THE SAFER ROTHERHAM PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

OVERVIEW REPORT

Victim MA 1

November 2014

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 **Appendix A Action Plan**

 **Appendix B Glossary of Terms**

**1. INTRODUCTION**

1.1The principal people referred to in this report are:

 MA 1 <60 years Victim White British

 MA 2 <55 years Perpetrator White British

 FA 1 <85 years Mother of MA 1 White British

1.2 In autumn 2013 South Yorkshire Police [SYP] were asked to attend Address 1 by Yorkshire Ambulance Service [YAS]. They had been called to the property by MA 2, advising them that MA 1 was unconscious and possibly dead.  MA 1 was found on the floor with a stab wound to his left hand caused by a broken bottle.  He was taken to hospital and died the next day.

1.3 SYP began a homicide investigation and a post mortem established MA 1 died from hypoxic anaemic brain damage caused by hypovolaemic shock with cardiac arrest resulting from an incised wound to his right hand.

1.4 MA 2 was charged with the murder of MA 1 on the day he died. In spring 2014 MA 2 appeared at a Crown Court and pleaded guilty to manslaughter. He was sentenced in summer 2014 to five and a half years imprisonment.

**2. ESTABLISHING THE DOMESTIC HOMICIDE REVIEW [DHR]**

**2.1 Decision Making**

2.1.1The Safer Rotherham Partnership [SRP] chair decided in autumn 2013 that the death of MA 1 met the criteria for a DHR as defined in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews August 2013 [the Guidance].

2.1.2The Guidance states that a decision to hold a DHR should be taken within one month of the homicide coming to the attention of the Community Safety Partnership and says it should be completed within a further six months. The completion date was set as spring 2014. That date was later revised to 08.12.2014 to allow additional time for many agencies to finalise their Individual Management Reviews [IMR] and supplementary meetings of the DHR Panel to discuss the complex facets of this case. Additionally, the DHR Panel felt it was important to see MA 2 and this could only be done post sentence.The SRP Chair and the Home Office Domestic Violence Unit were briefed on the delay.

**2.2** **DHR Panel**

2.2.1David Hunter was appointed as the Independent Chair and Author in autumn 2013. He is an independent practitioner who has chaired and written previous DHRs, Child Serious Case Reviews and Multi Agency Public Protection Reviews. He has never been employed by any of the agencies involved with this DHR and was judged to have the experience and skills for the task. The first of seven panel meetings was held during autumn 2013. Attendance was good and all members freely contributed to the analysis, thereby ensuring the issues were considered from several perspectives and disciplines. Between meetings additional work was undertaken via e-mail and telephone.

 The Panel comprised of:

* Ruth Fletcher-Brown Rotherham Metropolitan Borough Council [RMBC] Public Health
* Annette Carey Choices and Options [C&O] Area Manager
* Alison Lancaster Rotherham Doncaster and South Humber NHS Foundation Trust [RDaSH] Mental Health
* Sue Ludham South Yorkshire Probation Trust [SYPT] Deputy Director
* Helen Greig Action Housing and Support Director of Client Support Services
* Helen Wood Safeguarding Adults Coordinator and Domestic Abuse and IDVA Manager, RMBC Adult Services
* Jason Horsley Consultant Public Health RMBC
* Elisa Pack Victim Support Senior services Delivery Manager
* Cherryl Henry-Leach SRP Domestic Abuse Coordinator RMBC
* Sam Newton Service Manager Safeguarding Adults RMBC
* Steve Parry SRP Neighbourhood Crime and Anti-Social Behaviour Manager RMBC
* Katie Sidebottom Key Worker Care and Supported Housing
* Helen Smith Sergeant SYP
* Rob Stanton Headway
* Jean Summerfield Rotherham NHS Foundation Trust Named Nurse Adult Safeguarding
* Victoria Swinbourne Lifeline Service Manager
* Sue Bower  Safeguarding Adults Lead Professional
 Rotherham Doncaster & South Humber NHS Foundation Trust [RDaSH]
* Matt Pollard Drug and Alcohol Services Manager RDaSH
* Alun Windle Rotherham Clinical Commissioning Group post
* Paul Walsh Housing and Communities Manager RMBC
* David Blain Head of Safeguarding Yorkshire Ambulance Service
* Sue Wynne Refuge Coordination Rotherham Woman’s Refuge

**2.3** **Agencies Submitting Individual Management Reviews [IMRs]**

2.3.1The following agencies submitted IMRs.

* Choices and Options
* South Yorkshire Police
* Housing and Neighbourhood Services RMBC
* Headway
* Action Housing and Support
* Rotherham NHS Foundation Trust
* South Yorkshire Probation Trust [as was]
* St Ann’s Medical Centre
* Stag Medical Practice
* Lifeline
* Adult Services RMBC
* Yorkshire Ambulance Service
* Sheffield Teaching Hospitals NHS Foundation Trust
* RDaSH [mental health and substance misuse]
* Independent Domestic Violence Advocate [IDVA]

Non IMR written information was received from:

* Metropolitan Police Croydon
* Victim Support

**2.4 Notification/Involvement of Families**

2.4.1 The families of MA 1 and MA 2 were briefed by SYP Family Liaison Officers and provided with copies of the Home Office leaflet on domestic homicide reviews.

2.4.2 The following family members were seen by the SRP Domestic Abuse Coordinator and the independent chair. The families’ views appear as appropriate throughout the report.

The SRP Domestic Abuse Coordinator and the DHR independent chair/author met with MA 1’s sister 15.05.2014. Her views appear in the report as appropriate.

 MA 2’s mother was last written to on 09.06.2014 inviting her to contribute to the DHR. She did not reply and the DHR Panel felt it was inappropriate to contact her again.

 MA 2 did not respond to two letters inviting him to contribute to the review.

**2.5 Terms of Reference**

**2.5.1 The purpose of a DHR is to**:

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

[Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2013] Section 2 Paragraph 7]

**2.5.2** **Timeframe under Review**

The DHR covers the period 01.04.2007 [the date around which MA 2 sustained a brain injury, to MA 1’s death in autumn 2013]. Contextual information predating 2007 is also included.

**2.5.3 Case Specific Terms**

1. Were the risk indicators for domestic abuse present in this case recognised, properly assessed and responded to in providing services to MA 1 [the victim] and MA 2 [the alleged perpetrator]? If not, what was the reason for this?

