# REPORT INTO THE DEATH OF AA

Report produced by SoSafe - Stevenage Community Safety Partnership

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## 1. Introduction

1.1 This report of a Domestic Homicide Review (DHR) examines agency responses and support given to AA, a resident of Stevenage, Hertfordshire prior to her death on 8 November 2012.

1.2 The key purpose of this review is to understand what happened, what lessons have to be learned and most importantly, what has to change to reduce the risk of such tragedies in the future.

1.3 This review was commenced on 7 December 2012 and completed on 28 April 2014.

## 2. Confidentiality

2.1 The review has been approved by the Home Office Quality Assurance Panel, as outlined in a letter dated 22 July 2014, and included as Appendix 4. The Quality Assurance Panel stated that there were some issues which would benefit from further consideration and clarification and these have now been addressed. The report has been shared, without the names of staff, with the family members of the victim who asked to be involved in the review. The Stevenage Community Safety Partnership which commissioned the Domestic Homicide Review made a decision to publish the full report.

## 3. Dissemination

3.1 The following agencies have received copies of the report.

- Bedfordshire, Northamptonshire, Cambridgeshire and Hertfordshire BeNCH) Community Rehabilitation Company
- East and North Hertfordshire Clinical Commissioning Group
- Hertfordshire Community NHS Trust
- Hertfordshire Constabulary
- Hertfordshire Coroner Service
- Hertfordshire County Council Children's Services
- Hertfordshire County Council Health and Community Services
- Hertfordshire County Council Community Safety Unit
- Hertfordshire and South Midlands Area Team, NHS England
- Hertfordshire Partnership and university NHS Foundation Trust
- Herts Women's Centre
- Herts Young Homeless
- Stevenage Borough Council
- Victim Support

## Executive summary

### 4. The review process

4.1 This summary outlines the process undertaken by Stevenage DHR panel in reviewing the murder of AA.

4.2 JW was found guilty of her murder on 19 July 2013 and sentenced to life imprisonment, to serve a minimum of 19 years.

4.3 The review process began with an initial meeting on 7 December 2012 of all agencies that potentially had contact with AA and JW prior to AA's death.

4.4 Agencies participating in the case review are:

Aldwyck Housing Group
Department of Work and Pensions (DWP)
East and North Hertfordshire NHS Trust (E&NH NHS Trust)
Hertfordshire and South Midlands Area Team, NHS England
Hertfordshire Community NHS Trust (HCT)
Hertfordshire County Council (HCC) Connexions
HCC Children's Services
HCC Health and Community Services
Hertfordshire County Community Safety Unit (CCSU)
Hertfordshire Constabulary
Hertfordshire Partnership and University NHS Foundation Trust
Hertfordshire Probation Trust
Hertfordshire Public Health/Domestic Violence Strategic Programme Board (DVSPB)
Herts Women's Centre
Herts Young Homeless (HYH)
Hertfordshire Youth Offending Service (YOS)
North Herts College
Stevenage Community Safety Partnership (CSP)
Stevenage Borough Council (SBC) Housing Department
Victim Support, Independent Domestic Violence Advocate (IDVA) Service

Agencies were asked to give chronological accounts of their contact with the victim prior to her death. Where there was no involvement or insignificant involvement, agencies advised accordingly. Each agency's report covers the following:

- a chronology of interaction with the victim and/or their family; and analysis of involvement
- whether internal procedures were followed
- examples of good practice, lessons learned and recommendations from the agency's point of view.

4.5 The accounts of involvement with the victim cover different periods of time prior to her death and some of the accounts have more significance than others.

4.6 Those agencies which responded with information indicating some level of involvement with the victim or perpetrator are noted with an asterisk in 4.4 above. Hertfordshire Probation Trust reported as having had no contact.

4.7 The police report shows that they first had contact with the victim in respect of domestic abuse allegations on 31 October 2012 and there was one more contact with her before she died on 8 November 2012. The victim met with a Domestic Violence Officer (DVO). She declined to report a specific incident, police intervention and an offer to go to a refuge. She agreed to a referral to an Independent Domestic Violence Advocate (IDVA).

## 5. The purpose of the review

5.1 DHRs were established on a statutory basis under section nine of the Domestic Violence, Crime and Victims Act (2004) and this provision came into force on 13th April 2011. In Hertfordshire the county's Domestic Violence Strategic Programme Board (DVSPB) oversees the DHR process and invites the community safety partnership (CSP), covering the area where the victim was last resident, to conduct a review; in this case Stevenage.

5.2 The purpose of each review is contained in the terms of reference agreed by the review panel and in this case these were to establish:

- how effective agencies were in identifying AA's health and social care needs and providing support
- the appropriateness of agency responses to both AA and JW - both historically and within a month of AA's death
- whether single agency and inter-agency responses to any concerns about domestic violence were appropriate
- how well agencies worked together, and to identify how inter-agency practice could be strengthened to improve the identification of, and safeguarding of, vulnerable adults and children where domestic violence is a feature
- on the basis of the evidence available to the review, whether the death was predictable and preventable, with the purpose of improving policy and procedures in Hertfordshire and more widely.

5.3 Although there is reference to events in 2009 when AA went to live in Stevenage, the main events covered by the review are from August 2010 when AA commenced a relationship with JW.

## 6 Findings

6.1 The findings have been drawn from a review of the contents of each agency's Internal Management Review (IMR) and the comments made throughout the above chronology. In addition consideration has been given to how agencies measured up in respect of each of the terms of reference. The questions outlined in key lines of enquiry, in paragraphs 1.5.1 – 1.5.4, have also been taken into account.

6.2 Some of the agencies involved in this review have policies and procedures which are specific to domestic abuse whilst others use Hertfordshire's inter agency procedures for safeguarding children and vulnerable adults; and have been trained accordingly. The procedures for children are specific in respect of domestic abuse whilst those for adults are not, and are based on a definition of vulnerable adult which does not include a victim of domestic abuse. This is currently being addressed by the Safeguarding Board. Some of the agencies have recognised the need to revise their procedures and carry out additional training, and have included this in their IMR recommendations.

6.3 General Practitioner (GP) services do not have policies and procedures for domestic abuse but have access to Department of Health (DH) guidance entitled "Responding to Domestic Abuse: Guidance for General Practices" (2012); it is understood that GP's at the surgery where AA was a patient have not yet received training in domestic abuse.

6.4 DASH risk assessment (Domestic Abuse, Stalking and Honour based violence) is a widely recognised tool for assessing risk and identifying pathways for support in cases of domestic abuse and is adopted by Hertfordshire's County Domestic Violence Forum. However, it is not used by agencies involved in this review, other than the police and IDVA.

6.5 Prior to her disclosure that she was subject to domestic abuse AA presented to several agencies when she was seen as vulnerable because she had a number of problems including potential homelessness, teenage pregnancy, being a new young mum, physical and mental health and what she described as lack of family support. SBC and Aldwyck Housing provided help in relation to her homelessness and HYH offered support both when she was leaving the family home and when she was settled in her own home. The midwife and health visitors gave her assistance throughout the pregnancy and during the first few months she was a mother. This help continued to be available to her but she did not maintain contact.

6.6 In 2010 and prior to commencing a relationship with JW, AA had some unexplained injuries which were not investigated as possible domestic abuse or child safeguarding concerns by Accident and Emergency (A & E) or GP's. During the same period GP services, particularly GP2, the Community Adolescent Mental Health Service (CAMHS) and Enhanced Primary Mental Health Services (EPMHS) were effective in identifying that AA was suffering from mental ill health and she was offered appropriate interventions which included medication.

6.7 During this same two year period, AA was referred to Children's Services on three separate occasions, the first, when AA was under 18, was from the youth offending team (YOT), due to concerns that she might hurt herself and needed help. She also alleged she had been sexually abused in the past. The second referral was from SBC, because she was being given an eviction notice from the family home at the time she was pregnant and third, by the police because they had safeguarding concerns about AA's daughter who they had seen in JW's family home when they conducted a drugs raid. On each occasion Children's Services were not wholly effective in assessing AA or her child's needs because

they did not have enough information or the information they had was inaccurate. The third intervention was of particular concern because Children's Services did not see JW due to his lack of co-operation. They did not appear to take into consideration his family history and they based their assessment of AA's ability to protect the child on misinformation, that is, the child was not present when the drugs raid took place. There is no evidence that AA was offered support as a result of her contacts with Children's Services during this period. After the first contact, Children's Services were aware from AA's mother that AA was due to see her GP, and that AA's mother would request a referral to CAMHS. They also facilitated a referral to Connexions, but they did not check if either option for support was followed through.

6.8 During the period before she disclosed domestic abuse AA presented to some agencies, in particular GP services, with anxiety, depression, weight loss and urinary tract infections. These are recognised symptoms of domestic abuse but there is no evidence that this possibility was explored with her, which suggests a training need. AA also made some significant allegations of physical and sexual abuse to different agencies but no further enquiries were made.

6.9 AA started a relationship with JW in August 2010. She first disclosed he was abusing her in September 2012, and she said it had only been happening for a few months. It is possible that she had been experiencing domestic abuse throughout the relationship but either did not recognise it for what it was or chose to conceal it. This can happen for a variety of reasons as described by Women's Aid.

- that she was embarrassed or ashamed
- that she felt guilty she might be partly to blame because they argued
- that she was worried that others may consider her a bad mother and at worst her child might be removed from her care
- that she was depressed and suffering from low self-esteem, and feared she would not be believed
- that she cared for her partner and hoped she may be able to change him for the better
- that she did not want to leave her home and that it would be difficult to remove her partner, and if he were removed there could be repercussions for her and her family if this happened
- that she did not trust the agencies.

6.10 SBC was the first agency to which AA disclosed domestic abuse, on 26 September 2012. They did not carry out an assessment, as this was not part of their procedures, but they acknowledged concern for AA and her daughter and offered support by encouraging AA to use a range of resources including the Domestic Violence Helpline, police and Aldwyck Housing Association who managed her tenancy. They also facilitated her making an appointment with her GP. In line with safeguarding procedures for AA's child they made a referral to Children's Services and to a local Children's Centre. To be more proactive SBC could have offered to liaise with Aldwyck about how AA might evict JW and make the home safe. They could also have considered a referral to the Multi Agency Risk Assessment Conference (MARAC).

6.11 Children's Services were made aware of the domestic abuse on 26 September 2012 and following a contact from the Targeted Advice Service (TAS) the case was passed to the Early Intervention and Targeted Support Team (EITST). Given the contact was as a result of child safeguarding concerns raised by SBC it is not clear why the case was dealt with in this way. It should have been treated as a child safeguarding enquiry which would have been dealt with by the Assessment Team.

6.12 Once the case was allocated to the EITST caseworker there is some evidence he tried to make contact, but it was not until 31 October 2012 that he actually spoke to AA and this was an unacceptable delay given the safeguarding concerns.

6.13 In line with Hertfordshire Safeguarding Children Board inter agency child protection procedures Children's Services should have informed the police about the abuse when they found out, but they did not until the end of October, after they had received another referral, this time from EPMHS. Although it would be speculative to consider that the outcome would have been any different the month gap between EITST knowing about the abuse and either telling the police or seeing her themselves represented a significant missed opportunity to engage with AA and help to safeguard both her and her daughter.

6.14 After she had disclosed domestic abuse to SBC on 26 September and confirmed it to caseworker 3 from Children's Services two days later, AA saw a worker from EPMHS for triage assessment and met with her GP on two occasions during October. She did not tell them about the abuse. It was not until 30 October 2012, when she saw the high intensity worker from EPMHS that she disclosed again. The worker appropriately assessed there were safeguarding concerns for AA and her daughter and looked at the options with her. She told AA she would make a referral to Children's Services, which she did, and she encouraged her to attend the Women's Centre. The next day the worker followed up her contact with AA by which time she had been to the Women's Centre and had a planned appointment with EITST.

6.15 The day after AA saw the high intensity worker from EPMHS she referred herself to the Women's Centre, following some pressure from her mother who had just become aware that JW had subjected her daughter to domestic abuse. Although the Centre worker did not use a recognised assessment tool she did make an assessment using the Centre's own documentation, and this was discussed with her line manager. They were effective in identifying she was high risk and discussed a number of options for support including the police and going to a refuge. They also supplied her with information about the Domestic Violence Helpline. They understood she had an appointment with Children's Services as that was made whilst she was at the Women's Centre. Although they offered her a follow up appointment, which she declined, they did not know if she would go to the police. Given safeguarding concerns for her and her child they should have considered a referral to the police, particularly as there was an option for the police to meet with AA at the Women's Centre. They could also have offered AA further support by talking through a safety plan.

6.16 The police first became aware of the domestic abuse on 31 October 2012, following referral from EITST on that day. The inspector on duty was not in a position to carry out an effective assessment of AA's needs. The information he had was third hand and he understood she did not want police involvement. He sought intervention from the DVO but she was not available and after consulting AA's mother he made a decision not to visit AA due to concern that it could make matters worse. In making this decision he was aware that AA had accessed support from the Women's Centre and that Children's Services were due to see her.

6.17 On the following day the police DVO contacted AA's mother who confirmed that AA was due to see a caseworker from Children's Services on 5 November. Like her police colleagues the day before, she had not seen AA and her assessment of AA's needs were based on what AA had told others. She gauged it was too risky to make a home visit and hoped AA would contact her. She did this and on 7 November they had a meeting away from Stevenage. The DVO did not conduct a DASH on the basis that AA did not tell her directly about the abuse. However she should have done as she had enough information on which to complete it. Even without DASH the DVO was effective in assessing AA's needs; she saw her as high risk and discussed the various options available to her, which AA declined. The DVO also discussed involvement of the IDVA and then made a referral. Without evidence to support this conclusion, the DVO assessed AA's child was not at risk. However, she was aware AA had already been in contact with Children's Services.

6.18 The EITST caseworker from Children's Services met with AA and her daughter on 5 November 2012. The options he proposed at the end of the meeting, although supportive to AA and her child, did not reflect the fact that AA had already been assessed by the Women's Centre as high risk; police including the DVO had been informed; and that this could be a situation where safeguarding measures were needed for the child. AA was under no obligation to take up the offer of help from EITST, and it was not clear what the caseworker would do if she did not. Under the circumstances it would have been advisable to refer the case back to the Assessment Team.

6.19 There is little evidence of interagency working in AA's case. Some of the agencies made referrals to others once they became aware of domestic abuse. In particular SBC and EPMHS referred to Children's Services stating that they were doing so to safeguard AA's daughter. Children's Services made a referral to the police but this was over a month after they first received the information. Children's Services records do show a contact was made with the GP but there is no evidence the GP was told about the domestic abuse, and the GP has no record of this call. Also, caseworker 4 from Children's Services contacted SBC to check details of the referral. The police, including DVO, spoke with AA's mother because they had no means of contacting AA safely. The DVO made a referral to the IDVA. All of these contacts from one agency to another and to AA's mother seem appropriate. The other agency which had contact with AA once she disclosed was the Women's Centre and their staff did not refer on to any other agencies. They assessed that it was her choice to make but given they saw her as high risk, and that she had a child who could be at risk, they should have

contacted the police. They did not have information to suggest anyone else had, but were aware that AA was due to see Children's Services.

6.20 There were five agencies which were aware of the domestic abuse by 31 October 2012 – police, SBC, EPMHS, Children's Services and the Women's Centre – and it would have benefitted the situation greatly had they made a decision to sit down and discuss how to safeguard and help AA and her daughter. MARAC is said to be well established in Hertfordshire and yet none of the agencies chose to refer to it.

6.21 The IDVA was not in a position to assess AA's needs or offer support because she did not see AA. She had minimal information in the referral from the DVO but knew AA was seen as high risk.

6.22 During the period covered by the review JW had very little contact with agencies, and was known to be suspicious of them and probably hostile in respect of police and social workers. He had just one contact with police during this period, when he was arrested and cautioned for cultivating cannabis. He was not an active participant when he was seen by CAMHS and Children's Services, and as previously stated Children's Services missed an opportunity to question him more closely about another child he had, and to make a home visit at his family home where the drugs raid took place. JW was said to be dependent on cannabis use but there is no evidence he was in touch with GP, mental health services or drug agencies. AA's family had limited contact with JW and from their description this was his choice. Although they did not like him they would have preferred to remain in contact as a means of supporting their daughter and granddaughter.

6.23 The Women's Centre is the only agency of those involved in this review to suggest that AA's death was predictable, on the basis of national statistics covering the incidence of domestic violence, the number of assaults and homicides by men known to victims, calls to police, repeat victimisation, and women's fear of being killed. They also refer to an increase of domestic abuse incidents locally. This review has found that it would be very difficult to substantiate that AA's homicide was predictable or preventable due to a number of relevant and contradictory factors.

6.24 On the one hand the injuries she reported were not recent, and as far as the panel are aware had not necessitated medical care. On the other hand she may have been suffering for some time before she told anyone, and the abuse could have been much worse than she disclosed. When she did disclose she said that the abuse was escalating and she was clearly very fearful. She said JW had threatened to kill her if she told the police. The most recent incident had been threatening rather than violent, when she was intimidated into handing over money, and it shows a degree of recklessness on JW's part as it was done in front of others in a public place. AA had told JW that she wanted him to leave, a time at which research shows there is an increased risk to the victim. She told some agencies although not all (GP) that she was suffering but was not prepared to leave the home, did not want JW to know she had reported him and declined police involvement.

6.25 Although she visited the DVO on 7 November 2012 she did not make a formal report of abuse and declined police involvement. She agreed to a referral to the IDVA but there was no opportunity for contact before she was killed.

6.26 AA's death may have been preventable had she chosen one of the actions explored with her by agencies; to leave or to stay in her home and have JW removed, which would have necessitated police, Housing Association and possibly legal intervention. When she left her meeting with the DVO she was said by her mother to be more positive but it was not clear what action she hoped to take. She was well aware that taking either action still represented a risk to her and possibly her family. She was not encouraged to make a safety plan but this would not necessarily have guaranteed her safety.

