Safer Somerset Partnership

Feel Safe, Be Safe

Domestic Homicide Review

Executive Summary of the Overview Report

Into the death of Marie

Restricted until publication May 2016

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1. Introduction

This Domestic Homicide Review (DHR) was commissioned by the Safer Somerset Partnership following the tragic murder of Marie.

1.1 Case summary

On a morning in February 2015 at approximately 8.30am, police and ambulance were called to the garden of a house in a town in the Mendip area of Somerset where they there found 45-year-old Marie with multiple stab wounds which proved fatal.

Marie's estranged husband (H) was arrested a short time later having made off from the scene in his car and been involved in a single vehicle collision whereby he had turned the vehicle over in a hedge.

Although the couple had been married for approximately 25 years, Marie had separated from H during the summer of 2014 and was living in her own privately rented property about 5 miles away.

At the time of the murder H was living in the house with the couple's youngest child (C5) who was present and asleep in the property at the time. It is believed that H had called Marie at 7.41am and asked her to come to the house to look after C5 as C5 was unwell and would not be attending school that day.

Marie and H also had 4 other children ranging in age from 17-23 years. C5 was aged 10 years old at the time of Marie's murder.

1.2 Background

Marie was 45 years old at the time of her death and is described by her family and friends as being a fun loving woman who was fiercely protective of all her children whom she loved very much.

She is described as hard working and wanting to provide the best for them despite suffering significant emotional and sometimes physical abuse from H throughout their marriage.

Records of contacts with a wide range of agencies date back many years however, during the summer of 2014 from the time of Marie's separation from H up until the time of her death, the escalation of domestic abuse is apparent from the significant amount of information and contacts with and between different agencies during that 8-month period.

During that time, Marie also made significant remarks expressing her fear and frustrations to family, friends and many of the agencies involved. These included that H would kill her, he was getting away with his behaviour, and nobody was going to do anything until she was dead.

In particular, friends and family will describe Marie's contacts in relation to her housing issues as being extremely frustrating and overwhelmingly distressing. This was mainly due to the fact that the tenancy on the family home was in her sole name and she was committed to paying all the rent and bills for both that tenancy and also her temporary accommodation.

Marie also felt that the only option being presented to her by the Local Authority Housing Options Team was to flee to a refuge, when she felt that she needed to retain some stability for her children by continuing to work in order to pay all her accommodation and other household bills, with her ultimate aim being to return to the family home.

H was 50 years old when he murdered Marie in the garden of his home in Somerset. He had a long history of violence and had once served a term of imprisonment in 1987 for slashing the face of his previous wife with a knife after she had separated from him due to his coercive and controlling behaviour.

H also had many contacts with health services and his medical records note a history of drug and alcohol problems, aggressive behavior, recurrent bouts of anxiety and depression, and suicide attempts.

2. The Review process

2.1 Decision to conduct a Review

This Domestic Homicide Review (DHR) was recommended in April 2015 by the Safer Somerset Partnership in line with the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2011 and the Home Office were informed.

In July 2015, H pleaded guilty to the murder of Marie and was sentenced to life imprisonment with a recommendation that he serve a minimum term of 18 years.

At the conclusion of the criminal proceedings, this DHR was commissioned and the Review process began with an initial Review Panel meeting held on the 16th September 2015 of all agencies that potentially had contact with Marie, H and their family prior to her death.

Four further Review Panel meetings were held which concluded with the final meeting being held on 17th March 2016 which was attended by members of Marie's family. The independent chair also visited Marie's family to discuss and share the findings of the review prior to it being submitted to the Home Office.

This summary outlines the process undertaken by the Domestic Homicide Review Panel in reviewing the death of Marie.

2.2 Terms of Reference

Specific terms of reference for this review included:

- To review events for 9 years, from the beginning of 2006 up to the domestic abuse related homicide of Marie. Any other information considered relevant prior to that date was also to be included. This approach was taken given the known significant volume of information, and also because of many organisational changes which meant asking all agencies to review all records back beyond 2006 was impractical

- To particularly ensure that any adult and child safeguarding concerns were effectively considered and resolved

- To seek to fully involve the family, friends, and workplace colleagues within the review process

- To consider how (and if knowledge of) the non-physical types of domestic abuse were understood by the local community at large – including family, friends, employer and statutory and voluntary organisations. This was to ensure that the dynamics of coercive control were also fully explored.

2.3 Agencies participating in the Review

The following agencies were asked by the advisory group to search their files for known contacts with the victim, the perpetrator and their children:

- Avon and Somerset Constabulary
- National Probation Service
- South Western Ambulance Services NHS Foundation Trust
- Somerset Clinical Commissioning Group
- Somerset County Council Adult Social Care
- Somerset County Council Children's Social Care
- Somerset County Council Education Service
- Somerset County Council Youth Offending Team
- Somerset Partnership NHS Foundation Trust
- Taunton and Somerset NHS Foundation Trust (Musgrove Park Hospital)
- Bournemouth Church Housing Association (BCHA) domestic abuse service provider until January 2015
- Knightstone (SIDAS- Somerset Integrated Domestic Abuse Service) domestic abuse service provider from January 2015
- Yeovil District Hospital NHS Trust
- Mendip District Council
- Taunton Deane Borough Council
- South Somerset District Council
- Victim Support
- Somerset Drug and Alcohol Service
- Curo Group, Landlord for family

Agencies were asked to give chronological accounts of their contacts with the victim and perpetrator and their family prior to the homicide. Where agencies had no involvement or insignificant involvement, they informed the Review accordingly.

In line with the Terms of Reference, the DHR covered in detail the period from 1st January 2006 to the point of Marie's death on 26th February 2015, in addition to any events prior to that date which may have been relevant to violence or domestic abuse.

Of the fifteen agencies contacted, only two responded that they had had no contact with the victim or perpetrator, the National Probation Service and the Youth Offending Team.

All the remaining agencies provided information of their contacts with the family and ten agencies completed an Individual Management Review (IMR).

All the chronological information provided was integrated into one single chronology which was used to check and cross-check contacts to ensure that communication and actions across the agencies were timely and appropriate.

2.4 Family, friends and employer

Marie's family were contacted at the start of the Review process. Marie's eldest child and next of kin (C1) was initially the main point of contact and although cooperative, was reluctant to be involved in any great depth and Marie's eldest brother (B1) became the main family contact and provided the most significant information.

B1, together with his wife (BW) and Marie's new partner (BF) with whom she had formed a serious relationship during the latter part of 2014, were all very supportive, providing much useful information and participating with the Review process fully.

Two of Marie's brothers and her sister-in-law attended the final Review Panel meeting to meet the agencies involved and to ask questions and understand the lessons learned.

Marie's employer, colleagues and friends were also willing participants in the process and equally provided useful information, particularly over some of the difficulties and frustrations that Marie had encountered during the latter half of 2014.

2.5 Perpetrator involvement

Although the Chair and Author of the Review made several attempts to speak directly with H in prison, he was unreceptive to being interviewed stating to his prison offender manager that he knew what he had done, he'd held his hands up to it, and he wanted to move on and forget about it.

