic violence; including how their wishes and feelings were ascertained and considered.

Ian has stated that he felt he had been a DV victim as well as a perpetrator, but that as a man he experienced a barrier, because services assumed that the male partner could not be a victim. However, the DHR has not found evidence that would indicate Ian was at any significant risk of serious injury or homicide.

As a homeless person with alcohol problems, Janice experienced many barriers related to her lifestyle and flexibility of service provision. Many professionals genuinely listened to her wishes and feelings and she was offered support by specialist domestic violence services. However, as her basic need for safe and sustainable housing was not met, this undermined attempts to achieve consistent engagement with domestic violence services. Her homelessness created additional barriers for services trying to make and maintain contact. Even contact by mobile phone was unreliable, as Janice would not always be able to keep the battery charged. As a general rule, domestic violence services are reluctant to leave voice mail messages, due to fears that a perpetrator may pick up messages resulting in higher risks to the victim.

In summary, this DHR has highlighted the need for agencies to develop more flexible, creative and responsive services, in order to reduce or remove some of the barriers which impacted negatively on Janice.

10. To identify whether more could be done locally to raise awareness of services available to victims of domestic abuse.

There is evidence that there was a lack of awareness within local services of the voluntary perpetrator programme, which could potentially have worked with Ian to address what was a clearly established pattern of abusive and violent behaviour in this and in previous relationships.

11. To establish whether agency DV risk assessments and response to risk followed agreed local multi-agency procedures.

See responses above and to question 12. There were procedural breaches.

12. To establish how referrals into MARAC were responded to, whether these responses were in line with local multi-agency procedures and whether they were appropriate, in the light of information about risk which was available at the time of referral.

The first recorded MARAC referral was generated by QMC in March 2015, after they had scored Janice as being at high risk on the CAADA Dash risk assessment. This was following the incident when Janice attended the QMC Emergency Department after the incident when she stated Ian had poured boiling water on her head and stabbed her in the thigh. The evidence reviewed by the Police (including the apparently minor nature of Janice's injuries and a third-party witness statement which contradicted Janice's account) indicated no realistic prospect of successfully prosecuting Ian with any criminal offence.

A decision was taken by the MARAC office that this would not be discussed at MARAC. The primary basis for this decision appears to be that the allegations made by Janice that she had been violently attacked by Ian were, in the judgement

of police officers, not supported by the presenting evidence.

However, the decision in this instance was contrary to local MARAC protocol and procedures and represented a very significant **missed opportunity** to establish a coordinated multi-agency approach, which could have better recognised and more effectively managed ongoing domestic violence risks. It is fundamentally important to recognise that the lack of evidence to support a criminal prosecution was *not* an indicator for low risk of further domestic violence.

The second MARAC referral, also in March 201*5,* was recorded as having been made by UHL's Emergency Department. This was after Janice attended ED with bruising to her face and back, and a bump to her head. Whilst the MARAC referral is recorded by UHL as having been sent by email, UHL have been unable to locate any email history to confirm that is was sent to the correct MARAC email address. It is understood that this is due to weaknesses in UHL's electronic communications systems, which have since been addressed.

Due to the absence of reliable records, the DHR has not been able to ascertain precisely what happened, but the outcome was that no MARAC process followed.

13. To establish whether vulnerable adult / adult safeguarding concerns were recognised by agencies and were appropriate multi-agency procedures followed.

The DHR has not found significant learning in relation to this question

14. To consider how issues of diversity and equality were considered in assessing and providing services to Ian, Janice (protected characteristics under the Equality Act 2010 age; disability; race; religion or belief; sex; gender reassignment; pregnancy and maternity; marriage or civil

partnership)

Janice's gender, mental health problems, alcohol misuse and homelessness were all highly significant factors in relation to Janice's needs as a person who was at risk from domestic violence. Learning in relation to these factors is disseminated throughout the report.

15. How effective were local assessments on Ian & Janice's housing needs? Was appropriate housing support offered? How well did Leicester and Nottingham Housing agencies work together in safeguarding Janice?

Janice's homelessness status (after losing her space at the Dawn centre) was a critical risk factor for domestic violence, but this appears not to have been sufficiently recognised or acted on.

Janice was evicted from the Dawn Centre in January 2015 for an alleged incident of supplying an illicit substance to another resident. An internal review of this decision by Leicester's Homeless Service has since concluded that a final warning would have been a more appropriate response. On eviction, there was no assessment of the likely impact of this decision, even though it was known that she was at risk of domestic violence and had been assaulted on the day preceding her eviction.

When she was admitted to QMC in Nottingham there were attempts to negotiate some form of suitable housing, including a refuge placement (for which there were no vacancies in the local area) homeless provision in Nottingham and a return to the Dawn centre. However, none of these were offered.