6.27 Another way that AA's death may have been preventable is if one or more agencies took action against AA's expressed wishes. Realistically this could only have been the police, who had no current evidence with which to act. Alternatively Children's Services could have acted or threatened to act, to safeguard AA's child as a means of encouraging her to leave JW or have him removed from the home; however, they may also have lacked evidence to do this.

## 7 Conclusions

7.1 During the period covered by this review AA had contact with a number of agencies who considered that she was vulnerable. She seems to have been quite open when presenting problems and received help as a consequence. In particular she had a lot of support with accommodation, from health services during her pregnancy and as a young mother, and from mental health services.

7.2 AA commenced a relationship with JW in mid 2010 when she was 16 years old, and was confirmed pregnant early in 2011. JW had very little contact with any of the agencies involved with AA and it seems likely that only Children's Services were aware of his background; that there was a history of family violence in which JW had been a victim and perpetrator. Although it does not necessarily follow that he would go on to abuse a partner, with a consequent risk to children, research does confirm there is a significant risk. The panel concluded that Children's Services did not take this into consideration when they conducted enquiries in this case.

7.3 Although she had described other problems to agencies prior to September 2012 AA did not divulge domestic abuse. Questions have been raised in this review about whether agencies, particularly GP services, should have recognised, prior to disclosure, that symptoms experienced by AA, particularly anxiety, depression weight loss and urinary tract infections, could have been as a result of domestic abuse, and therefore warranted investigation. However, AA may not have disclosed any earlier than she did and even if she had, she may not have taken action and therefore the tragic events may still have occurred.

7.4 Before disclosing domestic abuse AA described her relationship with JW as positive and that he was supportive. This was not the experience of AA's parents who thought him a bad influence and that he had sought to turn their daughter

against her family They had tried not to criticise him too much for fear of alienating her.

7.5 Those agencies that came into contact with AA saw her as a good mother. Her daughter was described as bright and well cared for.

7.6 When on 26 September 2012 AA first disclosed to SBC that she had been abused by JW she appeared unclear about what she wanted to do which is not unusual for a victim of domestic abuse. During her contact with the TAS she spoke as if she may still stay with him, and that she had given him an ultimatum. There was then a month when she did not discuss the situation further with agencies; she saw her GP and attended for triage assessment with EPMHS and did not mention the abuse. It was not until 30 October 2012 when she saw the high intensity worker from EPMHS that she disclosed again that JW had been physically abusive to her. This worker encouraged AA to go to the Women's Centre which the panel saw as good practice, and she said she would refer to Children's Services which she did.

7.7 By the time caseworker 4 from EITST spoke with AA the referral had been outstanding for one month which represented a missed opportunity to engage with AA and the panel concluded that the delay was unacceptable. The decision of the TAS to refer the case to the EITST rather than the Assessment Team, and the subsequent approach taken by EITST caseworker 4 when he met AA on 5 November, suggests that safeguarding concerns in respect of AA's daughter were not taken seriously, also of concern to the panel.

7.8 AA told her mother about the violence on 31 October 2012, and it was her mother that helped her to make the decision to go to the Women's Centre on that day, and subsequently to the police on 7 November 2012.

7.9 By 31 October five agencies were aware that AA was subject to domestic abuse (SBC, Children's Services, EPMHS, Women's Centre, Police) and two others were currently providing a service to AA (GP and health visitor). In these circumstances the panel concluded that at least one of the agencies should have recognised the necessity of convening an interagency meeting, to discuss how risks to AA and her daughter might be managed.

7.10 Although AA did not say that she wanted to take action, either by leaving JW, which would have meant leaving her home and possibly the area, or seeking help in having him removed from the home, there were signs that she wanted a life without him and it would only be a matter of time before she was able to achieve this. Tragically and quite possibly because AA told JW what she wanted to do, she was murdered.

## 8 Recommendations

8.1 Each of the agencies which have produced IMRs for this DHR have made recommendations for their agencies, as contained in Appendix 1, and in some cases have action plans which are already being implemented. The overall recommendations included here have drawn on those identified in the IMR's.

8.2 In order to facilitate an understanding of how the agencies work and to make best use of resources, the agencies involved in this review should work together to ensure that they

- have a robust process for identifying domestic abuse, which includes clarity about when DASH should be used and by which agencies
- have information about services available to victims, which is brought together in a leaflet
- provide staff with clear pathways for referring victims on to the appropriate services
- provide awareness training for staff, which is updated every three years.

8.3 Herts Women's Centre should review their procedures to ensure that they use DASH as a means of assessing and providing clear pathways for assistance to victims of domestic abuse.

8.4 Hertfordshire Constabulary should re-enforce with staff, current procedures in respect of recording Domestic Violence crime and non-crime cases, and completing risk assessments.

8.5 Hertfordshire Constabulary and the Women's Centre should establish the improved reporting system for victims, which is in the process of development.

8.6 HCT should ensure health visitors carry out screening for domestic abuse in line with their existing best practice guidance.

8.7 Hertfordshire and South Midlands Area Team, NHS England should ensure that GP services adopt the DH Guidance on Domestic abuse.

8.8 Hertfordshire and South Midlands Area Team, NHS England should ensure that GP records contain sufficient detail for the purpose of completing adequate IMRs.

8.9 HCC Children's Services should examine their practice in this case and ensure that policies and procedures on safeguarding and domestic abuse are followed.

8.10 Hertfordshire DVSPB should establish an information sharing protocol in cases of domestic abuse to include agencies and voluntary organisations involved in this review. The protocol should include the role and purpose and timing of referrals to MARAC and IDVA's.

8.11 Hertfordshire DVSPB should ensure that the MARAC is promoted amongst staff and managers of the agencies which are most likely to encounter victims of domestic abuse.

8.12 The Hertfordshire DVSPB should facilitate learning events to ensure the findings of this review are disseminated within agencies.

**Stevenage Domestic Homicide Review Panel**
**Concluding Report**

## 1. Introduction

1.1 This review report is an anthology of information and facts from 13 agencies, all of which were potential support agencies for AA.

1.2 Following the murder of AA by JW on 8 November 2012, the Stevenage Community Safety Partnership (CSP) established a Domestic Homicide Review (DHR) panel which first met on 7 December 2012. The panel members were as follows:

1.3

| Name | Title | Organisation |
|---|---|---|
| Vanessa Bednarz | Director | Herts Women's Centre |
| Jemima Burnage | Head of Social Work & Safeguarding | Hertfordshire Partnership NHS Foundation Trust |
| Sue Darker | Assistant Director, Learning Disabilities and Mental Health | HCC Health & Community Services |
| Tom Elliot | Divisional Manager | Victim Support |
| Rebecca Froggett | Floating Support Manager | Herts Young Homeless |
| Karen Handscomb | Quality & Patient Safety Manager | Hertfordshire and South Midlands Area Team, NHS England |
| Liz Hanlon | Detective Chief Inspector, Deputy Director of Intelligence | Hertfordshire Constabulary |
| Maureen Hemley | Named Nurse Safeguarding Children | Hertfordshire Community NHS Trust |
| Mayank Joshi | Head of Safeguarding Locality Team West | HCC Children's Services |
| Gillian Mason | Area Manager | Aldwyck Housing Group |
| Dawn Morrish | Health Improvement Manager | HCC Public Health/Domestic Violence Strategic Programme Board |
| Nick Parry | Chief Executive Officer & Chair of Community Safety Partnership | Stevenage Borough Council |
| Susan Pleasants | Victim Care Manager | Hertfordshire Probation Trust |
| Richard Protheroe | Head of Housing | Stevenage Borough Council |
| Michel Saminaden | Chief Executive Officer & Chair of Domestic Homicide Review Panel | Welwyn and Hatfield Borough Council |
| Sarah Taylor | Programme Manager Domestic Violence and Hate Crime | HCC Community Safety Unit |

1.4 The panel agreed that the review would focus on events from 1 June 2010 when it was understood that the relationship with the alleged perpetrator

began (although this was more likely to be August 2010), until the time of her death and the agreed terms of reference were as follows:

- establish how effective agencies were in identifying AA's health and social care needs and providing support
- establish the appropriateness of agency responses to both AA and JW - both historically and within a month of AA's death
- establish whether single agency and inter-agency responses to any concerns about domestic violence were appropriate
- identify, on the basis of the evidence available to the review, whether the death was predictable and preventable, with the purpose of improving policy and procedures in Hertfordshire and more widely
- to establish how well agencies worked together and to identify how inter-agency practice could be strengthened to improve the identification of, and safeguarding of, vulnerable adults and children where domestic violence is a feature.

1.5 The panel also agreed the following key lines of enquiry:

1.5.1 **Information**: How was information about AA's health and social care needs received and addressed by each agency and how was this information shared between agencies?

1.5.2 **Assessments and diagnosis**: Was there any impact of JW's mental health on AA's physical and mental health? Were there any recent changes in the physical or mental health of either AA or JW that may have affected their behaviour? Was there any evidence to suggest there to be any physical conditions or behaviours that had an impact on AA's or JW's mental health? Is there any information in relation to domestic violence? Were any agency assessments completed? Were there opportunities for referral or signposting to, and within, agencies? Were there any additional needs? Were the appropriate referrals and service provision put in place?

1.5.3 **Contact and support from agencies**: What contact did each agency have with AA and JW? What support did they receive and from whom? Were there any indicators or history of domestic violence?

1.5.4 **Any additional information considered relevant**: If any additional information becomes available that informs the review this should be discussed and agreed by the independent chair and the review panel. The chair of the Domestic Violence Strategic Programme Board (DVSPB), the body which commissions DHR's in Hertfordshire, will be advised of the change.

1.6 Mr Michel Saminaden was appointed as the chair of the panel and Ms Carole McDougall was appointed as the overview report writer, both being independent of the agencies with which AA and JW had contact. Mr Saminaden is the Chief Executive of Welwyn Hatfield Borough Council, a post he has held for 17 years; he is also a magistrate. Ms McDougall is an independent consultant who previously worked at senior manager level in the Probation Service. She is a member of a panel appointed by the Hertfordshire Chief Officer Group to conduct reviews.

1.7 The panel requested chronologies from agencies in contact with AA and JW during the period to be covered by the review, listing dates, events and actions. After considering the chronologies the panel requested individual management reviews from those agencies with which AA and or JW had significant contact. Agencies were provided with a template to follow for the production of the Internal Management Review (IMR), in line with Home Office Guidance. The agencies providing information were as follows:

1.8

| Agency | Chronology | IMR | Author |
|---|---|---|---|
| Aldwyck Housing Assocation | √ | | Gillian Mason |
| Department of Work and Pensions | √ | | Jayne Dixon |
| East and North Hertfordshire NHS Trust | √ | √ | Mary Emson |
| Hertfordshire Community NHS Trust | √ | √ | Christine Mitchell |
| Hertfordshire County Council Connexions | √ | | Jackie Clementson |
| Hertfordshire County Council Children's Services | √ | √ | Janet Jones |
| Hertfordshire Constabulary | √ | √ | Martin Witchard |
| Hertfordshire Partnership NHS Foundation Trust | √ | √ | Sally Pegrum |
| Hertfordshire and South Midlands Area Team, NHS England – GP Services | √ | √ | Karen Handscomb |
| Hertfordshire Women's Centre | √ | √ | Tracey Burke |
| Herts Young Homeless | √ | √ | Glenn Middleton |
| Hertfordshire Youth Offending Service | √ | | Janet Meah |
| North Herts College | √ | | |
| Stevenage Borough Council Housing Department | √ | √ | Aidan Sanderson |
| Victim Support, IDVA Service | √ | √ | Tom Elliot |
| | | | |

1.9 With the exception of Victim Support Independent Domestic Violence Advocate (IDVA) service) all IMR's were undertaken by individuals who were not directly involved in the delivery of or management of the services provided to AA. The IMR's were quality controlled by the panel. In some cases additional information was required, to fill in gaps and for clarification. In the case of Hertfordshire County Council (HCC) Children's Services they provided a second IMR.

1.10 Each IMR was signed off as satisfactory by the panel member representative, on behalf of their agency.

1.11 Initial interviews were held with the mother and father of the victim with the purpose of explaining the DHR process and to enable them to contribute with their own perspective. Subsequently further meetings were held to share findings from the review. Both parents were accompanied at the meetings by an advocate from Advocacy After Fatal Domestic Abuse (AAFDA).

1.12 The overview report writer accessed a number of documents which were pertinent to the review.

1.13 Stevenage, where the review has been conducted, is one of ten district authorities in Hertfordshire, as identified on the map below.

1.14 The county of Hertfordshire is situated in the East of England and borders Greater London to the south, Essex to the east, Buckinghamshire to the west and Cambridgeshire and Bedfordshire to the north. With a population of around 1.1m Hertfordshire is a mixture of urban and rural communities, with a range of large and new towns of which Stevenage is one, market towns and villages. Regarded as a relatively affluent area benefiting from a thriving economy and a highly skilled working age population, the general standard of living is high. However, there remain areas of deprivation in all districts across the county and a number of specific wards where domestic abuse prevalence rates were recorded as high (153-276 incidents) over the 12 month period April 2012-March 2013:

- Hertsmere: 3 wards
- Welwyn Hatfield: 3 wards
- Watford: 1 ward
- Stevenage: 1 ward
- Broxbourne: 1 ward
- Dacorum: 1 ward

***Source: MIDAS (Community Information Unit), HCC***

1.15 Whilst domestic abuse accounts for approximately 15% of all violent crime nationally, local rates are higher and current trends indicate that domestic abuse accounts for approximately 20% of all violent crime in Hertfordshire. The annual cost of domestic abuse in Hertfordshire totals more than £517m.

1.16 In 2012/13 (April-March) Hertfordshire Constabulary recorded more than 11,900 reports of domestic abuse related incidents; 29.5% of these were determined as

‘crimes’. These reports are spread across the 10 district areas as detailed in the table below:

| | Crimes | | Non-Crimes | |
|---|---|---|---|---|
| | **2012/13** | **2011/12** | **2012/13** | **2011/12** |
| Broxbourne | 377 | 439 | 753 | 751 |
| Dacorum | 421 | 353 | 1034 | 978 |
| East Herts | 325 | 351 | 680 | 531 |
| Hertsmere | 311 | 311 | 944 | 856 |
| North Herts | 409 | 445 | 750 | 763 |
| St Albans | 291 | 346 | 697 | 739 |
| Stevenage | 518 | 527 | 936 | 1007 |
| Three Rivers | 193 | 234 | 587 | 608 |
| Watford | 330 | 325 | 931 | 930 |
| Welwyn Hatfield | 360 | 466 | 1141 | 1165 |
| **Totals** | 3535 | 3797 | 8453 | 8328 |

***Source: Hertfordshire Constabulary***

1.17 During the full year period 2012/13 the Hertfordshire Domestic Abuse Helpline received a total of 2,530 calls, an increase of 737, or 41% on the previous year.

1.18 Information and advice about resources available to victims of domestic abuse in Hertfordshire is contained on the Sunflower website, hertssunflower.org, and includes the Helpline, refuges in eight locations including Stevenage, twoWomen’s Centres, of which one is in Stevenage, and six IDVA’s who provide a service across the county. Stevenage Borough Council (SBC) have recently appointed a Domestic Abuse Coordinator.

## 2. The facts in the case

2.1 AA was born in Pembury, Kent on 20 October 1993, one of four children. The family lived in East Sussex when she was a baby. Her parents divorced and AA remained with her mother who re married. This marriage also ended in divorce and subsequently AA moved to Stevenage with her mother, second step father, younger sister and brother in 2009 whilst her natural father and elder sister remained in Sussex.

2.2 AA commenced a relationship with JW in August 2010 and on 17 November 2011 she gave birth to their daughter who was aged just less than 12 months at the time of her mother’s murder. The child is now living with AA’s elder sister.

2.3 JW was born in Stevenage on 4 August 1990, the second eldest of six children. The family were known to HCC Children’s Services whose records describe significant violence in the home, adult to adult, adult to children, and child to child. The children were said to be out of parental control and were subject to child protection plans due to neglect and emotional abuse between January 2001 and September 2004. Concerns are recorded about JW from a young age with

various professionals describing his behaviour as "strange" and "disturbed". Children's Services considered instigating care proceedings on more than one occasion but these were not progressed. Records suggest JW had a statement of his educational needs and was excluded from school aged 13 years following an assault on another pupil. He had a history of petty crime and between 2001 and 2012 received cautions or reprimands for offences of criminal damage, theft, possession of an offensive weapon and drug use. JW lost the sight in one eye following an incident at home involving his older brother, and he was registered disabled. During the murder investigation JW's mother described her relationship with him as being ruled by his smoking cannabis, which made him aggressive and violent. Other witnesses described him as heavily addicted and that he would become violent if he did not have access to the drug.

2.4 Witnesses also suggested AA used cannabis although to what extent it is unknown, and a drug test after her death confirmed that there was no evidence of the drug in her system.

2.5 Having left the family home in June 2011, when she was pregnant, AA was housed by SBC in accommodation specifically for pregnant teenagers and young mothers. Her daughter, whose father was JW, was born in November 2011 and in February 2012 AA and her daughter were re-housed. Soon afterwards JW moved in to live with them which remained the case until AA's death.

2.6 At 10am on Friday 9 November 2012 the partner of JW's mother attended Stevenage Police Station and reported that JW had murdered AA at their home address, and that her body had been buried with the assistance of JW's uncle. It is understood that AA was murdered between 23.30 on 7 November and 09.30 on 8 November 2012 and her body was found at 15.15 on 11 November 2012 as a result of JW's uncle taking officers to the scene. The cause of death was recorded as severe head injury caused by a long metal object.