Marie's family consider this to be another form of control by him, by denying them any explanation or formal closure after her brutal death, particularly as he pleaded guilty for Marie's murder and has never provided any answers or shown any remorse for his actions.

2.6 Individual Management Reviews (IMR)

The purpose of the IMRs were to provide accurate information concerning all the contacts that each agency had with Marie, H and their family. This information provided an important timeline and insight into the relationships between the individuals involved leading up to the homicide itself.

A summary of each of the ten IMRs completed is as follows:

2.6.1 Avon and Somerset Constabulary

The family was well known to the police with domestic disputes between H and Marie as well as other members of the family. In addition, the police dealt with several incidents of violence involving H and other people and the police IMR reviewed all the contacts that the family had with the police over a period of many years.

Whilst the DHR Review Panel examined in depth each police contact and incident, it must be noted that an Independent Police Complaints Commission (IPCC) investigation is currently ongoing and is not due to be concluded until after the finalisation of this Review. This IPCC

investigation is considering a number of police contacts that took place with the family prior to the murder. The terms of reference for this investigation include specifically determining whether the incidents brought to the attention of the police were appropriately resourced and progressed; and whether officers involved in progressing reported incidents complied with their training, force policy and relevant national guidance.

5.4 The IPCC investigation is not due to be completed until September 2016 and the DHR Independent Chair and author of this report has been in regular contact with the IPCC lead investigator to ensure consistency of information in respect of incidents under scrutiny.

Although there were a number of reports of verbal arguments and violence between H and one of his children during 2007 and 2008, reports of any domestic violence and abuse between Marie and H only started during 2011 with one incident reported in May 2011.

During that incident, Marie had been assaulted by H and had sustained a split lip and their eldest child (then aged 15) sustained two black eyes whilst trying to intervene. H was charged with battery on Marie but the case was subsequently withdrawn at Court as it is believed that Marie no longer wished to pursue the offence.

No further action was taken in respect of the assault on C4 and, although it is known that C2 was video interviewed and did not want to support any action against H, it remains unclear as to why no further criminal action was pursued other than a referral to Children's Social Care.

During 2012, during a time of separation between the couple, police received three reports of domestic abuse by H towards Marie, two in May and one in October. These included a verbal argument, threats to commit damage, stalking and harassment, and one of threats to kill her.

All of these cases resulted in no further police action other than removing H from the scene to his mother's address in one incident and, in all cases, completing DASH risk assessments and making referrals to Children's Social Care concerning domestic abuse.

On one of those reports during 2012, whereby H had threatened to kick Marie to death unless she left the house within 7 days, police attended two days after the report was made. This was due to demands on police resources at the time of the call, the fact that the call was made several hours after the incident had taken place, and subsequent requests to delay made by Marie herself due to work commitments. The outcome of this was that the passing of time and the de-escalation of what was at the time a highly charged incident, gave Marie the opportunity to become unwilling to support any further police action when she was finally visited.

On another incident in 2012 which was assessed as high risk by the attending police officers who removed H to his mother's address, Marie was contacted 6 days later by a specialist domestic abuse police officer. Again it would appear that the passing of time had provided Marie with the same opportunity to 'downplay' the severity of the incident and the risk assessment was subsequently downgraded to medium, which meant that it no longer met the threshold for referral to the Multi-Agency Risk Assessment Conference (MARAC).

In 2013, Marie had two contacts with the police, the first in January where she reported her handbag stolen. This has been identified as a potential missed opportunity to ascertain her current domestic situation with H, notwithstanding that it would have required personal contact by officers or staff who also had knowledge of the family domestic abuse history.

The second contact during June 2013, was when Marie made an emergency call to police concerned that H was becoming increasingly unstable, attempting to set fire to himself and making threats to harm police and his family. She stated that she was worried for her safety and that of her children.

H was located on a public road after he had doused himself with lighter fluid and was attempting to ignite a lighter. He was arrested for Breach of the Peace and taken into custody. Despite the concerns of police as to his mental state, he was assessed by custody medical staff as being fit to detain and, although it was recognised that he may require a psychiatric evaluation, it was deemed that he was not in need of an emergency mental health assessment and he was subsequently released.

Between August and November 2014, after Marie had separated from H, she made three reports to police of harassment by text messages and calls and threats to kill her.

In general, it is acknowledged that the police recognised the risk H posed to Marie and their children, and this is supported by evidence of the police making multiple referrals to social care and taking action to diffuse situations by arresting him or removing him from the scene of conflict or warning him regarding future conduct.

It is however recognised that with the benefit of hindsight, the police had opportunities to have dealt with incidents in a different manner and should have considered the use of more formal sanctions, such as the use of formal harassment warnings and, from the summer of 2014, Domestic Violence Protection Notices and Orders.

It is also recognised in the police IMR, that the action taken after the incidents in 2014 should have been more robust and the described additional safety measures, including a re-referral to MARAC, should have been considered for Marie.

Although it cannot be certain that any of these measures could have ultimately prevented Marie's murder, using more robust powers may have provided more opportunities to have arrested and dealt with H, so as to limit his contact and thus reduce the risks to Marie.

Lessons learned

1. Police should seek every opportunity to engage with domestic abuse victims outside of usual responses to domestic incidents themselves. Approach rather than wait to be approached.
2. Where DASH risk assessments are changed after the event, the rationale for doing so must always be recorded.
3. That training awareness of the paramountcy principle should be given and this DHR should be used as a case study.
4. To ensure that officers receive awareness in training and refreshers packages of all tactical options for progressing positive outcomes for domestic abuse, including DVPN/DVPO and Stalking and Harassment, coercion and control.
5. To ensure that pathways to support networks for victims and perpetrators are identified.

2.6.2 Somerset County Council Children's Social Care

Children's Social Care (CSC) records of contact with the family date back to 1991, although initial contact is not in respect of any concerns surrounding abuse.

During 2011, CSC received one referral relating to the assault on C4 whereby C4 had received two black eyes whilst intervening in a dispute between Marie and H. An initial assessment was completed but no further action was taken as H was no longer in the house, due to his police bail conditions.

In 2012, CSC received four referrals from the police in respect of reported incidents and Marie's concerns regarding H's propensity for violence. Three reports were directly related to arguments or violence or threats towards Marie and the fourth was where H had been involved in a violent incident at 2.30am with another person who was not a family member, but both his 2 youngest children then aged 14 and 7 had been present.

For two of the referrals relating to Marie, CSC took no further action after initial assessment as H was no longer living in the household and these, together with the referral in 2011, have been acknowledged by CSC as missed opportunities to get a better understanding of the family dynamics, to understand what the children were saying and to prevent and protect Marie and the children from other incidents.

It is also recognised that CSC were too optimistic that H would remain living outside the family home without contact with the family, and that conferences should have been arranged in order to share information and assess risks.

