A Domestic Homicide Review into the Death of Adult A

A report for the Plymouth Community Safety Partnership

Author: Martine Cotter MCMI
June 2014
I would like to express my sincere condolences to the family and friends of Adult A.

My gratitude is also extended to the professionals, agencies and panel members who dedicated their time, commitment and tenacious attention to detail throughout the Domestic Homicide Review.

Martine Cotter

Independent Chair 2014
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SECTION ONE

SECTION ONE: INTRODUCTION AND BACKGROUND

Introduction

1) At 0314hrs on Thursday the 5th of April 2012, Adult B called 999 using his mobile telephone. He advised the operator that he had returned home to (REDACTED ADDRESS), to find his partner, Adult A, badly beaten and possibly dead.

2) Paramedics arrived at the couple’s address at 0323hrs. Adult B was stood in the road with his baby daughter Child 1 (C1). He told Paramedics that he had recently returned from (REDACTED) to find Adult A slumped on the settee and not breathing.

3) The Paramedic approached Adult A in the living room, felt for a pulse and confirmed that she was dead. Police Officers attended the scene some minutes later and concluded that the extensive injuries sustained to Adult A were suspicious. Steps were taken to convey C1 to her grandparents before Adult B was arrested at 0342hrs on suspicion of murder.

4) Adult B first stood trial at Plymouth Crown Court in April 2013 but the jury was discharged after they failed to reach a verdict. A retrial saw Adult B convicted of murder at Bristol Crown Court on the 27th February 2014. He was sentenced to life imprisonment with a minimum tariff of 18 years. His sentence was later increased to 23 years by the London Court of Appeal.
Reasons for Conducting the Review

5) Domestic Homicide Reviews (DHRs) came into force on the 13th April 2011. They were established on a statutory basis under Section 9(3) of the Domestic Violence, Crime and Victims Act (2004). The act states that a DHR should review ‘the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—

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

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

6) Adult A was the ex-partner of Adult B. Although they had separated two months prior to the homicide they were still living together in the same household until the 5th April 2012.

7) The Plymouth Community Safety Partnership concluded that the death of Adult A met the criteria for a DHR and commissioned a review in consultation with partners, in line with the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2011) with the purpose of:

- Establishing what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations worked or work, individually and together to safeguard victims;

- Identifying clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

- Applying these lessons to service responses including changes to policies and procedures as appropriate;
Identifying what needs to change in order to reduce the risk of such tragedies happening in the future;

Improving service responses for all domestic abuse victims through improved intra and inter-agency working.

Scope of Review

8) The Review Panel learnt that Adult A and Adult B commenced their relationship in 2007; therefore records were secured in the City of Plymouth from 1st January 2007 up to the date of Adult A’s death on 4th April 2012, unless it became apparent that the timescale in relation to some aspect of the review should be extended or reduced.

9) The Independent Chair invited some agencies to review and include earlier contact to assist with the identification of early warning signs and/or opportunities for intervention on behalf of professionals and agencies.

10) This information is contained within the analysis of Individual Management Reviews within Section Four.

Terms of Reference

11) The following areas are addressed within this overview report;

12) A review of the actions of the agencies involved with the family and any other relevant agencies or individuals;

13) An assessment of whether the incident in which Adult A died was a ‘one off’ or whether there were any warning signs that would indicate that more could have been done in Plymouth to raise awareness of services available to victims and perpetrators of domestic violence;
14) An assessment of whether family, friends, key workers or colleagues (including employers) were aware of any abusive or concerning behaviour from the perpetrator to the victim (or other persons);

15) A review of any barriers experienced by the family/friends/colleagues in reporting any abuse or concerns in Plymouth or elsewhere, including whether they (or the victim) knew how to report domestic abuse had they wanted to;

16) An assessment of whether there were opportunities for professionals to enquire or raise concerns about domestic abuse in the household;

17) A review of any previous concerning conduct or a history of abusive behaviour from the perpetrator and whether this was known to any agencies;

18) An evaluation of any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and / or services in the city.

19) Consideration of any equality and diversity issues that appear pertinent to the victim, perpetrator or family members e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

20) Any other information that is found to be relevant.

21) The Review excludes consideration of how Adult A died or who was culpable.

22) The Terms of Reference have been shared with key family members of Adult A.
The Independent Chair

23) Plymouth Community Safety Partnership, on behalf of Plymouth City Council, commissioned Martine Cotter as Independent Chair to undertake this external review.

24) It was the responsibility of the Independent Chair in consultation with the Panel to:

- Conduct the review in accordance with the Terms of Reference and Provisional Review Framework;

- Prepare this Overview Report for the Plymouth Community Safety Partnership.

25) The Independent Chair has liaised (and will continue to communicate) with the Partnership Crime Reduction Officer on all matters including the process of publication of this report. The Independent Chair is responsible for the final overview report and its summary.

26) Martine Cotter is a qualified strategic manager and a member of the Chartered Institute of Management with over 10 years’ experience in the field of domestic abuse and sexual violence. Martine was the former Chief Executive of a specialist charity and was instrumental in developing the first Sexual Assault Referral Centre (SARC) in the Southwest. From 2009 - 2011, Martine was seconded to the Department of Health’s National Support Team for the Response to Sexual Violence as a Sessional Advisor. In 2010 Martine completed the DASH ‘Train the Trainers’ Master Class and has since delivered Domestic Abuse training to more than 700 frontline professionals throughout the UK, including workers from Children Centres, Sexual Assault Referral Centres (SARC)s, Social Services, Education, Armed Forces, Mental Health and Criminal Justice Agencies. Martine is the Independent Chair of three Domestic Homicide Reviews (at the time of this report).
Review Panel

27) The primary responsibilities of the Panel of Professional Advisers include;

   a. Reviewing the Individual Management Reports
   b. Summarising concisely the relevant chronology of events including the actions of all the involved agencies;
   c. Analysing and commenting on the appropriateness of actions taken;
   d. Making recommendations which, if implemented, will better safeguard victims of domestic violence in the future;

28) The Panel of Professional Advisers were sourced according to the specific modus operandi of the homicide. Core members include;

(Table 28a)

<table>
<thead>
<tr>
<th>Representative of</th>
<th>Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plymouth Community Safety Partnership</td>
<td>Community Safety Partnership Domestic Abuse Lead</td>
</tr>
<tr>
<td>Devon and Plymouth Constabulary</td>
<td>DCI Public Protection Unit</td>
</tr>
<tr>
<td>Plymouth Community Healthcare</td>
<td>Integrated Safeguarding Lead for Adults and Children</td>
</tr>
<tr>
<td>Plymouth Safeguarding Children’s Board</td>
<td>Child Protection Manager Plymouth City Council</td>
</tr>
</tbody>
</table>
Statement of Independence

29) Independence and impartiality are fundamental principles of Domestic Homicide Reviews. The ethical principles and impartiality of the Independent Chair and Review Panel are essential elements to protect the quality, legitimacy and credibility of the review and subsequent overview report.

30) The Independent Chair and Panel Members were asked to disclose or declare any matters that could affect their impartiality or that could reasonably be perceived to do so, and any other matters that might be of interest for transparency purposes. No such declarations were made.

31) The Chair certified that she had no connections or ties of a personal or professional nature with the family or any participating organisation at the time of
the review which would affect a fully independent judgement regarding the outcomes of the review, in either a positive or negative sense.

32) The panel members were appointed based on their independence, having had no previous connection or tie to the family or any responsibility for direct line management of any member of staff involved with the case over the past 5 years.

Guiding Principles for Panel and Review

33) The Review Panel were committed to the ethos of equality, openness, and transparency. There was no suspicion of concealment and all factors were thoroughly considered with an objective, open-minded, impartial and independent view. Due regard was paid to confidentiality and the balance of individual rights and the public interest.

34) The Review Panel sought to involve family, friends and employers to participate in the review and approached this with sensitivity and respect.

35) The Review Panel gave appropriate consideration to any equality and diversity issues in line with the Equality Act 2010 that appeared pertinent to the victim, perpetrator or family members e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

Panel Meetings

36) The first Review Panel was scheduled on the 12th October 2012 to review secured records.

The Domestic Homicide Review Panel met on three further occasions;

- 25th January 2013
- 24th March 2014
- 23rd October 2014
Full minutes were recorded for all meetings

**Timescales**

37) The Home Office was informed of the intention to conduct a DHR on the 31 July 2012. This was within 3 months of being notified of the domestic homicide (5th April 2012).

38) The Statutory Guidance for Conducting Domestic Homicide Reviews (March 2011) recommends that the Overview Report should be completed, where possible, within 6 months of the commencement of the Domestic Homicide Review (not including any judicial investigation and court proceedings).

39) On advice from the Senior Investigating Officer, the Review Panel deemed it necessary to temporarily delay the Overview Report until the conclusion of the criminal case. In this situation all relevant agencies were notified of the requirement to secure records pertaining to the homicide against loss and interference.

40) The Independent Chair and Review Panel ensured all records were reviewed and a chronology drawn up to identify immediate lessons to be learnt. All early lessons were shared with the relevant agencies for action and secured for the subsequent Overview Report.

41) Table 41a (below) sets out the original timescale for the completion of the DHR as stated within the full Terms of Reference;

Table 41a

<table>
<thead>
<tr>
<th>ACTION</th>
<th>ACHIEVE BY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Request for IMRs</td>
<td>17.10.12</td>
</tr>
<tr>
<td>Hold IMR Workshop</td>
<td>16.11.12</td>
</tr>
<tr>
<td>1st Draft of IMRs completed</td>
<td>18.01.13</td>
</tr>
<tr>
<td>1st Panel Meeting to Review IMRs</td>
<td>25.01.13</td>
</tr>
</tbody>
</table>
42) Unfortunately the timescale for completing the Domestic Homicide Review was significantly delayed by a number of unexpected factors;

- A request to grant IMR authors with an extension for 1st draft submissions;
- An acquittal of Adult B at the first criminal justice trial in April 2013
- The deferral of the second trial until February 2014;
- The availability of a local accredited Independent Chair

43) The Review Panel anticipate that the Overview Report will be completed by September 2014, fifteen months after the original timescale was set and seven months after the conclusion of the second retrial. The Review Panel is extremely apologetic for the delay and aim to complete the Overview Report in the earliest possible time, without compromising quality.

Methodology

44) This Review was guided by:

- The key processes outlined in the Home Office Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2011);

- A guide for the Police, Crown Prosecution Service and Local Safeguarding Children’s Board to assist with the Liaison and the Exchange of Information when there are simultaneous Chapter 8 Serious Case Reviews and Criminal Proceedings (April 2011);
Learning from other Domestic Homicide Reviews and Serious Case Reviews of child/vulnerable adult deaths across the UK;

The cross-government definition of domestic abuse (March 2013);

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

- psychological
- physical
- sexual
- financial
- emotional

45) The Review comprised of a thorough examination of all relevant information including documentation provided by the criminal justice investigation (including key witness statements), individual professionals, commissioners and agencies.

46) Four (4) Professionals were interviewed from five different organisations. Many professionals had since left organisations and were therefore unavailable for interview. There is no legal sanction or power to enforce a request made by the Review Panel or Chair that an individual attend for an interview.

47) The Review Panel did not need to seek the expert advice or opinion of any other specialist during the review as all questions were answered by members of the Review Panel or the original authors of the Individual Management Reviews.

48) The views and conclusions contained within this overview report are based on findings from both documentary evidence and some interview testimony and have been formed to the best of the Review Panel’s knowledge and belief.
Family involvement

49) The Review Panel invited Adult A’s Mother and Brother to participate in the review through their Victim Support Homicide Worker. Adult A’s paternal Grandfather was contacted direct. Each family member considered the invitation but declined to participate.

50) On advice from the Senior Investigating Officer the Review Panel did not make contact with the families until the conclusion of the second trial. The Chair was informed that Adult A’s mother did not initially believe that Adult B was responsible for her daughter’s death. This presented the Panel with a difficult situation whereby Adult A’s family did not necessarily believe that a domestic homicide had taken place. On reflection, and following Home Office training in April 2013, the Independent Chair accepts that this situation could have been approached differently, perhaps utilising the relationship with the family’s Victim Support Homicide Worker.

51) The Review Panel accept responsibility for the delay in contacting the family; which conflicted with Statutory Guidance for Conducting Domestic Homicide Reviews (2011) and the Terms of Reference for involving family members, at the time. This is a matter of regret for the Review Panel but also an opportunity to learn for future Domestic Homicide Reviews.

52) The Review Panel is unable to comment on whether the timing of the contact with family members had an impact on the decision of individual family members to participate or not.

53) To assist with producing a balanced Overview Report, the Independent Chair considered inviting Adult B to participate in the Domestic Homicide Review. The Review Panel discussed his participation at the Panel Meeting on 13th March 2013 but decided that his ongoing protest of innocence was unlikely to contribute anything positive to the review. In the absence of Adult B’s participation, the
Independent Chair reviewed his police interviews and defence statements presented during the criminal justice trial.

54) In the absence of participants representing the views and experiences of friends and work colleagues, the Review Panel included an analysis of witness statements obtained as part of the criminal justice investigation and within the public domain.

Confidentiality

55) The Independent Chair and Panel observed strict rules of confidentiality with regard to all information that came to their attention in connection with the Domestic Homicide Review insofar as confidentiality could reasonably be maintained.

56) Confidentiality would only be breached;

- If a person gives consent;
- Where there is a public interest in disclosing information: to protect individuals or society from risks of serious harm …" (Common law: W vs. Egdell 1989);
- Where there is risk to a child (Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children (HM Government, 2013)
- Under the prevention of crime and disorder" (S 29 Disclosure under the Data Protection Act 1998);
- Protecting a vulnerable adult from risk of abuse - where there is a serious risk or a vital interest that the client may harm themselves or others (No Secrets Guidance);
- In the interest of Public Security, prevention of crime and disorder, protection of health and morals and the protection of the rights and freedoms of others (Article 8 Human Rights Act);
For any acts of terrorism or suspected acts of terrorism (in the interest of national security) – *Crime and Disorder Act.*

**Requests to Secure Information**

57) To ensure that early lessons were not missed, the Panel decided that the DHR should not be delayed by pending legal action against Adult B and sought to notify agencies and interested parties of the requirement to secure records pertaining to the homicide to inform the subsequent Overview Report. Each agency was asked to contact the Independent Chair outlining the nature of the contact with the family.

58) The agencies asked to secure information are listed in table 59) below. Agencies highlighted in red confirmed that they held information relevant to the DHR. The remaining agencies (not highlighted in red) did not hold any information relevant to Adult A or Adult B;

59) Table 59);

<table>
<thead>
<tr>
<th>Area</th>
<th>Agency/Professional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plymouth</td>
<td>(REDACTED) General Medical Practice</td>
</tr>
<tr>
<td></td>
<td>Children’s Social Care</td>
</tr>
<tr>
<td></td>
<td>Devon and Cornwall Police</td>
</tr>
<tr>
<td></td>
<td>Plymouth Community Healthcare</td>
</tr>
<tr>
<td></td>
<td>Plymouth Hospitals NHS Trust</td>
</tr>
<tr>
<td></td>
<td>Drug and Alcohol Service</td>
</tr>
<tr>
<td></td>
<td>(REDACTED) Children’s Centre</td>
</tr>
<tr>
<td></td>
<td>(REDACTED) Centre Limited – Voluntary Sector</td>
</tr>
<tr>
<td></td>
<td>Mental Health Services</td>
</tr>
<tr>
<td></td>
<td>Devon and Cornwall Probation Trust</td>
</tr>
</tbody>
</table>
60) Letters were sent to all participants thanking them for their contribution. Agencies that did not hold information were informed that an Individual Management Review would not be required. Agencies with relevant information were notified in writing of a request to undertake an Individual Management Review (IMR) under Section 9 of the Domestic Violence, Crime and Victims Act 2004. Correspondence included:

- A Guide for Appointing an IMR Author *
- An IMR Author’s Guide *
- An IMR Template and Guidance for completing an IMR *
- A copy of the Terms of Reference*

These documents are available on request.

Commissioning of Individual Management Reviews (IMR)

61) The aim of an Individual Management Review is to look openly and critically at individual and organisational practice to see whether the case indicates that changes could and should be made and, if so, to identify how those changes will be implemented.

62) IMR reports provide a chronology of agency involvement and bring together and draw overall conclusions of agency involvement with Adult A and Adult B.

63) The findings from the IMR reports are endorsed and quality assured by the senior officer within the organisations who commissioned the report and who will be responsible for ensuring that the recommendations of the IMR are acted upon.

64) Each agency was asked to;

- Critically appraise their agency’s involvement with Adult A or Adult B and to identify any safeguarding or welfare concerns leading up to the homicide of Adult A;
Consider whether concerns were acted upon appropriately, and if not, identify what professional or agency issues/barriers prevented this from happening;

Consider the earlier history of Adult B to identify early warning signs and/or opportunities for early intervention (if applicable);

Construct a comprehensive chronology of involvement by their agency over the period of time set out within the scope of the review.

65) The Independent Chair developed an IMR workshop for new authors requiring additional support to write an IMR report. The workshop was held on the 12th October 2012 and was attended by six agencies. The IMR authors received a presentation about the DHR process and the expectations of the IMR report. There was also an opportunity to ask questions and seek clarification.

66) Following examination of the Individual Management Reviews, the Review Panel asked for additional information (where relevant) from each agency to address the specific questions or requirements of the Terms of Reference.

67) Upon viewing each of the IMR’s against the Terms of Reference and the scope of the review, the Independent Chair focussed on those that evidenced agency involvement between 2007 and 2012 unless there was a significant event that warranted inclusion.

68) The final Individual Management Reviews included for analysis within this report are;

a) Early Years Services (Children’s Centre)

b) (REDACTED) Services Limited

c) Plymouth Hospitals NHS Trust

d) Plymouth Children’s Social Care

e) Plymouth Community Healthcare
69) The Chair has included within section four of this report, a summary of agency involvement, an analysis of involvement and conclusions on whether the practice was in accordance with national and local requirements at that time.

70) In section five the Review Panel has drawn overall conclusions about what, if anything should have been done differently and, where appropriate, makes recommendations about what actions are required by each agency and by the Plymouth Community Safety Partnership to address the findings of the review. In addition, the Panel has made recommendations regarding any implications for national policy arising from the case.

Parallel Investigations

71) The Independent Chair contacted the HM Coroner for the City of Plymouth in writing on the 16th October 2012 advising Mr (REDACTED) of the commencement of the Domestic Homicide Review and inviting discussions on how to dovetail the Domestic Homicide Review and the Coroner’s Inquest.

72) The Coroner did not hold an inquest into Adult A’s death as the criminal investigation and subsequent trial sufficiently established who the deceased was and how, when and where the deceased came by her death.

73) Other than the Criminal Investigation, the Review Panel was not informed of any other parallel investigation or Serious Case Review (SCR).

Dissemination

74) It is anticipated at this stage that the final Overview Report and Executive Summary will be published. Internal Management Review reports will not be made publicly available. Whilst key issues will be shared with specific organisations the Overview Report will not be disseminated until clearance has been received from the Home Office Quality Assurance Group.
75) In order to secure agreement, pre-publication drafts of the overview report will be shared with the membership of the Review Panel, IMR authors and the Plymouth Safety Community Partnership.

76) The content of the Overview Report and Executive Summary has been suitably anonymised to protect the identity of the victim, perpetrator, relevant family members, staff and others to comply with the Data Protection Act 1998. The Overview Reports will be produced in a form suitable for publication with any redaction before publication.

77) Adult A’s family will be offered the opportunity to view the report prior to submission to the Home Office Quality Assurance Panel. After final changes, the family will receive a final copy of the report on the day prior to publication.
## SECTION TWO

### SECTION TWO: SYNOPSIS OF CASE

#### Table A: Key Relationships

<table>
<thead>
<tr>
<th>Name</th>
<th>Year of Birth</th>
<th>Extended Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult A (F)</td>
<td>1988</td>
<td>Deceased</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ex-partner of Adult B</td>
</tr>
<tr>
<td>Adult B (M)</td>
<td>1983</td>
<td>Perpetrator /Ex Partner of Adult A</td>
</tr>
<tr>
<td>C1 (F)</td>
<td>2010</td>
<td>Daughter of Adult A and Adult B</td>
</tr>
<tr>
<td>Adult D (F)</td>
<td>Unknown</td>
<td>Mother of Adult A</td>
</tr>
<tr>
<td>Adult E (M)</td>
<td>Unknown</td>
<td>Brother of Adult A</td>
</tr>
<tr>
<td>Adult F (F)</td>
<td>Unknown</td>
<td>Sister of Adult A</td>
</tr>
<tr>
<td>G1 (M)</td>
<td>Unknown</td>
<td>Paternal Grandfather of Adult A</td>
</tr>
</tbody>
</table>

M = Male    F = Female
Table C: Family Genogram

Victim Family

- **U/K**: Male
- **Female**: Male, Adult E, Adult F

Perpetrator Family

- **G1 Male**: Female
- **Male**: Adult A, Adult D, Adult F, Adult H, Adult I, Adult B

Other Fathers: Male, Female

Child C: Male
Circumstances

80) During the early hours of Thursday the 5th of April 2012 Adult B claimed to have found the body of Adult A, his ex-partner with whom he still lived, at their home address of (REDACTED).