2.7 JW pleaded not guilty to murder but guilty to manslaughter, and following a trial he was convicted of AA's murder on 19 July 2013. He was sentenced to life imprisonment on 22 July 2013 and the minimum tariff set by the sentencing judge is 19 years. When passing sentence the judge said "JW subjected the devoted mother to consistent and persistent physical and verbal abuse" and that it was his view that "she was terrified of you (JW) – you sought to control not just her but everything about her. She saw sense and was determined to end the abusive relationship. Your response to that was to attack her."

2.8 JW's uncle pleaded guilty to perverting the course of justice, assisting an offender and obstructing the coroner and was sentenced to two and a half years imprisonment.

*2.9* At the time of this review the inquest has not been concluded.

## 3 The family's perspective

3.1 AA's parents were each interviewed separately on two occasions, including to explain the review process and to share the draft report; and their contributions have been included within the report where possible. In addition the panel

thought it important to include their overall perspective and this is described below.

3.2 AA's mother said her daughter was popular, outgoing and funny when growing up. She saw a significant deterioration in her after she became involved with JW and his family. JW got AA involved in using cannabis and she lost a lot of weight. She was aware that his family sent AA text messages telling her to do things for them that they could do themselves. She found this very frustrating and said there would be rows between her and AA because of it.

3.3 She said that she had a bad feeling about AA's relationship with JW but felt she had to trust AA's judgement and did not want to push her away by rejecting him. After finding out AA was pregnant she was angry but she decided she should try to help the situation and she set JW up with an e mail address so he could look for work. After that he did not come to the house and did not talk with AA's family. She said that she and her husband, AA's second step father, gave AA a lot of practical help before and after she left the family home. When AA became pregnant she spoke to her about what she wanted to do and when she said she wanted to keep the baby they agreed that the only way she could do this was if she had her own home; and it was with AA's agreement that she served her notice to quit the family home, via the council. AA's parents feel that some of the things that AA said to agencies about her family and their relationship were a reflection of JW's views, and that he was trying to turn AA against her family, as part of his abuse of her. They also consider that JW was using their daughter as a means of getting somewhere to live.

3.4 AA's father said that he had maintained regular contact with his daughter after she moved to Stevenage and spoke to her most days on the telephone. He said that JW had broken her mobile telephone and its charger and he purchased an earpiece for her so they could have private telephone conversations; however JW fed it to a dog. He said he had not been aware of the physical violence until AA divulged it to her mother but he had wanted AA to go to a refuge prior to that because of his concerns about JW. He said she had previously told him that a bruise to her face was as a result of an accident but he understands now it was caused by JW. He was aware she had been to meet with a worker from Children's Services and went to the police, but did not get to speak to her afterwards and did not know if there was any outcome from these meetings.

3.5 AA's father said he only met JW once. He went round to AA's home to see her and his granddaughter. He was aware JW was there, in the kitchen, and he invited him to come out and introduce himself to his mother, AA's grandmother, and his son, but JW declined, and said that he knew AA's father did not like him and his family. He said this was so and he wanted AA to leave the relationship.

3.6 Neither parent was aware that JW had been physically violent towards AA until the end of October 2012 when AA told her mother about it. Although both parents were aware that JW's family background was problematic they were shocked to discover, during the DHR, the extent of the problems and in particular that there was a history of violence.

3.7 AA's father said that he thought the police could have intervened to help AA. Her mother said that she was shocked and angry to read about some of the findings recorded in the DHR.

## 4. Chronology of events prior to AA's death

The following is a chronology charting contact that agencies, professionals and others had with AA and JW prior to AA's death. Comments are included to reflect the analysis made by the panel during the course of the review as well as IMR authors when completing the IMR's.

**2009**

4.1 Although this period is not covered by the terms of reference it has been recorded as contextual information. AA first came into contact with agencies involved in this review in April 2009 when she registered with a GP in Stevenage. Later in 2009 she was twice referred by her GP to a paediatrician first because of fainting episodes and second because of photophobia and tingling in her arms and legs. An electroencephalogram (EEG) and an electrocardiogram (ECG) were undertaken in November 2009 and reported as normal. During this time she was also referred to the orthopaedic service for lax ligaments and joints, and an appointment took place in August 2010.

4.2 AA first came into contact with Connexions in October 2009 when their advisor explained the service they could provide, that is, confidential advice, support and guidance to young people in respect of training, careers and employment.

4.3 In December 2009 HCC Children's Services made Child Protection enquiries following AA's disclosure that a taxi driver who was taking her to school had sexually assaulted her. Enquiries substantiated the allegations and the case was closed in June 2010 by which time the taxi driver was no longer employed and AA was not considered at risk.

**1 January – 30 June 2010**

4.4 On 18 January 2010, when aged 16 years, AA referred herself to Accident and Emergency (A&E) at Lister Hospital Stevenage with a painful hand joint. The records show there was no history of trauma, the hand was strapped and gentle exercise advised.

4.5 On 26 April 2010, AA referred herself again to A&E. She said she had punched a door two days before. There was bruising and swelling, but no bony injury and strapping was applied.

4.6 On 30 May 2010 AA referred herself again to A&E with an injury to her right ankle, and reported she had been hit the day before with an iron bar. A sprain was diagnosed and AA was advised to apply ice and rest. For each of these events a discharge letter was sent to AA's GP, which were received by the GP.

**Comment on events 1 January – 30 June 2010**

4.7 As reported in the IMR completed by E&N Herts NHS Trust, there was a Domestic Violence Policy in place at the time and A&E staff had received training appropriate to their grade. However there was no evidence that questions were asked about what had caused AA's injuries and whether another person was involved, and so staff were not effective in identifying if AA was at risk of physical abuse.

4.8 For each of the attendances at A&E a discharge letter was sent to the GP in line with procedures, although there is no evidence that the GP reviewed these events. The same letter would also have been sent to the school nurse service, but because AA was in college rather than in school no action would have been taken at that time. Recent changes have resulted in there being safeguarding lead members in colleges, who will take action where appropriate. Although the criteria were met for completion of a sharing information form when AA reported punching a door and being hit with an iron bar, this was not done. Had it been there would have been a discussion between the school health nurse (AA was still only 16) and A&E professionals, which would have been an opportunity to identify any issues in order to safeguard AA as a young person. The IMR also noted that consideration should have been given to completing a mental health assessment and making a referral to the Community Adolescent Mental Health Service (CAMHS) following AA's self reported punch to a door.

**1 July – 31 August 2010**

4.9 For approximately three weeks around July 2010 AA was dating JW's younger brother and during this period on 21 July 2010 she attended the offices of the Youth Offending Team (YOT) with him. At this meeting AA made a number of disclosures that; she had violent thoughts towards her younger sister as she reminded her of her first step father who she alleged had sexually abused her when she was aged between three and 12 years; a few months previously a 25 year old man had tried to rape her; a taxi driver who took her to school behaved inappropriately towards her; she had taken a drug overdose (codeine) which had no effect; she had wanted to kill herself because she was fed up with life; she had abused drugs and alcohol intermittently; her boyfriend thought she had Attention Deficit Hyperactivity Disorder (ADHD) but her mum had said not. The YOT worker said that AA had told him she was worried she might hurt herself and needed help.

4.10 As a result of these disclosures the YOT worker made a referral on the same day to Children's Services Customer Service Centre and the case was allocated to the Targeted Advice Service (TAS) part of the Education and Early Intervention Service (non - safeguarding). TAS is a multi - agency team whose role is to gather further information, signpost and offer advice. Qualified social work practitioners and managers within TAS make decisions about next steps. In this instance TAS spoke with AA on the telephone, on the same day, when she said she was no longer concerned about harming her sister but was worried about hurting herself and described a history of self harm and suicide attempts dating back to when she was aged ten years. Following their discussion AA agreed to a referral to Connexions, which was facilitated by TAS, who also made a referral to

the Assessment Team (specialist and safeguarding services). Connexions do not have a record of any contact with AA at that time.

4.11 On 12 August 2010 a member of the Assessment Team telephoned and spoke to AA's mother. They recorded that she said AA was feeling better and had not been violent towards her sister, and that she reported that AA was due to see her GP on 18 August 2010 for a blood test and she would make a request for a referral to CAMHS.

4.12 The Assessment Team of Children's Services closed the case on 12 August 2010, on the basis that criteria for continuing involvement were not met and a referral for advice and support had been made to Connexions and that CAMHS was to be involved.

4.13 It is understood that AA commenced a relationship with JW during August 2010.

**Comment on events 1 July – 31 August 2010**

4.14 The YOT referral to Children's Services was undertaken in a thorough and timely way and TAS made contact with AA promptly over the telephone. Although Children's Services' records state they facilitated a referral to Connexions, Connexions did not have any contact with AA at that time. The Assessment Team understood that AA was due to see her GP and would be referred to CAMHS but they did not check that this happened. Children's Services IMR acknowledged that they did not respond robustly to the concerns AA had raised, and that they should have carried out an assessment, particularly in relation to the significant allegations she had made and her ability to keep herself safe.

**1 September 2010 – 31 December 2010**

4.15 AA was assessed by a nurse therapist from CAMHS on 17 September 2010, following a referral from her GP on 31 August 2010. The therapist described her as in a very low mood, with ideas of suicide and some thoughts of how she would kill herself. She had described traumatic experience in her life and poor family relationships. Protective factors were noted, namely that she enjoyed college and a part time job in a hairdressing salon, and she cared about her appearance. At the assessment appointment AA was given a helpline telephone number and advised to attend A&E if she felt worse. She was also given an emergency appointment with a psychiatrist on 23 September 2010. She went on to keep this appointment and was prescribed anti depressant medication.

4.16 AA had four further meetings with a nurse therapist at CAMHS. At AA's request JW joined in one of the meetings on 28 September 2010. The therapist asked them what they liked about each other, and suggested JW give compliments to AA and her try to accept them, as a means of boosting her confidence.

4.17 At another meeting with the therapist on 19 October 2010, AA was very upset because she had argued with her mother who believed she had taken some of her money. She spoke about committing suicide. AA's mother, who joined the meeting, was said by the therapist to be angry because of the missing money and said she had experienced years of being lied to. The therapist offered to see

them together on another occasion to discuss their relationship but neither was sure they wanted this. The therapist arranged for AA to see the psychiatrist the same day and later left a message on her mother's mobile and asked her if she could also attend, which she declined. AA kept the appointment but failed another on 9 November 2010 and did not respond to a written request to make contact with CAMHS team.

4.18 On 16 December 2010 CAMHS held a review and as AA had not kept an appointment or responded to a follow up letter, and had not renewed medication, it was decided to close the case. AA's GP was informed.

4.19 On two occasions, 31 October and 5 November 2010, AA was taken by ambulance to A&E due to vaginal bleeding and abdominal pain, and following triage assessment she was referred to the Hertdoc GP service on site at the hospital. It is standard practice for Hertdoc to then inform an individual's GP, and the GP confirmed that notifications were received. AA's mother said her daughter was living at home but she had not been aware of the hospital attendances.

4.20 In November and December 2010 AA was seen four times by her GP for sexual health consultations. The GP also encouraged her to attend CAMHS after finding out she had not kept an appointment.

**Comment on events 1 September - 31 December 2010**

4.21 This is the first time agencies record having seen AA with JW. There was no suggestion of domestic abuse during this meeting or others attended by AA. The IMR completed by Hertfordshire Partnership NHS Foundation Trust acknowledged a learning point from the review is that the assessment does not include specific questions about risk from others.

4.22 AA did not keep all the appointments offered to her by CAMHS, and there was no indication that the concerns expressed at referral had alleviated. CAMHS could have considered making contact with AA via her mother but given her age this would have required her consent.

4.23 Hertfordshire's Safeguarding Children Board Child Protection Procedures highlight that evidence of sexual or frequent gynaecological problems is a possible indicator of domestic abuse. AA's two visits to A&E for vaginal bleeding and abdominal pain, together with the four consultations with the GP for sexual health matters could have been indications that AA was experiencing sexual and/or domestic abuse. As questions were not addressed it suggests awareness needs to be raised through training.

4.24 AA had accumulated five attendances at A&E within a 12 month period, three for physical injuries and two for vaginal bleeding and abdominal pain, which is an unusually high number and should have given rise to questions of possible abuse both at A&E and with her GP service.

**1 January – 28 February 2011**

4.25 AA had two appointments with her GP in respect of urinary tract infection and for sexual health consultation. This adds further evidence to the point made in 4.23 above.

**March 2011**

4.26 On 3 March 2011 SBC contacted Herts Young Homeless (HYH) with a referral on AA as they understood she may be pregnant and anticipated she could become homeless. HYH is a registered charity which provides a housing advice service to young people aged 16 – 24 years. They can also provide ongoing support to a young person where they are living independently and are otherwise lacking support.

4.27 On the second time of trying, an advice worker from HYH made contact with AA on 9 March 2011. She confirmed that she had been to SBC following an argument with her mother's partner; she said she had pushed him and he had grabbed her arm causing a bruise. When asked about the arguments she said that her mother did not approve of her boyfriend. The worker spoke to her about a possible referral to Children's Services and AA said she did not want this.

4.28 On 16 March 2011 AA met with the HYH worker. She confirmed she was pregnant and said she had not told her mother yet. She said she had been in a relationship with JW for 8 months and they were "thrilled" about the pregnancy. She said that they wanted to rent a property away from Stevenage because JW was having some problems with drug dealers after he had given one of their names to the police. During this interview AA said she had been raped when in Sussex and been in a violent relationship when she was 14.

4.29 At the end of the meeting the worker agreed to contact AA in two weeks to talk again and that meanwhile AA would discuss private renting with JW and look into this.

4.30 On 30 March and 4 April 2011 the HYH worker tried to contact AA but could not get an answer, and her phone said the line was unavailable.

4.31 Also in March 2011 AA had four contacts with her GP, two due to a chest infection, one for a sexual health consultation and one to confirm the pregnancy.

**Comment on events March 2011**

4.32 By now, aged 17, AA was pregnant, and by her own account in a difficult situation in the family home. She reported an incident with her step father which she said had resulted in her being bruised and although she did not want this reported HYH should have done, to Children's Services, due to the nature of the allegations and because she was vulnerable due to age, pregnancy and risk of homelessness. In addition consideration could have been given to making enquiries of the police given what AA said about threats to JW from drug dealers.

4.33 AA did not disclose any current information with regard to domestic abuse. She presented for housing advice, not in housing crisis and therefore an initial assessment was not completed. Had it been, it would not have included specific questions about domestic abuse as these were not part of HYH assessment at that time.

4.34 In the light of the DHR and their own IMR, HYH acknowledged the need to review and update policies and procedures, including assessment documentation, and undertake further staff training. They established a working party which reviewed all related procedures and changes now include a requirement to complete an assessment using the DASH (Domestic Abuse, Stalking & Honour Based Violence) risk assessment and offer clear pathways for assistance and advice. Staff members are now trained to use DASH, which alongside the County Council's domestic abuse course is deemed to be core training for all front line staff at HYH.

**1 April – 31 May 2011**

4.35 On 6 April 2011 AA had her first contact with the community midwife. In line with procedures she was asked about domestic abuse and she reported a number of violent incidents within her family. This included abuse towards her from a previous partner, between her parents, from her father who she said had pushed her on hearing about her pregnancy, and from her brother who she said hit her in the stomach. However, she denied there was any violence in her relationship with JW and said he was very supportive of her. AA's parents and second step father told the DHR that they were not aware of the violent incidents within the family which AA had referred to.

4.36 AA had two further meetings with the midwife on 4 and 25 May 2011 and at the second meeting AA told the midwife that she was talking to SBC as her mother wanted her to move out of the family home.

4.37 Information sharing forms were completed by the midwife after each contact with AA, and shared with the multi agency team at a monthly meeting. This is a meeting attended by the Named Midwife (chair), Named Nurse Child Protection, East and North Hertfordshire Trust, Safeguarding Children Nurse, Hertfordshire Community NHS Trust, Social Worker and Liaison Health Visitor. The purpose of the meeting is to identify safeguarding concerns in pregnancy and risk assess with the multi agency team. Minutes are sent to all members to provide updates from the perspective of each member. It is understood that there was no discussion at the meetings about AA's relationship with JW, or his history. The case was closed to this meeting in October 2011. The circumstances are described below in paragraph 4.55.

4.38 AA had one visit to her GP during this period, with a sore throat.

**Comment on events 1 April – 31 May 2011**

4.39 AA established contact with the community midwife, and this appears to have been the first time she was specifically asked if she was subject to domestic abuse from her partner, JW, which she denied. It was good practice to ask her

because it has been established through research that pregnancy can increase risk of domestic abuse. A study by McWilliams and McKiernan in 1993 showed that 30% of cases of domestic abuse commence when a woman is pregnant.

4.40 AA did disclose violence from a previous (unnamed partner) and between her parents, although her parents have stated this did not happen, AA also referred to having been pushed by her father and hit by her brother but she was not questioned closely about it and no further enquiries or referrals were made, suggesting that the allegations may not have been taken seriously.

**1 June – 31 August 2011**

4.41 On 1 June 2011 AA's mother contacted SBC giving formal notice that AA had 28 days to quit the family home. She alleged that AA's behaviour had become challenging and violent causing issues with her younger sister, mother's partner and his children. She said AA had a history of mental ill health and possible substance misuse.

4.42 On 7 June 2011 SBC's Customer Service Centre manager referred concerns to their Children's Services and Safeguarding Officer and on the same day he telephoned AA's mother. He reported that she said that the father of AA's unborn child was JW and that he was violent. AA's mother recalls having said that JW was verbally abusive rather than violent, and expressed concern that AA was involved with him and did not want her daughter to be housed with him. She said that he had another child he was not permitted to see and that a teacher who knew AA from college shared her concerns about AA being in a relationship with JW. The chronology provided by North Herts College confirmed that AA was a student 2010/2011 during which time there were reports she suffered from bullying and that her behaviour also caused some problems. There was no specific information about JW. During the year AA transferred from hairdressing to retail, leaving without qualifications.