After the referral in July 2012, whereby H had been involved in an altercation with a third party, a Core Assessment was completed and a Child in Need meeting took place. This suggested that the family access services including a perpetrator's programme for H provided by BCHA and support for him through alcohol services. It also recommended that Marie be referred for domestic abuse outreach work to help her consider the level of risk within her relationship and to help her stay safe.

The family did not take up the suggested provision and the case remained open with CSC throughout 2012 as a 'Child in Need' as defined by Section 17 of the Children Act 1989 where there was no suspected actual or likely significant harm.

After the last incident referred in October 2012, a report of a verbal argument between Marie and H, it is believed that a home visit took place due to the 'Child in Need' aspect and the Child in Need case was subsequently closed in February 2013.

There are no further records of what actions were taken by CSC in respect of this 'Child in Need' case during the intervening four-month period from the last referred incident in October 2012 to its case closure.

It has been concluded that following a series of referrals from police regarding domestic abuse within the household during that period, that more information should have been recorded and subsequently provided to the DHR process. This is particularly so, in respect of what actions may or may not have been taken in respect of a 'Child in Need', and any rationale behind those decisions.

In June 2013, CSC received the referral relating to H attempting to set fire to himself. This triggered an initial assessment in respect of the children and a Child and Family Assessment was completed, which identified a safety plan based on support rather than protection.

This plan decreed that fortnightly visits were to be undertaken by a Senior Social Work Assistant (SSWA) and it is accepted that, given the serious nature of the incident, a Social Worker should

have undertaken the visits. It is also noted that the plan needed to be more specific and address the areas of risk including the escalating worries, and that a multi-agency and a strategy discussion should have taken place.

The records held by CSC in respect of any actions taken following this safety plan are poor and conflicting information has been provided on the chronology and the IMR in relation to visits that may or may not have taken place.

Nonetheless, it appears that the evidence to close the case in April 2014 was not based on any comprehensive assessment having been made, but merely on the basis of no further calls having been received.

During August 2014 after Marie had separated from H, CSC received two police referrals of incidents between them, one on the 5th where he had threatened to kill her unless she moved back into the family home, and a second on the 17th where H was using their disabled adult child to coerce her to move back.

At the end of August, a CSC Social Worker completed a risk assessment with Marie and correctly identified that H's behaviour had changed and that he was now using C5's contact arrangements as another way to control her.

Although an initial assessment and multi-agency discussion took place very quickly, a Child and Family assessment followed by a strategy discussion to decide if a Child Protection Conference should be held did not take place until October, two months after the referred incident had taken place.

From records provided to the DHR process and detailed examination within CSC, it has not been possible to determine why the decision to hold a Child Protection Conference was not made sooner, particularly after two incidents were reported and the CSC risk assessment identified an escalating concern.

At the Child Protection Conference which was held at the end of October, it was heard that the youngest child was frightened of H and was worried when he was drinking alcohol. As a result, C5 was made subject to a Child Protection Plan under the category of Emotional Abuse.

At the end of November, the first Core Group meeting to be held following the Conference was cancelled due to Social Worker illness. This Core Group meeting had been arranged nearly one month after the Conference and therefore did not meet Government guidelines to be held within 10 working days. CSC records have not been able to determine why this did not take place within the correct timeframe.

Two Core Group meetings were held on 4th December whereby only a Social Worker and C4 attended, and on the 16th December where only a Social Worker, H and C1 attended. HM Government Safeguarding Children guidelines outline that Core Group meetings should be multi-agency based and include family members and professionals who have direct contact with the family. Their purpose is to expand the Child Protection Plan and decide on what steps need to be taken. There is no further information as to why these Core Group meetings did not include other appropriate agencies or relevant family members, including Marie herself.

A further police referral was received by CSC at the end of November 2014 relating to harassing calls and texts being made by H who was using their youngest child (C5) as an excuse to ascertain

Marie's new address. There is no recorded information as to whether CSC took any action with regards to this referral.

In January 2015, a 3-month Review Conference decreed that C5 should remain subject to the Child Protection Plan. Records show that the second safety plan from the Review Conference was an exact duplication of the safety plan made at the first on 29.10.2014.

It was also recorded on the Review Conference outcome notes that 'no Core Group meetings had been held since the last CP Conference' although this clearly was not correct as two Core Group meetings had been recorded on the CSC recording system and another had been cancelled.

Concise recording of information by Children's Social Care was a notable issue of concern throughout this particular DHR making it difficult to ascertain clear decisions and actions undertaken in respect of specific incidents and concerns relating to a child living in a household experiencing domestic abuse.

Lessons learned

1. All cases should be audited for clarity of recording and rationales for decision making ensuring that there is management oversight of progress on actions and that the voice and experience of the child is heard.
2. Domestic abuse training should be made compulsory for all CSC staff proportionate to their role.
3. For Child in Need cases, ensure that the expectations of visiting frequency and regularity of review are set out in the practice framework and highlighted to all teams as the agreed standard.
4. Ensure that Core Groups are held in a timely manner in accordance with Government guidelines.

2.6.3 Somerset County Council Adult Social Care

Marie and H's second eldest child, C2, was 22 years old at the time of Marie's death. C2 had learning disabilities and Down's Syndrome and was living in supported accommodation close by. C2's Adult Social Care Social Worker liaised closely with Marie over C2's welfare and day-to-day arrangements and H had never been involved in this aspect of C2's care as it was believed he was busy with work commitments.

The most significant contact with Marie for the terms of this Review occurred on the 17th August 2014 when H collected C2 from C2's supported living placement to take C2 out for the day, then telephoned to say that he would not be returning C2 as C2 was not happy living there.

The following day C2's Social Worker spoke with Children's Social Care who advised of the incident 10 days previously where H had threatened to kill Marie, and she also spoke with Marie who disclosed that she had left H in July following a 25-year history of domestic abuse.

It has been concluded that had the Learning Disability Team been made aware of the incident of threats to kill Marie on the 8th August and been included in the multi-agency discussion that is known to have then taken place, there may have been some discussion and evaluation of the prospect of H taking C2 (a vulnerable adult) out for the planned day trip ten days later.

In the event, it was Marie's expressed belief that H used C2, by refusing to return C2 to C2's own home, in an attempt to get her to return to their family home.

Marie's disclosure of domestic abuse to C2's Social Worker was not recorded within her Adult Information System (AIS) file and, as AIS functionality allows for case notes to be linked to other AIS case records, this information was therefore not linked to C2's file, something which may have been crucial in determining any levels of risk posed to C2 from living with H. It was therefore not possible to have predicted that C2 was at risk of being used, as the risks posed by H were not known.

When it was established that the Community Team for Adults with Learning Disabilities (CTALD) could not remove C2 from H's house under any safeguarding process, but only through the Court of Protection, a letter was sent to H inviting him for a meeting to discuss C2's accommodation.

All efforts made by the CTALD to safeguard C2's freedoms once C2 was living with H did not appear to have been effective and did not recognise that C2 too was a victim of coercion and control. The view is that C2 was unable to comprehend the real dynamics of the situation and that C2 was being used, which was against C2's previously expressed wishes of living independently of family.