 2. Were the services provided for MA 1 and MA 2 timely, proportionate and “fit for purpose” in relation to the levels of risk and need that were identified?

 3. How did agencies ascertain the wishes and feelings of MA 1 and MA 2 about their victimisation/position and were their views taken into account when providing services or support?

 4. How effective was inter-agency information sharing and cooperation in response to MA 1 and MA 2’s situation? What consideration was given to sharing information between agencies from different authorities in support of MA 1 and MA 2 and was it effective?

 5. How do agencies within the Safer Rotherham Partnership support victims from LGBT [lesbian, gay, bisexual and transgender] and other minority groups who disclose domestic abuse?

 6. How were any racial, cultural, linguistic, faith or other diversity issues, taken into account during assessments and provision of services to MA 1 and MA 2?

 7. Were the reasons for MA 2’s abusive behaviour properly understood and addressed? Was there sufficient focus on reducing the impact of MA 2’s abusive behaviours towards MA 1 by applying an appropriate mix of sanctions [arrest/charge] and treatment interventions?

 8. Were single and multi-agency policies and procedures, including the MARAC protocols, followed and are they embedded in practice and were any gaps identified?

 9. How effective was the supervision and management of practitioners involved with responding to the needs of MA 1 and MA 2’s. Did managers have effective oversight and control of the case?

 10. Were there any issues in relation to capacity or resources within the Partnership and its agencies that affected the ability to provide services to MA 1 and MA 2 or to work with other agencies?

 On 06.02.2014, at the second Panel meeting, it was agreed that the terms of reference would be revised to include the following points for consideration by IMR authors:

 11. Was the risk to family members of MA 1 and MA 2, in particular their mothers, recognised as Domestic Abuse?

 12. When risks to family members were identified and managed, was the risk to either MA 1 or MA 2 as immediate partners considered?

**3. DEFINITIONS**

**3.1 DOMESTIC VIOLENCE**

3.1.1 The Government definition of domestic violence against both men and women [agreed in 2004] was:

 “Any incident of threatening behaviour, violence or abuse [psychological, physical, sexual, financial or emotional] between adults who are or have been intimate partners or family members, regardless of gender or sexuality”

3.1.2 The definition of domestic violence and abuse as amended by Home Office Circular 003/2013 came into force on 14.02.2013 is:

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

* psychological
* physical
* sexual
* financial
* emotional

 Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

 Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.”

3.1.3 Therefore, the experiences of MA 1 fell within the various descriptions of domestic violence and abuse. SRP preference is the term Domestic Abuse which is used in the report hereafter.

**3.2 Vulnerable Adult [No Secrets 2000]**

3.2.1 The broad definition of a ‘vulnerable adult’ referred to in the 1997 Consultation Paper Who decides? \* issued by the Lord Chancellor’s Department, is a person:

 “Who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation”.

 A consensus has emerged identifying the following main different forms of abuse:

* physical abuse, including hitting, slapping, pushing, kicking, misuse of medication, restraint, or inappropriate sanctions;
* sexual abuse, including rape and sexual assault or sexual acts to which the vulnerable adult has not consented, or could not consent or was pressured into consenting;
* psychological abuse, including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks;
* financial or material abuse, including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits;
* neglect and acts of omission, including ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating; and discriminatory abuse, including racist, sexist, that based on a person’s disability, and other forms of *harassment, slurs or similar treatment.*

Incidents of abuse may be multiple, either to one person in a continuing relationship or service context or to more than one person at a time. This makes it important to look beyond the single incident or breach in standards to underlying dynamics and patterns of harm.”

 Source: Section 2 No Secrets Department of Health 2000

 Note: South Yorkshire Police use two forms when sharing information about adults.

 One: CID 70 titled: “Adult Safeguarding Alert Form”. CID 70 is used when an officer is investigating the abuse of a vulnerable adult as defined by “No Secrets”. However, the practice is that CID 70 is used for all vulnerable adults, whether or not they meet the “No Secrets” definition. Adult Services and RDaSH are the main receiving agencies for CID 70 and on receipt determine which service is the most appropriate for the adult.

 Two: CID 70A titled: “Notification of Vulnerable Adult Concern”. CID 70A is used when an officer is dealing with an incident that does not involve a crime investigation. CID 70A uses the “No Secrets” definition of vulnerable adult, but like its counterpart CID 70, custom and practice sees CID 70A used for adults who do not meet the “No Secrets” definition. Similarly, Adult Services and RDaSH are the main receiving agencies for CID 70 and on receipt determine which service is the most appropriate for the adult.

3.2.2 The DHR found that agencies did not have a common understanding of the term Vulnerable Adult which lead to miscommunication and recommends the Safer Rotherham Partnership addresses the issue.

3.2.3 In this report the terms safeguarding adults, vulnerable and vulnerable adults do not mean the “No Secrets” Vulnerable Adults unless specifically stated.

**4. MA 1 and MA 2’s BACKGROUND**

 Note: The information in this section is drawn from the IMRs and family members.

**4.1 MA 1**

4.1.1 MA 1 was a native of South Yorkshire and one of three siblings. He was educated locally and on leaving school took up employment in a local bakery and for a while worked for a national charity. MA 1 also worked as a carer in residential care homes. His working life was interspersed with periods of unemployment which lengthened as he grew older and more dependent on services. MA 1’s mother [FA 1] lived very near him and at one time he was her nominated carer. It will emerge later in the report that their relationship had moments of friction and she was the victim of his domestic abuse.

4.1.2 MA 1’s sister, speaking on behalf of the family, described him as a caring loving person who would help anyone. She recognised his vulnerabilities increased in line with his escalating dependency on alcohol. She reported that MA 1 liked to cook; a past time he shared with MA 2. There were two fires in MA 2’s accommodation associated with cooking.

**4.2 MA 2**

4.2.1 MA 2 is also from Yorkshire and on leaving school gained employment in local industries. He trained as a bus driver in South Yorkshire and on moving to London obtained employment in that capacity. MA 2 stated his relationship with his mother and step father were important to him.