81) Adult A was found in the lounge in a seated position on the sofa. She was slumped to her right hand side. She was dressed in a towelling dressing gown and pyjamas. Her clothing had not been disturbed. Directly in front of Adult A was a low wooden coffee table on which a glass of juice, remote controls, a sheet of paper and two mugs could be seen. The glass of juice was still intact suggesting no disturbance of furniture or any indication that Adult A had resisted.

82) Adult B claimed that he had been out visiting a new girlfriend and had returned home to find the front door insecure on his arrival. The investigation found no evidence of forced entry to the premises or any evidence of a struggle or search.

83) Adult A’s death had been caused by severe head injuries inflicted by blows from a blunt instrument. Her body was in rigor mortis.

84) The instrument used to cause her injuries was not at the premises. Adult A’s mobile telephone, which she had been using during the evening of Wednesday 4th of April, was not at the premises. Her two year old child, C1, was asleep upstairs.

85) Adult B was arrested at the scene on suspicion of murder. On Wednesday the 8th of August 2012 Adult B was formally charged with the murder of Adult A.

The Deceased – Adult A

86) Adult A was born in 1988 and was the eldest child of Adult D. Her estranged father had little contact with Adult A throughout her life. Adult A and her two younger siblings (E and F) were placed on the Child Protection Register under the category of neglect for two years between 1991 and 1993. In 1995 all three children were subject to an Emergency Protection Order, removed from Adult D’s care and placed with foster carers. Adult A was found to have facial and body bruising and was under nourished.
87) Adult A was more distressed than her siblings at being separated from her mother so was returned home under Placement with Parents Regulations in 1996 and parented as a single child. Her Care Order was discharged in 1998 and replaced with a Supervision Order. Adult E and Adult F returned home in 1998 and Social Services closed the case on the family in 2000 when Adult A was 12 years old.

88) On leaving school Adult A studied photography at (REDACTED) and supported her studies with part time employment, including modelling and working at a café.

89) Adult A became a mother to C1 in 2010.

90) Leading up to the homicide Adult A had been working as an admissions/door collector at a night club, where she was considered a popular member of staff. Friends working at the Club said that Adult A had little money and would sometimes go without food. According to friends, Adult A would finish work late at night and was always reluctant to allow male friends to transport or accompany her home due to Adult B’s jealousy and paranoia of her seeing other men.

91) None of Adult A’s family disclosed knowledge that Adult B was ever physically abusive towards her.

92) She was 24 years old at the time of her death.

The Perpetrator – Adult B

93) Adult B was born in 1983 to Adult G and Adult I (see Family Genogram 79 above). Adult B lived in (REDACTED) with his Mother as a child but moved back to (REDACTED) to live with his Father aged 15 years. He worked for (REDACTED) Catering Services since October 2004. He was employed to work front of house until 2007 when he requested a move to the galley to wash pots.

94) Adult B was described by managers and co-workers alike as an individual who was kind, gentle and generous with a good sense of humour. Conversely work
colleagues also said that he could be emotional, impulsive and was known to lose his temper, but to no great degree.

**The Relationship**

95) Adult A had been in a relationship with Adult B since 2007. They had moved into (REDACTED) together in 2009 after Adult A became pregnant. Their daughter C1 was born in 2010.

96) The relationship was plagued by Adult B’s jealousy, distrust and controlling behaviour. By the end of 2011 the relationship *was in trouble* and by February 2012, they had separated. The lease on the property was due for renewal and Adult B told Adult A that she could stay until she found alternative accommodation. Adult A was desperately trying to source funds to raise a new deposit for a property for her and C1.

97) Initially they agreed to share custody of C1 but Adult B later announced that he wanted full custody of their daughter. He began taunting Adult A that she would lose C1. Adult A was so worried about this that she made arrangements to see a family solicitor days before the homicide.

98) Following the breakup of the relationship, Adult B struck up another relationship with an ex-girlfriend, Jess (fictitious name) and Adult A embarked on her own relationships with other men. Although Adult B claimed not to care about Adult A’s new relationships, evidence obtained through the criminal justice investigation suggests this was not an arrangement he was content with.

99) During the criminal investigation, Adult B admitted to fathering a child with a work colleague during a break up with Adult A.

**Police Investigation**

100) Devon and Cornwall Police were despatched to (REDACTED ADDRESS) immediately following an emergency call to Ambulance Services at 0314 hours on Thursday the 5th of April 2012. The Police attended at approximately 0330am to find Adult B sitting on the bottom stair near the open front door. He was holding his daughter C1. The Officer entered the property and saw Adult A in the
living room. It was clear to the Police and Paramedics that Adult A’s death was anything but natural.

101) Arrangements were made to transport C1 to her paternal grandparents nearby before Adult B was arrested on suspicion of murder. Adult B’s hands were bagged to secure any possible forensic evidence. He told Officers that he had been sick on the lounge table and that he had gone upstairs to check on his daughter before calling 999.

102) Scenes of Crime Officers attended the property to photograph and record evidence. Adult B was conveyed to (REDACTED) Police Station where he was interviewed over a number of days by DC (REDACTED) and (REDACTED).

103) During the interviews Adult B denied murdering Adult A, claiming that he had returned from work around 1930, made her a cup of tea, talked and cuddled on the sofa before she ‘waved him off at the front door’ at approximately 2055hrs. He said that he arrived at his girlfriend’s house just after 2100hrs and watched TV until around 0250hrs, stopping at a petrol station for fuel and tobacco before heading home; arriving just after 0300hrs.

104) Throughout the interview, Adult B maintained that he and Adult A had a good relationship with no secrets and that he had no hand whatsoever in her death.

105) Early Police investigations found that Adult A and Adult B’s relationship was anything but ‘good’ in the lead up to the homicide and statements obtained from Adult B’s work colleagues suggested that not only was the relationship deteriorating but Adult B had also discussed killing Adult A and had given consideration to the murder weapon.

106) Although the murder weapon was never found, it is thought that Adult B used a professional rolling pin, stolen from his workplace.

107) Five of Adult B’s work colleagues observed that a rolling pin had disappeared leading up to the homicide (four rolling pins were usually kept in the kitchen. By the 6th March, there were only three).
108) In addition to a possible murder weapon, the Police investigation revealed a 23 minute window of opportunity between the last text messages sent by Adult A and the first CCTV sighting of Adult B’s car leaving the family home. The Police proposed that Adult B killed Adult A during this time.

109) This evidence was placed before the Crown Prosecution Service (CPS) following the interviews. The CPS made the decision to formally charge Adult B with the murder of Adult A on the 8th April 2012.

110) In addition to Adult B’s account, Devon and Cornwall Police sought witness statements from approximately 150 friends, family, neighbours, work colleagues and acquaintances in the month following the murder as part of Operation (REDACTED).

Findings of Post Mortem

111) The Post mortem was conducted by Home Office Registered Forensic Pathologist Dr REDACTED on the 5th April 2012 at REDACTED Hospital Mortuary.

112) The preliminary findings included severe head and facial injuries including brain injury indicative of multiple blunt impacts with a weapon.

113) Adult A’s body was identified by her mother Adult D on Sunday the 8th of April 2012.

Coroner’s Inquest

114) Paragraph 15.1 of the Ministry of Justice Guide to Coroners and Inquests and Charter for Coroner Services (March 2012) states;

Where a person has been sent for trial for causing, allowing or assisting a death, for example by murder or manslaughter, any inquest is in most cases adjourned until the criminal trial is over. On adjourning an inquest, the coroner must send the Registrar of Births and Deaths a certificate stating the particulars that are needed to register the death and for a death certificate to be issued. When the trial is over, the coroner will decide whether to resume
the inquest. There may be no need, for example, if all the facts surrounding the death have emerged at the trial. If the inquest is resumed, however, the finding of the inquest as to the cause of death cannot be inconsistent with the outcome of the criminal trial.

115) The Coroner did not resume an Inquest into the death of Adult A after the trial as the criminal justice process sufficiently established who the deceased was and how, when and where the deceased came by her death. This was not disputed by the pathologists or the defence and prosecution teams.

**Court Dates and Outcome**

116) The first trial at (REDACTED) Crown Court commenced on the 8th of April 2013 and concluded on the 30th of April 2013, lasting 17 days.

117) The jury was discharged after failing to agree on a verdict after almost 20 hours of deliberations. They told Judge (REDACTED) that they were unlikely to reach a unanimous or majority verdict even if given more time. Adult B was remanded in custody to await a retrial at a different Crown Court, scheduled for February 2014.

118) The retrial commenced at (REDACTED) Crown Court on the 10th February 2014 and concluded on the 27th February 2014, lasting 14 days.

119) After 3 hours of deliberation, Adult B was found guilty by the unanimous verdict of a jury, of the murder of Adult A.

120) The Independent Chair attended (REDACTED) Crown Court on 28th February to observe the sentencing of Adult B.

121) The Honourable Mr Justice (REDACTED), sentencing Adult B said;

   “You have been convicted of murder. I pass a sentence of life imprisonment… When you killed (Adult A) she was in her early 20s and you were 28. You two had been in a relationship for some years. That relationship had come to an end in the early part of 2012, notwithstanding that you were still living together with your 2 year old daughter. The time was fast
approaching that all that was going to change. You were living separate lives. (Adult A) had been involved in several short term relationships. You had rekindled a romance with *Jess\(^1\). You had been re-introduced in February 2012. I am satisfied this had become serious and you were anxious to put this relationship on a permanent footing. (Adult A) was history and the only obstacle to the issue, custody. You were going to use any means at your disposal to secure custody. You invented a completely fictitious person to create and spread rumours about (Adult A) that were totally false to blacken her character and to improve your chances of custody. It was a building block towards a successful outcome. It didn't work. It wasn't going to work. (Adult A) was adamant about that outcome. You became increasingly desperate. The fact you planned the murder is revealed in the evidence of various witnesses about what you said in surprising unguarded moments. You took your work rolling pin as a weapon. You planned what you thought would be a watertight alibi that you had spent the evening with *Jess before having returned home and found (Adult A) murdered by a stranger who had walked in or she let in. Your planning and premeditation are clearly aggravating features.

When you had murdered (Adult A) you left your 2 year old daughter asleep in her cot. You were prepared to gamble that she would not wake up and she could not climb out. Perhaps you did not really mind what happened.

You came home intending to kill (Adult A). I don't know precise details of the periods between your arrival at home and the murder. Having seen and heard you and against the background of your inexhaustible capacity to tell lies I would not believe anything you said.

Throughout you lied and when your lies were exposed you gave further lies.

At some point you produced a rolling pin and bludgeoned (Adult A) to death. She was on the sofa in her dressing gown and pyjamas. She did not move save to fall sideways.

\(^1\) Fictitious name
It was an appalling and murderous attack. You clearly intended to kill her. There were severe blows and many of them in a ferocious attack.

You had planned the killing and your alibi. You had planned an exit strategy. You were meticulous not to leave any blood in the house or your car. You were calm in the aftermath to avoid a forensic trail and also to be able to present as normal to *Jess.

I assess you as cunning, deceitful, manipulative and someone who will continue to present a very real danger to any woman you are in a relationship with.

You deprived (C1) of her mother, (Adult A) of the joys of bringing up her child and those nearest and dearest to her of a young woman they spoke of with warmth and affection.

I set the minimum term before consideration is first given to your release as 18 years imprisonment”.

122) Following the sentencing, the Solicitor General, Oliver Heald QC MP, referred the case to the Court of Appeal, on the basis that the 18 year sentence was too lenient. The Appeal Court agreed and increased Adult B’s sentence to 23 years on the 12th June 2014. After the ruling, Oliver Heald QC said: “This was a terrible crime which has deprived a young child of both parents I hope this revised sentence offers a degree of comfort and reassurance to the public.”

123) Adult B’s will be eligible for parole from 2037.

Equality and Diversity Statement

124) This diversity statement was written following consideration of The Equality Act 2010 which came into force on 1 October 2010 to legally protect people from discrimination in the workplace and in wider society. The Equality Act 2010 replaces all existing equality laws with one single act, making the law easier to understand for individuals and strengthening protection in some situations.
125) Adult A (the deceased) was a white British National. She was 24 years old at the time of the homicide. Adult A was a Mother of a 2-year old daughter (C1). She was not pregnant at any other time during the scope of the review, nor did she have any known physical or learning disability.

126) Adult B (the perpetrator) is 31 (at the date of this report) and is also a white British National. Adult B does not have a physical or learning disability.

127) Adult A and Adult B were not married. They were in a relationship for approximately 5 years and had a daughter together. Adult B is the Father of another child, not connected to Adult A.

128) Neither Adult A nor Adult B had/have ever undergone any gender reassignment. Some friends of Adult A informed Police that Adult A was bi-sexual but preferred men. This cannot be substantiated by the Chair and there is no evidence of Adult A having had a relationship with another female.

129) Adult A and Adult B’s religion was recorded by Plymouth Community Healthcare as having ‘no religion’. It is not clear from the review whether Adult A or Adult B had any philosophical beliefs that had an impact on their life choices or the way in which they lived their lives or raised C1.

130) There is no evidence that Adult A or Adult B were directly or indirectly discriminated against by any agency based on the nine protected characteristics of people who use services under the Equality Act 2010 e.g. Disability, Sex (gender), Gender reassignment, Pregnancy and maternity, Race, Religion or belief, Sexual orientation, Age, Marriage or Civil partnership.

**NARRATIVE CHRONOLOGY OF AGENCY INVOLVEMENT**

131) A full tabular chronology of agency contact can be found at Appendix A.

**Summary of agency Involvement (Reverse Chronological Order)**
2007

132) 2007 - No local agency contact is recorded for Adult A or Adult B

2008

133) 2008 - No local agency contact is recorded for Adult A or Adult B

2009

134) 2009 - No local agency contact is recorded for Adult A or Adult B

2010

135) 17/05/2010 - First contact recorded with Plymouth City Council for antenatal care. Adult A attended Midwifery Services at her local Children’s Centre. Adult A was invited to join the Great Expectations Antenatal Programme.

136) Between 07/06/2010 to 05/07/2010 Adult A attended 5 Great Expectations anti-natal sessions to prepare for the birth of her first child. The course included sessions on:

- A healthy pregnancy
- Changes to relationships
- Preparation for birth
- Birth assistance
- Bonding with baby
- Parental support

137) There is no record of Adult B attending the Great Expectations Antenatal Sessions. Adult A did not disclose any concerns about her relationship with Adult B during the sessions, and particularly during the ‘changes to relationships’ session.
138) **(REDACTED D.O.B) 2010** – C1 born prematurely at 36 weeks + 2 days gestation by emergency caesarean section.

139) **(REDACTED)/2010** – C1 is discharged from the neonatal intensive-care unit.

140) **(REDACTED) 2010** – Adult A and C1 are discharged from Midwifery Services. Referral made to Health Visitor.

141) **11/08/2010** – First contact with Health Visitor. Home Visit. Health assessment completed for C1. The assessment states; ‘*Emotionally warm and responsive parents in a stable relationship….no disclosure of depression….domestic abuse question not asked as partner present*’.

142) Two further home visits from the Health Visitor were recorded in 2010 (**18/08/10** and **13/10/10**). No concerns were recorded.

143) Adult A and C1 attended 10 sessions at the ‘stop and play health clinic’ at the local Children’s Centre between **13/09/2010** and **06/12/2010**. As there are no corresponding notes within Health Visitor records, it is assumed that Adult A attended the ‘play and stay’ session and did not see a Health Practitioner. Adult B did not attend any sessions.

**2011**

144) Two Home Visits from the Health Visitor (**21/01/11, 26/01/11**) are recorded. Adult B was present on the latter occasion. The Health Visitor observed ‘*good interaction between parents*’.

145) Adult A and C1 attended 8 sessions at the ‘stop and play health clinic’ at the local Children’s Centre between **31/01/2011** and **12/12/2011**. As there are not corresponding notes within Health Visitor records, it is assumed that Adult A attended the ‘play and stay’ session and did not see a Health Practitioner. Adult B did not attend any sessions.
2012

146)  **20/01/2012** – Adult A and C1 attended the ‘stop and play health clinic’ at the local Children’s Centre.

147)  **27/01/2012** – Adult A and C1 attended the ‘stop and play health clinic’ at the local Children’s Centre. Children’s Centre Staff liaised with the Health Visitor to report that Adult A had separated from Adult B and was low in mood. The Health Visitor advised Children’s Centre Staff to contact Adult A and encourage her to access more community activities. This discussion and action was not recorded within records kept by the Children’s Centre.

148)  **15/08/2012** - Adult A and C1 attended Children’s Centre to meet with the Health Visitor. Domestic Violence Question was asked. No concerns identified.

149)  Between **10/02/2012** and **23/03/2012** Adult A and C1 attended 5 Stay and Play Sessions at the local Children’s Centre. Adult B attended a session with Adult A on **02/03/2012** to observe C1 during Rhyme Time (part of the Stay and Play Session). This was his first and only attendance and the Children’s Centre.

150)  On the **23/03/2012** Adult A approached one of the Early Years Workers (TX1) during ‘Rhyme Time’ and disclosed that ‘things between her and her ex-partner were turning sour’. Adult A said that her ex (Adult B) was threatening to obtain full custody of C1. Adult A said that she was really worried about the threats. She was feeling very down and was worried about money and housing. TX1 made an appointment for Adult A to see a Money Advice Worker on the 2\(^{nd}\) April 2012 and a Housing Adviser on the 23\(^{rd}\) April 2012. TX1 also signposted Adult A to a young parent’s group for additional social interaction and support.

151)  **30/03/2012** – Adult A attended the Stop and Play Session. Adult A informed TX1 that Adult B had now appointed a Solicitor to fight for full custody of C1. TX1 confirmed the appointment for the Money Adviser on the forthcoming Monday (2\(^{nd}\) April). Adult A told TX1 that she had seen pictures of Adult B on a social
networking site with another girl. She was also worrying about money and a loan that had been taken out in her name by another family member.

152) **02/04/2012** – Adult A attended an appointment with a Money Advice Worker at the Children’s Centre to discuss her benefit entitlements. During the assessment it became apparent that there was not enough time to complete the tax enquiry forms. A further appointment was offered to Adult A on the 05/04/2012 at (REDACTED) Centre Ltd to complete the assessments. Whilst discussing benefit entitlements, Adult A disclosed that she had recently separated from Adult B and that he was seeking to gain full custody of C1. The Money Advice Worker informed Adult A of a free legal service available through (REDACTED) Centre Ltd and offered to book a meeting with a Solicitor. Adult A agreed and back-to-back appointments were made for Money Advice and Legal Advice on the morning of the 5th April 2012.

153) **02/04/2012** – TX1 telephoned Adult A for a welfare check. Adult A seemed more positive and confirmed that she had attended her appointment with the Money Advice Worker. Following this meeting Adult A claimed that she was ‘feeling much better as everything seemed to be moving in the right direction’.

154) **05/04/2012** – Adult A failed to attend her appointments with the Money Advice Worker and the Solicitor at (REDACTED) Centre Ltd.

155) Adult A was murdered on the evening of the 4th April or the early hours of the 5th April 2012.
Summary of Evening of 4th April and Early Hours of 5th April 2012.

Wednesday 4th April 2012

156) Adult B is seen arriving at his workplace at 1035hrs wearing jeans and carrying a rucksack.

157) Adult A converses with friends on a social networking site throughout the afternoon. Between 1428hrs and 1614hrs Adult A sends outgoing text messages to 4 contacts, including Adult B.

158) At 1921hrs Adult B is seen leaving his workplace in the passenger seat of a work colleague’s car. Adult B is dropped at a layby and walks to the home address, arriving at approximately 1930hrs.