Another factor in Janice being refused services in Nottingham was her previous eviction from the Dawn Centre, so it can be seen that the earlier decision by the Dawn Centre then had significant 'knock-on' effects in further reducing the chances of her finding suitable and safe accommodation. This seems to have been compounded by the Dawn Centre then refusing to share further information with WAIS unless Janice completed a written consent form. Given the urgency of the situation when Janice was a patient at QMC, verbal consent over the telephone could have been sought.

In summary, housing and homeless services in Leicester and Nottingham did not

work effectively together to safeguard Janice from further domestic violence.

16. To establish how effectively Leicester / Nottingham agencies and professionals worked together to safeguard Janice.

There was very good communication from staff at QMC hospital and agencies in Leicester, but unfortunately this did not lead to any positive outcomes in relation to Janice's immediate need for safe and secure accommodation. See also response to question 15.

17.To establish whether domestic violence policies, protocols and procedures (including risk assessment tools) that were in place during the period of review, were applied and whether they were fit for purpose.

See responses above.

18. Identify any areas of good practice

This DHR has established a pattern dominated by missed opportunities, poor inter-agency communications and breaches of procedure in relation to risk assessments and the MARAC process. However, there were isolated examples of good practice, including:

- Responses by staff at Queens Medical Centre in allowing Janice to remain in hospital when medically fit for discharge, having assessed her as being at high risk from domestic violence, then attempting (unfortunately without success) to work with outside agencies in Nottingham and Leicester to establish a safe discharge arrangement.
- The Outreach Alcohol Support Worker demonstrated a good understanding of the risks Janice was facing and acted appropriately to meet her immediate needs and to try (unfortunately without success) to ensure her engagement with Housing Options services.

- There are several examples of good practice by GP Practice 1, when concerns about domestic violence were proactively explored by practitioners and referral for specialist support was offered.
- Following the first 3 police incidents, Leicestershire Police carried out a review and increased assessed risk levels from standard to medium, due to cumulative evidence of risk.
- UHL's completion of the CAADA DASH risk assessment and the application of professional judgement in deciding to generate a MARAC referral was also good practice, but it is unfortunate that did not result in implementation of the MARAC process. (See question 12)

Key learning points:

The following is a summary of all key learning points from the full report:

Key learning point 1: There were breaches of operational procedure at the LRI Emergency Department and Housing Options which resulted in missed opportunities to assess potential domestic violence risks. There had also been a missed opportunity to carry out a risk assessment (or refer to a specialist domestic violence service for assessment) at the GP practice. This highlights the importance of ensuring that staff awareness and understanding of domestic violence policy, procedure and good practice is promoted through training, supervision and management processes.

Key learning point 2: There is a potential misconception – possibly shared by some professionals as well as members of the public – that 'domestic abuse' can only take place within the confines of a domestic dwelling. This may result in homeless victims of abuse being effectively excluded from multi-agency domestic abuse procedures.

There is evidence that homeless people are likely to be at higher risk from domestic violence compared to the general population, as is illustrated by this

case and other recent DHRs[5]. It is therefore essential that all services which work with homeless people should ensure that staff understand that any abuse within the context of an intimate relationship – *regardless of the physical location of incidents* – should be recognised as domestic abuse and responded to accordingly, within local multi-agency policy, procedure and good practice guidance.

Key learning point 3: When conducting domestic violence risk assessments, police officers should review local and national police records relating to the perpetrator. Where these records confirm a history in previous relationships of serious domestic violence (including in this case criminal convictions resulting in custodial sentences) this is a strong indicator of higher risks in the current relationship. The time period which may have elapsed since the last recorded police incident should not unduly influence officers towards a lower risk score, as it is entirely possible that the abusive behaviour has continued but has not been reported to the police.

Key learning point 4: There was a pattern of assumption on the part of UCC staff that responsibility for addressing concerns about domestic violence risks to Janice lay with the police and other services she was in contact with.

As a minimum, UCC staff should have discussed ongoing domestic violence risks with Janice, with a view to referring her for specialist support. Additionally, concerns about domestic violence should have been flagged on UCC records and discussed with her GP and other relevant services. (The UCC DHR Action Plan addresses these issues in more detail.)

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[5] For example: DHR SW01 published June 16 by Safer South Warwickshire CSP: apps.warwickshire.gov.uk/api/documents/WCCC-671-101

In fairness, it must be acknowledged that a number of other services (such as housing, homelessness and primary healthcare services) appear to have followed a similar pattern of assuming that 'somebody else' would be leading in relation to domestic violence concerns, so this learning point is relevant not just to UCC.

Key learning point 5: There is a need to ensure consistency of practice in the use of CAADA-DASH assessments where people present as homeless and there is evidence that that domestic violence is a factor in this presentation. The risk assessment should be conducted at the time of the homelessness presentation and not delayed until a decision is made regarding the person's statutory homeless status, which may be up to 33 working days later. As is clearly shown by Janice's experiences, if the individual is fleeing a violent relationship this period of 33 working days may well be a particularly high risk period.