4.43 On 7 June 2011 SBC Children's Services and Safeguarding Officer made a telephone referral to HCC's Children's Services which he followed up in writing. Concerns as expressed by AA's mother were shared with Children's Services, with her knowledge and consent.

4.44 On 9 June 2011 SBC's Children's Services and Safeguarding Officer telephoned AA's mother to confirm the action taken. AA's mother disclosed further unacceptable behaviour by AA, and this was referred by the officer to Children's Services.

4.45 On 13 June 2011 the case was allocated to senior practitioner 1 in the Assessment Team (specialist and safeguarding services) of Children's Services who made arrangements to interview AA at home on 20 June 2011. This meeting took place and the practitioner gathered information from AA for a core assessment.

4.46 Practitioner 1 arranged for an interagency meeting on 30 June 2011 but this was cancelled because some people could not attend. Nevertheless, information was exchanged and practitioner 1 was able to complete a core assessment which

included gathering information for Section 47 Child Protection enquiries and Pre Birth Assessment in respect of AA's unborn child. The police said AA was not known to them, but JW had been cautioned for possessing an offensive weapon in 2009. Although these were not referred to, JW had received other cautions as noted in paragraph 2.3. CAMHS confirmed their contact with AA in 2010 and practitioner 1 also gathered information from the GP, midwife, SBC Housing Department and Connexions. However because Children's Services held duplicate records for JW, the practitioner was not aware that he had previously been known to Children's Services and that there was a significant and concerning history about his family, characterised by alcohol abuse, lack of parental control, poor school attendance, and aggression and violence between family members.

4.47 Practitioner 1 attempted to trace the name of the child with whom AA's mother said JW was not to have contact. She asked SBC Housing who asked AA's mother for more details, but she only had a first name, which practitioner 1 then used to search the Children's Services case database. No trace was found from this source.

4.48 Practitioner 1 attempted several times to meet with JW but he did not keep appointments offered and it was not until 24 August 2011 when she made an unannounced home visit to AA that she managed to meet him. By then AA had left the family home on 5 July 2011 and was living in temporary housing for pregnant teenagers and young mothers, allocated to her by SBC. Practitioner 1 reported that JW expressed a wish to be involved with the baby's life but had no permanent address and no regular income. He told practitioner 1 that he did have another child aged 18 months and stated her first name, and that he was not allowed contact because he had hurt her mother emotionally. AA's mother expressed surprise that JW was said not to have a permanent address as she understood he was living at his mother's house at the time.

4.49 On 31 August 2011 Children's Services closed the case having concluded that AA was putting her unborn child's needs first and making appropriate preparations for the birth.

4.50 On the same date she saw practitioner 1 from Children's Services, 20 June 2011, AA contacted HYH, explained she was now 20 weeks pregnant but still with her mother and about to be evicted on 29 June 2011. The HYH worker arranged to see her on 22 June 2011. On that date the worker telephoned AA to remind her of the meeting but she said she could not attend as she had a meeting with the midwife, and did not feel she needed HYH support now as she had weekly contact with a social worker.

4.51 During July 2011 AA had several contacts with Connexions whose advisors were able to help her with benefit claims.

4.52 Records also show that she continued to have contact with the community midwife, on 22 June, 3 and 24 August 2011 following which information was exchanged with other professionals as described in paragraph 4.37.

4.53 On 9 August 2011 AA spent a day on the labour ward following a referral from the GP as she had abdominal cramps.

**Comment on events 1 June – 31 August 2011**

4.54 AA was in contact with several agencies during this period and although she disclosed a number of problems, she did not say anything about abuse from JW. In June she told HYH that she was having weekly contact with a social worker but this was not an accurate reflection of the situation.

4.55 SBC made an appropriate referral to Children's Services who allocated a senior practitioner in the Assessment Team promptly, and she made an assessment based on a range of information from different agencies. This assessment focused on AA's unborn child. When practitioner 1 checked Children's Service's own records there were duplicates and the one she saw did not show JW's family history which would have given strong warning signs about the potential for domestic abuse. Also JW proved uncooperative as he did not attend several appointments made for him. When practitioner 1 did see him he was not responsive to the questions she asked about his plans with regard to AA and their baby. She did not get the details about his other child and as a result was not able to complete a more thorough check of Children's Services database. Had she had more detail she could also have checked if the child was known to health visitor services. Without the missing information the decision to close the case was flawed, as was the subsequent decision to stop discussing AA's case at the monthly inter agency meeting. Children's Services IMR acknowledged the assessment lacked robustness in respect of fully considering all the risk factors that had been identified.

4.56 Children's Services practitioner 1 did not advise SBC of the outcome of the intervention, which would have been appropriate given it was their agency which had raised the initial concerns about AA.

**1 September – 31 December 2011**

4.57 AA continued to have contact with the community midwife who made home visits on 21 September, 5 and 26 October and 16 November 2011. In addition AA saw a visiting health visitor when she attended the drop in clinic at her accommodation on 7 and 14 October 2011. On both occasions she expressed some anxiety, first because the baby was presenting as breach and secondly because she said her "sister in law", presumed to be the sister of JW, had recently given birth to a still born child. She also expressed her anxieties about this to the mid wife.

4.58 During this period AA had two visits to hospital, 11 October and 7 November 2011 in connection with her pregnancy, and on 17 November 2011 she gave birth to her daughter at the hospital. JW was not present and her mother was there as her birthing partner. According to AA's mother JW did not visit AA and the child until the following day.

4.59 The community midwife saw AA and the baby on 18 and 23 November 2011 as well as 3 December 2011. At the third visit AA said she was upset because she

felt she was getting post natal depression. She spoke about the still birth referred to previously and was upset because others were saying that baby looked like her own daughter. AA was worried she did not deserve the baby and said she felt guilty. She also expressed concern that she disengaged with her baby.

4.60 The midwife tried to make a further visit to AA in order to review her mood but did not find her at home. She spoke to her on the telephone on 16 December 2011 when AA said her mood was better, and at this point she was discharged by the midwife to the care of the health visitor who was already in contact with her.

4.61 Health visitor 1 first saw AA on 29 November 2011, when she said she had been staying at JW's family home, where there had been a recent still birth. AA reported that emotions were running high and she felt she was nurturing those around her as well as her baby. The health visitor gave her advice about how to access counselling services, but was not aware if she acted on this. The health visitor reported that the baby was alert, responsive and well.

4.62 Health visitor 1 saw AA and her daughter again on 9, 16 and 23 December 2011. The records show no reference to AA's mood or wellbeing; the baby was described as well, beginning to respond to cues from her mother.

4.63 During this period, AA had one contact with her GP, on 9 December 2011, for sexual health consultation. On 5 December 2011 a Keep in Touch advisor from Connexions telephoned AA to see if she needed any help or advice and she said she did not.

**Comment on events 1 September – 31 December 2011**

4.64 JW was not present at the birth of his daughter or at the appointments with health professionals prior and post the birth, raising a question as to whether he offered AA the support she said he did.

4.65 AA had a lot of contact with the midwife and health visitor 1; she did not say that she was subject to domestic abuse but neither was she asked. Health visitor 1's contact with AA on 29 November 2011 was a new birth visit and procedures require screening for domestic abuse. These procedures were not followed. AA was seen as vulnerable particularly in respect of having to be sensitive to grieving within JW's family where there had been a recent still birth. Also it seems from the way she presented that she did not have her own family support at a time when new mums look for this. As part of the DHR AAs parents reported that AA did have a lot of support at this time. Help was available to her on site at the accommodation where she was staying, which was specifically for pregnant teenagers and new mums, but she reported to health visitor 1 that she did not like it there because she felt there were too many rules. Health visitor 1 suggested counselling might be helpful, but there is no evidence that she was proactive in facilitating this. Neither the midwife or health visitor discussed the situation with AA's GP, which would have been good practice.

4.66 AA's case was closed to the inter agency meeting during this period and prior to her giving birth to her daughter. The IMR from East and North Hertfordshire NHS Trust, which covers midwifery services and A&E, questioned whether this was

appropriate given that AA was still vulnerable due to unplanned teenage pregnancy, mental health and housing issues, and that she had reported family violence past and present, past violent relationship, and the lack of family support. The decision to close the case to the inter agency meeting was informed by the decision Children's Services had made to close their enquiries, as described in paragraph 4.49.

**1 January – 31 January 2012**

4.67 AA was seen with her daughter by the health visitor on 6 and 13 January as well as by the GP on 10 January 2012 for the six weeks check and no concerns were noted.

4.68 On 19 January 2012 SBC's Children's Services and Safeguarding Officer telephoned AA's mother to follow up the contact from June 2011, and check on progress. AA's mother reported that AA was still with JW, and that she, mother, was not happy about this. She also said that Children's Services had closed the case.

4.69 On 20 January 2012 SBC made a referral to Aldwyck Housing Association for AA to have social housing, and by 25 January AA had submitted a housing application in which she had included JW as part of her household.

**Comment on Events 1 January - 31 January 2012**

4.70 Although AA was seen with her daughter for the six weeks check by both the health visitor and GP the two professionals did not discuss the case, which would have been best practice in the light of AA's age and past history.

4.71 It was good practice for the officer from SBC to make a follow up call to AA's mother to find out what the current situation was with regard to AA, but it highlighted the fact Children's Services had not advised the Council about the outcome of their intervention. Also in these circumstances it would have been advisable for the officer to contact Children's Services to find out what they had decided to do and why.

**1 February – 30 June 2012**

4.72 On 7 February 2012 AA met with two staff from Aldwyck to view the property they were proposing to allocate to her. She had expected JW to attend and when he did not she was said to have moaned about him not being there. However she did not appear concerned and did not present any issues.

4.73 On 13 February 2012 AA moved into the rented property in Stevenage. In the following three months Aldwyck tried to make contact with AA for a follow up visit but there is no evidence of her keeping an appointment.

4.74 On 17 February 2012 AA saw her GP when her social circumstances and mood were discussed. A follow up appointment was made for 1 March. This was not kept but on the same day AA attended the oral surgery clinical (referred to in paragraph 4.82).

4.75 Also on 17 February 2012 Hertfordshire Constabulary executed a drugs warrant at the family home of JW. They were concerned that a number of children and babies were present in an environment unsuitable for children and made a referral to the Child Abuse Investigation Unit (CAIU). They attended immediately and reported that the address was in a very poor condition upstairs with doors smashed off walls, sharp objects on the floor, sockets hanging off, no beds for teenage children, no linen or clear sleep space for a ten year old and overall a general mess. Downstairs was said to be better, with food in the fridge. Present at the address were JW's mother, her six children aged ten to 23 years, including JW, and her three grandchildren, one of whom was the daughter of AA and JW, at that stage aged 13 weeks. The CAIU officers were assured the babies / grandchildren would not be staying overnight. They considered removing the children to a place of safety but felt that the circumstances did not meet the criteria for a Police Protection Order, and following a discussion with Children's Services it was agreed Children's Services would deal with the case. CAIU were informed by Children's Services that there was still an initial assessment open to them in respect of AA's daughter; this was not so as the case was closed 31 August 2011. However there was ongoing contact between Children's Services and others present during the police raid.

4.76 As a result of the police executing the drugs warrant JW was subsequently cautioned for cultivating and possessing a small amount of cannabis.

4.77 Children's Service's records show that they received the referral from CAIU on 21 February 2012 (it is not clear why this was 4 days after CAIU were said to have made a report) and a manager made a decision to undertake an initial assessment within the Assessment Team. She noted that JW's family were known to the service, which had not been picked up at the previous referral from SBC in June 2011. Caseworker 2 was allocated to the case and it is clear from the initial assessment document that she was under the assumption that AA's daughter was not in JW's family home when the raid took place.

4.78 Caseworker 2 made an unannounced visit to AA at her home on 6 March 2012 when she saw AA and her daughter. JW was not present although AA said he was living with her (and records from the Department of Work and Pensions (DWP) show that AA and JW started to claim benefits as a couple from 1 March 2012). AA presented as appropriate and safeguarding her daughter and assured caseworker 2 that she would not let her daughter go to JW's family home if she thought it unsafe. She also told her that she was not aware if JW had a problem with cannabis and that he did not smoke in front of her and their daughter. Caseworker 2 told AA that she wanted to see JW to discuss issues around parenting particularly his cannabis use and she gave an appointment via AA. He did not attend and failed to attend two further appointments advised by letter, following which caseworker two made a telephone call to AA to express her concerns. There was no reply so she left a voicemail asking AA to call her urgently but she did not.

4.79 With manager approval a decision was taken to close the case and a closure letter was sent to AA and JW on 17 May 2012 advising that if further referrals were taken by Children's Services this could lead to child protection enquiries.

4.80 During this period a new health visitor 2 was allocated to the case who visited AA at home on 19 and 23 March 2012, when no concerns were noted, and AA seemed happy to engage with the health visitor. On 23 April 2012 health visitor 2 saw AA and the baby at home and discussed the possibility of counselling as AA seemed to have lot of unresolved issues. AA failed to keep a subsequent appointment with health visitor 2 on 29 May 2012.

4.81 Following a referral from SBC, HYH contacted AA on 23 February 2012 to offer their support now she was in her own home. She declined the contact. Connexions also telephoned her on 20 April 2012 to offer their service but she said she did not need it.

4.82 On 1 March 2012 AA was seen by an oral and maxillo facial surgeon following a referral from her GP due to pain in her jaw which "pops out and locks closed on a monthly basis." The referral from the GP did not include information about previous family violence. The letter received by the GP from the oral and maxillo team after they had seen AA included that she had been punched in the face. There is no evidence that questions were asked about the details of this injury, or whether there were present concerns about violence.

4.83 AA failed to turn up for a follow up appointment on 3 May 2012, and although she was seen again on 12 June 2012, a planned procedure to rectify the problem was not undertaken.

4.84 On 21 May 2012 AA saw her GP for a respiratory infection.

**Comment on Events 1 February – 30 June 2012**

4.85 The police who executed a drugs warrant at JW's family home acted swiftly by calling in CAIU when they saw that the home was unsuitable for children. CAIU made a judgement that they did not have grounds to remove the children and made a referral to Children's Services. CAIU were given to understand that the case was still open to Children's Services which was the case in respect of other members of JW's family, but not his daughter with AA.

4.86 Children's Services Assessment Team allocated caseworker 2 and within a few days she undertook an initial assessment in respect of AA's daughter. It is not clear how this happened but whereas police records show that the daughter of AA and JW was in JW's family home when the police raided it, caseworker 2 did not know this. In fact her records noted "the police felt that if the children had been in the home on their visit they would have been removed under police protection as the home was not safe for children". Had caseworker 2 known the child was in the house she would have been able to challenge AA's assertion that she would not allow her child to be there if she did not think it safe.

4.87 As a result of not having correct information caseworker 2's assessment was incomplete and based only on what she observed of AA and the child, and what AA told her. There is no evidence she checked with other agencies, for example health visitors, and she could not be reassured about JW's parenting because although she made several attempts to see him, he failed to keep any

appointments. Given the referral was a direct result of conditions reported at JW's family home, it would have been appropriate to make a visit there; there may even have been a chance of meeting up with JW.

4.88 Research conducted by UNICEF entitled *Behind Closed Doors - The Impact of Domestic Violence on Children* concluded "that although not all children fall into the trap of becoming victims or abusers there is a strong likelihood that domestic violence will become a continuing cycle of violence for the next generation. The single best predictor of children becoming either perpetrators or victims of domestic violence later in life is whether or not they grow up in a home where there is domestic violence. Studies from various countries support the findings that rates of abuse are higher among women whose husbands/partners were abused as children or who saw their mothers being abused. Also children who grow up with violence in the home learn early and powerful lessons about the use of violence in interpersonal relationships to dominate others, and might even be encouraged in doing so". Caseworker 2 had information about JW and his family history which showed JW was both a victim and perpetrator but neither she nor subsequent caseworkers seem to have taken this into consideration in dealing with AA and her child.

4.89 Once a decision had been made to close the case there is no evidence caseworker 2 reported the outcome to CAIU who had made the referral.

4.90 AA had a number of contacts with different agencies during this period, which presented opportunities for support and to enable her to disclose if she was suffering domestic abuse. Caseworker 2 did not ask as part of her initial assessment, and neither did either of the health visitors with whom AA had contact. Hertfordshire Community NHS Trust Domestic Abuse Practice recommends that health visitors routinely screen all women at around 12 weeks postnatal, but it was not done in AA's case, because they said they had no information to suggest domestic abuse was a concern.

**1 July – 25 September 2012**

4.91 Health visitor 2 wrote to AA on 25 July 2012 to arrange a developmental review. A second letter was sent on 29 July 2012 but she did not respond to either.

4.92 On 10 August 2012 a Connexions advisor telephoned AA's family home to speak to her and in her absence spoke to her mother. AA's mother confirmed that AA was a full time mum and did not want to work. She also said AA had moved but she could not remember the address and requested a call the next week so she could check. There does not appear to have been any follow up.

4.93 Aldwyck Housing Association had a meeting with AA in her home on 22 August 2012 to review the tenancy. She reported that JW was no longer part of the household. She gave no reason and did not express any concerns.

4.94 On 6 September 2012 JW attended HYH with his younger brother who HYH were supporting. The worker asked JW why his brother could not stay with him and he said that his partner thought that his brother had something to do with a burglary at her mother's house. As JW's brother was street homeless he was asked

where his belongings were and he explained that they were at JW's house, but his partner did not know as she was out.