4.2.2 Adult Services noted the following:

 “MA 2 experienced a subarachnoid haemorrhage **\*** [2007] after which he underwent surgery to remove blood clots from his brain. MA 2 has cognitive issues due to damage to the frontal lobe of his brain. The subsequent brain injury caused substantial impairment to his cognitive functioning, memory and difficulties with processing information and sequencing tasks. When MA 2 experienced new situations he reported feelings of anxiety, depression and panic. MA 2 also noted acute mood swings which meant that MA 2 could exhibit both verbal and physical aggression. MA 2 acknowledged his misuse of alcohol magnified these issues. MA 2 also suffers from Chronic Obstructive Pulmonary Disease [COPD] which has resulted in him feeling breathless on exertion and experiencing lethargy. MA 2 stated this issue also caused him to experience panic attacks. The health issues noted have had a significant impact on MA 2’s ability to undertake daily living tasks”.

 **\*** A subarachnoid haemorrhage is an uncommon type of stroke caused by bleeding on the surface of the brain. It is a very serious condition and can be fatal.

 Source: www.nhs.uk

**4.3 MA 1 MA 2 Relationship**

4.3.1 It appears MA 1 and MA 2 formed their relationship in 1977 and generally lived together from the beginning. In 1986 MA 1 was sentenced to two years imprisonment at Croydon Crown Court for inflicting grievous bodily harm on MA 2 by stabbing him in the chest. Croydon Community Safety Partnership advised that this was MA 1’s response to finding MA 2 in bed with another male. In 2007 MA 1 and MA 2 were in receipt of incapacity allowance and disability living allowance which continued until the homicide.By early 2009 they lived in separate houses about five miles apart in the greater Rotherham area. The relationship and pattern of abusive behaviour continued despite the geographical split. Neither had worked for several years.

4.3.2 MA 1’s sister knew from MA 1 that the relationship was abusive; primarily when they were in drink. She described the abuse as mutual with both men taking an equal part as the aggressor. She said this balance altered after MA 2’s head injury when in her opinion MA 2 became the main instigator of abuse. She believed his head injury impacted on his behaviour as evidenced by MA 2’s frustration at not being able to find the right words to use. This and the couple’s increasing use of alcohol meant they argued often and were sometimes violent.

4.3.3 The DHR report will show that the relationship between MA 1 and MA 2 was abusive, containing several elements which made identifying, assessing and managing risk very complex. They were a difficult couple to help and were often ambivalent to offers of help and support. On many occasions MA1 and MA2 were actively resistant to agencies attempts to provide services.

**5.** **THE FACTS BY AGENCY**

**5.1**  **Introduction**

5.1.1 The fifteen IMRs and other supporting documents contain a significant volume of material. Each agency’s involvement is dealt with separately in a narrative commentary which identifies the important points relative to the terms of reference. The main analysis of events appears in Section 6.

5.1.2 The narrative is preceded by an events table which picks out significant points that predate the DHR review period.

**5.2 Pre April 2007 Relevant Events**

 **Date Event**

Late 1985 MA 1 stabbed MA 2 in chest

 17.01.1986 MA 1 sentenced to 2 years imprisonment for above attack

 05.02.1999 MA 1 finished job; saw GP; abusing drugs; referred to psychiatrist

 03.09.1999 MA 2 drug overdose; depressed; no job, relationship problems [MA 1] 08.08.2001 MA 1 anxiety and depression referred by GP to community mental health

 09.08.2001 MA 2 drug overdose, drinks one bottle of vodka daily

 13.08.2001 MA 2 seen by mental health; heavy binge drinker; will not accept help

 11.09.2001 MA 2 drug & alcohol overdose; unemployed lives with boyfriend

 24.10.2001 MA 2 overdose drugs & alcohol; partner has debt problems; bailiffs

 05.12.2001 MA 2 overdose drugs & alcohol; 1 litre cider daily, lives with boyfriend

 12.03.2002 MA 2 tells medic he drinks ½ bottle vodka daily

 10.07.2002 MA 2 advised to reduce alcohol and stop smoking

 21.05.2003 MA 1 at GP anxiety depression; referred to community mental health

 19.11.2003 MA 1 at GP, hit on head in fight with MA 2; MA 1 having panic attacks

 29.12.2003 MA 2 fractured hand; someone pulled door shut on it

 19.02.2004 MA 1 saw GP; kicked on side of head; not recorded who did it

 05.08.2004 MA 1 saw GP; anxiety worse since reduction in medication;

 27.03.2006 MA 2 referred by GP to RDaSH; no reason or outcome recorded on GP record

 04.09.2006 MA 2 emergency admission after collapse, drinks 4 cans lager daily; bruising noted to both lower ribs

 17.02.2007 MA 1 cut off damaged skin to MA 2’s lower left eyelid, drinking with partner; admitted for repair to eye lid

 23.03.2007 MA 1 &MA 2 signed tenancy for house; both claiming incapacity & disability living allowance

**5.3 South Yorkshire Police**

5.3.1 SYP was involved with MA 1 and MA 2 for the whole of the DHR review period. Their first contact was on 02.08.2007 when MA 1 reported he was being attacked by MA 2. The couple were seen and given advice following what the officer described as a verbal argument. The incident was recognised as domestic abuse but the officer did not submit a domestic incident form. This would have alerted specialist officers to the incident and allowed them to complete a risk assessment and consider referrals to other agencies.

5.3.2 The last involvement of SYP prior to the homicide on 06.10.2013 was 19.08.2013 when officers responded to MA 2’s call that he was having problems with MA 1 and feared for his life. MA 1 and MA 2 were noted to be drunk and the incident was resolved when MA 1 left the house at the request of the officers. This incident was also recognised as domestic abuse and a domestic incident form was submitted. A referral was made to Choices and Options [domestic abuse community support service] as MA 2 agreed to the offer of support.

5.3.3 Set out below is a fair summary of SYP’s involvement, followed by the details of several incidents. The exact nature of some incidents is open to interpretation and the category allocation represent the judgement of the DHR independent author/chair.