159) On arrival Adult B claims he found Adult A sat in the living room dressed in her pyjamas and a dressing gown, watching the television and reading a book. She apparently told Adult B that she was feeling under the weather. C1 was in bed and probably asleep. Adult B suggested that Adult A take a Lemsip and have an early night. Adult B recalled making them both a cup of tea and sitting on the sofa together ‘cuddling in’ before changing his clothes. When he got up to leave Adult B claimed that Adult A followed him to the door and waved him off.

160) During this time Adult A was in constant contact on social media with a male friend between 1736hrs and 2031hrs when the conversation stopped abruptly. The male friend sent two further messages at 2034hrs and 2111hrs but received no reply. Adult A sent a female friend a text message at 2047hrs. There was no activity on Adult A’s social media or mobile telephone after 2031hrs and 2047hrs respectively.

161) At 2114hrs, Adult B’s car was seen on CCTV approximately 1mile from home heading towards (REDACTED). He took a detour to a railway embankment to
‘roll a cigarette and change the music in his car’ before continuing to his new girlfriend Jess’s house. On arrival at his girlfriends’ house Adult B claimed that he quickly emptied some rubbish from his car, including a piece of kitchen roll that Adult A had used following a nose bleed she had had in his car the previous Sunday (1st of April).

162) Adult B said he had entered Jess’s house and went straight to the toilet, he then stayed at her premises watching television. At 2334hrs Adult B sent a text message to Adult A in which he asks how she is feeling and letting her know that he would be late (in later interviews Adult B admitted to taking Adult A’s mobile telephone on the 4th April 2014 and could not provide an explanation for his text message on the same evening).

Thursday 5th April 2012

163) Adult B left Jess’s house at around 0250hrs. On leaving he went to the Tesco Express in (REDACTED) Road where he purchased fuel and tobacco. He then drove home arriving just after 0300hrs where he parked his car and had a cigarette. Adult B stated he could see flickering in the lounge and assumed that Adult A was up watching TV. He entered leaving his shoes at the door; he did not call out for fear of waking his daughter. He entered the lounge and immediately saw Adult A on the sofa. Adult B said he went towards her did not touch her as he “didn’t want to interfere”. He then ran upstairs to get C1 whilst he rang the emergency services.

164) NOTE: Adult B later admitted during the investigation to stealing a rolling pin from his workplace (claiming that he stole it in order to do some baking at the weekend with Adult A and C1). Although the rolling pin, Adult B’s clothes and Adult A’s mobile phone were never found, the Jury were satisfied that Adult B killed Adult A at some point between 2047hrs and about 2110hrs on the 4th April 2012 and discarded the evidence during his journey to Jess’s house.
165) In addition to an analysis of the response of services involved with Adult A and Adult B (see Section Four), the Review Panel wished to include the witness statements (already within the public domain) of family, friends and co-workers to establish whether they were aware of any previous abusive behaviour from the perpetrator to the victim as per the Terms of Reference.

Witness Statements of Family

166) Adult A’s Aunty states that the relationship between Adult A and Adult B seemed perfect until December 2011 when Adult B asked Adult A to have another child. Adult A did not want another child and the relationship started to break down but they continued to live together. Adult A’s Aunt was aware that the couple had agreed that C1 would stay with Adult A for 4 nights a week and Adult B for 3 nights a week but that Adult B had recently changed his mind and decided he wanted C1 full time.

167) Adult B’s Step Mother (SM) first became aware of difficulties in the relationship between the couple in February 2012. She was told by Adult B that Adult A was in contact with another man. He showed SM a ‘provocative’ picture of Adult A on his mobile telephone that had been sent to the said male. From this point SM believes Adult A and Adult B started to drift apart. She was aware that both had embarked on separate, probably sexual, relationships. SM knew that Adult A was intent on leaving the family address and was willing to assist her with a deposit on a new place.
Witness Statements of Friends

168) 11 police witness statements from friends have been included within the Domestic Homicide Review;

F1

169) **F1** was one of Adult A’s best friends who also knew Adult B reasonably well. F1 liked Adult B but found him jealous, possessive and controlling i.e. He disapproved of the way Adult A dressed and didn’t like her going out. She states that their relationship was ‘on and off’ and that Adult B would threaten that he would take C1 from Adult A. Adult A told F1 that she suspected that Adult B was seeing other women behind her back.

170) Text messages between F1 and Adult A on Tuesday the 27th of March 2012 show that all was not well in the relationship between Adult A and Adult B. In those text messages Adult A complains that Adult B was going through her phone, hated her friends and how she dressed, was calling her a slag and taunting her that she would lose C1.

F2

171) **F2** states that Adult B was controlling during his relationship with Adult A. F2 was told by Adult A that she had found footage on his mobile telephone of Adult B having sex with an ex-partner whilst they were together. She states that Adult A had been sleeping on the sofa prior to the homicide.

F3

172) **F3** was a very good friend of Adult A. F3 states that Adult A had told her that Adult B had threatened her with violence and that he would take their daughter C1 away from her. She had been told Adult B was obsessed by their daughter. She states that Adult B was very controlling of Adult A. He did not like her friends or the way she dressed. Adult A had told F3 that her relationship was in difficulties in December 2011. The last time she saw Adult A was February 2012
when she told her she was leaving Adult B due to the threats and the fact Adult B had assaulted her.

**F4**

173) **F4** had been in a casual relationship with Adult A since meeting her in club (REDACTED) in 2008. He has had significant contact with her from 2008 up until a week or so before her death. Their relationship took a back seat once Adult A became pregnant and they maintained contact by social media only. A few months after the birth of C1, F4 met with Adult A who complained that Adult B did very little to assist with bringing up C1 and spent most of his time playing video games. F4 states that Adult A was really concerned about lack of money and the custody of her daughter if she separated from Adult B. In a rare telephone conversation around Christmas 2011 she told him that her relationship with Adult B was ‘non-existent and they were having proper arguments’. Adult A wanted to move out but could not afford to do so. Adult A told F4 that Adult B had insisted that she remove F4 from her telephone and social media contacts.

**F5**

174) **F5** states that he was aware that Adult B had a new girlfriend but was told by Adult A that he was not happy with her seeing other men.

**F6**

175) **F6** states he was told by Adult A that Adult B was jealous of her seeing other men following their split.

**F7**

176) **F7** is the partner of F3. He knew Adult A very well but did not really know Adult B. During July 2009 he was in (REDACTED) city centre when he saw Adult A. As they met she threw an arm around him. As she did so F7 describes Adult B approaching them ranting and raving at Adult A. F7 was so concerned he thought Adult B was going to physically assault Adult A and thus intervened. He states that Adult B was shouting: “Who the hell is this? Who are all these men? Is
it any wonder I don’t trust you”. Eventually the couple walked off together with Adult A telling F7 it was ‘OK’.

F8

177) F8 visited (REDACTED) between Thursday 22nd and Monday the 26th of March 2012. He was introduced to a number of people including Adult A. He was instantly attracted to her and they struck up a relationship. F8 stayed in constant touch with Adult A following his return home to (REDACTED), they communicated by mobile telephone, text and social media. F8 had not met, did not know, nor ever communicated with Adult B in anyway; however, on Saturday the 31st of March 2012 he received a social media message from Adult B asking if he was seeing Adult A, and if anything had gone on between them. F8 did not reply, save to forward the message to Adult A on Tuesday the 3rd of April 2012.

F9

178) F9 had been a good friend of Adult B and it was through him that he met and became friendly with Adult A. He would occasionally see Adult A at (REDACTED) Nightclub but had not seen or had any contact with Adult B for many years.

179) F9 was at (REDACTED) Nightclub on Friday the 30th of March 2012 when he saw Adult A. She told him she was seeing a man called (F8) and asked him not to mention it to Adult B. The following evening F9 unexpectedly received a message from Adult B via social media, which said;

“Alright fella I hope you’re ok, strange question but I don’t really know who else to ask who goes to (REDACTED) Nightclub a lot and knows a sh*t load of people other than you. Last night while looking after (C1) while (Adult A) was out, I had a phone call saying there’s rumours flying around (REDACTED) Nightclub that (Adult A) has slept with a few people. Only name mentioned though was (F8)… Being honest even though me and (Adult A) live together, yet not together anymore I don’t mind what she gets up to, end of the day it’s her decision to do what she wants. But one thing I won’t stand for is people spreading sh*t about her. Can you give me heads up if you hear anything?
Cheers soz if you mind me asking you, just don’t want to ask (Adult A) as don’t want her embarrassed about shit**y rumours”.

180) F9 replied to this message as soon as it was sent to him. He was wary about his reply as he recalled Adult A telling him not to tell Adult B about F8. He replied:

“To be honest mate I have never heard of that guy, I don’t speak to Adult A that much, just say hi. Different circle of friends”.

181) F9 received a reply back from Adult B which said;

“OK cheers bud, think (F8) was only down last weekend but if you can keep an ear out for us cheers bud, like I said last thing I want is for (Adult A) to get a bad name due to shit**y rumours. But if it’s true fair one and I will keep my nose out of it. Oh sh*t forgot to ask when she left last night if you saw anything. Was she ok, I know you just say hi but heard something like she looked pi**ed off or along those lines”. F9 did not reply.

F10

182) F10 is the sister of F9. F10 received the same message sent to F9 from Adult B on the 31st March 2012 (see 179) above). She did not reply.

F11

183) F11 is a fictitious ex-girlfriend of Adult B. Initially it appeared that F11 reconnected with Adult B on the 23rd of March, inviting him around for tea after work (using a social media account) and informing him that if she saw Adult A tonight, she would ‘bottle her’. Adult A believed that F11 existed and was worried that she was spying on her to report back to Adult B.

184) NOTE: The Police never located F11 despite an extensive nationwide search. It later emerged that Adult B had generated a fake social media account and had invented F11 to incite fear and create a possible murder suspect for the subsequent homicide.
Witness Statements of Co-Workers

185) 12 work colleagues provided witness statements to the criminal investigation. These are identified below;

Work Colleagues of Adult A (deceased)

E1

186) **E1** used to work with Adult A at an ‘alternative fashion’ outlet (REDACTED business name). She states that she was told by Adult A that Adult B was possessive and during a troubled period in their relationship he had deleted all male contacts on her social media account. She saw bruising on Adult A’s arms prior to her getting pregnant; E1 asked if Adult B had caused the bruising; Adult A nodded but did not expand.

E2

187) **E2** assisted in running events at the Nightclub where Adult A worked. He befriended Adult A and states that at closing time he would sometimes drive or walk her to the area of her home address. He was aware she had little money and would sometimes go without food. Adult A would not allow E2 to walk her to her door as she stated that Adult B was jealous and paranoid about her seeing other men.

E3

188) **E3** owns an independent clothing shop called (REDACTED). Adult A modelled for her for discount rather than payment. Adult A told F3 that Adult B was ‘very jealous’.

E4

189) **E4** is a doorman at (REDACTED) Nightclub. E4 did not know Adult A very well and did not know Adult B at all. E4 was told by Adult A in February/March 2012 that she had split from her boyfriend, but continued to live with him. She said he would kick off and be in a temper if she was seen speaking to other men.
E5

190) **E5** walked with Adult A from the area of her home to the Nightclub where they worked on a number of occasions in February 2012. He states that he wasn’t allowed to meet her near her home as Adult B was jealous and wasn’t happy with her speaking to other men.

Work Colleagues of Adult B

E6

191) **E6** was a supervisor of Adult B. He states that Adult B was visibly upset during February 2012 and that this was due to his relationship breaking down, which this time he thought was for good. E6 recalls Adult B repeating; “I’m being made to look a fool” and “This time I think it has to be it”. Adult B told E6 that he had looked on Adult A’s phone and found texts between her and a student who he believed had had a relationship with her. Some two weeks prior to the murder of Adult A, Adult B spoke to E6, again telling him that he had looked at Adult A’s phone and found text messages relating to her and a man being ‘F*ck Buddies’. Further, that he wasn’t jealous but was sorry for Adult A as he had ‘moved on’.

E7

192) **E7** was Adult B’s Manager. She states that Adult B was a very good employee and a ‘nice chap’. On Tuesday the 3rd of April she spent around an hour with Adult B discussing his relationship with Adult A. He had sought advice about his tenancy and access to his child if he and Adult A split up. She says he was emotional but not crying. She states that he could be impulsive and could lose his temper, which he had done at work before but to no great degree.

E8

193) **E8** was a work colleague and a good friend of Adult B. He was aware that Adult B had problems with his relationship and had witnessed him in tears at work. On Monday the 2nd of March 2012 he recalls a specific incident with Adult B in the (REDACTED) area;
“(Adult B) had in his hand on a rolling pin and was waving it around in his hand….accidentally (Adult B) caught me on the peak of my cap and at first he was shit**ing himself, and said "Are you alright mate?" I said I was okay and (Adult B) just laughed….as he replaced the rolling pin, he said to me "Do you think this would kill someone?" referring to the rolling pin. I replied "Yes it would". (Adult B) then said "How would you hit someone, would you hit them on the top of the head or to the side?" I replied "I don't know!" and walked away”.

E9

194) E9 corroborates the incident with the rolling pin being swung around and further recalls Adult B saying; “If you were gonna hit someone, how and where would you do it?” … “How would you knock someone out with it?”

E10

195) E10 provides evidence that Adult B had been late to work over the weeks during his break up with Adult A and had been emotional at work; he had been challenged about this and had turned himself around.

E11

196) E11 described Adult B as a good worker and a popular member of staff. On Tuesday the 3rd of April Adult B asked E11 her opinion on whether “all women were bitches”. A discussion followed about custody issues with children and E11 advised Adult B to seek the advice of a solicitor.

197) The following day (Wednesday the 4th of April) E11 was walking along the corridor and over heard two voices which she recognised as Adult B’s and E12. As E11 walked by E12 said "Have you heard the latest?" E11 turned around to look back towards the two men and E12 continued "(Adult B) is going to kill his girlfriend". This was said in a light hearted way and so E11 said "Oh yeah right". To which E12 replied "Yeah, he’s even got the implement to do it". Adult B never spoke and simply looked down at the floor. E11 did not believe the comments to
be serious so reiterated, "Some women are bitches, you need to get a grip and go through a solicitor".

E12

198) E12 is described as Adult B’s best friend. On Thursday the 5th of April E12 told Police that Adult B had told him that he ‘feels like killing Adult A and taking his own life’, although E12 thought that Adult B calmed somewhat after meeting his new girlfriend.

199) On Monday the 2nd of April 2012, whilst travelling home from work together, Adult B told E12 that he had borrowed something from work, but elaborated no further. The following day, Tuesday 3rd April 2012, whilst at work Adult B said to E12 "I was stood at the end of the bed with a rolling pin in my hands but I didn't have the balls." E12 said that Adult B was laughing when he said this and therefore assumed that Adult B ‘was just mucking about’.

200) E12 said that since mid-January 2012, Adult B often made throw away comments about killing Adult A. On one occasion Adult B talked about drowning Adult A in the bath and wanted E12’s views about whether his DNA would be found on her body. During mid-March 2012, Adult B ‘tagged’ an internet site against E12’s social media account (Facebook page). The site tagged was all about how to dispose of a body. E12 never took any of the comments seriously believing that Adult B was not capable of such a thing.

201) E12 stated that Adult B stopped keeping money at home and either hid, banked or gave his money to his parents to stop Adult A getting hold of it.

Panel Conclusion from Analysis of Witness Statements

Were family, friends and co-workers aware of abusive behaviours from the perpetrator towards the victim?

202) The Mother of Adult A was not aware of any abusive behaviour from Adult B towards Adult A. The Independent Chair was informed that Adult A’s Mother did
not believe Adult B was responsible for her daughter’s homicide until the latter stages of the second trial.

203) It appears that Adult A’s Aunt and Adult B’s Step-Mother both became aware of the breakdown in the relationship between December 2011 and February 2012, although the reasons communicated for ‘drifting apart’ differed e.g. Adult A’s Aunt believed it was because Adult A did not want another baby; Adult B’s Step Mother believed it was due to Adult A’s alleged infidelity. Neither considered Adult A at risk from Adult B.

204) Of particular interest is the number of Adult A’s friends and work colleagues who were aware of Adult B’s jealous and controlling behaviour. Each friend appears to have received a ‘snippet’ of information relayed by Adult A but no one person seemed to be aware of the full extent of the escalating behaviour. Although Adult A appeared to ‘drip feed’ her concerns, her friends and work colleagues were still able to form the opinion that the relationship between the couple was not a happy one.

205) Only when these ‘snippets’ of information were pieced together during the course of the criminal investigation, did a picture emerge of a worrying escalation of behaviour from Adult B towards Adult A. Had the information been pieced together earlier, the following behaviours would have been identified to form a cumulative risk;

a) Monitoring Adult A’s phone activity, deleting contacts

b) Tracking and hacking social media accounts

c) Verbal and emotional abuse (name calling, derogatory remarks, threats)

d) Controlling and excessive jealous behaviour

e) Using isolation: Dictating what Adult A wore and who she spoke to

f) Financial/economic control – limiting her access to money and means of escape

g) Threats to take their daughter/child contact disputes
h) Stalking by proxy and jealous surveillance

i) Suicidal declarations

j) Separation anxiety

k) Use of Intimidation/inciting fear

l) Threats to kill

206) All of these behaviours appear to have been underpinned by the threat of, or use of violence. E1 refers to bruising of Adult A’s arms, F3 states that Adult A was going to leave Adult B in February 2012 after he had assaulted her and F7 recalled an incident whereby he thought Adult B was going to assault Adult A in public.

207) Although the majority of friends and family were not aware of physical violence towards Adult A, witness statements do suggest that Adult A was aware of Adult B’s quick temper and often took steps to avoid conflict by circumnavigating situations that would provoke him (e.g. by ensuring that she was not seen with friends, especially male friends). In doing this, Adult A subconsciously raised awareness of the relationship difficulties between herself and Adult B in such a way that her friends seemed to acknowledge her fears and respect her personal safety strategies.

208) In summary, friends, family and co-workers were individually aware of the breakdown in the relationship between Adult A and Adult B, and some were aware of abusive behaviours and tactics exhibited by Adult B, however, not one witness referred to ‘domestic abuse’ when asked to describe the relationship during the criminal investigation.

209) This may be attributed to the perceived ‘open nature’ of the relationship whereby both parties were known to have other casual encounters whilst living together (or at least this was what was portrayed by Adult B). After the relationship ended, the couple continued to live together but lead separate lives. Whilst Adult B rekindled a relationship with an ex-girlfriend, he was not so happy
with Adult A’s new single status – within weeks he embarked on a crusade to discredit her as a promiscuous person and a bad mother.

210) It is possible that Adult B’s tactics were successful in tainting the views of others into believing that Adult A was somehow responsible for Adult B’s behaviour and that he was justified in his actions and frustrations. As he continued to solicit sympathy from family and friends for the apparent wrongdoings of Adult A\(^2\), so they became less likely to see her as a victim and report domestic abuse.

211) This raises the question of whether there is enough public awareness of the complex nature of domestic abuse and the accumulative impact of coercive and controlling behaviours. Whilst Adult B demonstrated very common tactics of a dominant domestic abuse perpetrator, it would appear that the couple’s network of family and friends were unable to identify these manipulative behaviours.

**Note for future friends and relatives:** Plymouth Domestic Abuse Service (PDAS) provides support for men, women and children who need advice and protection from domestic abuse. PDAS can be contacted on 01752 252 033

Were there any barriers experienced by the family, friends, co-workers in reporting any abuse or concerns in Plymouth, including whether they (or the victim) knew how to report domestic abuse had they wanted to?

212) The Review Panel considered the apprehensiveness of individuals to intervene (see 209) to 210) above) and acknowledged that high risk domestic abuse can often be missed if each incident is considered in isolation. It is only when the cumulative incidents are pieced together that the picture emerges of sustained emotional and physical abuse. If the violence or threat to life is not overt, family friends and work colleagues may be reluctant to intervene on the off-chance that they may ‘get it wrong’, ‘waste valuable police resources’ or ‘make it worse for the victim’.

\(^2\) E6 witness statement: He recalled Adult B saying “I’m being made to look a fool”.
213) With hindsight it is evident that Adult B exhibited common abusive tactics to control and dominate Adult A. A professional specialising in the field of domestic abuse may compare these tactics with those identified within the Duluth Power and Control Wheel\(^3\). In addition to the abusive behaviours, there was also escalation, and the disturbing actions of a man who was becoming more and more desperate as Adult A made final preparations to leave.

214) On reflection it is understandable to the untrained eye why the homicide would appear to have ‘come out of the blue’. Adult B’s increasingly desperate behaviour was not witnessed or understood by one sole individual, including Adult A, who was equally unaware of her impending danger. Adult B’s behaviour leading up to the homicide was observed by many people but each instance was viewed in isolation and as such, did not meet the threshold for concern. His friends seemed to view his declarations or actions as ‘low-level’, justified or implausible.