4.95 On 12 September 2012 AA was seen by GP2 and presented with symptoms suggesting post natal depression, weight loss, increased anxiety and some paranoid ideas about people hating her and being against her (in particular she was said to be petrified of her sister and to have a difficult relationship with her mother). GP2 reported that AA said she felt supported by her partner, JW, who supervised her medication to ensure she did not take an overdose. She spoke about them having arguments which seemed to GP2 like any other couple. The GP had no concerns about the care she was providing for her daughter which she thought was exceptional. GP2 noted she had a past medical history of deliberate self harm but denied current intentions and said she was going to keep going because her "baby keeps her sane". GP2 agreed to see her on a 2 weekly basis or more urgently if needed until her mental health stabilised.

4.96 On 12 September 2012 AA attended a Children's Centre where she saw an outreach worker. She had gone there to have her child weighed thinking there was a Well Baby clinic being held. The outreach worker told her there was not and gave her details of the correct venue. AA spoke for some time to the worker and seemed to still have issues about the still birth experienced by a person she described as a relative. The outreach worker was concerned about AA who left without leaving her details. The outreach worker contacted health visitors who were able to work out it was AA. Health visitor 2 agreed to do a home visit to monitor, provide support and give AA information about the Children's Centre Parenting Group and the availability of contact with an outreach worker.

4.97 On 13 September 2012 AA attended a different clinic where she saw health visitor 3 and was given advice about weaning. Health visitor 3 did not know about the concerns raised the previous day, as it is not routine at clinics to open parent's case records when making an entry on to a child's records.

4.98 On 19 September 2012 health visitor 2 made a home visit to AA but there was no reply. She left a letter, requesting contact to arrange a visit. AA did not respond.

**Comment on Events 1 July – 25 September 2012**

4.99 AA's contact with the housing provider suggested that JW was no longer living with her, although this was at odds with what he said to HYH when he attended an appointment with his brother.

4.100 JW was not seen by any of the agencies in contact with AA, with the exception of HYH although it is understood they were not aware of his connection to AA.

4.101 Although she previously had a good level of contact with health visitors AA did not keep in touch with her allocated health visitor during this time. The IMR reports that it is not unusual for mothers to disengage as children get older and the mother becomes more confident in her ability. Development assessments and reviews are not always taken up by parents and there is no statutory requirement to attend. However, during this period AA attended the Children's Centre hoping there was a clinic there, and another clinic where she saw a

different health visitor (3), even though she must have known how to access health visitor 2 who she was used to seeing; and it does raise a question as to why she would do this. Judging by her contact with the GP she was very anxious. Symptoms were assessed as post natal depression but could have been as a result of domestic abuse, and this was not explored by the GP. When she failed to keep appointments with health visitor 2, a referral to the GP should have been considered given the concerns expressed following her meeting with the Children's Centre outreach worker.

**26 – 28 September 2012**

4.102 On 26 September 2012 AA attended SBC Customer Service Centre with her daughter where she told an advisor that she wished JW to be removed from her home. She gave the advisor a letter but it is not known what the contents were and it has not been found. In person, AA disclosed that JW controlled her money and that he had assaulted her twice. The advisor encouraged AA to contact her GP, and in the presence of the advisor an appointment was made for the same day.

4.103 The advisor also offered AA the details of Hertfordshire Domestic Violence Helpline which offers support and local agency information for anyone affected by domestic abuse. It is completely confidential and its usage does not show up on a telephone bill. AA declined the offer of making a call there and then, saying she "wanted to make it work for her family".

4.104 The Customer Service Centre advisor referred AA to a housing advice officer who also spoke to AA on 26 September. She told the officer that JW had assaulted her twice, once kicking her, the other time hitting her around the head. She said that they often argued but not always violently. AA said that she felt her daughter was safe from harm. She also said she had not informed the police as she was too scared and is often paranoid. The officer advised AA about the Helpline, or the option to seek housing from another authority; she explained Stevenage could not re-house her. She also advised her to contact the police and housing association (Aldwyck Housing) to make her home safe, and she told AA that she would be making a referral to Children's Services in respect of AA's child.

4.105 After this contact with AA the housing advice officer made a referral to Children's Services by e mail on the same day.

4.106 After seeing AA and referring AA to the housing advice officer, the Customer Service Centre advisor spoke to his line manager about the contact with AA, and on 27 September 2012 she made a separate referral to Children's Services.

4.107 After her visit to SBC on 26 September AA kept the appointment with GP2 who reported that AA presented with panic attacks and she was said to be anxious. She reported that her partner is away and "doesn't spend enough time with them". Domestic abuse was not referred to by AA and the GP did not ask. AA was prescribed Fluoxetine and Diazepam on this date.

4.108 On 28 September 2012 Children's Services records show a referral from the SBC Customer Service Centre manager that said AA was being physically and emotionally abused. The case was allocated to the TAS and on the same day an information and advice officer, (caseworker 3) telephoned AA who confirmed JW had been physically violent to her on two occasions. She said she was seeking support through her GP regarding anti-depressants. She also said JW was very safe and appropriate with their daughter and that she had told him she will not put up with further violence; this is his last chance or she would call the police. AA agreed with caseworker 3 to a referral to the Early Intervention and Targeted Support Team (EITST) of Children's Services. This team is no longer in place and has been replaced by Thriving Families Teams. When it was in place EITST worked directly with vulnerable children, young people and families with additional or complex needs, which did not meet the threshold for specialist and safeguarding services, to prevent escalation to those services.

4.109 On 28 September 2012 the Customer Service Centre Manager from SBC telephoned AA. She told the manager she would give it one more go with JW, that he was remorseful and that she believed he would not be violent towards her again. She also said that the behaviour of both of them needed to change. The manager e mailed Children's Services to update them with what AA had said. She also made contact with the Children's Centre, spoke to one of their workers and asked that they offer services to AA. The outcome of this referral is not known.

4.110 Also on 28 September caseworker 3 recorded that she contacted AA's GP who was said to be concerned that AA could be the victim of some kind of domestic violence and asked what support Children's Services could give. The worker explained there was to be a referral to EITST. It is not clear if she told the GP that AA had disclosed domestic abuse. The GP service has no record of this contact from Children's Services.

**Comment on events 26 -28 September 2012.**

4.111 This was the first time AA told any of the agencies that she was a current victim of domestic abuse and that JW was the perpetrator. She spoke about him being violent towards her as well as taking her money. She partly blamed herself and tried to assure those she spoke to her that he would not harm their child, both being coping strategies where domestic abuse is happening. At first she said she wanted JW to leave the house but then said she wanted to give their relationship another go. She was advised to go to the police but said she did not want to. She was also given information about the Domestic Violence Helpline and a referral was made to the Children's Centre who could offer services to her and her daughter. This advice and actions are in line with SBC's Domestic Violence Policy but they could have been more pro active by offering to liaise with Aldwyck about how AA might evict JW, and by making a referral to the Women's Centre or a Multi Agency Risk Assessment Conference (MARAC). According to her mother AA may have made contact with the DV Helpline, but it has not been possible to confirm this.

4.112 SBC policy does not include assessment of risk to a victim, so when they gave advice to AA and made a referral to Children's Services it would not be known if

the officers at the Council considered her high risk or not as defined by DASH. Had there been such an assessment it may have triggered a referral to MARAC.

4.113 SBC staff recognised they had a duty to protect the child. Two staff made separate and prompt referrals to Children's Services for what was one event, which demonstrates a lack of co-ordination, and could have led to misunderstanding or confusion, but did not appear to.

4.114 Children's Services IMR noted that although the decision to allocate the case to TAS rather than the Assessment Team could be queried it was also noted that the decision to refer to EITST had been made by a manager, based on what was said to be an improving situation between AA and JW. However, this was an over optimistic view given that AA admitted JW had struck her twice, and there were historical concerns about JW.

4.115 Although caseworker 3 recorded that she contacted AA's GP on 28 September and that the GP referred to concerns about domestic abuse, GP records did not confirm this contact and GP2 was said to be unaware of the abuse divulged by AA.

4.116 AA had presented to her GP with symptoms which could have indicated domestic abuse but this was not explored with her.

**1 – 30 October 2012**

4.117 On 2 October 2012 Enhanced Primary Mental Health Services (EPMHS) received a faxed referral, to their single point of access from AA's GP, the reason being that AA was suffering anxiety and depression. She was said to have been prescribed Fluoxetine and Diazepam. There was no mention of domestic abuse in the referral as the GP was not aware.

4.118 On 4 October 2012 EPMHS single point of access tried to contact AA without success. A letter was sent asking her to call to book an appointment which she did and she was seen on 12 October 2012 for a triage assessment. As previously stated the assessment does not include specific questions about domestic abuse, and AA did not volunteer the information she had already disclosed to SBC staff. At the triage assessment AA said that she was hooked on past issues which hurt her now, and that she had negative thoughts and bad things going through her mind which made her angry and frustrated. She also said she would become tearful and panic. As a result of the triage a referral was made to EPMHS for an assessment, and the GP was informed.

4.119 Following SBC referral to Children's Services on 26 September and their Targeted Support worker's contact with AA on 28 September, the case had been referred to EITST, and on 8 October 2012 caseworker 4 tried to telephone AA. He got no reply and left a voicemail. The same thing happened on 12 October 2012.

4.120 On 12 October 2012 AA was seen by her GP who noted that her weight was deteriorating and that she had serious thoughts about self harm. She said she did

not feel supported by her family. Medication was prescribed on a two weekly basis as AA was seen as high risk of self harm.

4.121 On 17 October 2012 a new health visitor (4) was appointed to the case and it was noted that AA's daughter had not been seen for her first year check.

4.122 AA was last seen by her GP on 22 October 2012 when her weight was checked and a food supplement prescribed. She expressed concern that JW's benefits had been stopped and GP2 recorded that a plan for her to receive Disability Living Allowance was completed due to her depression. DWP records confirm that benefits to JW were stopped on 15 October 2012 due to him not attending interviews at DWP as required.

4.123 On 26 October 2012 caseworker 4 from EITST made a telephone call to the housing advice officer at SBC who confirmed the details of the referral. The housing officer said that AA had sent in a letter requesting JW be re housed. The officer said there had been no evidence of the domestic abuse incident reported by AA and so there was a question as to whether the allegations were being used to secure a property for JW.

4.124 On 30 October 2012 AA was assessed at her GP surgery by a high intensity worker from EPMHS. She was accompanied to the surgery by her daughter and sister who remained in the waiting room. Notes from the assessment describe a complex history involving previous violence and abuse. AA was said to have flashbacks to when she was two years old when she said her father was violent to her mother. She also described an ongoing history of traumatic experiences which included her mother hitting her and her first step father tickling her inner thighs and watching her use the toilet. AA also described being victimised at school. As the session drew to an end AA said "I have to go home to a monster" and began talking about the violence from JW. According to AA the violence had commenced in August 2012 and had been escalating. She said JW was not abusive to their child but did describe an incident in the previous week where JW had "launched" a side table and a pair of scissors while both AA and her daughter were in the room. She gave other examples of violence including that he hit her on the side of the head, spat at her and regularly abused her verbally. He had threatened further violence if she went to the police. She reported that he said "I will snap your neck in your sleep". She also said he controlled her money.

4.125 EPMHS worker asked AA what she could do to keep herself and her child safe as this was a priority. She said her sister would be staying with her. She also said she did not want to go to a hostel; she had been to the Council and they had advised her to give JW notice to quit. The worker suggested the Women's Resource Centre could help as they offer counselling and practical help to women experiencing domestic abuse, and AA agreed. The worker also told AA that she would make a referral to Children's Services to ensure the safety of AA's child and AA was said to be in agreement with this.

4.126 The worker made a same day referral to Children's Services and they acknowledged that they had already received a referral from SBC.

4.127 On 30 October 2012 health visitor 4 tried to contact AA. Her mobile was answered by another woman who suggested a call back later. The health visitor was unaware of AA's disclosure of domestic abuse and the next time she tried to contact AA was after her death.

**Comment on events 1 – 30 October 2012**

4.128 AA saw her GP twice in this month and did not disclose domestic abuse. Although she was suffering symptoms which may have indicated domestic abuse there is no evidence this possibility was explored by her GP.

4.129 At the triage assessment with EPMHS on 12 October 2012 AA did not refer to the domestic abuse.

4.130 It was good practice that the worker from EPMHS who saw AA on 30 October 2012 suggested that she go to the Women's Resource Centre. She also made a referral to Children's Services out of concern for AA's daughter.

4.131 There was no basis for the suggestion by a housing officer at SBC that AA was using allegations about JW, in order to secure housing for him.

**31 October 2012**

**Children's Services Early Intervention and Targeted Support**

4.131 On 31 October 2012 EITST caseworker 4 from Children's Services spoke to AA on the telephone. He had tried to contact her previously but it is not clear from the records how many attempts he made and when. At the time of this call AA was at the Women's Centre and said she was receiving support from staff there. She also said she had been referred by her GP to EPMHS. AA told him that she was having serious difficulties with JW. She did not refer to physical abuse but that it was more verbal and mental. She reported not feeling safe and feeling anxious and fearful around JW and his brother. She referred to an incident when JW had threatened her because she would not give him £20. She said he stood there and did nothing whilst his brother was in her face and threatened to beat her up. She gave him the money because she was scared. She said she wanted to be out of the relationship and she had told him to leave several times but he told her he would not go unless she found him a flat.

4.132 Caseworker 4 recorded that AA seemed to realise the negative effect this situation could have on her daughter and it concerned her. She referred to having had a physical fight with her older sister when her daughter was in her arms and later when she reflected on this she was very upset. She took some tablets but not enough for a suicide attempt and she pressed scissors into her wrist but then stopped when she saw a picture of her daughter.

4.134 At the end of the call AA agreed to meet caseworker 4 on 5 November, in a café in Stevenage.

### Enhanced Primary Mental Health Services

4.135 On 31 October, following up the contact on the previous day, the EPMHS worker telephoned AA and she was at her mother's house. AA told her that Children's Services were now involved and she had an appointment for 5 November 2012. She said she had already been to the Women's Resource Centre and found them very helpful. AA told her she felt good that she had taken action. The worker noted that AA sounded upbeat and positive and was impressed how quickly she had acted.

4.136 Later the same day the police telephoned the worker from EPMHS to say that both they and Children's Services were now involved.

### Herts Women's Centre

4.137 On 31 October AA attended the Women's Centre in Stevenage accompanied by her mother and sister. This was not a planned appointment but AA was seen by a support worker immediately because of the nature of her enquiry. She was described as being very upset and scared. She reported that JW had been physically, emotionally and financially abusive. She spoke of an event earlier that day when she had been at the shops with her sister and when she saw JW he demanded money from her which she needed for nappies and electricity. She said he shouted at her in front of some of his family and friends and they were encouraging him. AA had been frightened and threw £20 at him and left with her sister. AA also told the support worker about a previous incident when JW had hit her around the head when she was sitting in bed. This had caused pain to her ear. AA's mother said she had not been aware JW had caused this injury, because AA had previously told her she banged her head. The support worker discussed the options of a refuge, which they said would have been out of area, most likely Cambridgeshire, because to stay in the area would have been too risky. Other options explored were staying with her mother or another family member outside the area. AA did not want to leave the area where she felt she got support from her mother, and thought there would be repercussions for her mother from JW if she moved in with her mother or moved away.

4.138 The support worker encouraged her to report the incidents to the police. She also informed AA about the Freedom Programme which would be available to her at the Women's Centre. This is a nationally recognised programme to help women understand an abuser's behaviour, its impact on them and their children and to develop safety strategies. The support worker gave AA a lip gloss which contains a contact for the Domestic Violence Helpline, without it being obvious should JW have gone through her handbag. AA was offered a follow up appointment which she declined, saying she would make contact when it was safe to do so.

4.139 While AA was with the support worker, she took a call from caseworker 4 from EITST and made arrangements to meet him on 5 November 2012. She agreed to make another appointment at the Women's Centre after she had seen caseworker 4.

4.140 The support worker completed a risk assessment as part of her session with AA and identified her as high risk. The case was discussed with her manager directly

after the session and the risk assessment was signed. They agreed there would be no further contact with AA until she made this herself. It was acknowledged that AA was in contact with Children's Services. She had also told them she was in contact with Mental Health services.

4.141 During the course of the review AA's mother stated that she had insisted AA go to the Women's Resource Centre that day as soon as she became aware that JW had been physically abusing her daughter. She said that AA had come to her house very upset after a visit to the shops where she said JW and his brother had threatened her into giving £20 to JW. When describing events to her mother she disclosed that he had been physically violent towards her. Although AA's mother had known about the bullying and that JW tried to isolate AA she said this was the first she knew he had been physically abusive.

**Hertfordshire Constabulary**

4.142 At 15.33 on 31 October 2012 police record that they took a call from a social worker at Children's Services, to say they had received a referral from Mental Health Services the night before, in respect of AA who had reported domestic abuse from her partner JW. It was said that it had got worse since August. He had broken her mobile so she could only receive calls on her loudspeaker enabling him to hear everything.

4.143 When dealing with the call from Children's Services the police tried to call the Domestic Violence Officer (DVO), Harm Reduction Unit but there was no reply. The communications sergeant on duty instructed for an e mail to be sent to the Harm Reduction Unit about the case and the duty inspector was informed so the information could be assessed. The inspector was reluctant to act by attending AA's address in case this should escalate the problem. He was aware that AA did not know a referral was being made by Children's Services to the police and he had been given AA's mother's telephone number, so he called her. She confirmed that AA had said she had been subjected to domestic abuse/violence during the past six months and that AA had disclosed to her that she was scared. She said AA had been to the Women's Resource Centre. She confirmed that AA was with JW at AA's home that evening. She agreed that it would be appropriate for the police to see AA in a more discreet manner.