There is no record of a protection plan being made for C2 as a vulnerable adult, despite the concerns over C2's capacity to consent to leaving own home, nor is there any record of any legal advice being sought from the Somerset County Council legal team over how to protect C2's rights or about what legal remedies would have been available e.g. urgent referral to the Court of Protection.

When Adult Social Care received more details from the MARAC relating to H's previous convictions and potential for violent behaviour, a multi-agency strategy meeting was requested for 2nd September. This was to include police, the IDVA, an advocate and representatives from both the service providers for C2's care. Records do not show if this meeting took place and there is no outcome recorded.

As a result of the letter sent to H, a meeting took place between him, C2's Social Worker and a CTALD team manager where H stated he planned to keep C2 at the family home but agreed that C2 could return to day care provision. Due to H's perceived threatening manner at the meeting CTALD staff were later instructed that he was only to be seen by two members of staff and in a public place.

Although the original Safeguarding Adults Referral Record was started on 21st August, a few days after H had removed C2, the threshold decision to accept C2 as a safeguarding case was not made until 19th December, four months later. This was also made after C2 had been returned to live in supported living accommodation at the beginning of September.

Despite this decision on the 19th December, C2 spent the Christmas period with H and was returned covered in eczema and stating that had been drinking with H. No further outcome is recorded in respect of any actions taken.

<u>Lessons learned</u>

1. The AIS functionality to copy case notes from one family member to another should be used to facilitate full record keeping.

2. Where a vulnerable adult is the victim of control and coercion, information on their wishes needs to be collated in a timely and speedy way.
3. Where a vulnerable adult is the victim of control and coercion, Social Workers should have access to prompt legal advice to ensure the protection of individual rights under the Human Rights and Mental Capacity Acts, and the Care Act. This should include information on referrals to the Court of Protection in urgent cases.
4. Where MARAC and multi-agency meetings are held in respect of domestic violence within families, contact should be made with the allocated worker of any identified vulnerable adult, or with the Adult Safeguarding Team, to ensure the effective sharing of information and invitation to subsequent meetings. This is to ensure that the risk of domestic abuse to the vulnerable adult is also considered within the MARAC. It is particularly important where a person may lack capacity and needs others to act in their best interests, under the Mental Capacity Act.
5. In cases where there is concern for personal safety ASC should review their Safeguarding Adults processes to ensure that referrals to the Police Public Protection Unit are pursued, so that teams are provided with advice on available actions and police support in all cases.
6. Adult Social Care needs to improve the clear recording of all:
    - Safeguarding Adults meeting minutes
    - Adult Protection Plans
    - Managers' decisions
    - Risk Assessments
7. The lessons from this DHR should be used within the training for all Adult Social Care staff.

2.6.4 Somerset Partnership NHS Foundation Trust (SOMPAR)

H had been known to Somerset mental health services since 2004, when he requested a mental health outpatient appointment after his release from prison. At that point he was known to have personality difficulties, a history of suspected mixed anxiety/depressive disorder and alcohol dependency problems. He had a history of traumatic past with subsequent criminal behaviour.

He was offered an appointment in 2004 which he failed to attend and was subsequently discharged until November 2006, when he was referred again by his GP to the Somerset Partnership Alcohol Team as he had a history of alcohol and cannabis problems.

At that time, a Consultant Psychiatrist assessed him and documented that H reported a stable family life. Risk screening indicated no apparent risk to children or of suicide, and a low risk of misusing drugs and alcohol. He was prescribed medication but failed to attend a review four weeks later. When contacted by the Consultant by telephone, H stated he did not wish to be seen again and as a result, he was discharged from secondary mental health services in May 2007.

In May 2011, the local Community and Mental Health Team (CMHT) were informed by Yeovil District Hospital that H had taken a large overdose of paracetamol tablets two days previously, following a split from Marie three weeks before.

The CMHT contacted the hospital and were told that H had discharged himself the day after his admission, stating that it was not a suicide attempt but he had taken the tablets as he wanted to sleep. As the referral from the hospital was not received during H's admission, secondary mental health services were not provided to him at that time.

In June 2013, police shared information with the Local Authority Somerset Direct relating to H being arrested after dousing himself in lighter fluid and attempting to ignite a lighter. Somerset Direct contacted Sompar Safeguarding Adults Team who requested that the local CMHT reviewed

the case and considered making contact with H for assessment. Four days later CMHT sent a letter to H inviting him for assessment.

At the same time the Police also referred H to the Sompar's Court Assessment and Advisory Service (CAAS) as they had concerns regarding his mental health in custody and the doctor who saw H whilst he was detained did not make a mental health referral, something the police believed he needed. CAAS agreed to complete an assessment when H was due to appear in Court and, at that meeting two weeks later, H confirmed that he had received the CMHT appointment but did not attend as he did not have mental health problems.

CAAS completed the forensic assessments but did not electronically record comprehensive risk alerts, screening and information due to domestic abuse assessment not being part of electronic risk screening. Consequently, staff were not being prompted historically to consider whether domestic abuse was a contributing factor to risk assessment.

Completion of the risk alert, risk screen and information forms would have promoted effective internal information sharing, risk management and have informed professionals to consider the need for safeguarding referrals.

In August 2014, Sompar's Safeguarding Children's Team were made aware of H's threats to kill Marie and on 28th August, Sompar's MARAC Lead attended the MARAC where an action was given to the Trust to inform H's GP of recent circumstances and the MARAC referral. This action was completed on the 12th September by way of written correspondence and telephone discussion with H's GP.

Although the Sompar Safeguarding Children's Team were aware of high risk domestic violence within the family prior to the MARAC, there is no record to evidence information sharing with the Sompar Adult Safeguarding Team or consideration of a Safeguarding Adult's referral.

Lessons learned

1. Somerset Partnership CAAS to record electronic risk alerts, screening and information following assessment of all patients.
2. Somerset Partnership Safeguarding Service to produce an internal domestic abuse and MARAC protocol/procedure.
3. Somerset Partnership Safeguarding Service to review and update Trust domestic abuse policy and flowchart.
4. Somerset Partnership Safeguarding Service to review protocols to share information and risk management of safeguarding cases which involve both adults and children.
5. The Trust will utilise the Multi-Agency Safeguarding Hub (MASH) to work with partner agencies ensuring timely response and co-working when appropriate.
6. The Trust will utilise more fully the existing safeguarding information pathways (e.g. staff newsletter, safeguarding intranet pages and staff training) to raise awareness of domestic abuse and the protocols for managing these cases.

2.6.5 Somerset Clinical Commissioning Group

Over a period of many years, and preceding the relevant date for the Terms of Reference of this Review, there exists a vast amount of information relating to contacts by H, Marie and their family with their GP surgery.

The family had all been registered with the practice for more than nine years preceding the time of Marie's murder. It is of note that no less than sixteen GPs provided consultations for the family members during the Review period, with Marie and H receiving consultations from eight GPs, with only two GPs seeing both of them at different times, giving little opportunity to see the relationship in its entirety.