215) Even when Adult B discussed killing Adult A with work colleagues on the day of her homicide, and asked questions about the method and the disposal of the body, his behaviour was not taken seriously as co-workers could not believe that Adult B could be capable of murder. Without the benefit of piecing together the escalating pattern of incidents or understanding the context of the controlling, coercive and threatening behaviour, it would have been difficult for friends and work colleagues to assess the increasing risk and the danger he posed to Adult A.

216) This highlights a fundamental barrier to reporting domestic abuse - despite all of the controlling behaviours being known, they were not fully understood by Adult A and B’s network of friends and work colleagues. In order for an individual to be motivated to report concerns, they must first acknowledge that a person is at risk or a crime has or is taking place. In this instance, no individual had all of the information or knowledge to see the escalation as a potential predictor of

\(^3\) [http://www.theduluthmodel.org/training/wheels.html](http://www.theduluthmodel.org/training/wheels.html)
dangerousness.

217) Unless further awareness raising activity is delivered within the wider community, there is an ongoing risk that victims and perpetrators will continue to be overlooked. If statutory agencies wish to encourage self-reporting or public reporting of domestic abuse, a fresh effort must be made to ensure the general public have the education and knowledge to identify the signs of domestic abuse and understand the nature of non-violent patterns of coercive and controlling behaviour.

218) In conclusion, the barrier to reporting concerns for family and friends was not necessarily an issue of knowing where to report abuse (had they wanted to) but more a question of whether they even suspected domestic abuse in the first instance. The Panel is of the view that this type of domestic abuse can be difficult to detect, (even for some professionals) due to its continuous nature and focus on control rather than conflict. If witnesses did not consider Adult B’s excessive jealousy and controlling behaviour to be ‘domestic abuse’ then it would unreasonable and unrealistic to have expected them to report their concerns. Put simply, their concerns of ‘domestic abuse’ just didn’t exist.
NOTE FOR FUTURE EMPLOYERS & EMPLOYEES: In June 2013 The Department of Health, in partnership with CAADA (Co-ordinated Action Against Domestic Abuse) developed two leaflets: one for employees to help them understand their rights and responsibilities within a workplace; and a separate leaflet for employers, providing guidance on how to support those who are in immediate need of help.

Plymouth Community Safety Partnership has included a link to each leaflet below in the hope that the lessons learnt from this domestic homicide review will encourage other employers within the city of Plymouth to read and cascade the guidance, to improve early identification of warning signs.

Employees:

Employers:
SECTION FOUR: ANALYSIS OF INDIVIDUAL MANAGEMENT REVIEWS

219) The focus for this section of the report will be an analysis of the response of Services involved with Adult A and Adult B; why decisions were made and actions taken or not taken.

220) Any issues or concerns identified are a reflection of the evidence made available with the benefit of hindsight and the application of foresight.

Hindsight bias

221) Hindsight bias can lead to grossly overestimating how obvious the correct action or decision would have looked at the time and how easy it would have been for an individual to do the right thing. It would be foolhardy not to recognise that a review of this type will undoubtedly lend itself to the application of hindsight and that looking back to learn lessons often benefits from such practice. That said, the Review Panel has made every effort to avoid hindsight bias and has viewed the case and its circumstances as it would have been seen by the individuals at the time.

222) The Review Panel has considered the way in which agencies and individuals responded to the family in the context of domestic abuse services accessible and available to victims during the period stated in the scope of the review.

223) All of the agencies involved in this review provided candid accounts of their involvement in order to learn lessons.
EARLY YEARS SERVICE - INDIVIDUAL MANAGEMENT REVIEW

224) The IMR Author has undertaken an analysis and an unbiased critique of Early Years involvement with Adult A and C1 within the specified period of this Domestic Homicide Review. Comprehensive information of all attendances may be found in the tabular chronology. (Appendix A).

225) The appointed IMR Author is employed by Plymouth City Council and has direct responsibility for managing the Managers of 6 Children’s Centres and the monitoring of contractual arrangements for 11 other Centres.

226) The IMR Author undertook two informal interviews with The (REDACTED) Children’s Centre Programme Manager and the Acting Children’s Centre Manager at the specific Children’s Centres involved with Adult A and C1. The IMR Author also reviewed and audited The Children’s Centre policies and procedures and family case files.

Summary of Involvement with Early Years Services

227) The documentary evidence suggests that Adult A first presented at (REDACTED) Children’s Centre on 17th May 2010 for an antenatal appointment. This was to be the first of five (recorded) routine appointments with the Midwife. 

NOTE: Children’s Centres do not have access to the health notes held by the Midwifery Service (these contacts are recorded within the Plymouth Hospitals NHS Trust IMR).

228) Adult A also attended four Great Expectations Antenatal Programme sessions from the 17th May 2010 to the 5th July 2010 (see 136) above for information on the programme’s content).

229) After C1 was born, Adult A attended the Children’s Centre for a Chatterbox Session. This session is an informal and open access group. Its structure includes baby weighting, contact with Health Visitors and Children’s Centre staff.
The Heath Visiting Service records all client contacts. These records are inaccessible to the Children's Centre.

230) The database shows that Adult A accessed two centres 35 times in total with (REDACTED) Children’s Centre recording 30 visits between the 6th September 2010 and her death in April 2012. This includes an appointment with a Financial Advisor at (REDACTED) Centre Ltd.

231) Adult B attended the Children’s Centre on one occasion prior to Adult A’s death (2nd March 2012).

232) Children’s Centres offer different levels of support to families dependent upon the need/complexity of the presenting issues. These include Level 1 (universal), Level 2/3 (enhanced support) and Level 4 (only offered in conjunction with Social Care, as part of a Care Plan). The Children’s Centre Policy is to only offer support at Level 2/3 following a self or agency referral. Adult A, Adult B and C1 were considered to be a ‘Universal Family’ requiring Level 1 minimal support. No formal assessment of needs/risks was ever undertaken or required because no referral (self or agency) was ever received.

233) On 23rd March 2012, during a Rhyme Time Session at the Children’s Centre, Adult A voluntarily explained to TX1 (Early Years Worker) that she felt concerned about her relationship with her ex-partner (Adult B), as he was threatening to gain custody of their daughter. She also disclosed that she was experiencing money and housing problems.

234) TX1 retrospectively recorded a discussion in the Children’s Centre Child File, as part of her employment handover in April 2012. It describes the conversation between Adult A and TX1 on the 23rd March 2012;

“Adult A approached me in Rhyme Time and said that things with her live-in ex-Partner were turning sour. She seemed quite down with the whole situation. Adult A has previously told me that she felt quite low when her
daughter (C1) was a baby. She split up with her partner a couple of months ago but due to their tenancy agreement decided to live together until their lease was up at the end of April 2012.

Today Adult A informed me that her ex-partner is threatening to get full custody of their daughter. She was really worried about these threats. Adult A said she has no money and is worried about where she and C1 will live in the future. I had mentioned money and housing advice in the past so Adult A agreed to let me book her in for an appointment on 2nd April 2012 at 10.20 a.m. for money advice and 23rd April at 10.30 a.m. for housing advice (With REDACTED) Centre Ltd. I also signposted her to a young parents group, as it seemed she had little support from friends and family (TX1, 23rd, March 12)

235) TX1’s next contact with Adult A occurred on 30th March 2012. Adult A came to the Children’s Centre for an activity. An entry in the Child File written by TX1 states:

“Adult A arrived for Rhyme Time today. I informed her it wasn’t on but asked her how she was. She seemed upset and said that her ex has got a Solicitor involved and again threatening for full custody. She also mentioned that she had seen pictures of her ex on Facebook with another girl.

I told Adult A to make sure she attends her appointment next Monday with the specialists and to come along to some of our Easter Groups (TX1, 30th March 2012)”

236) On 2nd April 2012, TX1 phoned Adult A. The notes contained within the Child File document;

“Phoned Adult A, she seemed much more positive today. Money advice man booked a longer meeting with her this Thursday 5th plus he has booked her in on the same day to see a solicitor at (REDACTED) Centre Ltd. She said he has also discussed housing with her so she feels that everything is moving in the right direction.
Adult A said that her ex-partner Adult B has told her he is going to be moving his ex-girlfriend and two children in the flat once Adult A moves out. He spent yesterday (Sunday) with C1 and Adult A found out that he had also spent it with his ex-partner which Adult A was upset about as she has never met her and wants to protect C1. Adult A said that she had kept (REDACTED) Centre’s Easter Programme and will be coming along to some of the sessions. I told her I was leaving the Centre but somebody would call her on Thursday to see how she gets on and that (REDACTED) will continue to support her (TX1 2nd April 2012)”

237) TX1 was temporarily employed by the Children’s Centre and this ended in April 2012. Before TX1 left the Children’s Centre there was a formal handover between TX1 and TX2 (Children’s Centre Leader) on 2nd April 2012. At this meeting a decision was made to record TX1’s previous conversations with Adult A in a family file. TX2 agreed to contact Adult A on Thursday 5th April 2012. TX2 did contact Adult A as agreed but there was no answer (Adult A had been murdered the previous evening).

238) At no point during her involvement with the Children’s Centres did Adult A disclose that she felt unsafe or give any indication there were incidents of harm or domestic abuse. At no point did Adult A disclose concerns for C1’s safety or wellbeing either.

Analysis of contact with Early Years Services

239) Based on the number of visits Adult A made to the Children’s Centre for antenatal care and postnatal sessions, a reader could assume that Adult A enjoyed the activities offered at the Children’s Centre and trusted TX1 enough to discuss her concerns openly with her. This is testament to TX1’s professionalism and the value of universal early year’s services.

240) Although Adult A had been accessing the Children’s Centre for almost two years prior to her death, it was not until the 23rd March 2012 (some two weeks prior to her homicide) that she disclosed to TX1 that she was suffering from
‘domestic disharmony’ and that this was causing stress at home.

241) The timing of the disclosure could indicate that Adult A was becoming more desperate for help as the expiry on the lease drew nearer, however, case records also suggest that Adult A discussed her concerns with TX1 on previous occasions (e.g. “Adult A has previously told me that she felt quite low when her daughter (C1) was a baby” and “I had mentioned money and housing advice in the past”); which may indicate a longer period of disharmony between the couple - though there is no evidence that these concerns were recorded or acted upon.

242) The IMR Author observed that TX1 did not activate safeguarding procedures due to Adult A not making a direct disclosure of harm or abuse. Whilst it is accurate that Adult A did not make a full disclosure, she did discuss her low mood, her perceived isolation (limited family support, housing concerns and financial issues), and her feelings of helplessness and of being threatened. Whilst it is commendable that TX1 sourced practical solutions for Adult A’s immediate problems around housing and financial advice, her support did not extend to exploring the underlying causes.

243) With the benefit of hindsight Adult A should have been offered level 2/3 support following a formal assessment, and a CAF meeting should have been initiated by the Children’s Centre. The Panel acknowledges that Adult A may have declined a CAF, as this is a consensual process, however, her proactive efforts to seek advice and attended appointments at the time suggests that she may have welcomed an enhanced level of support.

244) In addition to a CAF, further exploration of the cause of Adult A’s increasing anxiety should have prompted a DASH risk assessment, particularly in relation to her initial disclosures of feeling verbally threatened. It is possible that a formal risk assessment would have exposed other behaviours and afforded Adult A the opportunity to discuss her experiences in a safe and trusting environment, however, given Adult A’s past experiences with statutory agencies, this may

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4 Domestic Abuse, Stalking & Harassment & Honour-based Violence Risk Assessment
never have been an option, and conversely could have forced Adult A to retreat further from support (See Children’s Social Care conclusions).

245) Without the benefit of a formal risk assessment TX1 reacted to the situation in good faith and within the limits of her knowledge and the level of her responsibility at the time. Unfortunately though her actions were well intentioned, they held the risk of escalating matters further (e.g. Separation increases the risk of homicide with women and children more likely to be killed by a partner/ex-partner AFTER they leave the relationship\(^5\)). Providing Adult A with the means to escape the relationship was not a sole solution to her situation. There is every chance that the risk to Adult A would have intensified at the point of her finding new housing for herself and C1\(^6\).

246) Equally the threats made by Adult B to take C1 away from Adult A failed to raise alarm bells for TX1, her manager TX2 and the Financial Advisor (see REDACTED Centre Ltd IMR). Initiation of contact proceedings is often a means used by abusive partners to continue harassment and control over their partner and child.\(^7\) Although TX1 was not able to elaborate on the context of the threats within the relationship, it is possible that Adult B was using C1 as a form of ‘emotional property’ to further punish or harass Adult A and not a genuine expression of a commitment to C1’s future wellbeing.

247) C1 was almost 21 months old at the time of her mother’s death, and living in a potentially stressful environment. There is a possibility that she was witnessing her parents’ conflict (750,000 children per year witness domestic abuse\(^8\) with 90% of children being in the same room or next room\(^9\)) or picking up on her mother’s anxiety. The dispute over custody was certainly a stressor for the family and appeared, in part, to be a cause for the pressing escalation. With adult

\(^5\) (Wilson and Daly, 1993; Wilson, Johnson and Daly, 1995; Browne, Williams and Dutton, 1999).
\(^6\) (Kurtz, 1996; Wilson, Johnson and Daly, 1995; Mahoney and Williams, 1998).
\(^7\) (Radford et al, 1997; Harrison, 2008; Thiara 2010; Thiara & Gill, 2012).
\(^8\) Department of Health (2002)
\(^9\) Hughes, 1992
domestic abuse known to have a physiological and physical impact on children\textsuperscript{10}, the needs of C1 should have been a consideration.

248) It is surprising that neither TX1 nor TX2 considered the welfare of C1 when facilitating support, particularly as they worked in Early Years Services and were well versed in child safeguarding principles. It is possible that they prioritised what they considered to be the most pressing issue at the time, but crucially, they missed indicators of domestic abuse and its link with child abuse; which the IMR Author speculates was probably due to a lack of specific domestic abuse training. Had they suspected domestic abuse, it is highly probable that further discussions would have taken place between TX1 and TX2 with an entirely different response sanctioned in line with the company’s safeguarding policies.

249) It is important to note that at the time of the homicide there was no local and/or citywide Domestic Abuse Guidance for Practitioners. Though material existed about domestic abuse there was no overarching document that combined the information to communicate a cohesive guide for Practitioners to reference. The absence of a citywide protocol at the time of Adult A’s homicide resulted in a sporadic response to Domestic Abuse support with many agencies approaching presenting issues in different ways. TX1 undoubtedly did what she thought was best for Adult A at the time, within her knowledge of what was available in the local community.

250) In some respects, taking into account her knowledge at the time, TX1 went above and beyond what was required of her and her responsibilities when responding to Adult A’s concerns. Adult A and C1 accessed level 1 universal services open to all members of the general public. This categorisation process meant that the TX1 was under no obligation to discuss Adult A’s concerns with Managers at the Children’s Centre, yet TX1 did ensure that she discussed the family with TX2 on the 2\textsuperscript{nd} April 2012, as part of her exit interview. Although it was not a requirement to keep personalised records on families accessing level 1 services, TX1 did record conversations, albeit it retrospectively, to assist with an

\textsuperscript{10} Women’s Aid 2009, Barnardos, Anderson and Templeton 2012)
effective handover. These notes were subsequently very useful to the criminal justice investigation.

251) It is impossible to know whether a different level of intervention would have produced a different outcome in this case. The Panel cannot second guess how Adult A would have responded to more ‘probing’ questions or whether she would have agreed to enhanced support. What can be concluded is that there were missed opportunities and gaps in knowledge that meant that other options were never offered. The actions taken carried risks in the absence of appropriate safety planning and inadvertently this escalated the risk of significant harm to Adult A.

Conclusions

252) The Individual Management Review for Early Years Services identified some areas of good practice and a number of areas for improvement as a result of an in-depth analysis of the Children’s Centre’s involvement with Adult A. These issues apply to all Children’s Centre’s across Plymouth. The areas of improvement relate to;

a) A specific guidance/reference tool for Practitioners

b) Training around Domestic Abuse

c) The role of Universal Services

d) Policy for referring for level 2/3 support/CAF

e) Ante Natal Information and Guidance

f) Company Domestic Abuse Policy

g) Record Keeping for Level 1 services

h) Listening to Children
253) Over the course of the past two years, many of the areas of improvement identified by the Early Years Services have been addressed by the Review Panel in an effort to respond immediately to early lessons learnt. The narrative below outlines the changes agreed to prevent similar tragedies happening again in the future and whether these changes have been implemented or remain outstanding;

**Practitioner Guidance/Reference Tool**

254) Since Adult A’s homicide in April 2012, there have been a number of significant changes within Children’s Centre practice. Children’s Centres have always worked with families experiencing domestic abuse however often in isolation, without coordination or a reference tool. With the introduction of the City Wide Early Intervention and Prevention Strategy (2012-2014) Children’s Centre are now commissioned to work with complex families. As a consequence they are more involved in Domestic Abuse work, alongside specialist support agencies. Plymouth now has an active Domestic Abuse Partnership and this has been charged with developing a citywide strategy to tackle this growing issue. A best practice guidance document has been produced in conjunction with a commissioned programme of training, and this is embedded within the new domestic abuse policy for all Children’ Centres in Plymouth.

**Domestic Abuse Training**

255) It appears that TX1 did not receive any Domestic Abuse or DASH risk assessment training prior to working with Adult A and C1. In addition TX1 did not receive any case load supervision with her managers, as the family were not considered to be an open Level 2/3 case. This meant that TX1 was effectively left accountable for her own decisions and actions, leaving her very vulnerable as a worker, especially given the outcome in this case.

256) Plymouth City Council has since made a commitment to ensure group workers within all Children’s Centre’s have access to a commissioned programme of domestic abuse and DASH training (8 x 2 day courses delivered during 2013/14). This training has resulted in there being at least 3 workers
within each centre available to undertake a DASH Risk Assessment and refer to MARAC\(^{11}\) or Plymouth Domestic Abuse Service if necessary.

257) Staff have also accessed Plymouth Safeguarding Children’s Board safeguarding training and will continue to attend as appropriate for Continued Professional Development (CPD).

The Role of Universal Services

258) This review has shown that universal activities are ideally placed to identify emerging needs within the families accessing them. Many parents build trusting relationships with workers during the course of their child’s development, and as such, it is not surprising that they disclose personal information about relationships within universal settings. To ensure that opportunities are not missed to help parents and children who make tentative steps to seek help, the Early Years’ Service has made a commitment to ensure Level 1 workers know how to identify subtle signs and respond to concerns effectively.

259) As a result of this homicide the Children’s Centre has developed a procedure for asking all families about domestic abuse (even if it is not disclosed). The routine question “do you feel safe?” has been implemented as part of day–to-day discussions with families. It is hoped that the question will encourage and/or invite adults and children to talk openly about safety concerns, personal fears or anxieties, however trivial they may seem. In doing this, the Children’s Centre’s wishes to reduce the stigma associated with domestic abuse and encourage open dialogue.

260) With a high turnover of staff operating within Early Years’ Services, it is imperative that this initiative and the knowledge contained within Level 1 universal services, does not suffer ‘slippage’ as workers move on or transfer between Centres. The Panel would welcome a regular audit of training for Workers in Universal Services to ensure that the lessons from this Domestic Homicide Review are not lost in the mists of time.

\(^{11}\) Multi Agency Risk Assessment Conference (MARAC)
Policy for referring to Level 2/3 Support

261) The Children’s Centre Policy at the time of the homicide stated that families could only receive enhanced support (level 2/3) if they were referred by another agency or if requested by the family specifically. Consequently Adult A was not offered enhanced support, including a CAF\(^{12}\), because she did not know how to request this and nobody within the Centre recognised the significance of the information they held. In light of this Domestic Homicide Review this policy was revised.

262) Children’s Centres have since developed a pathway for families to progress or de-escalate between universal (Level 1) and enhanced (Level 2/3) support.

Ante Natal Information and Guidance

263) Adult A attended ante-natal services and classes. She also attended a session about relationships and post natal depression. This programme was redesigned in line with The Department of Education’s best practice guidance, Preparation for Birth and Beyond (2011).

264) The redesign was a prime opportunity to ensure that all attendees receive advice and information on healthy relationships. In 2013 Plymouth City Council commissioned a training programme for the facilitators to be trained on domestic abuse and the DASH risk assessment so that they can recognise the signs of abuse and respond to disclosures from participants.