**Comment on events 31 October 2012**

4.144 Caseworker 3 from Children's Services TAS spoke to AA promptly after receiving the referral from SBC and then the case was referred to EITST rather than the Assessment Team. This is difficult to understand given the referral was due to safeguarding concerns. Although it is not clear how many times, EITST caseworker 4 tried to make contact with AA but it was a month before contact was established, which represented an unacceptable delay given the nature of the referral.

4.145 The TAS multiagency team and Children's Services EITST were aware of the safeguarding concerns for AA and her child as a result of a referral from SBC on 26 September 2012, but there was no notification to the police until EITST

received a second referral, from EPMHS on 31 October 2012, which is also an unacceptable delay.

4.146 Although they only have a small staff group the Women's Centre were able to give AA immediate priority which was appreciated by her mother who visited them after her death to thank them for the support they had given.

4.147 The assessment being used by the Women's Resource Centre is not DASH but a generic assessment for users of the Centre. Nevertheless they did assess that AA was high risk of domestic violence. The Centre's assessment tool does not include a safety plan or actions for risk management and the expectation is that safety measures are included and recorded at each contact. In AA's case measures were consideration of a refuge or other places she might get away from JW, a self referral to the police, encouragement to return to the Centre, and provision of a helpline contact via the lip balm. There is no evidence that AA was encouraged to make a safety plan, such as the one which is included in the Survivor's Handbook on the Women's Aid website.

4.148 Recognising that there are barriers to women reporting domestic abuse to the police, the Women's Centre has started work with the police to try to establish a safe system for reporting. This involves having a liaison named police officer to act as initial contact. However, this does not always work satisfactorily as the officer may not be available and the IMR cited two negative examples which reflect that they do not as yet trust the system. It is noted that although AA was encouraged to contact the police there was no suggestion of asking her if she would consider a police officer coming to talk to her at the Centre. This may have been a viable option given Centre staff considered her high risk.

4.149 None of the agencies considered making a referral to MARAC. The author of the IMR for the Women's Centre suggested there may be a question of trust from their service due to a previous incident when information provided by the Centre at a MARAC was used inappropriately by another agency.

4.150 The police decision not to make a home visit on 31 October was based on concern that they could make things worse. They were aware that AA was reluctant to speak to them and judged that if they attended she may not have confirmed that JW had physically abused her, giving them no reason to arrest him; and if she did not leave then (with her daughter) she and the child would have been even more vulnerable than before the police visit. This was a judgement call which was reasonable.

**1 November 2012**

4.151 On 1 November 2012 the DVO from the Police Harm Reduction Unit telephoned AA's mother, as she had judged on the basis of what she had already been told, that it would not be safe for AA if she contacted her directly. AA's mother reiterated that AA would not engage with the police as she was frightened of JW and his family. She said she too was worried about repercussions after one of JW's family members burgled her house. She said that AA was due to meet an outreach worker on 5 November. This was the appointment with the caseworker

from EISTS as referred to above in paragraph 4.132. AA's mother said she would encourage her daughter to speak with police.

4.152 Following this contact the police log recorded that the "IP and her child are at risk. Equally this is a third hand report of abuse (believed to be credible). Direct action at this stage is likely to make the victim more hostile towards police and may compromise evidence. Equally police action may escalate risk. Therefore there is insufficient evidence to crime anything at this time. I am content that proactive actions are being progressed by IP's mother, outreach worker/Harm Reduction Unit to assist the IP".

4.153 The DVO noted there was no indication that the child had been threatened or was in any danger. She arranged for associated persons (AP) markers on AA and JW indicating domestic violence which effectively meant that if any incident involving them had come to the police attention, wherever they were, the police would have known to intervene as a matter of priority. The police IMR suggested they could also have put SIG markers on the relevant addresses

**Comment on events 1 November 2012**

4.154 The DVO, an experienced officer, tried to contact AA via her mother as soon as she was informed about domestic abuse. She understood that AA was reluctant and judged like other police colleagues that to intervene at that stage could have increased the risk to AA. The normal practice is for the DVO to see a victim prior to making a referral to an IDVA and because she had not seen AA she did not make a referral. She could, however have made a referral to MARAC to provide an opportunity for inter agency exchange and case management.

4.155 Although the DVO had expected Children's Services to be seeing AA on 5 November 2012 she did not inform them of the decision that police would not be intervening. Her assessment that AA's daughter was not in any danger was based on what AA had told her and was unrealistic. The link between child physical abuse and domestic violence is high with studies estimating 30 – 66%. Also, a study by Hughes, 1992 showed that in 75 – 90% of domestic violence incidents a child or children were in the same room.

**5 November 2012**

4.156 On this date caseworker 4 from EITST met with AA as previously arranged. She had her daughter with her who seemed to the caseworker to be "well, happy, inquisitive and busy". She said she had preferred to meet outside the home as she did not know how JW would react if he knew she had reported the domestic abuse to anyone official. She spent much of the two hour meeting recalling events from her childhood most of which have already been covered in this report. She did say for the first time that she had resented moving back to Stevenage from Sussex as she was in the middle of exams and did not achieve what had previously been predicted. She also said she looked back on her introduction to JW's family with regret as how they lived was an eye opener to her. They lived in a state of chaos and she said she should have known better than to get involved with them. She thought JW was different, quieter. She said she was asked to leave her mum's house when she was pregnant as she did not

get on with her stepfather. She expressed resentment that her mother had chosen him rather than her.

4.157 AA told caseworker 4 that JW was under the impression he was named on the tenancy of the property they shared, but he was not, and she seemed concerned about him finding out.

4.158 AA stated JW had anger problems and described arguments between them and that he had been physical with her although she did not give details. She was quick to say he would not hurt their daughter but the caseworker explained the effects of domestic abuse on children. They discussed options for supporting AA and her daughter and working with JW. AA said JW was suspicious of social workers and the caseworker suggested they could explain the focus would be to support the child.

4.159 At the end of the meeting caseworker 4 agreed to contact AA to arrange a further appointment and meanwhile asked AA to consider options which included the Sunflower service (support specific to domestic abuse), Children's Centre, health visitor, home start and support from Children's Services using the CAF. The latter would have been voluntary on AA's part and would have provided multi agency support, with one lead professional allocated to ensure integrated support.

**Comment on Events 5 November 2012**

4.160 Caseworker 4 concentrated on trying to gain AA's confidence so that she would commit to working with him to the benefit of her daughter. He hoped that he would also be able to engage JW but this was unrealistic given his reluctance thus far.

4.161 There is no evidence that caseworker 4 saw this as urgent or a significant child safeguarding concern in respect of AA's daughter and as acknowledged in Children's Services IMR, EITST should have referred the case to the Assessment Team for further assessment. Caseworker 4 did not give AA a date for their follow up appointment, and it was not clear what he would do next if AA did not co-operate with the options he had discussed with her. He would still have been left with the fact she had reported abuse and both she and her daughter were at risk. He should have considered other options, such as liaison with other agencies and a referral to MARAC which would have provided an opportunity for sharing information and to consider how risks to AA and her daughter could be managed.

**6 November 2012**

4.162 The Keep in Touch Advisor from Connexions telephoned AA. She said she was having some difficulties in respect of her ex partner and that she did not need help from Connexions as she was accessing support through another agency. She was encouraged to use the one stop shop if she wanted to. The Connexions advisor was not aware of domestic abuse.

4.163 AA made contact with the DWP to request a crisis loan. She was advised she had income to spend on the next day and she withdrew her request. She also

made enquiries about Employment Support Allowance and a claim form was sent to her.

**7 November 2012**

4.164 After a telephone call from AA the DVO met with her at Hatfield police station. Her mother and daughter were also present. AA said she would have to make something up to JW to explain her whereabouts. She said she was feeling stronger and stated she believed JW was seeing someone else and she had asked him to leave, but he had said he had every right to be there. She was given advice by the DVO that as they had only been together a short time and he was not on the tenancy agreement and refused to leave, the police could assist. She stated that if JW's brother was there when she returned to the address they would start smashing things up. She was advised not to go in and call the police. She was offered refuge but refused stating she would not leave her mother as they would then target her. Her mother stated they would stop at nothing to get to AA. Information about support networks were explained to AA. The DVO told AA she would make a referral to the IDVA and ask her to make contact with AA via her mother.

4.165 AA's mother recalled when they left the police station after seeing the DVO that her daughter was very positive about the future; that she would get her life back in order when she ceased the relationship with JW.

4.166 The DVO made the referral to the IDVA on 8 November 2012 and said she would have followed it up a couple of days later if she had not had a response. If the IDVA had not been able to make contact with AA the DVO said that she would have referred AA to the MARAC.

4.167 The DVO confirmed that AA was extremely scared of JW, would not officially report any incidents of violence and said she did not want further police involvement.

4.168 It is understood that AA was murdered between 23.30 on 7 November and 09.30 on 8 November 2012.

**Comment on events 6 and 7 November 2012**

4.169 Her contact with DWP suggests AA was making arrangements as a single mother, without JW.

4.170 By all accounts AA was frightened of JW and it therefore took great courage on her part, with the support of her mother, to go to the police. She declined their intervention but accepted the referral to IDVA.

4.171 The DVO did not follow policy in that she did not record that this was crime or non crime domestic, which would have triggered a risk assessment. She did not consider that she had enough information on which to base a DASH assessment but the police IMR challenged this as she did have information about JW's abuse of AA, even if AA was reluctant to provide it to the police.

Although she did not conduct an assessment, the DVO clearly thought AA was high risk as she referred to the IDVA.

4.172 The DVO advised AA that the police could assist her in getting JW out of her property, an option which had also been mooted with her previously by SBC and the Women's Centre.

**8 November 2012**

4.173 The IDVA received a referral from the DVO on AA; she was advised to try contact via AA's mother.

**9 November 2012**

4.174 The IDVA sent a text to AA's mother asking her to make contact. She did not receive a reply. Although it would not have made a difference in this case the IMR has highlighted the need to have local guidance for IDVA's and this is being acted on by Victim Support, the organisation which manages the IDVA service in Hertfordshire.

**11 November 2012**

4.175 On this date AA's body was found. After her death a number of letters were found by police in her home. These were requests from AA to JW referring to the breakdown in their relationship and asking him to vacate the house; the content indicates she was trying to cope with the situation in a calm way. JW had made an attempt to respond, with poor literacy skills. There was a letter from AA, addressed to SBC, asking that they find JW somewhere else to live. It is not known if this was a copy or if it was ever sent. There was also a letter from AA dated 12 August addressed to her "nana", who was no longer alive, describing how she was feeling; getting skinny, hating who she was, not being able to control her mood swings and not having any help. AA said she needed her "nan" to comfort her like she used to.

## 5 Findings of the Review

5.1 The findings have been drawn from a review of the contents of the IMR's and the comments made throughout the above chronology. In addition consideration has been given to how agencies measured up in respect of each of the terms of reference. The questions outlined in key lines of enquiry, in paragraphs 1.5.1 – 1.5.4, have also been taken into account.

5.2 Some of the agencies involved in this review have policies and procedures which are specific to domestic abuse, whilst others use Hertfordshire's inter agency procedures for safeguarding children and vulnerable adults; and have been trained accordingly. The procedures for children are specific in respect of domestic abuse whilst those for adults are not, and are based on a definition of vulnerable adult which does not include a victim of domestic abuse. This is currently being addressed by the Safeguarding Board. Some of the agencies have recognised the need to revise their procedures and carry out additional training, and have included this in their IMR recommendations.

5.3 GP services do not have policies and procedures for domestic abuse but have access to Department of Health guidance entitled "Responding to Domestic Abuse: Guidance for General Practices" (2012); it is understood that GP's at the surgery where AA was a patient have not yet received training in domestic abuse.

5.4 DASH is a widely recognised tool for assessing risk and identifying pathways for support in cases of domestic abuse and is adopted by Hertfordshire's County Domestic Violence Forum. However, it is not used by agencies involved in this review, other than the police and IDVA.

5.5 Prior to her disclosure that she was subject to domestic abuse, AA presented to several agencies when she was seen as vulnerable because she had a number of problems including potential homelessness, teenage pregnancy, being a new young mum, physical and mental health, and what she described as lack of family support. SBC and Aldwyck Housing provided help in relation to her homelessness and HYH offered support both when she was leaving the family home and when she was settled in her own home. The midwife and health visitors gave her assistance throughout the pregnancy and during the first few months she was a mother. This help continued to be available to her but she did not maintain contact.

5.6 In 2010 and prior to commencing a relationship with JW, AA had some unexplained injuries which were not investigated as possible domestic abuse or child safeguarding concerns by A&E or GP's. During the same period GP services, particularly GP2, CAMHS and EPMHS were effective in identifying that AA was suffering from mental ill health and she was offered appropriate interventions which included medication.

5.7 During this same two year period, AA was referred to Children's Services on three separate occasions, the first, when AA was under 18, was from the YOT, due to concerns that she might hurt herself and needed help; she also alleged she had been sexually abused in the past. The second referral was from SBC, because she was being given an eviction notice from the family home at the time she was pregnant and third, by the police because they had safeguarding concerns about AA's daughter who they had seen in JW's family home when they conducted a drugs raid. On each occasion Children's Services were not wholly effective in assessing AA or her child's needs because they did not have enough information, or the information they had was inaccurate. The third intervention was of particular concern because Children's Services did not see JW, due to his lack of co-operation. They did not appear to take into consideration his family history and they based their assessment of AA's ability to protect the child on misinformation, that is, the child was not present when the drugs raid took place. There is no evidence that AA was offered support as a result of her contacts with Children's Services during this period. After the first contact, Children's Services were aware from AA's mother that AA was due to see her GP, and that AA's mother would request a referral to CAMHS. They also facilitated a referral to Connexions, but they did not check if either option for support was followed through.

5.8 During the period before she disclosed domestic abuse AA presented to some agencies, in particular GP services, with anxiety, depression, weight loss and urinary tract infections. These are recognised symptoms of domestic abuse but there is no evidence that this possibility was explored with her, which suggests a training need. AA also made some significant allegations of physical and sexual abuse to different agencies but no further enquiries were made.

5.9 AA started a relationship with JW in August 2010. She first disclosed he was abusing her in September 2012, and she said it had only been happening for a few months. It is possible that she had been experiencing domestic abuse throughout the relationship but either did not recognise it for what it was or chose to conceal it. This can happen for a variety of reason as described by Women's Aid.

- that she was embarrassed or ashamed
- that she felt guilty she might be partly to blame because they argued
- that she was worried that others may consider her a bad mother and at worst her child might be removed from her care
- that she was depressed and suffering from low self esteem, and feared she would not be believed
- that she cared for her partner and hoped she may be able to change him for the better
- that she did not want to leave her home and that it would be difficult to remove her partner, and if he were removed there could be repercussions for her and her family if this happened
- that she did not trust the agencies.

5.10 SBC was the first agency to which AA disclosed domestic abuse, on 26 September 2012. They did not carry out an assessment, as this was not part of their procedures, but they acknowledged concern for AA and her daughter and offered support by encouraging AA to use a range of resources including the Domestic Violence Helpline, police and Aldwyck Housing Association who managed her tenancy; they also facilitated her making an appointment with her GP. In line with safeguarding procedures for AA's child they made a referral to Children's Services and to a local Children's Centre. To be more proactive SBC could have offered to liaise with Aldwyck about how AA might evict JW and make the home safe. They could also have considered a referral to MARAC.

5.11 Children's Services were made aware of the domestic abuse on 26 September 2012 and following a contact from the TAS the case was passed to the EITST. Given the contact was as a result of child safeguarding concerns raised by SBC it is not clear why the case was dealt with in this way. It should have been treated as a child safeguarding enquiry which would have been dealt with by the Assessment Team.

5.12 Once the case was allocated to the EITST caseworker there is some evidence he tried to make contact, but it was not until 31 October 2012 that he actually spoke to AA and this was an unacceptable delay given the safeguarding concerns.

5.13 In line with Hertfordshire Safeguarding Children Board inter agency child protection procedures, Children's Services should have informed the police about the abuse when they found out, but they did not until the end of October, after they had received another referral, this time from EPMHS. Although it would be speculative to consider that the outcome would have been any different, the month gap between EITST knowing about the abuse and either telling the police or seeing her themselves, represented a significant missed opportunity to engage with AA and help to safeguard both her and her daughter.

5.14 After she had disclosed domestic abuse to SBC on 26 September and confirmed it to caseworker 3 from Children's Services two days later, AA saw a worker from EPMHS for triage assessment and met with her GP on two occasions during October and did not tell them about the abuse. It was not until 30 October 2012, when she saw the high intensity worker from EPMHS that she disclosed again. The worker appropriately assessed there were safeguarding concerns for AA and her daughter and looked at the options with her. She told AA she would make a referral to Children's Services which she did and she encouraged her to attend the Women's Centre. The next day the worker followed up her contact with AA by which time she had been to the Women's Centre and had a planned appointment with EITST.

5.15 The day after AA saw the high intensity worker from EPMHS she referred herself to the Women's Centre, following some pressure from her mother who had just become aware that JW had subjected her daughter to domestic abuse. Although the Centre worker did not use a recognised assessment tool, she did make an assessment using the Centre's own documentation, and this was discussed with her line manager. They were effective in identifying she was high risk and discussed a number of options for support including the police and going to a refuge. They also supplied her with information about the Domestic Violence Helpline. They understood she had an appointment with Children's Services as that was made whilst she was at the Women's Centre. Although they offered her a follow up appointment, which she declined, they did not know if she would go to the police. Given safeguarding concerns for her and her child they should have considered a referral to the police, particularly as there was an option for the police to meet with AA at the Women's Centre. They could also have offered AA further support by talking through a safety plan.