* 52 domestic abuse incidents
* 13 other incidents [e.g. nuisance, self-harm, theft]
* 34 incidents where alcohol was noted as a feature
* 16 incidents where MA 1 was viewed as the victim
* 17 incidents where MA 2 was viewed as the victim
* 5 incidents where MA 1 and MA 2 were both viewed as victims
* 10 incidents where the victim was FA 1 [MA 1’s mother] of these 10, MA 1 could be viewed as the perpetrator for nine and MA 2 for one.
* 6 incidents resulted in arrests: MA 1 was arrested four times [once for assaulting his mother and three where MA 2 was the victim] and MA 2 was arrested twice for alleged assaults against MA 1.
* 19 opportunities to submit domestic violence forms were missed
* 2 incidents referred to knives
* 8 incidents had Adult Protection Forms submitted [CID 70/70A]

5.3.4 The following 13 incidents reflect the nature of SYP’s dealings with MA 1 and MA 2 and illustrate the repetitiveness of issues.

1. On 16.03.2008 MA 1 was arrested to prevent a Breach of the Peace when he was trying to retrieve clothing from MA 2.
2. On 24.03.2008 MA 1 was verbally abusive to MA 2 who retaliated and assaulted MA 1. SYP arrested MA 2 and assessed the risk posed by MA 2 to MA 1 as medium.
3. On 14.09.2008 a third party reported that MA 1 had assaulted his mother who when seen by the attending officers, insisted she had not been assaulted. The incident was clearly domestic in nature but was not recorded as such. It was dealt with as anti-social behaviour. This was the first incident between MA 1 and his mother; several more were reported over the coming months.
4. On 09.07.2009 MA 2 contacted SYP. He had made a report to the Department for Work and Pensions of benefit fraud against MA 1’s niece. She then contacted MA 2 and told him he had picked on the wrong person. MA 2’s support worker heard the call and MA 2 was observed to be physically sick after it. MA 2 was given advice by SYP.
5. On 14.08.2010 MA 1 was arrested for assaulting his niece. He received a suspended sentence order, a twelve month supervision order and a six month alcohol treatment order. SYPT risk assessment Offender Assessment System [OASys] judged MA 1 posed a medium risk of causing serious harm to his niece.
6. On 05.04.2011 MA 1 was arrested for damage at his mother’s house. He was released without charge due to her reluctance to give evidence. The risk level was set at medium, but the attending officers did not submit a CID 70 which would have alerted other agencies to the incident.
7. On 23.04.2011 FA 1 reported to SYP that MA 2 had hit MA 1 with a bottle and was bleeding from his head and hands. Two of MA 1 fingers were fractured in the same incident. Officers attended and found MA 2 had left. MA 1 went to hospital and the officers located and arrested MA 2 despite MA 1’s wish for no further action. MA 2 was verbally cautioned for the assault. The risk assessment showed that MA 2 presented a medium risk of causing serious harm to MA 1.
8. On 05.06.2011 MA 2 told SYP that MA 1 had thrown water over him and that his telephone was in the bin. Police attended and arrested MA 1 and charged with assault and damage. SYP discussed with Choices and Options the most appropriate way to deal with the situation between the couple. Choices and Options advised they were referring the case to MARAC because their risk assessment found MA 1 posed a high risk of causing serious harm to MA 2.
9. On 27.07.2011 MA 1’s niece told SYP that MA 1 was threatening to slit his wrists and trying to get a knife from the kitchen. MA 1’s niece had tried to contact the GP and the crisis team and they have advised her to call the police. An officer attended and MA 1 went to A & E to see the crisis team. A CID 70A was not submitted.
10. On 31.08.2012 FA 1 contacted SYP and reported a disturbance. Officers attended and removed MA 2. MA 1 later told officers MA 2 had assaulted him. They noticed that MA 1 had what appeared to be a “healing” black eye. However he did not want to complain of assault or say how he received the injury. The risk assessment showed that MA 1 faced a medium risk of serious harm from MA 2.
11. On 14.12.2012 MA 2 told SYP he had been assaulted by MA 1. MA 2 appeared to be drunk. The attending officer stated that it was a verbal argument only.
12. On 10.04.2013 MA 2 told SYP that he thought MA 1 was going to attack him. MA 2 seemed confused and scared in the call handler’s opinion. The attending officers noted both were in drink and concluded no offences had taken place. Domestic abuse forms were submitted to the Public Protection Unit.
13. On 13.08.2013 a call was received from Rothercare [Community Alarms] from FA 1 who had pressed her alarm. MA 1 was drunk and had argued with his mother. He was throwing things around and refusing to leave. Officers attended and removed MA 1 to his address. On 19.08.2013 SYP submitted a CID 70 and domestic violence forms for MA 1’s mother.

5.3.5 The DHR Panel heard from RDaSH and Adult Services that the submission of CID 70 and CID 70A by SYP had significantly drifted from their original use of notifying agencies about “No Secrets” vulnerable adults, to one which now routinely included: information only, domestic abuse, concerns regarding mental health, requests for assessments and adults who had social care needs. RDaSH and Adult Services also felt that the referrals from SYP were not always explicit or clear in what they wanted or the reason for submitting the CID 70 or CID 70A.

5.3.6 SYP Action Plan includes a recommendation to address this, viz:- “The SYP adult protection referral process will be re-launched to officers as a timely reminder of when these referrals need to be competed”. The DHR Panel thought that while the recommendation was appropriate there was an opportunity for the Safer Rotherham Partnership to determine whether there was benefit for all its constituency agencies to use the same documentation for making a safeguarding alert and accordingly makes a recommendation.

**5.4 Housing and Neighbourhood Services [H&NS]**

5.4.1 Housing and Neighbourhood Services provide a range of services in the borough. Services relevant to this case include providing approximately 21,000 Council tenancies, and the Community Protection Unit which undertakes investigations and enforcement action in line with the Environmental Protection Act 1990. This includes anti-social behaviour and statutory nuisances such as that caused by noise.

5.4.2 MA 1 and MA 2 were re-housed to Address 1 in the spring of 2007. Address 1 is a bungalow in a complex reserved for the over 60’s or those with a medical priority, which in this case was MA 2’s head injury. FA 1 lived in the same street in sheltered housing. In December 2008 MA 2 moved into temporary supported housing and gave up the joint tenancy of the couple’s home. MA 1 told Headway that MA 2 moved out because of domestic abuse. MA 1 would not move because the property was near his mother’s property. The DHR Panel noted the couple were allocated the property because of MA 2’s injury and the “enforced” move by MA 2 could be an example of MA 1’s control over MA 2. MA 2 moved to Address 2 in February 2009; which was about five miles from Address 1. Both properties belonged to RMBC but were managed by different teams. This and different information databases resulted in poor communication and some staff lacked the detail about some incidents.