265) The whole ante-natal course is now designed to have a consistent keyworker present at all sessions to encourage positive working relationships with women (and their partners) to aid the early identification of potential relationship difficulties or domestic abuse.

\(^{12}\) Common Assessment Framework - [http://www.plymouth.gov.uk/commonassessmentframework](http://www.plymouth.gov.uk/commonassessmentframework)
Company Domestic Abuse Policy

266) Although the Children's Centre had robust systems in place for safeguarding and supervision at the time of the homicide, they did not have a specific domestic abuse policy. Domestic Abuse was referenced in section 3 (.2) of the Child Protection and Safeguarding Policy but as domestic abuse was not suspected in this case (nor child abuse for that matter) TX1 did not refer to the policy documents.

267) The Domestic Abuse Best Practice Guidance has since been embedded into a new policy and has been disseminated to ALL Plymouth Children's Centres. Training to support the guidance document has been rolled out to ensure that theory is also applied to practice.

268) Adult A’s death highlighted a gap in the support offered to staff in the event of a death (homicide). In response, bereavement guidelines for staff have also been developed and implemented within the new Domestic Abuse Policy.

Record Keeping for Level 1 Services

269) This Domestic Homicide Review identified that it is not routine practice or a requirement to record conversations or concerns for level 1 service users. To ensure that there is evidence of concerns being raised and actions being followed up, the Children’s Centre has introduced a ‘One Off Support Form’ to record single conversations, incidents or observations within Children’s Centre’s and specifically level 1 universal services. The form is designed to be used as a tool for highlighting minor concerns to managers. This documentation is monitored and used to record actions and decisions, and ascertain if an official referral is required.

270) Safeguarding is now a standard item on every supervision agenda across all Centres which provides a further opportunity for staff to discuss any niggles or interaction with families that they want to explore further (reflective practice).
271) A new electronic case management system has also been introduced which enables workers to place an alert on specific case files to flag suspected or known domestic abuse relationships or households. The system is an improvement on the existing database as it now provides an option to add narrative and recorded actions and decisions.

Listening to Children

272) Although C1 was still under two years old at the time of her mothers’ death, Early Years Workers were ideally placed to work with, listen and to hear what C1 was experiencing. Other serious case reviews have highlighted the importance of talking and listening to the needs of children in these situations and claim that children need a chance to tell their side of the story too (Cantrill 2011).

273) In light of this review, the Panel recommends that ‘Listen to Children’ techniques are built into all processes involving adults. Although children are considered within the DASH Risk Assessment process, it is not a risk assessment for children per se. Children Centre Staff will still need to observe children to identify change, spot emerging issues and raise concerns through existing safeguarding channels.

Overall Conclusions from Early Years IMR

274) The Children’s Centre and specifically TX1 worked proactively to support Adult A and facilitate the support she needed. There is some evidence to suggest that this support was successful in making Adult A feel more positive about the future\(^\text{13}\). At a time when Adult A seemed to be becoming more desperate and anxious, it is reassuring to know that she trusted a Professional and took steps to share her concerns and seek help. This highlights the unique position that universal community services play in providing an environment in which to identify early indications of domestic abuse.

275) As such, it is regrettable that TX1 was not trained to identify signs of domestic abuse and therefore missed opportunities to discuss safety plans and the

\(^{13}\) Phone call from TX1 to Adult A on the 2\(^{\text{nd}}\) April 2012 - “she seemed much more positive today”
importance of a cautious and well-managed exit strategy.

276) Without this specialist training TX1 referred Adult A, with good intentions, to a similar universal service for people with generic finance issues. Unfortunately this service did not suspect economic abuse or domestic abuse either; which meant that important safety advice, such as not telling Adult B about the pending appointments with the Solicitor and Finance Advisor, was not shared with Adult A.

277) It is not known for sure if Adult A told Adult B about her appointment with the family Solicitor (Scheduled for the 5th April 2012), or if this had any connection with her homicide on the evening of the 4th April 2012. It was certainly a counter-move on Adult A’s part which had the potential to exacerbate Adult B’s desperate need to control the situation. In a cruel twist of fate, it is possible that the very actions Adult A took to distance herself from Adult B; became the catalyst for her murder.\(^\text{14}\)

278) In light of the learning from Adult A’s homicide, The Early Years’ Service has since reviewed all of its policies and procedures, and made modifications to improve practice. Their efforts to improve systems evidences the willingness of Children’s Centre’s to truly foster a learning ethos and to ensure that families are better safeguarded in future.

279) If a person were to present again today in any Children’s Centre throughout Plymouth, staff would be much more knowledgeable, aware and able to discuss a person’s safety; identify and assess the level of risk, and refer to appropriate domestic abuse services if necessary.

\(^{14}\) 76% of all domestic homicides occur after the relationship has ended (Metropolitan Police 2003)
(REDACTED) CENTRE LTD. Individual Management Review

280) (REDACTED) Centre Ltd is a Plymouth based local charity that manages a range of projects funded by local and national funding streams. Its projects serve to enhance the social, emotional and economic well-being of local communities by providing choice and opportunity to individuals, across a diverse range of people including children, young people and their families.

281) The IMR Author for (REDACTED) Centre Ltd is a Safeguarding Officer with over 15 years’ experience in a support or training role.

282) The IMR Author undertook an analysis of the documentation and notes relating to Adult A and reviewed the charity’s policies and procedures. An interview with the worker (RW2) involved with Adult A was not possible initially as RW2 was a witness for the Prosecution. On completion of the second trial, RW2 was interviewed by the senior management team at (REDACTED) Centre Ltd to identify further information and respond to key questions raised by the DHR Panel.

Summary of Involvement with (REDACTED) Centre Ltd.

283) RW2’s first contact with Adult A took place on the 2nd April 2012. The appointment was arranged by (REDACTED) Children’s Centre.

284) At the time (REDACTED) Centre Ltd conducted benefit advice sessions at the Children’s Centre as an Outreach Service. Staff at the Children’s Centre would arrange a list of people to attend using a standard booking form. (REDACTED) Centre Ltd was not given a list of clients prior to the day nor any background information.

285) Each referral was allocated a 20 minute appointment. Appointments were booked consecutively with no breaks. If it transpired that more time was needed,
a follow-up appointment at (REDACTED) Centre Ltd was routinely offered to continue or complete the discussions/work.

286) The purpose of the Outreach Service was to help clients identify any benefits they may be entitled to and to help apply for them. RW2 undertook benefit calculations and provided information and support with maternity grants and allowances, child tax credits and child benefit, working tax credit and housing benefit advice.

287) The first meeting took place in a small interview room at the Children’s Centre. The initial interview with Adult A took approximately 10 minutes. She was accompanied by C1 who was playing happily with a toy during the conversation and showed no signs of distress or upset or cause for concern. RW2 was not made aware of any concerns or worries about Adult A that, in hindsight, may have been known by the referring agency.

288) Adult A explained to RW2 that she had separated from her partner, although they were still living under the same roof whilst she arranged accommodation. She wished to discuss her benefit entitlement so she could rent a home for her and C1. RW2 started to complete an Enquiry Form with Adult A, however, it became clear there would not be enough time to complete the work as it would involve terminating current claims and making new claims as a single person. RW2 suggested, as was normal practice, to schedule a longer meeting at (REDACTED Centre Ltd.). RW2 agreed to call Adult A later that afternoon when he had access to his diary to arrange a meeting to conduct a more detailed review. Adult A agreed to this.

289) Before leaving RW2, Adult A stated she was worried that Adult B would seek custody of their baby C1. RW2 suggested that Adult A took advantage of a free legal session with a solicitor at (REDACTED) Centre Ltd. RW2 informed Adult A that the Family Information Service was delivered in partnership with a local solicitor’s firm and offered free family legal advice including separation,
cohabitation disputes and child contact issues. Adult A agreed and RW2 arranged to contact Adult A later that day to confirm both appointments.

290) As promised RW2 contacted Adult A later that day with proposals for back-to-back appointments with the Solicitor and RW2 on the 5th April 2012.

291) Adult A was murdered on the evening of 4th April 2012 and did not attend the scheduled appointments.

**Analysis of contact with (REDACTED) Centre Ltd.**

292) As part of the Individual Management Review into the contact (REDACTED) Centre had with Adult A days before her homicide, RW2 was asked if, with the benefit of hindsight and with the level of experience and knowledge he has now, if he would have done anything differently or if any of the information given by Adult A would have made him act/think differently.

293) RW2 stated that he had thought about this often and still does, but was clear that Adult A did nothing or said nothing during that very short meeting to give cause for concern about safety or abuse. Adult A did not stress the urgency of an appointment with a solicitor. The appointment was made quickly simply because there were times available in the calendars.

294) It is important to remember that this was a very brief 10 minute outreach appointment with a focus on benefit advice as per the request received by the Children’s Centre. RW2 was not party to any preceding discussions or information held by TX1 (referring professional) prior to the meeting. If Adult A had discussed verbal threats or concerns about her ex-partner with TX1, these were not shared with RW2.

295) The Tax Credit Enquiry Form completed by RW2 on the 2nd April 2012 was part-complete, verifying that the appointment was halted midway through discussions, pending further work. A hand-written footnote at the bottom of the
form states “Call for an appointment” and “Solicitor”. It is worth noting that, in the absence of detailed records of discussions, RW2 was being asked by the Panel and his Senior Management Team to recollect a 10-minute discussion with Adult A that had occurred two years earlier.

296) It is possible that RW2 would have been able to gain more information at the extended meeting scheduled for the 5th April 2012, and that he would have initiated further explorative dialogue if Adult A had expanded on previous discussions or indicated deterioration in the situation.

297) That said; RW2 had not received any domestic abuse training at the time. Although he was conversant with safeguarding principles and knew how to escalate concerns and refer to appropriate services, he was not au fait with high risk indicators of domestic abuse and serious harm; of which separation and child contact disputes are of concern.

298) Furthermore, (REDACTED) Centre Ltd did not have a bespoke Domestic Abuse Policy as a reference point if RW2 had wanted to escalate concerns at the time. This would have been beneficial given that (REDACTED) Centre Ltd offered services that could invite disclosures of abuse e.g. Legal Advice for Domestic Abuse.

Conclusions

299) The Individual Management Review from (REDACTED) Centre Ltd raises the question of whether it is realistic, even today, to expect a worker in universal services, without dedicated domestic abuse training, to identify a subliminal intimation of abuse, within a 10 minute window of opportunity, and with no prior information from partner organisations.

300) Whilst with hindsight it seems like a missed opportunity by RW2 to ask simple welfare questions, such as ‘How are you feeling about the separation? Is
everything okay? It must be difficult living in the same house with your ex-partner, how is that working out?’ – These questions would only have been effective if RW2 knew what he was looking for (high risk factors) and what to do with the information if it was forthcoming (proceed to DASH Risk Assessment). As it was, RW2 did not explore further and Adult A did not elaborate. Consequently, the conversation was formal and solution-focussed.

301) It is difficult to establish the significance of the pending appointments on Adult A’s homicide. The timing could be an unfortunate coincidence, or, her efforts to seek professional advice could have been an aggravating factor. As it is not known if Adult A told Adult B about her appointment with a solicitor, the Panel cannot speculate on whether safety advice could have protected her or changed the outcome.

302) Since Adult A’s Homicide, the Senior Management Team have attended Domestic Abuse and DASH Risk Assessment Training and cascaded this learning to its workforce. The DASH Risk Assessment has been embedded into a new Domestic Abuse Policy and all employees are now conversant with high risk factors of domestic abuse and where to signpost for support.

303) These improvements will undoubtedly increase the awareness of domestic abuse within (REDACTED) Centre Ltd and focus workers to be more vigilant of indirect disclosures of potential economic and domestic abuse in future. However, it is work in progress for universal services in general and unless there is a concerted effort to increase the knowledge of workers in universal services, there is every chance that a similar case presented today, will be met with the same enthusiastic and well intentioned support, but without the necessarily understanding of risk or the vital safety considerations.
PLYMOUTH HOSPITALS NHS TRUST - Individual Management Review

304) The IMR Author is the Named Nurse for Safeguarding Children and has been in post for 6 years. She has previous experience in Health Visiting and Emergency Nursing. The IMR Author carried out a detailed review of the electronic and paper hospital records for Adult A, Adult B and C1. She also undertook a review of policies and procedures alongside an informal interview with a Senior Midwife to clarify the process.

305) IMPORTANT NOTE: The IMR Author requested permission to include information on Adult A that rests outside of the scope of the review. The information relates to Adult A’s childhood and notes pertaining to neglect and mistreatment. The Independent Chair has included a brief synopsis of this information for the purpose of exploring Adult A’s previous experience of statutory agencies. The Review Panel thought it important to establish if Adult A’s childhood experience had any bearing on her trust of professional relationships in adulthood, and whether this could have presented as a barrier to reporting domestic abuse as an adult.

Summary of Involvement

306) Plymouth Hospitals NHS Trust was involved with Adult A for a number of years from 1989 through to the birth of C1 in 2010.

307) In 1991 Adult A (age 3 years) underwent an examination by a Paediatrician due to allegations of abuse and neglect. An emergency protection order was put in place.

308) In 1995 Adult A was once again admitted to hospital as a result of non-accidental injuries.
309) In 1996 Adult A was the subject of a 6-month period of intensive CAMHS involvement. Records state that Adult A (then 7 years old) was a ‘quiet, passive and co-operative little girl who would respond to her mothers’ distress by being quiet and tearful. She often took a parental role in reference to her siblings’. 

310) Hospital records state that Adult A spent a period of time on the Child Protection Register and a significant time in Local Authority Care due to Adult A’s mothers’ inability to meet her needs. It is documented that Adult A felt frightened of the abuse she witnessed and experienced in the family home but did not tell her mother in an attempt to protect her. Adult A was described as ‘an adult child’ often taking on a caring role for her mother and younger siblings.

311) No further input from hospital services are recorded until Adult A booked in for her own pregnancy in 2010. C1 was born by emergency caesarean section on (REDACTED) 2010.

312) There is nothing documented in the notes to suggest Domestic Abuse was discussed or considered during Adult A’s pregnancy related admission.

Adult B

313) There are no records pertaining to Adult B for the period outlined within the scope of this review.

Child C1

314) There are no records for C1 apart from her birth records.

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Child and Adolescent Mental Health Services
Analysis of Contact

315) Although the hospital records do not hold comprehensive notes about Adult A’s childhood experience at home with her family, there is evidence that she witnessed domestic abuse and felt responsible for protecting her mother and her siblings, despite being a young child herself.

316) Research has evidenced that exposure to domestic abuse as a young child can increase the likelihood of the cycle of violence continuing when the child reaches adulthood. Essentially the child learns that violence; threats and aggression are viable means of resolving interpersonal conflicts and therefore becomes more accepting of this behaviour when faced with similar situations as an adult\textsuperscript{16}.

317) It is possible that Adult A’s childhood exposure to domestic abuse had an impact on how she viewed her relationship with Adult B and her reluctance to report his abusive, threatening and aggressive behaviour to statutory authorities. Her experience of being compulsorily removed from her family as a child could have increased her apprehension to involve professionals as an adult, which would have increased her sense of isolation and helplessness.

318) This is covered in further detail in Plymouth Children’s Services Individual Management Review.

319) In relation to Adult A’s antenatal records for C1, there does not appear to be any evidence of Adult A being asked about Domestic Abuse as per Plymouth Hospital’s NHS Trust Ante Natal Guidelines, which states;

\begin{itemize}
  \item \textquoteleft Routine enquiry should be made about domestic abuse, either when taking a social history at booking or at another opportune point during a woman’s antenatal period. Routine enquiry involves asking all pregnant women a direct question regarding domestic abuse whether or not it is suspected\textquoteleft.
\end{itemize}

\textsuperscript{16} Kwong et al (2003)
320) The IMR Author has indicated that the question may have been asked but not recorded. The process for documenting the outcome of routine enquiry was not required at the time.

321) Without knowing whether the question was asked or not, it is difficult for the Panel to conclude on whether this was a missed opportunity to enquire or identify domestic abuse during Adult A’s antenatal care.

Conclusions

322) The absence of any recorded concerns would indicate that Adult A never made any disclosure of domestic abuse or presented to antenatal services in such a way as to raise concerns. Nevertheless, the Review Panel would welcome an update of the policy for recording ‘routine domestic abuse questions’ to ensure that Midwifery Staff document the date and outcome of the routine question.
PLYMOUTH COMMUNITY HEALTHCARE – Individual Management Review

323) Plymouth Community Healthcare provide community, physical and mental healthcare to around 270,000 people in Plymouth as well as some specialist services for those living in Devon and Cornwall.

324) Plymouth Community Healthcare CIC officially formed on 1st October 2011 as an independent health services provider, separate to the commissioning organisation, NHS Plymouth. It works as part of the NHS family in a similar way to GP’s, Dentists and Pharmacies.

325) The IMR Author for Plymouth Community Healthcare is a qualified Nurse and Health Visitor. Since 2009, the IMR Author has been the named Nurse for Child Protection with responsibility for promoting good professional practice within Plymouth Community Healthcare.

Methodology used to undertake IMR

326) The IMR Author for Plymouth Community Healthcare reviewed C1’s electronic and paper child health records containing health assessments and records of contact with C1, Adult A, Adult B and Professionals.

327) Plymouth Community Healthcare Policies, procedures and documentation pertaining to the Health Visiting Service were also reviewed in relation to this case.

Summary of Involvement

328) The Health Visiting Service received notification of C1’s birth on (REDACTED) 2010 by emergency caesarean section from Maternity Services.

329) A review of the records indicates that both parents engaged with the Health Visiting Service. Between August 2010 and January 2012 there were seven contacts with the family recorded. Five of these contacts were home visits and
one contact was at the local Children’s Centre. Adult A and Adult B were both present at two of these contacts.

330) On 11/08/10 a Health Visitor (HV1) undertook a Child and Family Health Needs Assessment and recorded that ‘Adult A and Adult B were first time parents who were emotionally responsive to C1, were in a stable relationship, were both employed and were able to meet their child’s needs’. The Health Visitor recorded that she did not ask the routine domestic abuse question\textsuperscript{17} during the assessment as Adult B was present. It is recorded that the parents had the support of family members and friends who lived locally. The outcome of the assessment was that the family would be offered an enhanced health visiting service due to the prematurity of C1 as per Healthy Child Programme (2009). There is no evidence of historical information that could have been used to inform the assessment.

331) As part of the enhanced Health Visiting Service, C1’s development was reassessed in January 2011 and August 2011. The outcomes of the assessments were that C1’s growth and development was age appropriate. It is recorded that the Health Visitor asked Adult A the routine domestic abuse question at C1’s developmental assessment in August 2011. No concerns were raised.

332) It was observed during the assessment (August 2011) that C1’s parents were providing emotional warmth and good basic care for C1 and as no risk factors were identified, the family were offered Universal Health Visiting Services.

333) On 27/01/12 a Community Public Health Nurse (CPHN2) liaised with a Children’s Centre Worker who stated that Adult A and C1 attended the “Stay and Play” sessions at the Centre and Adult A had informed her that she had recently separated from her partner. Adult A was reported to be feeling low in mood. CPHN2 suggested that the Children’s Centre Worker contact Adult A and encourage her to access more activities at the Centre.

334) The contacts (mentioned above) are the only interactions Plymouth Community Healthcare had with Adult A, C1 and Adult B. At no point during the visits or assessments did HV1 or CPHN2 suspect abuse or consider Adult A or

\textsuperscript{17} as per Plymouth Community Healthcare Domestic Violence Routine Enquiry Guidance
C1 to be at risk. Adult A did not raise any concerns nor did she indicate domestic abuse when asked specifically about it by HV1 in August 2011.

**Analysis of Contact**

335) The Practitioners from the Health Visiting Service were sensitive to the needs of the family and knowledgeable about potential indicators of domestic abuse. The Child and family Health Needs Assessment incorporated consideration of parenting capacity, child’s health and developmental needs and family and environmental factors. The needs of C1 were considered within the context of the family. The Health Visitor and Community Public Health Nurse were competent in their ability to assess actual or potential risk factors based on their observations during contact with the family and information available to them. The routine domestic abuse question was asked as per Plymouth Community Healthcare policy and procedure (introduced into Health Visiting Practice in 2010).

336) The Practitioners were compliant with mandatory training requirements which included safeguarding children, safeguarding adults and domestic abuse awareness training as part of the Health Visiting Service core skills requirements.