5.16 The police first became aware of the domestic abuse on 31 October 2012, following referral from EITST on that day. The inspector on duty was not in a position to carry out an effective assessment of AA's needs. The information he had was third hand and he understood she did not want police involvement. He sought intervention from the DVO but she was not available, and after consulting AA's mother he made a decision not to visit AA due to concern that it could make matters worse. In making this decision he was aware that AA had accessed support from the Women's Centre and that Children's Services were due to see her.

5.17 On the following day the police DVO contacted AA's mother who confirmed that AA was due to see a caseworker from Children's Services on 5 November. Like her police colleagues the day before, she had not seen AA, and her assessment of AA's needs were based on what AA had told others. She gauged it was too

risky to make a home visit and hoped AA would contact her. She did this and on 7 November they had a meeting away from Stevenage. The DVO did not conduct a DASH on the basis that AA did not tell her directly about the abuse. However she should have done as she had enough information on which to complete it. Even without DASH the DVO was effective in assessing AA's needs. She saw her as high risk and discussed the various options available to her, which at that stage AA declined. The DVO also discussed involvement of the IDVA and then made a referral. Without evidence to support this conclusion, the DVO assessed AA's child was not at risk. However, she was aware AA had already been in contact with Children's Services.

5.18 The EITST caseworker from Children's Services met with AA and her daughter on 5 November 2012. The options he proposed at the end of the meeting, although supportive to AA and her child, did not reflect the fact that AA had already been assessed by the Women's Centre as high risk, police including the DVO had been informed and that this could be a situation where safeguarding measures were needed for the child. AA was under no obligation to take up the offer of help from EITST, and it was not clear what the caseworker would do if she did not. Under the circumstances it would have been advisable to refer the case back to the Assessment Team.

5.19 There is little evidence of interagency working in AA's case. Some of the agencies made referrals to others, once they became aware of domestic abuse, in particular SBC and EPMHS referred to Children's Services stating that they were doing so to safeguard AA's daughter. Children's Services made a referral to the police but this was over a month after they first received the information. Children's Services records do show a contact was made with the GP but there is no evidence the GP was told about the domestic abuse, and the GP has no record of this call. Also, caseworker 4 from Children's Services contacted SBC to check details of the referral. The police, including DVO spoke with AA's mother because they had no means of contacting AA safely. The DVO made a referral to the IDVA. All of these contacts from one agency to another and to AA's mother seem appropriate. The other agency which had contact with AA once she disclosed was the Women's Centre and their staff did not refer on to any other agencies. They assessed that it was her choice to make, but given they saw her as high risk, and that she had a child who could be at risk, they should have contacted the police. They did not have information to suggest anyone else had, but were aware that AA was due to see Children's Services.

5.20 There were five agencies which were aware of the domestic abuse by 31 October 2012 – police, SBC, EPMHS, Children's Services and the Women's Centre – and it would have benefitted the situation greatly had they made a decision to sit down and discuss how to safeguard and help AA and her daughter. MARAC is said to be well established in Hertfordshire and yet none of the agencies chose to refer to it.

5.21 The IDVA was not in a position to assess AA's needs or offer support because she did not see AA. She had minimal information in the referral from the DVO but knew AA was seen as high risk.

5.22 During the period covered by the review JW had very little contact with agencies, and was known to be suspicious of them and probably hostile in respect of police and social workers. He had just one contact with police during this period, when he was arrested and cautioned for cultivating cannabis. He was not an active participant when he was seen by CAMHS and Children's Services, and as previously stated, Children's Services missed an opportunity to question him more closely about another child he had, and to make a home visit at his family home where the drugs raid took place. JW was said to be dependent on cannabis use but there is no evidence he was in touch with GP, mental health services or drug agencies. AA's family had limited contact with JW and from their description this was his choice; although they did not like him they would have preferred to remain in contact as a means of supporting their daughter and granddaughter.

5.23 The Women's Centre is the only agency of those involved in this review to suggest that AA's death was predictable, on the basis of national statistics covering the incidence of domestic violence, the number of assaults and homicides by men known to victims, calls to police, repeat victimisation, and women's fear of being killed. They also refer to an increase of domestic abuse incidents locally. This review has found that it would be very difficult to substantiate that AA's homicide was predictable or preventable, due to a number of relevant and contradictory factors.

5.24 On the one hand the injuries she reported were not recent and as far as the panel are aware had not necessitated medical care. On the other hand she may have been suffering for some time before she told anyone and the abuse could have been much worse than she disclosed. When she did disclose she said that the abuse was escalating and she was clearly very fearful; she said JW had threatened to kill her if she told the police. The most recent incident had been threatening rather than violent, when she was intimidated into handing over money, and it shows a degree of recklessness on JW's part as it was done in front of others in a public place. AA had told JW that she wanted him to leave, a time at which research shows there is an increased risk to the victim. She told some agencies although not all (GP) that she was suffering but was not prepared to leave the home, did not want JW to know she had reported him and declined police involvement.

5.25 Although she visited the DVO on 7 November 2012 she did not make a report of abuse and declined police involvement. She agreed to a referral to the IDVA but there was no opportunity for contact before she was killed.

5.26 AA's death may have been preventable had she chosen one of the actions explored with her by agencies; to leave or to stay in her home and have JW removed, which would have necessitated police, Housing Association and possibly legal intervention. When she left her meeting with the DVO she was said by her mother to be more positive but it was not clear what action she hoped to take. She was well aware that taking either action still represented a risk to her and possibly her family. She was not encouraged to make a safety plan but this would not necessarily have guaranteed her safety.

5.27 AA's death may have been preventable if one or more agencies took action against AA's expressed wishes. Realistically this could only have been the police, who had no current evidence with which to act. Alternatively Children's Services could have acted or threatened to act to safeguard AA's child, as a means of encouraging her to leave JW or have him removed from the home; however, they may also have lacked evidence to do this.

## 6 Conclusions

6.1 During the period covered by this review AA had contact with a number of agencies who considered that she was vulnerable. She seems to have been quite open when presenting problems and received help as a consequence. In particular she had a lot of support with accommodation, from health services during her pregnancy and as a young mother, and from mental health services.

6.2 AA commenced a relationship with JW mid 2010 when she was 16 years old, and was confirmed pregnant early in 2011. JW had very little contact with any of the agencies involved with AA and it seems likely that only Children's Services were aware of his background; that there was a history of family violence in which JW had been a victim and perpetrator. Although it does not necessarily follow that he would go on to abuse a partner, with a consequent risk to children, research does confirm there is a significant risk. The panel concluded that Children's Services did not take this into consideration when they conducted enquiries in this case.

6.3 Although she had described other problems to agencies prior to September 2012, AA did not divulge domestic abuse. Questions have been raised in this review about whether agencies, particularly GP services, should have recognised, prior to disclosure, that symptoms experienced by AA, particularly anxiety, depression weight loss and urinary tract infections, could have been as a result of domestic abuse, and therefore warranted investigation. However, AA may not have disclosed any earlier than she did and even if she had, she may not have taken action and therefore the tragic events may still have occurred.

6.4 Before disclosing domestic abuse AA described her relationship with JW as positive and that he was supportive. This was not the experience of AA's parents who thought him a bad influence and that he had sought to turn their daughter against her family. They had tried not to criticise him too much for fear of alienating her.

6.5 Those agencies that came into contact with AA saw her as a good mother; her daughter was described as bright and well cared for.

6.6 When on 26 September 2012 AA first disclosed to SBC that she had been abused by JW she appeared unclear about what she wanted to do, which is not unusual for a victim of domestic abuse. During her contact with TAS she spoke as if she may still stay with him; she had given him an ultimatum she said. There was then a month when she did not discuss the situation further with agencies; she saw her GP and attended for triage assessment with EPMHS and did not mention the abuse. It was not until 30 October 2012 when she saw the high intensity worker from EPMHS that she disclosed again that JW had been physically abusive to her. This worker encouraged AA to go to the Women's

Centre which the panel saw as good practice, and she said she would refer to Children's Services which she did.

6.7 By the time caseworker 4 from EITST spoke with AA the referral had been outstanding for one month which represented a missed opportunity to engage with AA, and the panel concluded that the delay was unacceptable. The decision of the TAS to refer the case to the EITST rather than the Assessment Team, and the subsequent approach taken by EITST caseworker 4 when he met AA on 5 November, suggests that safeguarding concerns in respect of AA's daughter were not taken seriously, which was also of concern to the panel.

6.8 AA told her mother about the violence on 31 October 2012 and it was her mother that helped her to make the decision to go to the Women's Centre on that day, and subsequently to the police on 7 November 2012.

6.9 By 31 October, five agencies were aware that AA was subject to domestic abuse (SBC, Children's Services, EPMHS, Women's Centre and Police) and two others were currently providing a service to AA (GP and health visitor). In these circumstances the panel concluded that at least one of the agencies should have recognised the necessity of convening an interagency meeting to discuss how risks to AA and her daughter might be managed.

6.10 Although AA did not say that she wanted to take action, either by leaving JW, which would have meant leaving her home and possibly the area, or seeking help in having him removed from the home, there were signs that she wanted a life without him and it would only be a matter of time before she was able to achieve this. Tragically, and quite possibly because AA told JW what she wanted to do, she was murdered.

## 7 Recommendations

7.1 Each of the agencies which have produced IMRs for this DHR have made recommendations for their agencies, as contained in Appendix 1, and in some cases have action plans which are already being implemented. The overall recommendations included here have drawn on those identified in the IMR's.

7.2 In order to facilitate an understanding of how the agencies work and to make best use of resources, the agencies involved in this review should work together to ensure that they:

- have a robust process for identifying domestic abuse, which includes clarity about when DASH should be used and by which agencies
- have information about services available to victims, which is brought together in a leaflet
- provide staff with clear pathways for referring victims on to the appropriate services, and
- provide awareness training for staff, which is updated every three years.

7.3 Herts Women's Centre should review their procedures to ensure that they use DASH as a means of assessing and providing clear pathways for assistance to victims of domestic abuse.

7.4 Hertfordshire Constabulary should re-enforce with staff, current procedures in respect of recording Domestic Violence crime and non-crime cases, and completing risk assessments.

7.5 Hertfordshire Constabulary and the Women's Centre should establish the improved reporting system for victims, which is in the process of development.

7.6 Hertfordshire Community NHS Trust should ensure health visitors carry out screening for domestic abuse in line with their existing best practice guidance.

7.7 Hertfordshire and South Midlands Area Team, NHS England should ensure that GP services adopt the Department of Health Guidance on Domestic abuse.

7.8 Hertfordshire and South Midlands Area Team, NHS England should ensure that GP records contain sufficient detail for the purpose of completing adequate individual management reviews.

7.9 Hertfordshire County Council Children's Services should examine their practice in this case and ensure that policies and procedures on safeguarding and domestic abuse are followed.

7.10 Hertfordshire Domestic Violence Strategic Programme Board should establish an information sharing protocol in cases of domestic abuse to include agencies and voluntary organisations involved in this review. The protocol should include the role and purpose and timing of referrals to MARAC and IDVA's.

7.11 Hertfordshire Domestic Violence Strategic Programme Board should ensure that the MARAC is promoted amongst staff and managers of the agencies which are most likely to encounter victims of domestic abuse.

7.12 Hertfordshire Domestic Violence Strategic Programme Board should facilitate learning events to ensure the findings of this review are disseminated within agencies.

## Appendix 1

## Action plan

Domestic Homicide Review Action Plan AA

**Recommendation 1**

In order to facilitate an understanding of how the agencies work and to make best use of resources, the agencies involved in this review should work together to ensure that they

a) Have a robust process for identifying domestic abuse, which includes clarity about when DASH should be used and by which agencies,

b) Have information about services available to victims, which is brought together in a leaflet

c) Provide staff with clear pathways for referring victims on to the appropriate services and

d) Provide awareness training for staff, which is updated every three years.

| Related DHR | Action | Lead agency | Key Milestones | Target date | Date of completion & Outcome |
|---|---|---|---|---|---|
| Stevenage – AA<br><br>**Actions a, c & d complete** | Implement DASH RIC for those who disclose abuse to Stevenage Borough Council officers. | Stevenage CSP | Procedure drafted for responding to disclosures of abuse<br><br>Staff nominated to act as points of contact to | April 2014<br><br>April 2014 | 15th May 2014. Procedure in place for responding to disclosures of abuse which ensures that those disclosing are offered a RIC, and appropriate level of services are offered and referrals made. |

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| | Produce leaflet about services available for victims. | | carry out DASH RIC<br><br>Staff trained to carry out DASH RIC | May 2014<br><br>Nov 2014 | IDVA service to work more closely with Stevenage Borough Council through offering fortnightly drop in sessions for staff, members of the public and professionals.<br><br>**Update Oct 2014**: IDVAservice now offered weekly.<br><br>**Update: Oct 2014**<br><br>DA Panel implemented, to be coordinated by SBC. This panel will work on the MARAC model, but working with victims who fall below the MARAC threshold.<br><br>Leaflet currently in draft. To be produced for SADA conference Nov 2014. |

**Recommendation 2**

Herts Women's Centre should review their procedures to ensure that they use DASH as a means of assessing and providing clear pathways for assistance to victims of domestic abuse.

| Related DHR | Action | Lead agency | Key Milestones | Target date | Date of completion & Outcome |
|---|---|---|---|---|---|
| Stevenage - AA | | Herts Women's Centre | Procedure reviewed | 16/06/14 | 16/06/14<br><br>DASH will be introduced<br><br>**Oct 2014:** NO UPDATES TO REPORT THIS QUARTER |
| **Recommendation 3**<br>Hertfordshire Constabulary should re-enforce with staff, current procedures in respect of recording Domestic Violence crime and non-crime cases, and completing risk assessments. | | | | | |
| Related DHR | Action | Lead agency | Key Milestones | Target date | Date of completion & Outcome |
| Stevenage – AA<br><br>**Complete** | | Herts Constabulary | | Complete | Dec 2012<br><br>This recommendation has already taken place and advice has been given to all staff within the unit in relation to the importance of following the procedures. |
| | | | | | |

| **Recommendation 4**<br>Hertfordshire Constabulary and the Women's Centre should establish the improved reporting system for victims which is in the process of development. | | | | | |
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| Related DHR | Action | Lead agency | Key Milestones | Target date | Date of completion & Outcome |
| Stevenage - AA | | Herts Constabulary & Herts Women's Centre | Herts Constabulary to identify a contact for Women's Centre to liaise with.<br><br>Initial meeting to draw up protocols for reporting systems<br><br>Reporting system established and operative | 08/06/14 | Contact identified, Women's Centre is awaiting call back from him.<br><br>**Police update: October 2014 update**<br><br>ST has spoken to M. Regular ride a long was offered again, and an initial date was agreed for 12 Oct 2014.<br><br>**HWC - Oct 2014:** NO UPDATES TO REPORT THIS QUARTER |
| **Recommendation 5**<br>Hertfordshire Community NHS Trust should ensure health visitors carry out screening for domestic abuse in line with their existing | | | | | |

| best practice guidance. | | | | | |
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| Related DHR | Action | Lead agency | Key Milestones | Target date | Date of completion & Outcome |
| Stevenage - AA | To ensure that health visitors undertake domestic abuse screening as part of the routine health visiting screening | Herts Community NHS Trust | HCT have carried out an audit of domestic abuse practice for HV in February 14 and the action plan from the audit is being embedded across HCT<br><br>Training is mandatory with a three yearly update for HV in Asking the question, and has commenced. | April 2015 | Training is being delivered.<br><br>**October 2014 update**<br><br>Established training that is Mandatory and to re audit in February 2015 |
| **Recommendation 6**<br>Hertfordshire and South Midlands Area Team, NHS England should ensure that GP services adopt the Department of Health Guidance on Domestic abuse. | | | | | |
| Related DHR | Action | Lead agency | Key Milestones | Target | Date of completion & |

| | | | | date | Outcome |
|---|---|---|---|---|---|
| Stevenage - AA | An item to go in the bi-monthly GP newsletter signposting GPs to the DoH guidance | Herts & South Midlands NHS | | July 2014 | The next newsletter is in July and the item has been written. This goes to all GPs in Hertfordshire and South Midlands.<br><br>**October 2014 update**<br><br>This did not go in the July issue due to pressure of space but will go in the autumn issue which is currently being prepared |
| **Recommendation 7**<br>Hertfordshire and South Midlands Area Team, NHS England should ensure that GP records contain sufficient detail for the purpose of completing adequate individual management reviews. | | | | | |
| Related DHR | Action | Lead agency | Key Milestones | Target date | Date of completion & Outcome |
| Stevenage - AA | GPs will be reminded through a reflective piece in the GP newsletter the importance of | Herts &South Midlands NHS | | July 2014 | The next newsletter is in July and the item has been written. This goes to all GPs in Hertfordshire and South Midlands.<br><br>**October 2014 update** |

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| | good record keeping and their responsibilities | | | | This did not go in the July issue due to pressure of space but will go in the autumn issue which is currently being prepared. |

**Recommendation 8**
Hertfordshire County Council Children's Services should examine their practice in this case and ensure that policies and procedures on safeguarding and domestic abuse are followed.