Consultations with different GPs is not unusual for a busy practice but does give heavy reliance for the need for high-quality record keeping ensuring that all records of attendance are fully comprehensive. On most occasions there is little record of social or family history having been asked or recorded for Marie or H.

From 2006, records relating to H, show that he had issues with alcohol, depression and anxiety and throughout the Review period until the time of Marie's death, he was attending chronic anxiety reviews with his GP and was prescribed anti-depressant medication, although this was continually fluctuating.

In general, it appeared that H was invited to attend regular chronic anxiety reviews, but between 2007 and 2013, his attendance was sporadic and he missed numerous appointments.

Of those he attended, his responses varied from he 'could be evil in terms of his temper' (2009) to, he 'was feeling fine and his mood had improved and he was well controlled if taking his medication and had no suicidal thoughts or thoughts to hurt others' (2012).

After H's referral to the GP following his paracetamol overdose in 2011, the GP attempted to make telephone contact with him and five days later H recalled the surgery stating that he was working away but he felt better in himself. At this point H requested to only have appointments with this same GP and for the most part this continuity was maintained and when he was seen in September 2011 he stated that he had taken the overdose as he could not sleep, not because he was suicidal.

In June 2013, H attended a chronic anxiety review and told his GP that he had attempted to set himself alight five days previously. He stated that he was no longer suicidal and agreed to increase his medication.

It would appear that this disclosure was made directly to the GP and that the surgery had not received any formal referral from any other agency despite the fact that the police, Sompar's Adult Safeguarding team and Community Mental Health services, and Somerset County Council Children's Social Care had all been involved.

In 2014, It would appear that H had no chronic anxiety reviews and only one contact with his GP in July stating that he was craving alcohol. He was advised to contact Somerset's alcohol services.

Taken in context with H's history of depression and self-harm, the advice given to self-refer is questionable and it may have been more appropriate for an appointment to have been made for further discussion resulting in a formal referral being made to alcohol services.

In September 2014, as a result of the MARAC action, H's GP surgery were informed by the Sompar Adult Safeguarding team that he had been involved in a High Risk domestic incident against Marie and that this could impact on his health.

A domestic abuse alert was put on the records and it is noted that the GP was going to call H in for a medicine review. No further information has been provided with regards to any action

taken by the GP at that time, but it is later recorded that H was sent an invite at the beginning of January 2015 for a mental health monitoring review to be held a month later, on the 4th February, which he subsequently failed to attend.

During the Review period, Marie had a number of contacts with the GP, starting in July 2006, where she reported low mood, depression and insomnia and she was prescribed anti-depressant medication and given the opportunity to access counselling.

There is no evidence of exploration of issues in her family life and as she attended only two of six counselling sessions offered, through non-attendance and cancelling rearranged sessions, there was little opportunity to provide adequate support. She later commented that she had not found the sessions helpful.

In July 2007, August 2010 and February 2011, Marie made further appointments reporting depression and that she was struggling at home. The dynamics of her personal relationship with H were again not explored further, she did however state that she had no thoughts of self-harm.

During this time Marie also attended the surgery for minor ailments and routine appointments, however, there appear to be no records of her being asked about her relationship with her partner or of any support available.

Equally, although the options of both medication and counselling were offered appropriately to Marie, it may have been more helpful to have explored in more depth her non-attendance at sessions, rather than accepting frequent cancelled appointments or failing to appear as her right to choose.

Regular anxiety reviews with patients are excellent practice, however a history of missed appointments should also have triggered an opportunity to explore social history further.

There is no evidence that practitioners had an awareness of domestic abuse during the consultations, nor was there any disclosure. Depressive illness has a significant impact on partners, but particularly children and there was no documentation supporting seeing the child behind the adult.

Lessons learned

1. Feedback and debrief to be offered to the General Practice prior to final publication.
2. For the practice to consider a review of consultations to include social questions.
3. Specific training in domestic abuse and knowledge of the GP champion approach.
4. Adoption once ratified the CCG domestic abuse policy for primary care for all practices, in consultation with NHS England and LMC.
5. Circulate lessons learnt from DHRs regarding the need to clearly document social history during consultations.

2.6.6 Integrated Domestic Abuse Service (IDAS)

Integrated Domestic Abuse Services in Somerset were provided by Bournemouth Churches Housing Association (BCHA) until January 2015, when the service provision was taken over by Knightstone Housing.

Until January 2015, BCHA had responsibility for the Domestic Abuse FreeFone Helpline and for the IDVA, Refuge and Outreach services and Pattern Changing courses that were offered.

Marie's first contact with IDAS was on 26th June 2014 when she rang the Helpline asking for support stating that she had been physically abused up to 3 years ago, however she was now facing emotional abuse. A DASH risk assessment was completed and Marie scored 15 which triggered a MARAC referral being sent to the MARAC Coordinator and the BCHA IDVA service.

In summary, Marie's referral to the IDVA service took 3 weeks to be acknowledged and allocated to an IDVA and a further 10 days until the IDVA first met with her on 24th of July.

This was a significant delay for Marie's case to be picked up by the IDVA service. BCHA procedure stated that a case should have been allocated within 24 hours of receipt of the referral and contact by the IDVA made within 24 hours after the case allocation.

Despite the delays in allocation and initial contact, once the IDVA had engaged with Marie, she actively supported her in many ways with many different agencies. This included attending a meeting with a Solicitor to discuss legal advice to apply for a Non-Molestation Order and an Occupation Order, obtaining a letter of support from the MARAC Chair outlining that she was a High Risk victim of domestic abuse and meeting with the CSC Social Worker to discuss concerns regarding Marie's youngest child's emotional health whilst still living with H.

Over the first few weeks of contact, the IDVA also attempted three times to arrange a multi-agency meeting to discuss Marie's housing issues, however was unsuccessful due to cancellations and the unavailability of external professionals. This was a difficult period in Marie's life and the inconsistency and uncertainty would have failed to reassure her.

Advice given to Marie around housing was clearly contradictory at times in respect of retaining her tenancy, giving up her tenancy and any benefits she could claim or costs she may be liable to. Agencies needed to work more closely together to ensure they were delivering a consistent message.

As such, the IDVA would have benefited from an escalation process within the IDVA service to obtain line manager's guidance and support to communicate to external senior managers within relevant services, in order to arrange a multi-agency meeting for a comprehensive discussion to find a suitable resolution for Marie's housing needs.

Throughout all of her contacts, Marie was adamant that she did not want to go into a refuge as she needed to continue to work to be able to pay for her accommodation and bills on both properties and she wanted to retain some stability for her children, particularly her youngest child. BCHA records that on 3 separate occasions Marie stated she felt bullied by professionals to go to a safe house and they considered that her experience of H's behaviours during their 20+ year relationship made her the expert on the risks she faced.

This case also identified the importance of actions needing to be reviewed at MARAC after they had been set. Whilst the responsibility of actions remained with individual agencies, there appeared to be no checking mechanism to ensure that they were completed to a final or satisfactory level. Had this been available, this may have assisted Marie to resolve her housing situation sooner and with a more appropriate outcome.