5.4.3 In August, November and December 2008 H&NS dealt with complaints of shouting and swearing at Address 1. They approached the problem from an anti-social behaviour perspective and did not appreciate they were dealing with domestic abuse despite knowing of the volatility between them. H&NS told the DHR Panel that it did not recognise that the two males were in a relationship and therefore overlooked the fact that their behaviour constituted domestic abuse.

5.4.4 In August 2010 H&NS received a complaint of drunken fighting between MA 1 and MA 2 in the street outside Address 1. Again this was approached from an anti-social behaviour stance. In September 2010 the anti-social behaviour officer who saw MA 1 got the impression that MA 1 was not liked because he was homosexual and the bungalow was not clean. This impression was formed after the anti-social behaviour officer spoke with an elderly neighbour who referred to MA 1 as “gay”. MA 1 declined help for his alcohol problems. A tenancy warning letter was issued on the 13.10.2010 and case closed on 05.12.2010 because the property had been cleaned, curtains put up and there were no further complaints. The anti-social behaviour officer did not identify the domestic abuse element in the situation.

5.4.5 The H&NS IMR author interviewed an area housing officer who stated he had liaised with the support worker and named a worker. The area housing officer also stated he had telephoned RDaSH to see if there was support for MA 1 and stated the advice given was “it was down to himself”. The contacts with the support worker and RDASH are not recorded in H&NS or RDaSH’s notes.

5.4.6 MA 2 occupied Address 2, a ground floor flat, from February 2009. There was a note on MA 2’s file saying he was receiving support from Headway [brain injury support service] and Action Housing and Support. It was also noted that MA 2’s housing benefit forms had been completed by a social worker. A few months later a neighbour reported MA 2 was naked, drunk and knocking on doors. The housing officer investigated and the incident was less stark than initially portrayed. The housing officer liaised with MA 2’s Action Housing and Support, worker and approached the issue informally, judging that a warning letter was unlikely to have any impact on MA 2 and that it was better to find a solution to his problems given his head injury and alcohol misuse. MA 2 was referred to the substance misuse floating support project.

 5.4.7 In August 2010 there were reports of persistent shouting and swearing from MA 2’s flat. In was apparent that MA 1 was a frequent visitor and the disturbances were consequential to their arguments. Again the issue was approached more informally and from a non-enforcement angle. In the same month MA 2 was experiencing anti-social behaviour and wanted to move closer to MA 1 who he described as his carer. This position was contradicted when in September 2010 MA 2 told a housing officer he wanted move away from Rotherham so MA 1 could not find him. However, soon after, MA 2 changed his mind about moving anywhere.

5.4.8 MA 2’s case was closed in April 2011 but re-opened in May 2011 following a report of a fire in his kitchen caused when pans were left unattended on the cooker. There is no evidence that a fire risk assessment was carried out at that time which is surprising given MA 2’s history of alcohol abuse, head injury and volatile relationship with MA 2. Those in potential danger were MA 2 and any visitors together with other residents of the block of flats. South Yorkshire Fire and Rescue Service [SYFRS] attended the property in mid-September 2011 and conducted a Home Safety Check which revealed a high risk of fire. SYFRS fitted smoke alarms; provided a fire retardant throw and gave risk reduction advice.

5.4.9 In July 2011 a housing officer contacted the Police, Action Housing and the IDVA, to make MARAC aware that MA 1 was back in a relationship with MA 2. A file note states there was a MARAC meeting on the same day. The note suggested that IDVA and Action Housing had withdrawn visits to MA 2’s property because of his violence to staff. However, adult safeguarding matters were not raised or discussed at this MARAC. After the MARAC, IDVA confirmed to the housing officer that MA 1 was back in a relationship with MA 2 whose drinking was “out of control” and three support agencies are aware; these agencies were: H&NS, C&O and RDASH. SYP also knew because they were at MARAC. A referral should have been made to adult safeguarding by any of the agencies who attended MARAC.

5.4.10 The housing officer told the IMR author, “I felt a bit deflated, I was encouraged by all the interagency work” ... MA 2’s drinking was out of control but nobody appears to be supporting him. I felt if all these specialist agencies could not help him, how could I”. The housing officer said MA 2 had the capacity to make decisions and was responsible for his own actions.

5.4.11 The above two paragraphs illustrate the complexities of this case. There were many risk factors but no evidence of a structured multi-agency problem solving approach.

5.4.12 The maintenance records for Address 2 do not show damage typical of domestic abuse. A door in the property was re-hung in November 2011 but there is no causal explanation noted. The IMR’s author’s thought processes in connecting damage to property with domestic abuse is creative and demonstrates a less obvious method of identifying domestic abuse.

5.4.13 In April 2013 there was report that MA 1 and MA 2, who were drunk and cooking, had started a fire in the kitchen of MA 2’s flat. The Police attended but not the fire service. Adult Services undertook a general assessment. This was the third fire at MA 2’s flat and the risk factors of cooking, alcohol consumption and domestic abuse, present in May and September 2011, still existed in April 2013.

5.4.14 In May 2013 H&NS were alerted to another episode at MA 2’s flat. This time it was alcohol fuelled screaming, shouting and threats to kill people. A decision was taken in July 2013 to serve Acceptable Behaviour Contracts on MA 1 and MA 2. There is evidence within the IMR of liaison between Action Housing and the housing officer who was supporting MA 2.

5.4.15 On 14.05.2013 the housing officer made an Adult Safeguarding referral for MA 2 through the Assessment Direct telephone line, stating there were arguments in the property, both were in drink and while MA 1 was relatively able bodied, MA 2 was not and was vulnerable. The housing officer added there had been talk of domestic abuse but there was no evidence. The housing officer thought that following the referral an assessment would be completed and supported provided for MA 2. The housing officer did not tell the IDVA because they thought the referral to Safeguarding would result in appropriate services being informed. The housing officer re-contacted Assessment Direct because there was no evidence of intervention. There was and remains some confusion whether a referral to adult safeguarding is also a referral to IDVA and/or MARAC, and vice versa. [Recommendation 6 applies]

5.4.16 In mid-September 2013 a housing officer visited MA 2’s flat. MA 2 was out but MA 1 was in. MA 1 was not wearing any pants. The housing officer felt there had not been sufficient improvement since the last visit and was firm with MA 1 stating he was supposed to be MA 2’s carer and he should care for him. The housing officer said they would return with the Police to serve Acceptable Behaviour Contracts on MA 1 and MA 2. MA 1 thought people were reporting them because they did not like MA 2. The DHR Panel felt that a safeguarding adult referral should have been made. Such a referral would have allowed Adult Care to assess whether MA 1 was a vulnerable adult within the “No Secrets” definition.