Key learning point 6: Even if Janice's eviction from the Dawn Centre had been unavoidable due to concerns about other vulnerable service users, there should have been careful consideration of her ongoing vulnerability as a domestic violence victim. Attempts should have been made at finding more suitable alternative accommodation or at the very least signposting to specialist support services.

Key learning point 7: When carrying out DASH risk assessments officers should consider cumulative risk, especially when there has been a succession of similar incidents within a short space of time. A risk assessment which fails to consider such recent events and evidence of escalation is likely to be unreliable. (See also key learning point 3.)

Key learning point 8: It should be recognised that people with multiple and complex needs such homelessness, alcohol problems and domestic violence (i.e. those in the most critical and urgent need of help) are very frequently the most

difficult people for services to meaningfully engage with and effect positive change. However, there could have been more concerted and proactive attempts at getting Janice to attend Housing Options with a view to finding her somewhere safe to stay. This did not happen and the outcome was that Janice remained dependent on her violent partner for accommodation, which was apparently her only option other than rough sleeping.

Key learning point 9: **Clarifying victim / perpetrator roles and identifying risks**	
Ian	**Janice**
Confirmed history / criminal convictions as perpetrator of domestic abuse and serious physical assaults in previous relationships.	**Risk factor:** Self-reported history as victim of domestic abuse and physical assault in previous relationships
Recent and repeated history of assaulting Janice, causing significant injuries requiring hospital treatment	**Risk factor:** Observed on occasions to be physically aggressive and towards Ian, not known to have caused him serious injuries, but has received serious injuries in these conflicts.
Securely housed	**Disempowered:** Homeless, largely dependent on staying at Ian's as alternative to rough sleeping
Serious problems with binge drinking	**Risk factor:** Serious problems with binge drinking. **Risk factor:** History of mental health problems.

Key learning point 10: In an urgent situation where a person is fleeing domestic abuse and potentially seeking a refuge placement, the requirement for written consent before sharing information with the refuge service may create an unnecessary barrier to them being able to access the service. Where the person is willing and able to confirm verbal consent over the telephone (provided their identity can be verified with reasonable certainty) this should be a sufficient basis for sharing information.

Key learning point 11: The MARAC referral should not have been screened out of the MARAC process, regardless of any doubts that police officers or others may have regarding the reliability of an alleged victim's statement. That there was insufficient evidence to bring criminal charges should not have resulted in any assumptions about levels of domestic violence risks.

To screen and reject MARAC referrals on such a basis completely undermines a key principle: MARACs should consider risk assessments and risk management strategies from a *shared and multi-agency* perspective.

There is a need to ensure that the above points are made completely clear in the local MARAC Protocol.

Key learning point 12: When agencies refer to MARAC they must ensure that they retain a clear record of the risk assessment and the MARAC referral and request and receive a confirmation that the referral has been received. They should also be notified when the case will be discussed at MARAC and invited to attend the MARAC meeting.

Key learning point 13: It is important that GPs and other primary healthcare professionals have a good knowledge and awareness of domestic violence issues in general and of the MARAC process in particular. If there is any doubt about whether there is a current MARAC referral or MARAC coordinated risk management plan, this should be checked with the MARAC Coordinator.

Key learning point 14: This report has appropriately focussed very much on the availability and effectiveness of services to support and protect Janice. However, it is equally important to acknowledge the potential benefits of targeted interventions with repeat domestic violence perpetrators, which may ultimately change this behaviour pattern and protect other women from future abusive relationships. This also highlights the need to increase knowledge and awareness of local services which can offer such interventions.

PART 3: RECOMMENDATIONS

3.1 Recommendations reproduced from the Single Agency Action Plans attached to Individual Management Reviews:

Leicestershire Police recommendations:

1) It is recommended that supervisory officers are reminded of their responsibility to supervise domestic abuse investigations and the importance of fully recording the rationale for their decision making**.**

2) It is recommended that officers are reminded of the various support agencies that are available to persons who are alcohol dependent in order that they are signposted to the most appropriate agency to receive the required support.

3) It is recommended that officers are reminded of the need to adopt a more lateral problem solving approach to domestic abuse when faced with a victim who is reluctant / reticent to engage beyond the initial report of the abuse.