337) There is evidence of good information sharing between the Health Visitor (HV1) and the New-born Screening Co-ordinator and between the Community Public Health Nurse (CPHN2) and the Children’s Centre Worker (27/01/12) to ensure the needs of C1 and the family were considered.

338) C1 was not subject to a child protection plan and there were no welfare concerns documented within the child’s health record.

339) There was no information contained in C1’s health records to indicate whether Adult A or Adult B had been subject to a child protection plan or care order in the past.

340) Outcomes of assessment and reassessments were recorded clearly and concisely within the child health records in compliance with health visiting standards and Plymouth Community Healthcare’s record keeping policy.
Conclusions

341) Plymouth Community Healthcare, and specifically HV1, was the only Professional to specifically ask Adult A about Domestic Abuse. This provides the Panel with an indication that Adult A was not experiencing domestic abuse in August 2011 or, alternatively, that she did not view her relationship as abusive or that she did not wish to disclose it.

342) The Panel enquired further about the precise domestic abuse question raised by HV1 and was told that the recording policy at the time did not require staff to document which question was asked. The Panel was informed that routine enquiry could be anything from an indirect question such as “Is everything alright at home?” to a more direct question such as “Have you ever been slapped, kicked or punched by your partner?” A list of the 10 questions HV1 could have asked was provided to the Panel and has been attached at Appendix B: ‘Plymouth Community Healthcare Domestic Violence Routine Enquiry Guidance’

343) Without knowing what specific question was asked by HV1, the Panel is unable to establish whether the enquiry was direct or indirect. In future it would be good practice for all healthcare staff to document which domestic abuse question was asked and the answer given.

344) There was perhaps one further opportunity for CPHN2 to refer to the Plymouth Healthcare Domestic Violence Routine Enquiry Guidance on the 27/01/2012 when the Children’s Centre Worker informed CPHN2 that Adult A was low in mood after a relationship breakdown. Although the invite to attend more activities was well-intentioned and aimed at improving her mood, the introduction of routine domestic abuse question may have teased out further dialogue about the relationship breakdown, Adult A’s fears and worries, and the context of the threats being made by Adult B at the time.

345) The Chair has observed that the Guidance produced by Plymouth Community Healthcare does not require Professionals to refer to routine enquiry outside of specific review/assessment periods. For example, the Guidance states;
a) Routine Enquiry Questions should be asked at the following:-

i) Primary Assessment - New Birth visits

ii) 6-12 month review

iii) 2- 2.5 year review

346) Whilst it could be assumed that Professionals such as Health Visitors and Community Public Health Nurses are competent to introduce routine enquiry outside of these times, Plymouth Community Healthcare may wish to consider a reference to the application of professional judgement to reduce the potential for the Guidance to be taken literally.
PLYMOUTH CHILDREN’S SOCIAL CARE – Individual Management Review

347) The IMR Author on behalf of Plymouth Children’s Social Care qualified as a Social Worker in 1995 and has held Senior Management Positions since 2000.

348) The decision to include historical information held by Plymouth Children’s Social Care (outside of the scope of this review) was taken by the Panel in the spirit of thoroughness, and to determine whether Adult A’s experience of Statutory agencies as a child may have influenced her perception and trust of professional agencies as an adult.

349) This section has been included with the aim of establishing whether;

a) Adult A’s childhood experiences of family life may have had an impact on how she viewed domestic abuse as an adult;

b) Whether these experiences may have made her more vulnerable or accepting of domestic abuse as an adult;

c) Whether Adult A’s confidence in statutory services (as a result of her childhood experiences) may have influenced her trust in Professionals and thus presented a barrier to reporting domestic abuse as an adult.

Summary of Involvement

350) Children’s Social Care Files for Adult A indicate parenting concerns stretching back three generations. Adult A was the first child of a young mother, who had herself been subject to physical abuse in childhood.

351) Concerns regarding neglect of Adult A were identified from birth, prompting six years of family centre involvement. A Child Protection Case Conference was held in 1991, following concerns about neglect of Adult A’s younger sister. This child was unwell and remained in hospital after her birth. Although staff were concerned about the mother’s lack of visiting this conference led to no further action. A Place of Safety Order was obtained in May 1991, after Adult A’s mother
forcefully smacked Adult A in front of a family support worker and left her and her
sister unattended in the property. The children had some abrasions but the
paediatric examination was inconclusive & the children were returned home.

352) Adult A and her siblings were placed on the Child Protection Register under
the category of neglect for two years. There were two further reports of bruising in
1994. In February 1995 significant bruising and burns were found on Adult A’s
younger siblings and Adult A was found to be under nourished. The children were
removed from their mother’s care and Care Orders were obtained.

353) Two residential assessments followed. During the first assessment, significant
problems were identified with the mother’s anger and parenting, however, Adult A
showed more distress (than the younger children) at being separated from her
mother and was returned home under Placement with Parents Regulations.

354) After a six month delay, psychological assessment and therapeutic input
commenced which including individual work with Adult A. In 1997 Adult A’s
mother applied to discharge the Care Orders as she now had a new partner and
had moved to a property in better condition.

355) A second residential assessment was undertaken which was more positive
and all three children were returned home as a result; initially under a
Supervision Order for Adult A. After a period of family support and respite foster
care, the children appeared to do well and the case was closed in April 2000,
when Adult A was 12 years old.

Adult B

356) Adult B was not known to Children’s Social Care.

C1

357) In this case there was no involvement with C1 prior to the death of her
mother, Adult A. Following Adult A’s homicide and Adult B’s arrest; Children’s
Social Care undertook a brief assessment of C1’s wellbeing, given that she had
been temporarily placed with paternal grand-parents under a family arrangement.
The assessment established that the paternal grandparents were able to protect C1 and were willing to secure C1’s long term future in their care. As no safeguarding issues were outstanding Children’s Social Care closed the case for this family in May 2012.

Analysis of Contact

Historical records relating to Adult A as a child indicate that she was involved with Children’s Social Care for most of the first 12 years of her life. This included a 2-year period on the Child Protection Register following a Place of Safety Order and a period of several years where she was subject to Care Order (initially accommodated in care) before being allowed to return home under Placement with Parents Regulations and a Supervision Order.

Thresholds for dealing with chronic neglect are different in current practice. It is likely that in similar circumstances today, Adult A’s early years would have been subject to more robust assessment and scrutiny, including pre-birth assessments of her mother’s subsequent pregnancies.

There is limited evidence of ongoing assessments regarding the first period of Child Protection Registration. Given that Adult A was named on the Child Protection Register for two years, this would not be acceptable today. A similar case presenting in 2014 would be subject to more quality assurance and professional challenge from the Independent Chair.

The case appears to have escalated appropriately through the legal processes once a referral was received for non-accidental injuries found on the younger children, however, there appears to have been some drift/delay, particularly in accessing psychological input, thereafter. Child and Adolescent Mental Health Services have restructured and changed provider since this time and again the enhanced role of the Independent Reviewing Officer, together with the timescales imposed by the Family Justice Review, mean that this would be subject to greater challenge and scrutiny today.

The assessments undertaken by the Residential Care Home appear to be of good standard and the plan to return home was accompanied with a
comprehensive and appropriate support package. Adult A’s mother adhered to the plan and significantly improved her parenting. With no further indications of safeguarding concerns the case was appropriately closed after a period of monitoring.

364) Adult A’s childhood history exposed her to physical harm, verbal aggression, and some emotional dependency issues with her mother. With hindsight, it is possible to conjecture that this history might have left Adult A psychologically vulnerable to a controlling or abusive partner in adulthood, however, there were no indications from the records to suggest that opportunities were missed to intervene or prevent this.

Conclusions

365) Several studies have revealed that children who witness domestic abuse are more likely to be affected by violence as adults – either as victims or perpetrators. Although Plymouth Children’s Social Care did not receive a direct referral for domestic abuse, Adult A told Health Professionals that she was too afraid to tell her mother about the abuse she witnessed as a child (see hospital records above).

366) If Adult A did witness domestic violence or maternal abuse as a child, it is possible that she learnt early and powerful lessons about the use of violence in interpersonal relationships. Unless these negative experiences were neutralised with positive experiences and healthy role models whilst growing up, it is conceivable that Adult A became ‘hardwired’ to accept abusive behaviour as a conventional way to respond to conflict.

367) Adult A was also described by Health Professionals as ‘The adult child in the family…caring for mum and younger siblings’ (see 310). This is an important


factor for Adult A as research shows that children who grow up with abuse in the home often mature faster than the average child. They take on household responsibilities such as cooking, cleaning, and caring for younger children. As a result of these responsibilities children, like Adult A, become socially isolated and unable to participate in activities that are normal for a child of their age; consequently they are at greater risk of becoming involved in turbulent relationships as adults because of their isolation and limited experience of forming successful, healthy relationships.

368) There is no doubt that Adult A showed remarkable resilience whilst growing up, and we must be careful to not assume that her dysfunctional childhood automatically made her more vulnerable to abusive relationships as an adult. To the contrary, her attempts to leave the relationship signify a resistance to such abuse. That said, Adult A’s childhood may have had a long lasting influence on her self-esteem which would have been belittled further by Adult B’s emotional abuse and deeply personal attacks on her appearance, competence and character.

369) Whether Adult A’s childhood experiences of Children’s Social Care influenced her perception of professional agencies and how they would respond to a plea of help, is impossible to establish without speculation. Records show that Adult A was undoubtedly stressed and upset by the separation from her mother when taken in to care as a child – so much so, that she was returned. This deeply distressing experience could have formed a negative memory for Adult A whereby the separation was viewed as a form of punishment rather than as an act of protection.

370) Due to her own childhood experiences, Adult A would have been aware of the powers Children’s Social Care hold to intervene in the lives of individuals and families, generally with consent but compulsorily if necessary. Adult A may have been deterred from reporting domestic abuse or concerns about Adult B’s escalating behaviour due to fears that it could have resulted in professional

22 Finkelhor, 2008.
judgements about her ability to cope independently or care adequately for her daughter.

371) It would not be unreasonable, given Adult A’s experience with professionals as a child, to hypothesise that ‘trust’ may have been a factor in her not reporting concerns or actual incidents of assault to statutory services. Whether more could have been done to improve her perceptions of statutory services is speculative and would have depended, in part, to her ‘testing’ them as an adult. It is reassuring to know that Adult A was starting to trust professionals and that the universal services she was accessing were starting to respond to her needs, offer support and gain her trust, to a point where, with a bit more time, Adult A may have disclosed more.
SECTION FIVE: OVERALL CONCLUSIONS

SECTION FIVE: CONCLUSIONS

372) The content of this section will address the case specific Terms of Reference identified in Section One of this Overview Report (11) to 20) above). To reduce repetition in answering the issues raised some terms of reference have been combined.

373) The overall conclusions summarise the main findings of the Individual Management Reviews. Principle lessons identified from this DHR focus on what, if anything should have been done differently and changes required today to prevent a similar tragedy happening again.

374) The final sections will record all recommendations about what actions are required by individual agencies to address the findings of this review. The Panel has also made recommendations regarding any implications for national policy arising from the case.

TOR CONCLUSIONS

Were family, friends, key workers or colleagues (including employers) aware of any abusive or concerning behaviour from the perpetrator to the victim (or other persons), prior to the homicide?

375) Approximately 25 family, friends and co-workers were individually aware of the breakdown in the relationship between Adult A and Adult B, and some were aware of coercive behaviours and tactics exhibited by Adult B.

376) No concerns or reports of domestic abuse were ever raised by worried friends or co-workers. This may be attributed to them not interpreting the coercive behaviour as ‘domestic abuse’ or simply not relating to the seriousness of the
abuse due to the way in which information was relayed by both Adult A (who was unaware of the escalating risk) and Adult B (who deflected, justified and disguised his controlling behaviour with humour, concern or charm).

377) Adult A appears to have communicated extracts of her concerns about Adult B to a number of acquaintances but no one individual seemed to be aware of the full extent of the escalating behaviour. Only when these ‘snippets’ of information were retrospectively pieced together during the course of the criminal investigation, did the cumulative risk of her situation emerge.

378) After the relationship ended Adult B embarked on a crusade to discredit Adult A as a promiscuous person and a bad mother. He often sought to solicit sympathy from family, friends and co-workers for the apparent wrong-doings of Adult A. This tactic was deployed to taint the views of others into believing that Adult A was somehow responsible for Adult B’s behaviour and that he was justified in his actions and frustrations.

379) This Domestic Homicide Review has identified the need to increase public awareness of the complex nature of domestic abuse and the accumulative impact of coercive and controlling behaviours. Whilst Adult B demonstrated very common tactics of a dominant domestic abuse perpetrator, his manipulative behaviours went unchallenged insofar as family and friends did not perceive him to be a threat, nor Adult A to be a victim.

380) Was the incident in which Adult A died a ‘one off’ or was there any warning signs that would indicate that more could have been done to protect her?

381) Were there any barriers experienced by the family/friends/colleagues in reporting any abuse or concerns in Plymouth or elsewhere?

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23 E6 witness statement: He recalled Adult B saying “I’m being made to look a fool”.
In hindsight it is now apparent that Adult A was being emotionally, verbally, physically and economically abused by Adult B. He was known to be controlling and jealous. He regulated her friendships, criticised her clothes and degraded her privately and publicly with disparaging remarks. He discredited her as a mother and withheld financial support to limit her means of leaving (making her more isolated). He monitored her movements, her phone contacts and her social media accounts. He feigned concern in order to glean further information from unwitting acquaintances, which he used to continue his harassment and intimidation. Finally, when the relationship ended, Adult B turned to the only means left to control and frighten Adult A; child contact. He threatened to take C1 and to obtain a full residency order, prohibiting Adult A’s contact with their daughter. When Adult A took steps to resist this threat, and sought the help of a family Solicitor, Adult B turned to murder.

Sadly Adult A’s homicide was not a ‘one-off’. On the contrary, her experiences are an all-to-familiar occurrence for thousands of victims of coercive and controlling domestic abuse, in the UK today.

The controlling and obsessive behaviour exhibited by Adult B was not atypical of common tactics used by abusers to dominate and control partners. A growing body of research suggests that the presence and level of control in this relationship was an indicator of the violence to come, and in this case, fatal violence.

On that basis, the extent to which more could have been done to protect Adult A is somewhat dependent on society’s understanding of ‘coercive control’ – not just as an expression but as a set of multiple tactics and behaviours used to target and restrict one’s liberty.

The friends and co-workers of Adult A and Adult B were unable to distinguish between individual acts and a pattern of dominating tactics employed to intimidate, monitor, isolate and regulate Adult A. Taken on their own, many of the

coercive and controlling tactics used by Adult B were interpreted as a sign of a “bad relationship”.

387) Unless there is a greater effort locally (and nationally) to explain ‘coercive control’ and communicate examples of behaviours that victims, friends, families and co-workers can detect, relate and respond to, there is every chance that this type of domestic abuse will go undetected and unchallenged, by professionals and the general public, leaving victims, like Adult A, vulnerable and without appropriate support.

**Did the victim, family, friends, neighbours or co-workers know how to report domestic abuse had they wanted to?**

388) The Panel cannot speculate on whether family, friends and co-workers knew how to report domestic abuse had they wanted to. It is likely that they would have dialled 999 in an emergency, however some of Adult B’s discussions, actions and threats were deemed seemingly trivial incidents (when viewed in isolation) therefore it is unlikely that they would have met the threshold of ‘an emergency’.

389) Even Adult B’s threats to kill Adult A on the day that of her homicide, were not taken seriously by work colleagues, who either dismissed the remarks as ‘matelot humour’ or did not consider Adult B capable of murder. Had these threats been reported to the police, they may have had the opportunity to establish if Adult B intended for Adult A to fear the threat would be carried out. It would be entirely speculative to predict the outcome of such discussions at the time, or if the crime would have resulted in prosecution or a referral to specialist services.

390) However, as these threats were made in the workplace, it would be advisable for Plymouth Community Safety Partnership to establish if this particular employer had a domestic abuse policy or knew how to raise concerns had they wanted to. This homicide demonstrates the importance of domestic abuse being taken seriously in the workplace and the need to raise awareness of local domestic abuse services within the private sector.
391) Whilst Plymouth has a well-established Domestic Abuse Service which has been operating since the 1980’s, longevity is not a guarantee of familiarity. It is entirely possible that large, corporate employers do not know how to escalate concerns or raise a referral to local specialist services. An audit of ‘awareness within the private sector’ would reveal how much work is still left to do in this area.

Were there any opportunities for Professionals to enquire or raise concerns about domestic abuse in the household?

392) From the information available, there was no evidence of any professional agency outside of the Children’s Centre and (REDACTED) Services Ltd having any information to suggest that Adult A was a victim of domestic abuse. Adult A nor Adult B were known to the Police or local Police Community Support Officers, who had a very active presence in the area, at the time.

393) As stipulated within the IMR conclusions for the Children’s Centre and (REDACTED) Services Ltd, opportunities were missed to enquire further about the context of threats being made in relation to C1. Although the professionals involved each acted with good intentions, and responded to the presenting needs; a lack of training around coercive control meant that warning signs of possible domestic abuse were missed.

394) This oversight has been addressed in part by the roll-out of specific domestic abuse training to all Children’s Centres across Plymouth and the Manager’s at (Redacted) Services Ltd.
Did the perpetrator have any previous concerning conduct or a history of abusive behaviour and was this known to any agencies?

395) Adult B had a minor police history for incidents relating to criminal damage, theft and assault. Each received a caution or no further action. All of these incidents occurred outside of the scope of this review.

396) During court proceedings, the prosecution did raise an assault which took place in 2002 and involved Adult B grabbing a female friend by the arm and pushing her to the floor before punching her once in the face. The victim did not wish to prosecute and Adult B was given a warning.

397) No other agency, contacted by the Chair during the course of this DHR, held information to suggest Adult B had a history of concerning behaviour.

Were there opportunities for agency intervention in relation to the perpetrator (e.g. drug/alcohol/mental health issues or child protection arrangements) that were missed?

398) From the information available to agencies at the time, there were no opportunities for agency intervention in relation to the perpetrator.

Could more be done to raise awareness of services available to victims and perpetrators of domestic violence?

399) This domestic homicide review has highlighted the need for further awareness around the definition and explanation of ‘coercive control’. Adult B displayed all the hallmarks of a dominating, controlling, desperate and obsessive individual who manipulated, monitored and harassed Adult A – yet these behaviours were never interpreted by family, friends, co-workers, or even Adult A, as domestic abuse.
400) Although the definition of domestic abuse was updated in March 2013 to include ‘any incident or pattern of incidents of controlling, coercive, threatening behaviour...” work is still required to encourage victims (or concerned friends and relatives) to identify and report a ‘pattern of incidents’ to Police, especially when a ‘pattern of behaviours’ is not explicitly recognised as a crime within relationships (in the same way as physical acts of violence) and may appear seemingly non-violent and covert.

401) With population data such as the British Crime Survey likely to be dominated by reports of “situational couple violence”, due to its focus on incidents of ‘crime’, Community Safety Partnerships are going to need to consider how they are going to reach and educate victims of “intimate terrorism” or “coercive control” within intimate relationships; whereby the abuse is ongoing over a long period of time and is made up of a multitude of tactics aimed to subordinate, humiliate, intimidate, frighten and isolate victims.

402) Whilst 24hour services exist in Plymouth for male and female victims of (all forms of) domestic abuse, the issue is not one of accessibility but one of understanding and interpretation. To encourage more victims like Adult A to seek help through specialist channels, they must first acknowledge and understand that the behaviours they are experiencing are abusive, potentially dangerous and unacceptable. When victims do then report, the judicial and community response must be effectual in holding perpetrators to account; otherwise reporting ‘coercive control’ may become far more dangerous for victims of intimate terrorism (due to the consequences imposed by the abuser).

Was there any evidence that Adult A or Adult B were directly or indirectly discriminated against by any agency based on the nine protected characteristics of people who use services under the Equality Act 2010 e.g. age, disability, gender reassignment, marriage and civil partnership,

27 Professor Johnson, M. 2008 “Typologies of Domestic Violence”
pregnancy and maternity, race, religion and belief, sex and sexual orientation?

403) There is no evidence to suggest that Adult A or Adult B were discriminated against based on the nine protected characteristics of the Equality Act 2010.

Are there any training requirements necessary to ensure a greater knowledge and understanding of domestic abuse processes and / or services in the city?

404) The Panel identified training requirements early in the review and acted immediately to address training needs through a commissioned programme of training. Since the homicide of Adult A in 2012, domestic abuse, stalking and harassment and honour based violence training has been delivered to key personnel in all Children’s Centre’s throughout Plymouth. Attendees included Manager’s, Nursery staff, Key Workers and Pre-School Workers.