5.4.17 Overall H&NS acknowledge that they did not identify domestic abuse as feature of MA 1 and MA 2’s relationship. They categorised the issues as anti-social behaviour and instead of tackling the problem through the normal route of enforcement, adopted a more tolerant approach because of MA 2’s head injury and alcohol dependency. There was substantial information sharing and some joint working between H&NS and several other support agencies.

5.4.18 H&NS identified a number of weaknesses and oversights in its handling of the case. Some of these were organisational, for example; information was held on separate different databases making access to a complete picture cumbersome, and others were attributed to individual practice as demonstrated by the non-enforcement line taken by a housing officer.

5.4.19 Had the organisation identified domestic abuse as an underlying feature of its dealings with MA 1 and MA 2 it would have added weight to the substantial body of existing information and led to a referral to MARAC.

5.4.20 However, what is clear from H&NS’s IMR is the fact that while staff had received some domestic abuse awareness training, they were not trained in DASH risk assessment nor had most even heard of it. Therefore their ability to support MA 1 and MA 2 would have been limited even had they recognised the domestic abuse aspect of the case.

**5.5 Yorkshire Ambulance Service [YAS]**

5.5.1 Yorkshire Ambulance Service [YAS] NHS Trust was established on 1st July 2006 when the county’s three former services merged.

5.5.2 The YAS IMR contains the following paragraph which the DHR Panel felt accurately reflected YAS’s dealings with MA 1 and MA 2.

 “Of the 16 incidents YAS staff attended, MA 1, MA 2 or the niece of MA 1 were conveyed to a hospital on 13 occasions and Police were present on 8 on those occasions. Whilst there is evidence of good inter-agency working with the police, YAS staff may have felt falsely reassured by their presence and wrongly assumed Police would signpost and undertake the social care referrals, due to their involvement in the incident, both from a criminal perspective and for victim support”.

5.5.3 YAS did not always leave it to other agencies to make referrals. MA 1 and MA 2 were referred to adult social care on separate occasions and MA 2 to alcohol misuse services on another occasion.

5.5.4 YAS was marginally aware of domestic abuse between MA 1 and MA 2. However, the presenting history of the couple was predominately peripheral to domestic abuse and the central issue was hidden.

**5.6 Action Housing and Support [AH&S]**

5.6.1 AH&S is a not-for-profit organisation operating in South Yorkshire and the Midlands. The organisation has been working with offenders, homeless individuals and people with substance misuse issues for more than thirty years providing housing-related support. The remit was broadened in more recent times to also provide services for young people, people with mental health issues and domestic abuse. In Rotherham specifically, AH&S provides housing-related floating support services for offenders and people with substance misuse issues, accommodation-based services for young people, offenders, and people with mental health needs. AH&S is not commissioned to provide specific services for victims or perpetrators of domestic abuse in Rotherham.

5.6.2 A summary of AH&S involvement reveals support sessions were carried out regularly with MA 1 and MA 2, sometimes alone, sometimes together and often at MA 1’s mother’s house, because MA 1 was too embarrassed about his property to allow people in.

5.6.3 When MA 2 left the property he shared with MA 1 in 2008 he moved to a hostel operated by AH&S saying he was escaping from an abusive relationship. MA 2 moved to independent accommodation in February 2009 and AH&S allocated him a floating support worker.

5.6.4 MA 2 told AH&S that he had fled from domestic abuse perpetrated by MA 1. However, it was apparent to AH&S that MA 2 was still in a relationship with MA 1. At this point an internal risk assessment document should have been undertaken to determine the level of risk faced by MA 2 and how it could be reduced. AH&S records from that period were destroyed under its then retention and destruction policy. However, the DHR Panel was told by the AH&S DHR Panel member that it was standard practice at the time to complete the internal risk assessment document. The IMR author declared that AH&S’s domestic abuse policy was not written until July 2010 and prior to that the organisation did not have a clearly defined approach to domestic abuse across the company.

5.6.5 By July 2009 it was clear to AH&S that MA 2’s alcohol abuse problem was significantly worse than first thought and he was referred to the substance misuse project run by another team within AH&S.

5.6.6 During this period MA 2’s support worker recalls seeing MA 2 with several cuts, which he explained as being caused through fighting with MA 1. AH&S policy and practice at the time was to complete internal risk assessments on victims and therefore it is very likely that one was done for MA 2. The support worker believes that she made a referral to adult safeguarding but was advised that they could not do anything as the couple remained together. That belief comes from the worker’s memory. There is no corresponding entry in Adult Services IMR but adult services were engaged with MA 2 through referrals from Headway and SYP. The point that a AH&S worker thought nothing could be done for the couple because they chose to stay together is a reoccurring oneand will be explored later in the report.

5.6.7 In July 2009, MA 2 contacted AH&S’s out-of-hours service who judged he was drunk and suicidal. AH&S made a referral to the mental health crisis team but was advised that as MA 2 continued to drink and remained in the relationship there was nothing that could be done. A similar response was received following a referral to Lifeline [substance abuse support]. During the same period [July 2009], MA 2’s AH&S worker made a report to the police and Adult Services regarding concerns about financial exploitation of MA 2 by MA 1’s niece. MA 2 said the niece encouraged him to get very drunk before taking his bank card to remove money from his account. The DHR Panel considered whether the niece’s actions amounted to domestic abuse but noted that she was not a family member as defined. However, MA 2 should have been referred to Adult Services.

5.6.8 In January 2010 AH&S, judged MA 1 to pose a high risk of causing harm to MA 2 using an internal risk assessment tool. At that time AH&S was not an agency that referred to MARAC. AH&S referred to adult safeguarding in the mistaken belief that a referral would be made to MARAC if the thresholds were met. Since 2011 AH&S have been able to make direct referrals to MARAC. This is another example of the confusion around referrals to adult safeguarding.