When Marie finalised her own privately rented accommodation in November 2014, the IDVA told her that she would now be closing her file but would refer her to a Pattern Changing course and also to Outreach for further support. Neither Marie's risk assessment nor her safety plan were

formally reviewed prior to case closure as per BCHA Procedure and this was a failing on the part of the IDVA.

The referrals to Pattern Changing and Outreach were completed and sent on the 5th December 2014, however there is there is no evidence of these referrals being received by either service.

As the IDAS Outreach team failed to receive or pick up the referral sent by the IDVA on 5th December, they instead used a previous referral made in July after Marie had first made contact with the service. This earlier referral information lacked detail including information gained through the IDVA and also the correct telephone number for Marie, therefore not highlighting the risks related to her case in more detail.

On 12th December an Outreach worker phoned Marie on her old number but the phone could not be connected. It was judged by the Outreach service to be too high risk to send a letter as this may have been intercepted by H and a decision was made to wait for Marie to make contact. This decision was based on the outdated information from July that Marie was still living with H and, considering the length of time that had passed since the initial referral information had been recorded, this should have triggered some question as to how accurate the information was. It would have been appropriate under the circumstances for the Outreach worker to have at least made contact with the IDVA for more up-to-date information.

When handing service over from BCHA to the new Somerset IDAS provider Knightstone in January 2015, Marie was identified on a document titled 'Clients waiting list' sent by BCHA to Knightstone, however Marie's Outreach case file was not sent over by BCHA.

This was potentially due to the fact that the Outreach worker, working from old information, considered it too dangerous to contact Marie and decided to wait for her to re-contact the service, hence her Outreach file was either pending, lost or closed.

<u>Lessons learned</u>

1. Case intake policy and process to meet 'Safe Lives Leading Lights' required standard by ensuring that clients are contacted within 24-48 hours from referral date, and engagement to take place within 5 days of the initial contact if it is safe to do so
2. Where an IDVA service is being transferred from one provider to another all active cases 6 weeks prior to the transfer date should remain active throughout the transition to the new provider and the new provider should not close cases until a full review has been undertaken to ensure all actions have been completed and risks managed and reduced.
3. The outgoing provider should provide the incoming provider with client case files as soon as practicable and no less than 3 weeks prior to transfer date, enabling consent forms from clients and the files organised ready for transfer.
4. Clearer communication between IDVA and Outreach services with particular focus on transfer of referrals and hand over process for the client. Ideally this would be a team meeting with written records which can be audited.
5. All cases should be closed as per the required standards of 'Safe Lives Leading Lights' whereby a recorded case management meeting is held and exit actions are completed with a client to include a final assessment of risk as part of that procedure.
6. All agencies need to take into consideration the client's wishes and risks around recommended safety plans offered by professionals, with particular understanding that the client will understand the perpetrators patterns of behaviour the most. Where possible, these wishes should be accommodated in options provided.

7. Promotion of escalation processes within all agencies for all professionals working with high risk victims of domestic abuse to find resolutions.
8. MARAC to review actions agreed for cases with specific focus on actions which are not complete due to a barrier. MARAC attendees to seek resolution as multi-agency group and agree alternative actions to reduce the risk.

2.6.7 Mendip District Council Housing Department

Marie's initial contact with Mendip District Council was at the end of June 2014 when she telephoned the Housing Options Team seeking some advice on her situation. As Marie advised that she was soon to be discussed at MARAC and that she was already engaged with Domestic abuse support services, the Officer recognised the seriousness of the domestic abuse and the level of risk that was posed to her.

It is recorded that she was still living at the family home at the time and she wanted to know what assistance she would receive from the Local Authority if she fled her current home. In the first instance, the Housing Officer advised Marie that she would be found a refuge if she was fleeing violence and therefore homeless.

Although the Housing Officer's primary concern was for Marie's safety and a refuge placement was consistent with Government guidance in a high risk case, standard internal procedures stated that Marie's case should have been opened as a 'prevention case' straight away.

A prevention case is a case where somebody believes that they may be homeless in the near future and is recorded as such so that it can be monitored on a periodic basis by a Housing Options Officer. The view is that this case met the threshold but, as this did not happen, no Officer was assigned to the case which resulted in numerous contacts from Marie and her IDVA and subsequently her frustrations.

In August, Marie attended a Housing Options drop-in session where she informed the duty Housing Options Officer that she had been "kicked out" of the family home since the 15th July and had been sofa-surfing at a friend's house and was now living in a caravan. She also advised that her Solicitor was assisting her to apply for an Occupation Order to remove her husband from the property.

The duty Housing Options Officer talked to Marie about her potential status on the Homefinder Somerset register if she managed to get an Occupation Order and return to live at the family home with her youngest child, as she would be under-occupying the 4-bedroom house and this would entitle her to Gold banding on the register. Marie declined to make a Homefinder application at that stage.

Another offer of refuge was made to her on the basis that she did not appear to be safe as H had attended the caravan the previous day so knew where she was staying. Again, Marie declined the offer of refuge as she wanted to be closer to her children.

Although the Local Authority had some temporary accommodation units, the Housing Officer decided that placing her in this, within a few miles of her home, would not have been a safe option for her with no security measures and specialised support in place to help protect her.

The notes show that Marie became frustrated with the meeting and left before it had concluded. This was another opportunity for the Housing Officer to have raised a prevention case on the system, however this was not done.

At the end of September 2014, Marie made a paper application to join the Homefinder Somerset housing register. It has not been possible to determine why it took Marie 3 months to make the application when she was set up on the system and given a unique reference number with instructions at her initial contact in June.

At the beginning of October, a Housing Options Team Officer rang Marie's IDVA who confirmed that Marie knew that she could apply for an Occupation Order, but this would have been very costly, and that she had also declined to go to a refuge as she was concerned about the costs. The Housing Officer re-emphasised that they believed Marie should go to a refuge.

The LA Housing Options Team have recently been made aware that the National Centre for Domestic Violence (NCDV) provides a free, fast emergency injunction service to survivors of domestic violence regardless of their financial circumstances. It is understood that the NCDV will do an immediate assessment for legal aid over the phone with a client suffering from Domestic Abuse and that, depending on the income of the client, the cost could be anything up to £100 for clients on higher incomes and this would be to cover the costs of the Court application fee and process serving costs.

The NCDV can also arrange stage payments and other payment options so that nobody is excluded from receiving help, and the calculation involves looking at the applicant's income, the number of dependent children, the outgoing rent or mortgage and other outgoings.

As it appeared that Marie's income was approximately £1200 per month and she was still liable to pay rent and had dependent children, it is likely she might not have incurred any costs for an injunction. Marie could have used this service in June 2014 and it is possible she could have had an injunction in place the following day.