**Please note, actions 8.2 – 8.9 have been identified to support the overall learning for Children's Services in this case as well as supporting the requested actions within this plan.**

**PLEASE SEE OCTOBER 2014 UPDATE – SUPPLEMENTARY PAPER.**

| Related DHR | Action | Lead Agency | Key Milestones | Target Date | Date of Completion & Outcome |
|---|---|---|---|---|---|
| Stevenage - AA | 8.1<br><br>Children's Services to examine whether their Safeguarding and Domestic Violence procedures were followed in this case, and if not, to identify | HCC Children's Services<br><br>erformance & Improvement (P&I) Team | | 04.07.13 | |

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| | actions to address this. | | | | |
| | 8.2<br><br>Performance and Service Improvement team to organise a workshop with reps from TAS,TF,TYS,Assessment,DCT and Locality to review the practice in this case and consider any amendments needed to referral pathways for Domestic Abuse<br><br>Raise awareness amongst staff of the role of MARAC, role of IDVAs and referral pathways for vulnerable adults | | | 11.07.13 | |
| | 8.3<br><br>L&D to develop training and learning sets so staff are more confident about supporting victims of Domestic Abuse and knowledgeable about procedures.<br><br>Practice Development sessions to be developed by L&D to share the learning from | | | End of July 2014 | |

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| | this DHR across each of the 3 sites.<br><br>The Domestic Homicide Review to be condensed and learning shared in a Service Improvement newsletter and used as a basis for reflective learning in team meetings. | | | | |
| | 8.4<br><br>Recommendations for any change in Policies and Procedures to be taken to HSCB policies and procedures subgroup | | | End of July 2014 | |
| | 8.5<br><br>Children's Services identified that JW had a duplicate record on their electronic systems. Therefore the Customer Service Centre, TAS and all Assessment Teams to be reminded of the need to check for duplicate ICS entries and to report these to the ICT User Support team for merging. | | Avoidance of inaccurate relationship. | End of July 2014 | |

| | | | | | |
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| | - Reminder/Practice Guidance Note to be circulated to all relevant teams | | | | |
| | 8.6<br><br>Children's Services recognised the need for a county wide review of the interagency procedures in respect of Domestic Violence and the roles and responsibilities of partners as well as children's social care.<br><br>- This action to build on work commenced in March 14 and be further considered against the findings of this DHR<br><br>-HSCB and HSAB to be asked to review roles and responsibilities in protecting vulnerable adults | | | End of July 2014 | |
| | *It is further recommended that audit work be undertaken within the P&I Team in the 12 months post completion of this action plan to ensure changes* | | | | |

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| | *to practice are fully embedded.* | | | | |
| **Recommendation 9**<br>Hertfordshire Domestic Violence Strategic Programme Board should establish an information sharing protocol in cases of domestic abuse to include agencies and voluntary organisations involved in this review. The protocol should include the role and purpose and timing of referrals to MARAC and IDVA's. | | | | | |
| Related DHR | Action | Lead Agency | Key Milestones | Target Date | Date of Completion & Outcome |
| Stevenage - AA | Establish protocol. | Herts DV Strategic Board | | ongoing | **October 2014 update**<br><br>MARAC information sharing protocol is in place and is maintained/updated by the MARAC Steering Group under national CAADA guidance. Work is ongoing with the IDVA service to relook at their referral criteria/pathways |
| **Recommendation 10**<br>Hertfordshire Domestic Violence Strategic Programme Board should ensure that the MARAC is promoted amongst staff and managers of the agencies which are most likely to encounter victims of domestic abuse. | | | | | |
| Related DHR | Action | Lead Agency | Key Milestones | Target Date | Date of Completion & Outcome |
| Stevenage - AA | | Herts DV Strategic Board | | ongoing | **October 2014 update**<br><br>One-day Awareness course |

| | | | | | is facilitated by county community safety unit – promotion of MARAC and referral system.<br><br>CCSU is currently liaising with CAADA to firm up allocated time for the forthcoming year including discussing MARAC/RA agency awareness training.<br><br>The current CAADA review should help inform work around pathways etc. |
|---|---|---|---|---|---|
| **Recommendation 11**<br>Hertfordshire Domestic Violence Strategic Programme Board should facilitate learning events to ensure the findings of this review are disseminated within agencies. | | | | | |
| Related DHR | Action | Lead Agency | Key Milestones | Target Date | Date of Completion & Outcome |
| Stevenage - AA | | Herts DV Strategic Board | | Ongoing | The DASPB is due to next meet on 2 July, at which two of the recently submitted (3) DHRs are to be discussed and the action plans/recommendations agreed. Upon consulting with relevant DHR Panel |

| | | | | | |
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| | | | | | Chairs and CSP Chairs it was agreed that the 2 DHRs being considered at this forthcoming meeting will not include AA. The HO has the overview report and action plan and I have been notified that it will be discussed at the next DHR Quality Assurance Group meeting scheduled for July - after which we will get formal notification/endorsement etc.<br><br>**October 2014 update**<br><br>CCSU has recently facilitated 2 days to SPECTRUM/CRI and 2 half-days to GPs; we have also provided DA, MARAC / RA input to a Children's Centre and HV CPD day in July and will be doing similar at a forthcoming multi-agency TF conference. |

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| | | | | | Comms Officer is pulling together ideas for Awareness week – based on a push for focus on the Herts Sunflower partnership.<br><br>I will also highlight these actions to the Chair, as part of the wider DHR action plan the Board is maintaining. |

☑ CheckBox1

**Domestic Homicide Review Action Plan AA**

**Hertfordshire Children's Services. Version 2 August 5th 2014**

| **Recommendation 8**<br>Hertfordshire County Council Children's Services should examine their practice in this case and ensure that policies and procedures on safeguarding and domestic abuse are followed. |
|---|

| Please note, actions 8.2 – 8.9 have been identified to support the overall learning for Children's Services in this case as well as supporting the requested actions within this plan |
| --- |

Policy and Practice Team (Sue Goff) to track progress of Actions and report back to Mayank Joshi on 6 weekly basis.

| **Related DHR** | **Action** | **Lead Agency/Staff** | **Key Milestones** | **Target Date** | **Date of Completion & Outcome** |
| --- | --- | --- | --- | --- | --- |
| Stevenage - AA | **8.1** Children's Services to examine whether the Safeguarding and Domestic Violence procedures were followed in this case, and if not, to identify actions to address this. | For overall plan - HCC Children's Services Performance & Improvement (P&I) Team | A clear understanding of any policies and procedures is held that these were not always effectively followed | Dec 2014 | The IMR indicates that learning about the implementation of procedures and processes is relevant and will be taken forward to training workshops |
| Stevenage - AA | **8.2** Learning from 8.1 to be taken forward: consider any amendments needed to referral pathways for Domestic Abuse, in particular for vulnerable adults.<br><br>Raise awareness | MJ to discuss with J C | Identification of amendments required to Domestic Violence pathways (to feed in to 8.6)<br><br>Clear plan in | Dec 2014 | SW to take forward the need for adult safeguarding policy to have joint screening by HCS and CS re: adults who require safeguarding. |

| Related DHR | Action | Lead Agency/Staff | Key Milestones | Target Date | Date of Completion & Outcome |
|---|---|---|---|---|---|
| | amongst staff of the role of MARAC, role of IDVAs, new police powers and referral pathways for vulnerable adults | and rep. of Interface Team to TYS, TAS, Thriving Families and CS Social Workers | place as to how to raise awareness of MARAC and IDVA role. | Dec 2014 | JC/MJ to inform SG of progress so this Action Plan can be updated |
| Stevenage - AA | **8.3** L&D to ensure training and learning sets are accessed by staff every two years so staff are, and remain, more confident about supporting victims of Domestic Abuse and knowledgeable about procedures. This training to include learning from this DHR. Training to be delivered across the three sites<br><br>L&D to obtain 3 copies of BBC documentary 'Murdered by My Boyfriend' for each | SG to contact L&D and ask for audit of all those staff who have and have not had training in DV in last 2 years and to target them for attendance<br><br>SG to DM<br><br>SG | Ensure all staff attend training at least every 2 years<br><br>All teams have seen at team meeting | System in place by Dec 2014<br><br>Dec 2014 | |

| Related DHR | Action | Lead Agency/Staff | Key Milestones | Target Date | Date of Completion & Outcome |
|---|---|---|---|---|---|
| | building and each team to view at team meeting<br><br>The Domestic Homicide Review to be condensed and learning shared in a Good Practice Bulletin and used as a basis for reflective learning in team meetings. | | Completed article for GPB to be disseminated to all relevant staff | Oct 2014 | |
| Stevenage - AA | **8.4** The IMR for this case identified an issue around duplicate ICS records. Serco report about 2,000 such duplicates. The system for identifying and reporting duplicate records needs to be clarified along with the actions taken to amend this. Thereafter, the Customer Service Centre, TAS and all Assessment Teams to be reminded of the | RW to set up project | Avoidance of inaccurate ICS relationship recording and a clear process in place to address inaccuracies when identified | Review Dec 2014 | |

| Related DHR | Action | Lead Agency/Staff | Key Milestones | Target Date | Date of Completion & Outcome |
|---|---|---|---|---|---|
| | need to check for duplicate ICS entries and to report these to the ICT User Support team for merging. | with Serco to address issue of duplicate records | | | |
| Stevenage - AA | **8.5** Children's Services recognised the need for a county wide review of the interagency procedures in respect of Domestic Violence and the roles and responsibilities of partners as well as children's social care. Work to be undertaken to build on the work that commenced in March 14 and be further considered against | SW | An understanding of any additional developments required of the current interagency Domestic Violence procedures. To ensure this includes clear roles and responsibilities for children's and adult's | To review Dec 2014 | |

| Related DHR | Action | Lead Agency/Staff | Key Milestones | Target Date | Date of Completion & Outcome |
|---|---|---|---|---|---|
| | the findings of this DHR action plan<br><br>HSCB and HSAB to then be asked to review roles and responsibilities in protecting vulnerable adults. | SW, PP, SD | service areas. | | |
| | **Collation of progress for review of this action plan** | SG | Update of Action Plan as required. | Dec 2014 Senior Management Group | |

*c*

# Appendix 2

## Recommendations from the Individual Management Reviews

**1 Hertfordshire Community NHS Trust**

1.1 The guidance on the need to carry out an emotional and wellbeing assessment which includes domestic violence screening with health visitor best practice guidance 2012 to be highlighted to health visitors via team meetings.

1.2 Health visitors should attend a refresher in the identification of domestic violence every 3 years.

1.3 An audit on the screening of domestic violence by health visitors should be undertaken in six months to ensure that the practice guidance is being adhered to.

1.4 Health visitors to discuss all cases where vulnerable mothers disengage and there are historical concerns regarding either parent, with their Safeguarding Nurse.

1.5 ccWhen there is a change of health visitor and there are concerns about the vulnerability of the client, a robust handover should include an action plan ensuring that early contact will be initiated by the receiving team.

1.6 Where there are concerns about the emotional or physical impact of the health of a client the health visitor should liaise with the GP to ascertain how this will impact on her vulnerability and resilience to manage social problems.

**2 Hertfordshire County Council Children's Services**

2.1 For all Children's Services staff who receive information to ensure that **all** the concerns identified are explored, and that there is effective management oversight and sign-off of this.

2.2 For the Customer Service Centre, TAS and all Assessment Teams to be reminded of the need to check for duplicate ICS entries and to report these to the ICT User Support team for merging.

2.3 That all assessments undertaken within Specialist & Safeguarding Teams assess both parents, unless there are specific reasons (documented by the Practice Manager) not to do so. That lack of engagement be pursued and if necessary S47 enquiries considered, in order to gain information that will inform risk

2.4 That when a direction is made by a Group or Practice Manager on a case, that the case not be closed until these directions have been completed (unless there are specific reasons not to, documented by the Group/Practice Manager).

2.5 That any safeguarding concerns identified by Early Intervention Teams are recognised and escalated immediately.

2.6 That relevant Children's Services staff undertake mandatory Adult Safeguarding training, and that this training includes a focus on adults who are vulnerable as a result of domestic violence.

2.7 That when an adult service is identified for a parent of a child Children's Services are working with, all attempts are made to ensure engagement with this professional.

2.8 That there be a county wide review of the interagency procedures in respect of Domestic Violence.

**3 East and North Hertfordshire NHS Trust**

3.1 Staff in Emergency Department and Oral and Maxillo Facial Surgery should question injuries and consider child abuse / domestic abuse and if other children remain at risk.

3.2 GP's, School Health Advisers must receive timely discharge letters from each attendance.

3.3 Staff must complete sharing information forms for vulnerable young people.

3.4 Maternity should consider obtaining past medical records for booking teenage pregnancy and risk assesses teenage pregnancy prior to removal from maternity database.

**4 GP Services**

4.1 That there is a meeting held within the practice to discuss AA's care when the full DHR report has been made available, including response to the wider recommendations.

4.2 That the wider DHR recommendations are discussed within the Hertfordshire and South Midlands Area Team Safeguarding forum, and an action plan is agreed and taken forward as appropriate.

**5 Hertfordshire Constabulary**

5.1 The current procedures surrounding the recording of DV crimes and non crimes and the recording of risk assessments should be reinforced throughout the harm reduction unit.

**6 Hertfordshire Partnership NHS Foundation Trust**

6.1 The Single Point of Access (SPA) and EPMHS teams need to receive training in issues relating to domestic violence (risks / signs and appropriate action to take).

6.2 More cohesive inter-agency working should be in place.

6.3 Risk assessment to include questions regarding risk to the individual from others as part of robust risk management process, and ensure effective signposting to the appropriate agency.

**7 Herts Women's Centre**

7.1 The recognition and lobbying of support for agencies providing front line support for victims. The HWC is the only front line service available for victims in Stevenage, but it does not receive regular local or central government funding, and this agency is now at risk of closure due to lack of funding.

7.2 More robust and secure methods of communication and reporting of incidents of domestic abuse need to be implemented. These need to take into account the views, fears and experiences of victims.

7.3 That it is acknowledged that the domestic abuse that was happening was first fully disclosed within a women only environment.

**8 Herts Young Homeless**

8.1 HYH will be taking this opportunity to:

- review safeguarding policies and procedures, specifically related to domestic abuse
- review staff training on domestic abuse
- review staff requirements for specific DASH training
- refresh staff on integrated practice and information sharing protocols

- review internal assessment documents.

**9 Stevenage Borough Council**

9.1 Stevenage Borough Council should review its Domestic Violence Policy, which was last updated in May 2010, to specifically include appropriate risk modelling, assessment and response to presenting victims of domestic abuse.

9.2 Stevenage Borough Council procedures do not currently require the assessment of victims. Stevenage Borough Council should develop procedures which require the assessment of clients who present as victims of domestic abuse.

9.3 Training for appropriate staff to identify services for clients who present as victims of domestic abuse currently occurs in specific teams without a formal procedure for referral. The Council should deliver training to all staff deemed to have contact with high risk sectors of the public and link this with a procedure for the appropriate referral of clients who present as victims of domestic abuse.

9.4 Stevenage Borough Council does not currently make use of the DASH Risk Model or any other DV assessment process. Stevenage Borough Council will take advice on an appropriate risk model for implementation into its services which are most likely to meet with clients who present as victims of domestic abuse.

**10 Victim Support (IDVA service)**

10.1 Victim Support should provide local service delivery operating instructions for the IDVA service which compliment Victim Support's Domestic Violence Service Delivery Operating Instructions (DVSDOI) and the CAADA training.

10.2 All IDVA services should be relocated to Hertfordshire police headquarters.

## Appendix 3

## Glossary

| | |
|---|---|
| AAFDA | Advocacy After Fatal Domestic Abuse |
| ADHD | Attention Deficit / Hyperactivity Disorder |
| A&E | Accident and Emergency |
| CAADA | Coordinated Action Against Domestic Abuse |
| CAF | Common Assessment Framework |
| CAIU | Child Abuse Investigation Unit |
| CAMHS | Community Adolescent Mental Health Service |
| CCSU | County Community Safety Unit |
| CSP | Community Safety Partnership |
| DASH | Domestic Abuse, Stalking and Honour Based Violence |
| DH | Department of Health |
| DHR | Domestic Homicide Review |
| DVO | Domestic Violence Officer |
| DVSDOI | Domestic Violence Service Delivery Operating Instructions |
| DVSPB | Domestic Violence Strategic Programme Board |
| DWP | Department of Work and Pensions |
| ECG | Electrocardiogram |
| EEG | Electroencephalogram |
| EITST | Early Intervention and Targeted Support Team |
| E&NH NHS | East & North Herts NHS Trust |
| EPMHS | Enhanced Primary Mental Health Services |
| GP | General Practitioner |
| HCC | Hertfordshire County Council |
| HCT | Hertfordshire Community NHS Trust |
| HWC | Hertfordshire Women's Centre |
| HYH | Herts Young Homeless |
| IDVA | Independent Domestic Abuse Advocate |
| IMR | Individual Management Review |
| MARAC | Multi Agency Risk assessment Conference |
| NHC | North Herts College |
| SBC | Stevenage Borough Council |
| SPA | Single Point of Access |
| TAS | Targeted Advice Service |
| YOS | Hertfordshire Youth Offending Service |
| YOT | Youth Offending Team |

## Appendix 4

**Safeguarding & Vulnerable People Unit**
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Ms Sarah Taylor
Programme Manager Domestic Abuse
Stalking and Harassment, and Hate Crime
County Community Safety Unit
Hertfordshire County Council
Farnham House
Six Hills Way
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Herts
SG1 2FQ

22 July 2014

Dear Ms Taylor,

Thank you for submitting the Domestic Homicide Review (DHR) report from Hertfordshire (Stevenage) to the Home Office Quality Assurance (QA) Panel.

The QA Panel would like to thank you for conducting this review and for providing them with the Executive Summary, Overview Report, and Action Plan. In terms of the assessment of 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.

There were some issues that the QA Panel felt would benefit from further consideration and clarification before you publish the final report:

- The QA Panel felt that the text should be revisited to ensure the tone and language used in the report could not be construed as victim blaming;

- The QA Panel felt that the Action Plan could be strengthened by including named leads, milestones and targets; and,

- Please ensure that all acronyms are explained in full when first referenced in the report or consider the addition of a glossary to assist the reader.

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 report is published.

Yours sincerely,

Christian Papaleontiou, Acting Chair of the Home Office Quality Assurance Panel
Head of the Interpersonal Violence Team, Safeguarding & Vulnerable Peoples Unit