5.6.9 MA 1 was referred to AH&S by South Yorkshire Probation Service [SYPS] in May 2011. SYPT was seeking support for MA 1 to help him with budgeting, tenancy and to divert him from alcohol use. MA 1’s AH&S worker at the time did not consider the relationship between MA 1 and MA 2 was abusive despite knowing the definition of domestic violence. The worker thought it was “volatile” and they were just bickering at each other. This is another example of a professional not fully understanding thenature of the relationship between the couple. The DHR Panel wondered if the same behaviour was observed between heterosexual couples whether professionals would have viewed it differently. That point will be explored later in the report.

5.6.10 In September 2011 a AH&S worker saw MA 1 and MA 2 together, noting they both had physical injuries. There is no evidence that either was asked about the bruising. This reinforces the view that AH&S staff were not operating within a domestic abuse framework. Positively AH&S referred MA 1’s mother to Rothercare because of an incident between her, MA 1 and his niece.

5.6.11 AH&S undertook an internal risk assessment in December 2012 and concluded that MA 1 and MA 2 still presented a medium risk of harm to each other. It was noted that in November 2012 MA 1 had a cut to his head. MA 1 explained that he was arguing with MA 2, slipped and fell. MA 1 did not want the matter referring to any agency.

5.6.12 MA 1 had a new AH&S worker in April 2013 who initiated support for MA 1’s alcohol misuse; however, MA 1 would not engage. The IMR author notes the quality of the risk assessments was variable and sometimes contradictory adding that the general view of AH&S staff was they, “seemed to feel that they were not comfortable with taking steps to progress referrals to safeguarding or domestic abuse services... as they had not seen enough evidence of an abusive relationship”. The DHR Panel’s view is that the evidence of domestic abuse was overwhelming. The IMR author also recognises this and has made appropriate recommendations to improve AH&S’s approach to domestic abuse.

5.6.13 The following entry relating to MA 1’s mother [FA 1] was found within an AH&S’s employee’s case notes and provides an insight into their relationship.

 “MA 1 has never hit her [FA 1] and she did not believe he ever would, although he does shout. She also said she did not fear him”.

5.6.14 If MA 1 was shouting at his mother in anger, then his behaviour could be threatening and seen as emotional abuse, thereby making it domestic abuse.

5.6.15 MA 1’s sister reflected on the relationship between him and their mother, commenting that while FA 1 was concerned about his behaviour, she recognised he could become hostile when in drink. MA 1’s sister said her mother did not believe that MA 1 would harm her. However FA 1 always supported MA 1 because he was her son.

**5.7 Headway**

5.7.1 Headway Rotherham aims to promote understanding of all aspects of brain/head injury and to provide information, support and services to help people with brain injuries, their families and their carers in Rotherham. Headway Rotherham has a safeguarding adult’s policy which covers domestic abuse and has almost completed a bespoke domestic abuse policy. Headway reported that following this case the level of domestic abuse awareness had been raised amongst its staff.

5.7.2 Headway was involved with MA 1 and MA 2 from 30.07.2007 until 11.04.2012. Adult Services referred MA 2 to Headway in October 2007 requesting support with his benefit claims. The Headway IMR contains over 100 entries many of which were contacts with MA 1 and/or MA 2. The IMR author identified seven contacts that were particularly relevant to the DHR.

5.7.3 On 19.09.2008 MA 2 attended Headway’s office and was seen with a black eye and a cut nose. MA 2 explained that MA 1 had caused the injuries and that they fought regularly. MA 2 asked for and was given a “brain injury survivors” card. Headway referred the incident and MA 2 to Adult Services for a needs assessment and safeguarding assessment. Headway does not have a record of the outcome. It is known from Adult Services, that a care assessment was completed on 12.12.2008 by which time other incidents has been referred to them. MA 2 was judged to be a vulnerable adult under the No Secrets definition. A strategy meeting was held but the outcome was not to progress to a safeguarding investigation.

5.7.4 On 03.12.2008 there was a meeting between MA 1, MA 2 [supported by his mother and step-father], adult services and Headway at which MA 2 disclosed regular physical and financial abuse perpetrated by MA 1. MA 1 confirmed this adding the violence was escalating and they had agreed to live separately.

5.7.5 On 01.04.2009 MA 1 and MA 2 attended an appointment at Headway. MA 1 said his niece and her partner had stolen money from MA 2. MA 1 and MA 2 agreed to report the theft to SYP. On 16.4.2009 an update was received from SYP that the allegation of theft could not be pursued as a criminal investigation because of the way the account was handled.

5.7.6 The Headway worker described MA 2 as "evading conversation" and noted MA 2 had two black eyes and a grazed and swollen forehead. The Headway worker asked MA 1 to return home so that MA 2 could be seen alone. MA 2 then explained he could not fully recall how he came by the injuries but had flashbacks of the niece’s partner shouting at him. He further recalled that the niece and her partner also said something to MA 2 about a taxi driver having mugged him.

5.7.7 On 29.04.2011 Headway received a telephone call from AH&S saying that MA 2 had been arrested following an allegation of assault by MA 1; however MA 1 was not “pressing charges”. It is known from SYP that MA 2 was cautioned for the assault. The following month Headway were told by adult services that MA 1 had poured bleach on MA 2 and also cut away some damaged skin from his eye lid. There is no information on what Headway did with that information or that it enquired whether any agency had done anything about what appears to be another serious domestic abuse incident. It is known that the skin was hanging loose from MA 2’s lower eye lid following some unexplained injury and that MA 1 removed it with scissors. The damage caused by the scissors required corrective plastic surgery.

5.7.8 On 25.07.2011 Headway noted that the IDVA was closing the case because MA 2 was unwilling to end his relationship with MA 1. The IDVA agreed to accept another referral should that position alter. It will be seen later in the report that the issue of IDVA not working with victims who remain in a partnership is not as simple as portrayed in Headway’s note of the conversation with the IDVA.

5.7.9 Headway provided services to MA 2 who was their client also gave useful support to MA 1. There is good evidence of information sharing with several agencies. Headway knew the relationship was toxic and while domestic abuse is not the focus of their work and they missed some opportunities to explore the subject with MA 2 and determine his wishes. MA 1 and MA 2 had complex needs and as such they were a very challenging couple to work with.