Although it is accepted that the Housing Options Team were not aware of this NCDV service at the time, their IMR states that they would have assumed the IDVA, as a specialist domestic abuse worker to have been aware of all the options available to the client to seek injunctions irrespective of their income. Had this service been used then Marie would also have been able to consider other legal remedies such as a Prohibited Steps Order which she may have been able to obtain to prevent H from taking her children away from her.

When Marie presented concerns about the affordability of a refuge placement, she should have been advised by the Housing Options Team and her IDVA that she would have been entitled to a much higher rate of housing benefit and that she would have been able to claim Housing Benefit, in addition to housing benefit for the refuge, under the Dual housing benefit regulations. There is no evidence on file that either of these options were discussed by the Housing Options Officer.

During October 2014, there were a number of contacts between the Housing Options Team and the IDVA and CSC Social Worker to keep updated on Marie's situation regarding her Legal Aid application and options around injunctions and, in each of these contacts, the offer of a refuge placement was reiterated.

Whilst the Homelessness code of guidance is clear on the requirements for the 'safety of the applicant and ensuring confidentially must be of paramount concern' for victims of violence who have fled their home, and the Housing Officer was right to continue to encourage and offer this, a more lateral approach should have been taken when clearly faced with someone who was adamant and determined that refuge accommodation was not appropriate for them.

Being presented with only one possible option, going to a refuge, would appear to have been one of Marie's biggest causes of frustration and distress through all her interactions with the Housing Options Team.

In relation to Homefinder Somerset applications, it is noted that that victims of domestic abuse who are accepted as homeless following a formal homelessness application can get reasonable preference (gold band) on the register. However, if they are not deemed homeless, applicants can be awarded gold banding for a category called 'Harassment', but the current wording of this category does not support it being used for domestic abuse cases, rather for violence or harassment from somebody outside of the home (i.e. non-domestic Violence). It has been identified that the Homefinder Somerset Group should look at the wording of this category and consider changing it to include domestic violence and abuse.

When Marie independently found and moved into her privately rented property in November 2014, the Housing Options Team considered that it was not appropriate on safety grounds for Marie to live in a location so close to her perpetrator. In addition, as it was believed that she had not received the intensive advice and support from a refuge, it was considered that she may not have had the knowledge and skills to stay safe from her perpetrator in the medium term.

Lessons learned

1. Housing staff should have a clear procedure for dealing with domestic abuse cases which should include that such cases are raised as prevention cases at the earliest opportunity.
2. Procedures should reflect that options such as homelessness applications, access to private sector options, staying with friends, injunctions etc. should always be discussed in parallel with any refuge offer, with these options confirmed in writing.
3. Housing staff who are working with Domestic abuse victims need to be aware of the national and local organisations that offer emergency injunction services and the costs of such services (especially where the client is working).
4. Housing staff who are working with Domestic abuse victims need to be able to advise on affordability issues relating to existing accommodation commitments and refuge placements

2.6.8 Curo Group (Landlord)

During the last six months of 2014, it is recorded that some difficult conversations took place between Marie and her Landlord surrounding the tenancy of the family home. In the main, Marie's five contacts were phone calls around the status of her tenancy and the legal implications surrounding H's matrimonial home rights.

A review of these contacts shows that upon her initial call on 6th August, domestic abuse was talked about and Marie's case manager was aware of its high risk as she was being supported by an IDVA. Marie also confirmed that she did not want to move to a refuge as she needed to continue to work and she wanted to be close to her children. She stated that she was seeking Solicitor's advice in relation to divorce proceedings, a Non-Molestation Order, an Occupation Order and the fact that her husband had matrimonial rights to the home.

Between September and December 2014, there were a number of telephone conversations between Marie's IDVA and her Landlord case manager to discuss housing issues. Additionally, one meeting was setup and although this had to be cancelled, it is considered by Curo Group that the telephone contacts explored all possible options and clarified Marie's rights to tenure.

At the beginning of December 2014, Marie's Landlord case manager telephoned Marie's IDVA who told her that the case had been closed to the IDVA service. It is not known what other information was shared between the IDVA and the case manager as, although Marie had already moved into her privately rented accommodation 11 days previously, the case manager sent a letter to the LA Housing Options Officer ten days later giving an overview of Marie's tenancy and asking that she be given some priority on the housing register.

At the beginning of January 2015, the case manager spoke with the Local Authority Housing Options Officer who stated that they had written to Marie but had not heard anything back. They also indicated that they wanted Marie to fight for her tenancy on the family home through the Court. This again, was some 6 weeks after Marie had already moved into her private rental property so it would appear that neither the Landlord nor the Local Authority had been made aware at that stage of Marie's move to a more permanent privately rented address by either Marie or her IDVA.

On the 6th February 2015, Marie called her Landlord and informed them of her new address. She stated that she had been unable to pursue the tenancy on the family home and an injunction through the Court as she did not qualify for Legal Aid and she stated that she was unable to contribute to the rent on the family home as she was now paying for a different property. It was agreed that the tenancy would be re-assigned to H once the arrears had been cleared.

The information provided by Curo Group in relation to their knowledge of NCDV assistance towards obtaining injunctions and orders is confusing. As a Landlord, they state that they were aware of the NCDV information however, they believe that whilst the advice is free, any action taken is not and they further state that this is something they cannot get involved in, and this role should be performed by the IDVA.

Despite their awareness, it would appear that no NCDV information, or signposting towards them, was shared with Marie in order to help her retain her tenancy and take the course of action that she wanted, but felt unable to pursue due to her financial worries.

Marie's Landlord was fully aware that they were one of a number of agencies who were supporting her at the time and they believe that in their capacity as her Landlord, they followed procedure at all times and did everything they could as a Landlord and that all the advice given was in line with policy.

Whilst Marie herself perceived that she received little help in respect to her housing situation and vocalised her distress and frustrations on many occasions to family, friends and colleagues, Curo Group as her Landlord considers that the lack of a joint meeting is insignificant as they believe that all the information and advice that would have been shared at a face-to-face meeting, was given over the telephone to both Marie and her IDVA at various times.

The Landlord also believes that the correct advice was given at all times and, as a number of conversations took place directly between the case manager and the IDVA, mirroring those that had been had directly with Marie, there was no need to reschedule or reprioritise a previously cancelled meeting.

Although Curo Group were aware from her initial phone call that Marie was being referred to MARAC, they were unaware of when that was taking place as they were not routinely invited as a social housing Landlord.

As a result, it has been identified that they should be represented on MARACs for any cases that involve any of their tenants. Understandably, this will require them being made aware of incidents being referred to MARAC, but does not preclude case managers from also undertaking 'professional curiosity' when presented with tenants apparently experiencing difficulties.

Lessons learned

1. To gain representation on Somerset MARACs by signing up to the Somerset MARAC Operating Protocol.
2. To ensure that where any clients are identified as victims of domestic abuse, then discussions will be had with other specialist supporting agencies to determine who will be the lead professional coordinating support.

2.6.9 Yeovil District NHS Trust

There is no evidence of failure to appreciate any domestic difficulties from any presentations of Marie or H at the hospital and, due to the nature of their attendances, it is evident that they were not seen together as a couple within the Trust.