405) Multi-agency training days were also organised and were attended by (Redacted) Services Ltd, Drug & Alcohol Services, The Sexual Assault Referral Centre, Devon and Cornwall Probation Trust, Advice and Assessment (Children’s Social Care), Housing Options and The Families with a Future Initiative.

406) Although training has been delivered to address the learning from this review, it is vital that professionals keep abreast of changing legislation and best practice guidelines by refreshing knowledge and skills through continued professional development.
SECTION SIX: LESSONS IDENTIFIED

What lessons have been identified from the domestic homicide regarding the way in which local Professionals and organisations worked or work, individually and together to safeguard victims?

407) This section will summarise the key lessons identified from this Domestic Homicide Review (DHR). The number in Column One is the reference to the paragraph(s) within the main body of the report that describes the issue in full. The number in Column Six is a reference to the corresponding recommendation (if applicable) within Section 7.

28 The Chair has chosen to avoid the term ‘lesson learnt’. Lessons cannot be learnt until they are acted upon.
### Table: Lessons Identified

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<tr>
<td><strong>Para.</strong></td>
<td><strong>LESSON IDENTIFIED</strong></td>
<td>What changes are required to practice, policies and procedures?</td>
<td>What needs to change in order to reduce the risk of the incident happening again in the future?</td>
<td><strong>Rec.</strong></td>
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<td><strong>Ref</strong></td>
<td><strong>Conclusions</strong></td>
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<td><strong>Rec 1</strong></td>
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**Employers need to be more aware and responsive to signs of Domestic Abuse in the workplace.**

Adult A’s previous employer suspected domestic abuse on witnessing physical injuries but did not report concerns or

With a third of all domestic homicides occurring on workplace grounds[^29] and a proportion of our national workforce making up either victims, perpetrators or witnesses to domestic abuse[^30] it is imperative that employers know how to identify and respond to disclosures, suspicions or incidents of domestic

Very few public and private sector organisations have a specific domestic abuse policy. With domestic abuse being associated to presenteeism and absenteeism, the workplace can be a place of safety or threat. To respond appropriately to employees who are potentially victims, witnesses or perpetrators, it is imperative that we progress towards mandatory domestic


| Friends and co-workers | Non-violent coercive and controlling patterns of abuse were not recognised as ‘domestic abuse’ by Adult A, friends, work-colleagues or universal services. Although Adult B displayed all the hallmarks of a dominating, controlling, desperate and abusive. Unless the local domestic abuse strategy for Plymouth includes a public awareness campaign to explain ‘coercive control’ and communicate examples of behaviours that victims, friends, families and co-workers can detect, relate and respond to, there is every chance that this type of domestic abuse will go unchallenged, leaving perpetrators undetected and abuse policies within the workplace. Unless further awareness raising activity is delivered within the wider community, there is an ongoing risk that victims and perpetrators of coercive, controlling domestic abuse will continue to be undetected. If statutory agencies wish to encourage self-reporting or public reporting of domestic abuse, a fresh effort must be made to ensure the general public and universal services. |
| Rec 2 |
| Analysis |
| (205) to (218) |
| Conclusions |
| (384) to (387) and (399) to |

Adult B’s employer did not act on Adult B’s escalating frustration or the threats he made to kill Adult A. Work colleagues did not link Adult B’s threats to kill with discussions on whether a particular workplace implement would be capable of killing someone. (This implement was subsequently stolen from the workplace and is the suspected murder weapon). Domestic Abuse policies and protocols in the workplace would mitigate the corporate risk and increase the safety, health and wellbeing of victims, and the accountability and management of perpetrators. In the absence of a dedicated Domestic Abuse Policy, domestic abuse in the workplace should be incorporated into wider health and safety and/or HR employee welfare policies. Charter marks similar to those associated to CHAS, ISO or other Health and Safety or Quality accreditations, would encourage employees to adopt domestic abuse policies, especially if accreditations had a positive impact on contract awards, insurance policies or industry accolades.
| Early Years IMR 258) | Universal Services are in a unique position to respond to early indicators of domestic abuse, however, workers within universal settings are not routinely trained to identify and | The Plymouth Domestic Abuse Strategy for 2014 to 2019 should include a plan for the roll out of DASH training for other relevant Universal Services such as GP Surgeries, Emergency Services and | Because of the unique role Universal Services play in the early identification of domestic abuse, specialist DASH training should be prioritised for an appropriate ratio of staff (per setting). |

| 402) Error! Reference source not found. | obsessive individual; friends and co-workers were unable to demarcate between individual acts and a pattern of coercive and controlling behaviours designed to manipulate, intimidate, isolate, regulate and harass Adult A. | victims vulnerable and unsupported. The Plymouth Strategic Partnership will need to consider how they reach and educate victims of “intimate terrorism” aka coercive control” whereby the abuse is ongoing over a long period of time and is made up of a multitude of tactics aimed to subordinate, humiliate, intimidate, frighten and isolate victims. As these cases are unlikely to show in reported crime figures, Plymouth Community Safety Partnership will need to consider how the prevalence of domestic abuse, and specifically coercive control in Plymouth, will be measured. | have the education and knowledge to identify the signs of domestic abuse and understand the nature of non-violent patterns of coercive and controlling behaviour. A new specific crime of ‘domestic abuse’ is required to explicitly recognise dominating, coercive controlling behaviours within intimate relationships. Criminal law must recognise patterns of continuing acts that incite fear and entrap victims rather than the narrow focus on prosecuting individual incidents (which do not portray the true restraints on one’s liberty). |

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31 Domestic Abuse, Stalking & Harassment and Honour Based Violence Risk Assessment
| Early Years IMR 273) | **respond to warning signs.** | Schools.  
An appropriate ratio of DASH trained staff should be agreed to ensure that Universal Services have appropriate internal and/or external systems for risk assessment and management. |
|---|---|---|

There is an ongoing risk of the 'voice of the child' being overlooked by professionals when responding to the immediate, presenting needs of adults/parents.  
Although children are considered within the DASH Risk Assessment process, it is not a risk assessment for children per se.  
The impact on the child should be considered, especially where there is a perpetrator of continuing, coercive and [Note: The table is incomplete, additional content is missing or not properly formatted.]  

‘Listen to Children’ techniques should be built into all processes involving adults.  
The Plymouth Domestic Abuse Strategy (2014-2019) should outline a clear process for all agencies to observe children, identify change, spot emerging issues and raise concerns through existing safeguarding channels, if appropriate.  

Ofsted’s analysis of 67 Serious Case Reviews which highlighted the importance of the ‘voice of the child’ as a reoccurring theme should be cross referenced with the DHR Process and IMR Authors should be encouraged to provide an analysis of professional consideration to the ‘voice of the child’, when applicable.  

Rec 4
| **Plymouth Hospitals NHS Trust**<br>**319)**<br>**Plymouth Community Healthcare**<br>**342)** | **There is a need for Health Visitors, Midwives and any other Healthcare Professional (conducting routine questioning) to record within clinical records the specific domestic abuse question asked, and the response received.**<br>Although the Health Visiting and Midwifery Service each purported to have asked Adult A ‘the routine domestic abuse question’, neither agency could evidence the specific question asked. | **A new policy should be implemented within Plymouth Hospitals NHS Trust and Plymouth Community Healthcare to explicitly require Midwives and Health Visitors to record, within clinical records;**<br>a) When and how many times the question about domestic abuse was asked;<br>b) What the specific question was;<br>c) the response received (verbatim if possible). | **All agencies operating a routine questioning policy for the identification of domestic abuse should ensure that recording principles are explicitly stated to evidence compliance within clinical records/case files.** | **Rec 5** |
If a similar case presented today, could we expect a different outcome?

409) This Domestic Homicide Review has identified lessons and areas of improvement for our coordinated response to patterns of coercive and controlling behaviours. Although the Panel cannot speculate on whether the outcome would have been different if these challenges had of been addressed differently at the time, the Panel can consider the likeliness of a similar outcome if a comparable case presented today.

410) To answer this question, the Panel focused on the principle lessons of the case and asked whether future or current victims are more vulnerable as a result;

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<th>Question</th>
<th>Answer</th>
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<tr>
<td>If domestic abuse is not recognised within the workplace, is there a risk that victims and perpetrators of incidents or patterns of incidents of controlling, coercive, threatening behaviour, violence or abuse will be missed by managers and co-workers?</td>
<td>Yes</td>
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<td>Is there a chance that employers will not know how to identify, and respond appropriately to disclosures, incidents or suspicions of domestic abuse if policies and protocols are not in place?</td>
<td>Yes</td>
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<td>If the current definition of domestic abuse is not explained and communicated for a wider audience, is there a risk that the general public will not relate patterns of (non-violent) controlling and coercive behaviour (aimed at subordinating and frightening victims) with the term ‘domestic abuse’?</td>
<td>Yes</td>
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<tr>
<td>Are victims of coercive and controlling abuse at more risk due to the law not explicitly recognising entrapment and liberty-reducing subordination within intimate relationships, as a crime?</td>
<td>Yes</td>
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<tr>
<td>Is there a risk that victims of coercive and controlling tactics will not report domestic abuse if they feel that the law (as it currently stands) will be unable to protect them?</td>
<td>Yes</td>
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Given the answers to the above questions, the Panel conclude that a similar case presenting today could result in the same tragic consequences.
SECTION SEVEN: RECOMMENDATIONS

This Domestic Homicide Review has identified a number of recommendations for local and national practice. For ease of reading, the recommendations have been separated into the following headings;

- Plymouth Recommendations
- National Recommendations

PLYMOUTH RECOMMENDATIONS (1 - 5)

RECOMMENDATION 1: Plymouth Community Safety Partnership should liaise with the Plymouth Chamber of Commerce and the Business Health Network to raise awareness of domestic abuse in the workplace and to encourage more corporate employers to adopt a dedicated domestic abuse policy.

Addressing Recommendation 1; Action 1

RECOMMENDATION 2: Plymouth Community Safety Partnership should lead on a public perception campaign to raise awareness of domestic abuse in its varying forms, with a specific focus on high risk coercive and controlling tactics (that are measured by the degree of entrapment rather than the severity of individual incidents).

Addressing Recommendation 2; Action 2

RECOMMENDATION 3: The Plymouth Domestic Abuse Strategy (2014 to 2019) should include a plan on how to improve awareness of domestic abuse and DASH within Universal Services in Plymouth (such as GP Surgeries, Emergency Services

32 Recommendations are linked to actions (to achieve the recommendations) – See SMART Action Plan
34 Domestic Abuse, Stalking & Harassment and Honour Based Violence Risk Assessment
and Schools) to ensure opportunities are not missed to respond appropriately to early warning signs and/or subtle disclosures.

Addressing Recommendation 3; Action 3

RECOMMENDATION 4: The Plymouth Domestic Abuse Strategy (2014-2019) should outline a clear process for all agencies to observe and listen to ‘the voice of the child’ within all adult processes. Professionals should be encouraged to act on early signs of change or emerging concerns through existing safeguarding channels, as appropriate.

Addressing Recommendation 4; Action 4

RECOMMENDATION 5: Plymouth Hospitals NHS Trust and Plymouth Community Healthcare should provide assurances to the Plymouth Strategic Domestic Abuse Partnership of the application of new policies explicitly requesting Midwives and Health Visitors to record routine domestic abuse questions and answers within clinical records.

Addressing Recommendation 5; Action 5

NATIONAL RECOMMENDATIONS (6)

RECOMMENDATION 6a: The Government should review the effectiveness of the law (as it currently stands) to respond to ongoing coercion and control within intimate relationships and the powers of police to act on concerns of high risk coercive and controlling abuse (measured by the degree of entrapment and subordination).

RECOMMENDATION 6b: If the law does not currently protect victims from (or hold perpetrators to account for) all forms of domestic abuse, as per the cross Government definition (2013), the law should be reformed to ensure powers exist to

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Note: Plymouth Community Safety Partnership cannot implement an action plan on behalf of the Government.
protect victims, and prosecute perpetrators, of high risk continuing coercive and controlling abuse.
SECTION EIGHT

SMART ACTION PLAN

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<tr>
<td>1.</td>
<td>Plymouth Community Safety Partnership should liaise with the Plymouth Chamber of Commerce and the Business Health Network to raise awareness of domestic abuse in the workplace and to encourage more corporate employers to adopt a dedicated domestic abuse policy.</td>
<td>Audit the current numbers of businesses (registered with the chamber of commerce) with a dedicated domestic abuse policy and aim to increase the number of businesses by 5% year on year.</td>
<td>The Partnership Crime Reduction Officer with responsibility for Domestic Abuse to liaise with the Chamber of Commerce and the Business Health Network to agree a strategy for implementation.</td>
<td>The Partnership Crime Reduction Officer with responsibility for Domestic Abuse will be satisfied that the timescale and targets are achievable at an operational level.</td>
<td>The Partnership Crime Reduction Officer with responsibility for Domestic Abuse will share the lessons from this review with Plymouth Strategic Domestic Abuse Partnership by December 2014 and report quarterly updates on the take up of new businesses with a dedicated domestic abuse policy from</td>
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36 The dates suggested within the SMART Action plan are based on the principle that the Home Office will approve the report by December 2014. Dates may be subject to change if the Home Office is unable to approve the report by the December 2014.
<table>
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<th>Plymouth Community Safety Partnership should lead on a public perception campaign to raise awareness of domestic abuse in its varying forms, with a specific focus on high risk coercive and controlling tactics (that are measured by the degree of entrapment rather than the severity of individual incidents).</th>
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<td>2.</td>
<td>Create a communication strategy to raise public awareness of the definition of coercive and controlling behaviours as per the cross government definition of domestic abuse (2013).</td>
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<td>Year on year aim to increase the number of self or police reported incidents of coercive and controlling patterns of domestic abuse.</td>
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<td>Record annual figures from 2015 – 2019.</td>
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<td>The Partnership Crime Reduction Officer with responsibility for Domestic Abuse will lead discussions with The Strategic Domestic Abuse Partnership to devise a strategy for raising awareness of coercive and controlling abuse.</td>
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<td>The public awareness campaign will need to be realistic in its desired outcomes for 2015-2019. Any marketing and communication campaign to increase public confidence takes time to build awareness and achieve desired results.</td>
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<td>Prioritise and agree outcomes for the Communication Strategy by March 2015.</td>
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<td>Share Communication Strategy with the Strategic Domestic Abuse Partnership by end of April 2015.</td>
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<td>Identify budgets or sources of funding to support the awareness raising campaigns - ongoing 2015-2019.</td>
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<td>Start implementation of public awareness campaign within timescales set for each objective.</td>
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<td>3.</td>
<td>The Plymouth Domestic Abuse Strategy (2014 to 2019) should include a plan on how to improve awareness</td>
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<td>When the Domestic Abuse Strategy is reviewed in 2014, a</td>
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<td>The Partnership Crime Reduction Officer with responsibility for</td>
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<td>The Strategic Domestic Abuse Partnership to decide on the</td>
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<td>The Plymouth Domestic Abuse Strategy to include a</td>
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March 2015.
4. **The Plymouth Domestic Abuse Strategy (2014-2019) should outline a clear process for all agencies to observe and listen to ‘the voice of the child’ within all adult domestic abuse processes. Professionals should be encouraged to act on early signs of change or emerging concerns through existing safeguarding channels, as appropriate.**

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<tr>
<th>Specific Plan</th>
<th>Action</th>
<th>Responsible Parties</th>
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<tr>
<td>Specific plan should be included to increase the number of relevant Universal Services in Plymouth with an appropriate ratio of DASH trained staff.</td>
<td>Domestic Abuse to raise this as an agenda item at the next Strategic Domestic Abuse Partnership Meeting.</td>
<td>The Strategic Domestic Abuse Partnership to agree a DASH training programme for the said organisations and an appropriate referral pathway for risk management.</td>
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<tr>
<td>Appropriate ratio of DASH trained staff per organisation (dependent of staff numbers). The Strategic Domestic Abuse Partnership to agree a DASH training programme for the said organisations and an appropriate referral pathway for risk management.</td>
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5. **Plymouth Hospitals NHS Trust and Plymouth Community Healthcare should provide assurances to the Plymouth Strategic Domestic Abuse Partnership of the application of new policies explicitly requesting Midwives and Health Visitors to record routine domestic abuse questions and answers within clinical records across the organisations.**

| **5.** | **Plymouth Hospitals NHS Trust and Plymouth Community Healthcare should provide assurances to the Plymouth Strategic Domestic Abuse Partnership of the application of new policies explicitly requesting Midwives and Health Visitors to record routine domestic abuse questions and answers within clinical records across the organisations.** | **The Policies for routine questioning should be reviewed and implemented by December 2014 across Plymouth Hospital NHS Trust Midwifery Services and Plymouth Community Healthcare Health Visiting Service.** | **An annual dip-sample audit should be introduced to quality assure compliance and standards.** | **The Integrated Safeguarding Lead for Children and Adults should lead the policy review, implementation and quality assurance audit on behalf of Plymouth Community Healthcare.** | **The Named Nurse for Safeguarding Adults and Children should lead the policy review, implementation and quality assurance audit on behalf of Plymouth Hospitals NHS Trust.** | **The Policy for asking routine questions around domestic abuse should explicitly require Midwives and Health Visitors to record;**

a) When and how many times the question about domestic abuse was asked;

b) What the specific question was;

c) The response received (verbatim if possible).** | **Assurances of Policy review to be fed back to the Strategic Domestic Abuse Partnership by January 2015.**

An Annual Quality Assurance Report of compliance and standards should be presented to the Domestic Abuse Strategic Partnership every January thereafter. |
## APPENDIX A: FULL CHRONOLOGY OF AGENCY CONTACT