4) It is recommended that the police DASH risk assessment be amended with notes of guidance in the 'professional judgement' field, to guide decision makers regarding factors, outside of the main DASH questions, which should lead an assessor to increase the risk level. These are to include:

   - History of DV offending against other separate victims (serial perpetrator)
   - Significant increase in frequency of Standard and Medium risk incidents

This change will be marketed to all officers involved in completing DASH risk assessment and otherwise reviewing DV (DAST team)

Leicester City Council Homeless Prevention & Support Service recommendations:

1) Consider how services are withdrawn for victims of Domestic Abuse
2) Service Users presenting with Alcohol Issues should receive additional support to encourage access to treatment.
3) Ensure that Homelessness Services staff are fully aware of ASC responsibilities for vulnerable adults.
4) Assist One Roof to compile a referral form to highlight indicators of DV.
5) Ensure the learning from this IMR is shared amongst Homelessness Services Management Team.

Leicester City Council Housing Options Service recommendations

1) Provide further guidance to Officers as feedback from completing this process of lessons learnt and examples of good practice.

2) Case Management procedures reviewed.

Safe project:

No recommendations

GP Practice 1 recommendations:

1) A DVA lead be designated to lead on this area of work and ensure the practice remains up to date in its protocols and activity.
    a. Improve awareness of the agencies (such as UAVA) and processes (such as MARAC) involved with supporting people experiencing Domestic Abuse within the team.
    b. Improve understanding of CAADA-DASH risk assessment process
    c. Ensure appropriate training for clinical and non-clinical staff
    d. Guard against desensitisation to risks and optimise understanding of HIGHER risks in mutually violent relationships
    e. Engage with local safeguarding and DVA organisations and systems to improve primary care involvement more generally.

2) Systems to flag both victims and perpetrators of DVA within the clinical system (IT) are sought and that routine queries and offers of support and referral take place when flags are present.

Anchor Centre recommendations

No recommendations

Nottingham University Hospitals NHS Trust recommendations

No recommendations

Leicestershire Partnership NHS Trust recommendations

No recommendations

University Hospitals of Leicester NHS Trust Recommendations

1) Improve staff knowledge and awareness of domestic abuse and where to seek specialist advice by incorporating domestic abuse information / training into the mandatory adult safeguarding e-learning module.

2) Revise the face to face training on domestic abuse for ED / UCC staff to incorporate the learning from this review.

3) Review and revise the Emergency Department Standard Operating Procedure for Domestic Abuse, in line with the Trust's overarching DA Policy and best practice. This should include routine enquiry where domestic abuse is disclosed or suspected.
4) Review and revise the Emergency Department Standard Operating Procedure for Safeguarding Adults, in line with the Trust's overarching SA Policy and the Care Act.

5) Increase ED / UCC staff knowledge, awareness and confidence when dealing with domestic abuse, in light of this review (by implementing the above).

6) Explore the possibility of securing additional funding to recruit a permanent IDVA to work across UHL, alongside the UHL safeguarding teams

7) Ensure that the organisation maintains a secure record of all MARAC referrals made by ED / UCC staff.

3.2 Overview Recommendations agreed by DHR Panel

1) Leicestershire Police should review operating procedure, guidance and training for domestic violence risk assessments using DASH, to include a requirement that checks must be made on police records (Police National Computer and Police National Database) to ascertain whether the alleged domestic violence perpetrator has a history of reported domestic violence incidents and / or criminal convictions. Where such a history exists, but the current risk score has not reached the threshold for automatic referral to MARAC, officers should consider a MARAC referral based on professional judgement. (*Key learning point 3*)

2) There should be a multi-agency review of the MARAC procedure and domestic violence training needs, in the light of learning from this case, to include

- Systems for sending, receiving and recording MARAC referrals
- Potential need for clarification of guidance for specialist domestic violence staff, particularly around the requirement that any domestic violence victim identified as high risk in CAADA-DASH must be considered at a multi-agency MARAC meeting. *(Key learning points 11 & 12)*
- Need for wider agency training and awareness raising about domestic violence and the role of MARAC, with a specific focus on training needs in primary healthcare and housing and homelessness services, to

include appropriate use of the DASH risk assessment tool in cases where there are presenting concerns relating to domestic abuse.

- Supporting and training staff responsible for assessing domestic violence risks where there are multiple and complex needs, including evidence of mutually violent behaviours. (*Key learning point 9*)
- Ensuring that service users' wishes and intentions are clearly accounted for in safety planning and that follow actions are in place; particularly when the service user is identified as being high risk.

3) There should be work to increase awareness about local services which carry out specialist and targeted work with serial domestic abuse perpetrators. Perpetrators who have a history of criminal domestic abuse offences should be prioritised for such targeted interventions, which may be on a voluntary basis or as an element of criminal court imposed sanctions. If this recommendation highlights issues of insufficient capacity to meet demand, this should be considered by commissioners as a potential area for increased resource allocation. (*Key learning point 14*)

4) All of key learning points from this DHR should be disseminated as widely as possible to local health, social care, housing, homelessness and criminal justice agencies likely to be working with people affected by domestic violence. (*All Key learning points)*