Although H had been admitted to the hospital in June 2011 for a suspected suicide attempt following a reported overdose, his disclosure that this had been triggered by a split from his wife three weeks previously was not probed any further.

Had this been considered as an opportunity to obtain social history, this may have provided more information as to the state of their relationship and may have revealed concerns in relation to mental health issues or domestic abuse.

The self-discharge of H the following day could not have been prevented, as he was deemed to have mental capacity and could not be detained. However, it appears there was a failure to ensure that he attended an appointment for a psychiatric review following a significant overdose. H's GP surgery was advised, but with no clear request to ensure that a follow-up occurred.

Neither Marie nor H had been flagged to the trust at any time in respect of potential domestic violence or abuse.

Lessons learned

1. Ward staff need to be reminded to ensure clear direction for GP in respect of follow-up appointments especially when these relate to psychiatry.

2.6.10 Musgrove Park Hospital NHS Trust (MPH)

Although there were numerous attendances at MPH over a period of years by all members of the family, each case was examined and there were no clear domestic abuse issues identified.

Once again, whilst recognising that each visit in this case may not have presented a clear opportunity, it is accepted that exploring family history further should always be considered, particularly whenever the merest suspicion of DA is raised.

There were no lessons to be learned from any of the contacts with this NHS Trust.

3. Other findings/ lessons learned

In addition to the lessons learned identified by each individual agency involved in Marie's case, the following points have been recognised as needing consideration and action:

The fact that the IDVA, the Local Authority Housing Options Team, the Landlord and Marie herself were all in contact with one another at different times, sometimes with conflicting information, has been recognised as a major problem in this case. The identification of a single agency to take responsibility would have provided consistency and may have helped to allay Marie's concerns and frustrations.

It has been agreed that it was vital for a lead agency to have been clearly identified and appointed as the risk to Marie appeared to be escalating. This action should have been undertaken through the MARAC process to have ensured that the flow of information and management of actions was more consistent.

Throughout the Review process it became more and more apparent that there existed many inconsistencies and poor recording of information amongst many of the agencies. In particular, Children's Social Care found it difficult to provide clear information as to what actions were or were not taken and were unable to answer many of the questions raised during the course of the Review.

Both the police and Adult Social Care also had some difficulties in identifying whether correct courses of action had been taken in respect of their contacts with the family, and the Clinical Commissioning Group also acknowledge that the GP's very many contacts missed opportunities to explore and understand the family dynamics better.

Equally, Somerset Partnership and Yeovil District Hospital did not maximise opportunities to ensure a more detailed examination of H's mental health.

It is acknowledged that examining incidents with the benefit of hindsight is difficult to eliminate, consequently it is very important to recognise that this Review faced none of the pressures and distractions faced by police officers or any other agency staff on the spot.

Whilst it has been shown that there was a wealth of information and communication between all the agencies at varying times over many years, it does appear that a 'rule of optimism' existed in relation to dealing with this family, and robust actions and sometimes sanctions, were often not sought or implemented.

4. Conclusions

In reaching their conclusions the Review Panel focused on the questions:

- Have the agencies involved in the DHR used the opportunity to review their contacts with Marie, N and their family in line with the Terms of Reference?
- Have the agencies openly identified lessons to be learned and addressed?
- Will the actions they take improve the safety of domestic abuse victims in Somerset?
- Was Marie's death predictable?
- Was Marie's death preventable?

The IMRs have been open, honest and thorough. The agencies have used their participation in the Review to consider their policies and practices and, where appropriate, have identified lessons learnt from their contacts with Marie in line with the Terms of Reference.

The panel has acknowledged that there were very many contacts significant to the risks posed to Marie.

In considering all of the information provided relating to those contacts, the Review Panel believes that, whilst there existed a high risk of significant harm or injury, there was nothing to suggest that Marie's case had any factors unique to other high risk cases.

It is therefore the view of the Review panel that, although Marie had predicted her own death on a number of occasions, her death was not predictable to any of the agencies involved.

It has been agreed however by the Panel, that there were many missed opportunities, particularly between June and December 2014, to have lowered those risks.

It was clear that Marie was adamant that she wanted to be in her own home. The tenancy was in her sole name and she received conflicting advice from different agencies in respect of what she could, should, and shouldn't do.

Marie considered that the only option being offered to her was to flee to a refuge with her youngest child, something she communicated very strongly on numerous occasions to many agencies that she was not willing to do.

It is considered by the Review Panel, that if Marie had been enabled to move back into the family home by whatever means available, then she would have taken back a level of control, which in turn would have reduced H's control of her circumstances.

Taking into consideration all the factors and contacts with H, particularly by police and health services, more positive action in respect of opportunities for his detention and prosecution for offences and any subsequent mental health assessments may also have had a bearing on the outcome.

It is also believed by the Review Panel that Marie considered that, in her own way, she was self-managing her risks by allowing or accommodating H's demands and control over her child access arrangements in order to keep him as calm as possible and not overly inflame the situation.

It must not be underestimated however, that Marie herself was the best judge of the risks imposed by H on her safety and her persistent remarks over the 6 to 8-month period of their separation prior to her death, that he would kill her, should have been taken more seriously, notwithstanding that many friends, family and colleagues did not believe that it would actually happen.

It has therefore been agreed by the Review Panel, that had all the above factors been taken into consideration and implemented, Marie's death may have been preventable.

5. Recommendations

The Review Panel is satisfied that the agreed recommendations address the needs identified from the lessons learnt, as described within this report. Provided those recommendations are fully and

promptly implemented, they should improve the experience of victims seeking help and advice and will improve the safety of victims of domestic abuse in the Somerset area.

Appendix A

Glossary of Terms

ASC	Adult Social Care
CAADA	Co-ordinated Action Against Domestic Abuse *(now known as Safe Lives)*
CAAS	Court Assessment and Advisory Service
CCG	Clinical Commissioning Group
CMHT	Community Mental Health Team
CPS	Crown Prosecution Service
CSC	Children's Social Care
CTALD	Community Team for Adults with Learning Difficulties
DAFFS	Domestic Abuse Freephone Service
DASH	Domestic Abuse Stalking and Honour Based Violence (*Risk Indicator Checklist)*
DHR	Domestic Homicide Review
DVPO/ DVPN	Domestic Violence Protection Orders/ Notices
GP	General Practitioner
Guardian	Police Crime and Intelligence management system
ICPC	Initial Child Protection Conference
IDAS	Integrated Domestic Abuse Service
IDVA	Independent Domestic Violence Advocate
IMR	Individual Management Review
LMC	Local Medical Committee
MARAC	Multi-Agency Risk Assessment Conference
MASH	Multi-Agency Safeguarding Hub
NCDV	National Centre for Domestic Violence
NMO	Non-Molestation Order
OO	Occupation Order
SOMPAR	Somerset Partnership NHS Foundation Trust
SSP	Safer Somerset Partnership
STORM	Police command and control system

Appendix B Action Plan