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<thead>
<tr>
<th>Date</th>
<th>Agency</th>
<th>Contact with or by Adult A or B</th>
<th>Contact with the Child/Family (specify)</th>
<th>Communication - (identify if within agency or to another agency)</th>
<th>Actions taken/decisions made</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>06/02/2007</td>
<td>PHNT</td>
<td>Adult A</td>
<td>Gastroenterology</td>
<td></td>
<td></td>
<td>Outpatient Appointment</td>
</tr>
<tr>
<td>18/09/2007</td>
<td>PHNT</td>
<td>Adult A</td>
<td>Gastroenterology</td>
<td></td>
<td></td>
<td>Outpatient Appointment</td>
</tr>
<tr>
<td>11/02/2010</td>
<td>PHNT</td>
<td>Adult A</td>
<td>Obstetrics</td>
<td></td>
<td></td>
<td>Antenatal Clinic</td>
</tr>
<tr>
<td>31/03/2010</td>
<td>PHNT</td>
<td>Adult A</td>
<td>Ultrasound</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17/05/2010</td>
<td>PCC</td>
<td>Adult A</td>
<td>N/A</td>
<td>Ante-natal appointment with midwife</td>
<td>Records held with the Midwifery Service</td>
<td>N/A</td>
</tr>
<tr>
<td>07/06/2010</td>
<td>PCC</td>
<td>Adult A</td>
<td>N/A</td>
<td>Ante-natal appointment</td>
<td>Records held with the Midwifery Service</td>
<td>N/A</td>
</tr>
<tr>
<td>Date</td>
<td>Ref</td>
<td>Patient</td>
<td>Type</td>
<td>Description</td>
<td>Records held with service</td>
<td>Information on attendance only</td>
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<tr>
<td>11/06/2010</td>
<td>PHNT</td>
<td>Adult A</td>
<td>Ultrasound</td>
<td></td>
<td></td>
<td>Information on attendance only</td>
</tr>
<tr>
<td>14/06/2010</td>
<td>PCC</td>
<td>Adult A</td>
<td>N/A</td>
<td>Ante-natal appointment with midwife</td>
<td>Records held with the Midwifery Service</td>
<td>N/A</td>
</tr>
<tr>
<td>21/06/2010</td>
<td>PCC</td>
<td>Adult A</td>
<td>N/A</td>
<td>Ante-natal appointment with midwife</td>
<td>Records held with the Midwifery Service</td>
<td>Information on attendance only</td>
</tr>
<tr>
<td>28/06/2010</td>
<td>PCC</td>
<td>Adult A</td>
<td>N/A</td>
<td>Attendance at the Great Expectations Course emotional support and relationships</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>05/07/2010</td>
<td>PCC</td>
<td>Adult A</td>
<td>N/A</td>
<td>Attendance at the Great Expectations Course emotional</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Date</td>
<td>Organisation</td>
<td>Position</td>
<td>Subject</td>
<td>Notes</td>
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</tr>
<tr>
<td>12/07/2010</td>
<td>PHNT</td>
<td>Adult A Obstetrician</td>
<td>Urinary Tract Infection during pregnancy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15/07/2010</td>
<td>PHNT</td>
<td>Adult A Obstetrician and Surgeon</td>
<td>Pregnancy related disorders</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>(REDACTED) 2010</td>
<td>PHNT</td>
<td>Adult A Labour</td>
<td>Delivery of Child C by caesarean section</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No date stamp on receipt of letter</td>
<td>PCH</td>
<td>Health visiting team received NICU discharge summary letter dated (REDACTED) 2010</td>
<td>C1 born prematurely at 36+2 weeks gestation by emergency caesarean section.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No date stamp on receipt of letter</td>
<td>PCH</td>
<td>Health visiting service received Midwifery discharge form dated</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>Time</td>
<td>Type</td>
<td>Description</td>
<td></td>
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</tr>
<tr>
<td>10/08/2010</td>
<td>PCH</td>
<td>HV1</td>
<td>HV1 left telephone message for Adult A. Home visit planned for 11/08/10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11/08/2010</td>
<td>PCH</td>
<td>HV1</td>
<td>Home visit by HV1 C1, Adult A and Adult B present. Adult A reported good postnatal recovery. No disclosure of depression. Not asked about domestic abuse as partner present. No concerns identified</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>C1’s health assessment completed. HV assessment: C1’s basic care needs met by parents. Emotionally warm and responsive parents who are in a stable relationship. Bottle feeding, receiving treatment for oral thrush. Family living in ground floor, 2 bedroom maisonette, both parents working, support from family locally.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>HV plan: For enhanced health visiting service due to risk factors associated with C1’s prematurity</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Robust assessment Unable to ask domestic abuse question</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Date</td>
<td>Organisation</td>
<td>Person</td>
<td>Child</td>
<td>Activity</td>
<td>Notes</td>
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<td></td>
</tr>
<tr>
<td>18/08/2010</td>
<td>PCH</td>
<td></td>
<td>C1</td>
<td>Home visit by HV1. C1 and Adult A present. C1 continues to feed well.</td>
<td>Management of constipation discussed. Good growth recorded. Unsettled at times but Adult A observed to be very patient with C1.</td>
<td></td>
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<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>HV plan: For enhanced health visiting service as assessed</td>
<td></td>
</tr>
<tr>
<td>06/09/2010</td>
<td>REDACTED Children’s Centre</td>
<td>Adult A</td>
<td>Child C1</td>
<td>Attendance at Chatterbox (Stop and play health clinic)</td>
<td>Possible record in Health Care records (Health Visiting)</td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>May have just attended the stay and play and not seen a health practitioner</td>
<td></td>
</tr>
<tr>
<td>13/09/2010</td>
<td>REDACTED Children’s Centre</td>
<td>Adult A</td>
<td>Child C1</td>
<td>Attendance at Chatterbox (Stop and play health clinic)</td>
<td>Possible record in Health Care records (Health Visiting)</td>
<td></td>
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<td>May have just attended the stay and play and not seen a health practitioner</td>
<td></td>
</tr>
<tr>
<td>20/09/2010</td>
<td>REDACTED Children’s Centre</td>
<td>Adult A</td>
<td>Child C1</td>
<td>Attendance at Chatterbox (Stop and play health clinic)</td>
<td>Possible record in Health Care records (Health Visiting)</td>
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<td>May have just attended the stay and play and not seen a health practitioner</td>
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<tr>
<td>Date</td>
<td>Location</td>
<td>Name</td>
<td>Action</td>
<td>Note</td>
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<tr>
<td>24/09/2010</td>
<td>PCH</td>
<td></td>
<td>Telephone liaison with new-born screening co-ordinator. Test incomplete</td>
<td>New-born screening co-ordinator to contact Adult A. Good interagency communication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27/09/2010</td>
<td>REDACTED Children’s Centre</td>
<td>Adult A</td>
<td>Attendance at Chatterbox (Stop and play health clinic)</td>
<td>Possible record in Health Care records (Health Visiting). May have just attended the stay and play and not seen a health practitioner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>04/10/2010</td>
<td>REDACTED Children’s Centre</td>
<td>Adult A</td>
<td>Attendance at Chatterbox (Stop and play health clinic)</td>
<td>Possible record in Health Care records (Health Visiting). May have just attended the stay and play and not seen a health practitioner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11/10/2010</td>
<td>REDACTED Children’s Centre</td>
<td>Adult A</td>
<td>Attendance at Chatterbox (Stop and play health clinic)</td>
<td>Possible record in Health Care records (Health Visiting). May have just attended the stay and play and not seen a health practitioner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11/10/2010</td>
<td>PCH</td>
<td></td>
<td>Telephone liaison with new-born screening co-ordinator. Test incomplete</td>
<td>HV plan: To contact parents to follow up whether screening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>Location</td>
<td>Adult</td>
<td>Child</td>
<td>Activity Details</td>
<td>Possible Record in Health Care records</td>
<td>Notes</td>
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<tr>
<td>18/10/2010</td>
<td>REDACTED Children’s Centre</td>
<td>Adult A</td>
<td>Child C1</td>
<td>Attendance at Chatterbox (Stop and play health clinic)</td>
<td>Possible record in Health Care records (Health Visiting)</td>
<td>May have just attended the stay and play and not seen a health practitioner</td>
</tr>
<tr>
<td>25/10/2010</td>
<td>REDACTED Children’s Centre</td>
<td>Adult A</td>
<td>Child C1</td>
<td>Attendance at Chatterbox (Stop and play health clinic)</td>
<td>Possible record in Health Care records (Health Visiting)</td>
<td>May have just attended the stay and play and not seen a health practitioner</td>
</tr>
<tr>
<td>01/11/2010</td>
<td>REDACTED Children’s Centre</td>
<td>Adult A</td>
<td>Child C1</td>
<td>Attendance at Chatterbox (Stop and play health clinic)</td>
<td>Possible record in Health Care records (Health Visiting)</td>
<td>May have just attended the stay and play and not seen a health practitioner</td>
</tr>
<tr>
<td>08/11/2010</td>
<td>REDACTED Children’s Centre</td>
<td>Adult A</td>
<td>Child C1</td>
<td>Attendance at Chatterbox (Stop and play health clinic)</td>
<td>Possible record in Health Care records (Health Visiting)</td>
<td>May have just attended the stay and play and not seen a health practitioner</td>
</tr>
<tr>
<td>Date</td>
<td>Centre</td>
<td>Adult</td>
<td>Child</td>
<td>Activity</td>
<td>Possible Record</td>
<td>Notes</td>
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<tr>
<td>06/12/2010</td>
<td>REDACTED Children’s Centre</td>
<td>Adult A</td>
<td>Child C1</td>
<td>Attendance at Chatterbox (Stop and play health clinic)</td>
<td>Possible record in Health Care records (Health Visiting)</td>
<td>May have just attended the stay and play and not seen a health practitioner</td>
</tr>
<tr>
<td>31/01/2011</td>
<td>REDACTED Children’s Centre</td>
<td>Adult A</td>
<td>Child C1</td>
<td>Attendance at Chatterbox (Stop and play health clinic)</td>
<td>Possible record in Health Care records (Health Visiting)</td>
<td>May have just attended the stay and play and not seen a health practitioner</td>
</tr>
<tr>
<td>07/02/2011</td>
<td>REDACTED Children’s Centre</td>
<td>Adult A</td>
<td>Child C1</td>
<td>Attendance at Chatterbox (Stop and play health clinic)</td>
<td>Possible record in Health Care records (Health Visiting)</td>
<td>May have just attended the stay and play and not seen a health practitioner</td>
</tr>
<tr>
<td>21/03/2011</td>
<td>REDACTED Children’s Centre</td>
<td>Adult A</td>
<td>Child C1</td>
<td>Attendance at Chatterbox (Stop and play health clinic)</td>
<td>Possible record in Health Care records (Health Visiting)</td>
<td>May have just attended the stay and play and not seen a health practitioner</td>
</tr>
<tr>
<td>09/05/2011</td>
<td>REDACTED Children’s Centre</td>
<td>Adult A</td>
<td>Child C1</td>
<td>Attendance at Chatterbox (Stop and play health clinic)</td>
<td>Possible record in Health Care records (Health Visiting)</td>
<td>May have just attended the stay and play and not seen a health practitioner</td>
</tr>
<tr>
<td>Date</td>
<td>Location</td>
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<td>Client</td>
<td>Activity</td>
<td>Possible Record</td>
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<tr>
<td>16/05/2011</td>
<td>REDACTED Children’s Centre</td>
<td>Adult A, Child C1</td>
<td>Adult A</td>
<td>Attendance at Chatterbox (Stop and play health clinic)</td>
<td>Possible record</td>
<td>May have just attended the stay and play and not seen a health practitioner</td>
</tr>
<tr>
<td>04/07/2011</td>
<td>REDACTED Children’s Centre</td>
<td>Adult A, Child C1</td>
<td>Adult A</td>
<td>Attendance at Chatterbox (Stop and play health clinic)</td>
<td>Possible record</td>
<td>May have just attended the stay and play and not seen a health practitioner</td>
</tr>
<tr>
<td>15/08/2011</td>
<td>PCH</td>
<td>Adult A, Child C</td>
<td>Adult A</td>
<td>Health promotion and well person topics discussed. Domestic violence question asked - no concerns</td>
<td>HV plan: For universal health visiting service Parents to access clinic as required</td>
<td>Evidence of ongoing assessment Opportunity taken to ask domestic abuse question. No concerns identified</td>
</tr>
<tr>
<td>15/08/2011</td>
<td>REDACTED Children’s Centre</td>
<td>Adult A, Child C1</td>
<td>Adult A</td>
<td>Attendance at Chatterbox (Stop and play health clinic)</td>
<td>Possible record</td>
<td>May have just attended the stay and play and not seen a health practitioner</td>
</tr>
<tr>
<td>Date</td>
<td>Location</td>
<td>Adult</td>
<td>Child</td>
<td>Activity Description</td>
<td>Record Details</td>
<td>Practitioner Details</td>
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<tr>
<td>12/12/2011</td>
<td>REDACTED Children’s Centre</td>
<td>Adult A</td>
<td>Child C1</td>
<td>Attendance at Chatterbox (Stop and play health clinic)</td>
<td>Possible record in Health Care records (Health Visiting)</td>
<td>May have just attended the stay and play and not seen a health practitioner</td>
</tr>
<tr>
<td>20/01/2012</td>
<td>REDACTED Children’s Centre</td>
<td>Adult A</td>
<td>Child C1</td>
<td>Attendance at the Children’s Centre Stay and Play Session</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27/01/2012</td>
<td>REDACTED Children’s Centre</td>
<td>Adult A</td>
<td>Child C1</td>
<td>Attendance at the Children’s Centre Stay and Play Session</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27/01/2012</td>
<td>PCH</td>
<td>Adult A</td>
<td></td>
<td>CPHN2 liaison with children Centre staff. Reported that Adult A had separated from Adult B and was low in mood</td>
<td>Children centre staff to contact Adult A and encourage her to access more activities at children’s centre</td>
<td>Good multiagency working</td>
</tr>
<tr>
<td>10/02/2012</td>
<td>REDACTED Children’s Centre</td>
<td>Adult A</td>
<td>Child C1</td>
<td>Attendance at the Children’s Centre Stay and Play</td>
<td>None recorded</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>Location</td>
<td>Adult</td>
<td>Child</td>
<td>Session</td>
<td>Notes</td>
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</tr>
<tr>
<td>17/02/2012</td>
<td>REDACTED Children’s Centre</td>
<td>Adult A</td>
<td>Child C1</td>
<td>Attendance at the Children’s Centre Stay and Play Session</td>
<td>None recorded</td>
<td></td>
</tr>
<tr>
<td>02/03/2012</td>
<td>REDACTED Children’s Centre</td>
<td>Adult A and Adult B</td>
<td>Child C1</td>
<td>Attendance at the Children’s Centre Stay and Play Session</td>
<td>None recorded</td>
<td></td>
</tr>
<tr>
<td>16/03/2012</td>
<td>REDACTED Children’s Centre</td>
<td>Adult A</td>
<td>Child C1</td>
<td>Attendance at the Children’s Centre Stay and Play Session</td>
<td>None recorded</td>
<td></td>
</tr>
<tr>
<td>23/03/2012</td>
<td>REDACTED Children’s Centre</td>
<td>Adult A</td>
<td>Child C1</td>
<td>Attendance at the Children’s Centre Stay and Play Session and Toy Library</td>
<td>None recorded</td>
<td></td>
</tr>
<tr>
<td>23/03/2012</td>
<td>REDACTED Children’s Centre</td>
<td>Adult A</td>
<td>N/A</td>
<td>Rhyme Time Session in Children’s Centre.                           Conversation between Adult A and Children’s Centre worker TX1.</td>
<td>A referral was made by TX1 for Adult A to attend a Money Advise Appointment on 2nd April 2012.</td>
<td></td>
</tr>
</tbody>
</table>
Adult A disclosed that:

- Things with ex-partner turning sour.
- Adult A was feeling low.
- Adult A had split up with her partner several months before but due to having a Joint Tenancy Agreement they had decided to continue to share the same accommodation until the end of April 2012.
- The ex-partner (Adult B) was threatening to get full custody and was really worried about these threats.

Adult A was also signposted to the Young parents Group as she presented as unsupported by friends and family.
<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
<th>Adult</th>
<th>Child</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/04/2012</td>
<td>REDACTED Children’s Centre</td>
<td>Adult A</td>
<td>Child C1</td>
<td>Adult A disclosed that she has no money and was worried about where she a C1 would live in the future. TX1 rang Adult A. Adult A was much more positive. She had booked another meeting with the Money Advise Advisor (5th April) and she had also booked an appointment with a Solicitor at REDACTED Centre Ltd for the same day. She had discussed housing with her and she felt that everything was going to work out. The note also states: Only record of attendance recorded. TX1 explained that she was leaving the centre however someone would call Adult A on Thursday to see how she gets on and that REDACTED Children’s Centre will continue to support her.</td>
</tr>
</tbody>
</table>
was moving in the right direction.

Adult A said that Adult B had told her that he was moving his ex-girlfriend and her children into the flat when Adult A moves out. Adult B had spent yesterday (Sunday) with Child C1 and Adult A had found out that he had also spent the day with his ex-partner, which Adult A was upset about as she had never met her and wants to protect C1.

Adult A said that she has kept the REDACTED Children's Centre Easter programme and will come along to some of the

 CW agreed to call Adult A on Thursday
<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/04/2012</td>
<td>REDACTED Centre Ltd</td>
<td>Contact with Adult A at REDACTED Children’s Centre</td>
<td>Two following appointments made for 05/04/2012 for Adult A to meet with RW2 and a solicitor at the REDACTED Centre Ltd. RW2 not interviewed due to attending court as a trial witness.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>None</td>
<td>A brief initial meeting between Adult A and the outreach worker (RW2) on 02/04/2012 at a Children’s Centre regarding benefit calculations where a Tax Credit enquiry form was completed.</td>
</tr>
<tr>
<td>04/04/2012</td>
<td>OIS Log 63</td>
<td>Adult B</td>
<td>Adult B pronounced dead at scene.</td>
</tr>
<tr>
<td></td>
<td>CIS ED/12/1955</td>
<td>Police</td>
<td>Adult B reports finding Adult A on settee with severe head injury.</td>
</tr>
<tr>
<td>05/04/2012</td>
<td>REDACTED Children’s Centre</td>
<td>Not answering phone</td>
<td>Telephone call to Adult A’s land line. No answer.</td>
</tr>
<tr>
<td>Date</td>
<td>NSPIS</td>
<td>Agent</td>
<td>Incident</td>
</tr>
<tr>
<td>----------</td>
<td>-------------</td>
<td>-----------</td>
<td>-------------------</td>
</tr>
<tr>
<td>05/04/2012</td>
<td>50EC/2290/12</td>
<td>Adult B</td>
<td>Police</td>
</tr>
</tbody>
</table>
APPENDIX B: Domestic Abuse Routine Questions

Domestic Violence Routine Enquiry Questions

Each locality base has now been allocated a folder with all relevant required paperwork needed to follow up on disclosures from Domestic Violence Routine Enquiry Questions.

Please can you follow the Domestic Abuse Policy for Managers and Practitioners when completing any paperwork. An up to date copy can be located on Health Net.

Guidance

Routine Enquiry Questions should be asked at the following:-

Primary Assessment- New Birth visits
6-12 month review
2- 2.5 year review

Questions can be asked by raising the issue in the following way:-
Health Services are now asking questions about domestic abuse of all service users. I need to ask you some routine questions if that is ok with you?

And then the preferred questions can be asked.

- Could you tell me how you got those injuries?
- Do you ever feel frightened of your partner or other people at home?
- Have you ever been slapped, kicked or punched by your partner?
- Have you ever been in a relationship where you have been hit or hurt in some way?
- Are you currently in a relationship where this is happening to you?
- Does your partner often lose their temper with you? If they do, what happens?
- Has your partner ever:-
  Destroyed or broken things you care about
  Threatened to hurt your children
Forced sex on you or made you have sex you did not want.
Withheld sex or rejected you in a punishing way.

- Does your partner get jealous of you seeing friends, talking to other people or going out, if so what happens?
- Your partner seems very concerned and anxious about you, sometimes people react like that when they feel guilty, was he responsible for your injuries?
- Does your partner use drugs or alcohol excessively, if so how does he behave at this time?

If a person is experiencing domestic abuse

1. Complete DASH Risk Assessment
2. Follow locally agreed DASH score threshold outcomes

- High Risk Scores of 14 and above on the CAADA DASH Risk Assessment Tool are assessed as high risk and must trigger a referral to MARAC and the Plymouth Domestic Abuse Service with or without persons Consent.

- Medium Risk Scores of 6-13 on the CAADA DASH Risk Assessment Tool are assessed as medium risk and must trigger a referral to Plymouth Domestic Abuse Service (PDAS).

- Standard Risk Scores of 0-5 on the CAADA DASH Risk Assessment Tool are assessed as a standard risk and must trigger a referral to Victim Support with persons consent.
Short term solution is to have a pack of blank DASH Risk Assessments & MARAC Referral Forms to take to visits. File to be kept at each base with blank copies/completed copies for audit purposes. A copy to be kept in client’s record.

**ePEX**

Recording contacts for Questions asked and not asked:

There is a code for Questions asked and ePEX codes for reasons why questions not asked.

- K6A1 Domestic Abuse question asked
- K62A Domestic Abuse questions not asked – partner present
- K62B Domestic Abuse questions not asked – Other present
- K62C Domestic Abuse questions not asked – No confidential environment

The previous code K62 for question not asked has now been taken out of use.

Accessing the electronic version of the DASH Risk Assessment is difficult due to lack of ePEX knowledge/training.
Sue Warren
Partnership Crime Reduction Officer
Homes & Communities
Plymouth City Council
Civic Centre
Plymouth
PL1 2AA

18 December 2014

Dear Ms Warren,

Thank you for submitting the Domestic Homicide Review (DHR) report from Plymouth to the Home Office Quality Assurance (QA) Panel. The review was considered at the QA Panel meeting in December.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. In terms of the assessment of DHR reports the QA Panel judges them as either adequate or inadequate. It is clear that a lot of effort has gone into producing this report, and I am pleased to tell you that it has been judged as adequate by the QA Panel.

The QA Panel would like to commend you on this report which they felt was well written and demonstrated appropriate professional curiosity, which greatly assisted the narrative. The QA Panel also felt that the report reflected a good understanding of coercive control as well as an understanding of domestic violence and abuse.

There were some issues that the Panel felt might benefit from more detail and which you may wish to consider before you publish the final report:

- Please revisit the information reflecting the post mortem report to ensure it is appropriately concise and appropriately handled for a wider audience;

- The Panel felt that the report brought out some important findings around the limitations of friends and family in responding to domestic violence. They consequently suggested you may wish to consider signposting appropriate tools that the community may find helpful, such as the Domestic Violence Pledge: https://responsibilitydeal.dh.gov.uk/organisations-commit-to-supporting-staff-facing-domestic-violence/, and promoting local information to
help inform the community about how they may safely respond to friends and family in similar situations in the future;

We do not need to see another version of the report, but I would ask you to include this letter as an appendix to the report when the lessons and actions from the Action Plan are disseminated.

Yours sincerely,

Christian Papaleontiou, Chair of the Home Office Quality Assurance Panel
Head of the Interpersonal Violence Team, Public Protection Unit