5.7.10 The IMR says that Headway is “developing a bespoke domestic abuse police” and recommends staff are trained in use of the Domestic Abuse, Stalking and Honour Based Violence [DASH] risk assessment tool. Therefore the DHR Panel recommends the Safer Rotherham Partnership supports Headway in developing and introducing its policy and support training.

**5.8 Adult Social Care [ASC]**

5.8.1 Adult Social Care had little contact with MA 1 and substantial contact with MA 2.

 **MA 1’s Contacts**

5.8.2 On 08.03.2011 ASC received a referral from YAS who attended MA 1’s home the previous day and noted he was a chronic alcoholic with self-harm tendencies who lived in a house they described as uninhabitable because of “mess and trip hazards”. There was also a risk of fire because MA 1 smoked while intoxicated. YAS added that MA 1 was without homecare and would accept help.

5.8.3 An adult safeguarding social worker completed a telephone assessment with MA 1 and established he had an alcohol worker and a probation officer. MA 1 said he was a carer for his mother. The adult safeguarding social worker signposted MA 1 to adult services if he wanted any help.

5.8.4 The case was discussed with the social worker’s manager who recommended that RDaSH was contacted in case he was known to them. That was done and RDaSH [mental health] reported he was not currently a service user and suggested that MA 1 may be known to RDaSH [substance misuse services]. On checking with that service the social worker was told that MA 1 had been discharged from the substance abuse service in November 2010. The case was finalised as no further action for safeguarding. ASC could have referred MA 1 back to RDaSH to allow them to consider re-offering services to MA 1.

5.8.5 On 18.07.2013 SYP made a referral to adult safeguarding [CID 70] expressing the following concerns about FA 1.

* MA 1 is carer for his mother and is taking her money and spending it on drink
* MA 1 verbally abuses his mother
* MA 1 had urinated on her floor
* MA 1’s home was extremely dirty and almost uninhabitable
* MA 1 is not fit to look after his mother
* MA 1 argued with his boyfriend in front of his mother

5.8.6 An adult safeguarding social worker made enquiries with RDaSH substance misuse and discovered they were not currently engaged with MA 1. Adult Services held a strategy meeting for FA 1 and decided not to undertake a safeguarding investigation; however they offered her a full package of support.

 **MA 2**

5.8.7 ASC first became involved with MA 2 in April 2007 when they received notice of his discharge from rehabilitation following his head injury and surgery. The information received included:

* Alcohol dependency
* MA 2 has a long psychiatric history.
* He lives with his partner of 30 years
* He is independent in activities of daily living
* Refuses to get washed
* He is independently mobile and has no physical goals
* He has no motivation or goals

5.8.8 Following that referral, occupational therapy at TRFT undertook a home visit to MA 2 and the case was closed. In August 2007 MA 1 contact ASC requesting an assessment for MA 2 because he was neglecting himself. The assessment commenced in September 2007. In November 2007 the case was closed with the following note: “MA 2 did not require services at this time however during assessment several issues arose which made him feel that a referral to Headway would be helpful”. At this point there was no indication of domestic abuse between the couple.

5.8.9 In September 2008 Headway requested ASC [via Assessment Direct] to assess MA 2. The pre-existing issues were identified. Headway also reported that MA 2 had a cut to his nose and a black eye. He said MA 1 was responsible but MA 2 did not want to involve the police. Assessment Direct consulted a social worker who asked for the matter to be routed to ASC as it was not a safeguarding issue. The DHR Panel felt it was a safeguarding matter; the injuries and attendant circumstances of MA 2’s head injury and alcohol dependency made it such.

5.8.10 Thereafter there was frequent contact between several agencies and ASC which centred on MA 2’s multiple problems. There are many examples of sharing information and agencies supporting MA 2 from their specialism but no co-ordinated approach to the engrained matters and no recognition by ASC that domestic abuse was a significant feature in MA 2’s life.

5.8.11 This can be exampled by a contact received by ASC from a Housing Officer on 14.05.2013. The Housing Officer reported noise nuisance from property, excessive shouting, swearing and fighting and that MA 1 was heard threatening to kill MA 2. ASC dealt with the call by asking the Housing Officer to refer it to RDaSH. That referral was made on 31.05.2013 to an RDaSH access worker who requested the Housing Officer to complete a vulnerable adult’s form with all the details and then Access would take it forward. There is no record of a vulnerable adult’s form being submitted. The RDaSH Access worker should have taken the details over the telephone and dealt with the matter. The DHR Panel felt that passing information backwards and forwards was an example of the problem being moved about without any effective action being taken. It required someone to take responsibility and develop a coordinated response to a complex problem.

5.8.12 The ASC IMR author was critical of their approach to MA 2 and wrote the following:

 “There is evidence throughout RMBC’s Social Care Record for MA 2 of a lack of adherence to RMBC’s policies and procedures around Safeguarding Vulnerable Adults and use of the DASH risk assessments [from 2011].

 There were clear indicators for assessors, of issues around domestic abuse but no one identified MA 2’s same sex relationship as abusive so MA 2 was not supported through the IDVA process, probably due to many contributory factors, including assumptions made of the professionals that there wasn’t a specific perpetrator of abuse between MA 1 and MA 2 because they were in a same sex relationship, without the clarity that MA 2 was the ‘vulnerable adult’ and what this meant in terms of the Local Authority responsibility.

 The narrow focus of Social Care professionals to MA 2’s assessment of need should have been wider. Because of this they failed to highlight any risks except the risks around falls which meant MA 2 was given appropriate housing, therapy input and Rothercare, but didn’t deal with the presenting health and social care issues holistically and, as already stated the issues around Domestic Abuse were not addressed at any point”.

5.8.13 The DHR Panel strongly agreed with the above analysis.

**5.9 Choices and Options [C&O]**

5.9.1 Choices and Options is a project of Metropolitan Housing Partnership who provide a confidential support and advice and floating support services to people experiencing domestic abuse regardless of sexual orientation, age, disability and race; service users are enabled to make informed choices at their own pace.

 Examples of service provision as outlined in the Supporting People contract are;

* Advice, advocacy and liaison work, help in establishing personal safety and security, social contacts and activities
* Help maintaining safety and security of the dwelling
* Supervision and monitoring of health and well being
* The service aim to provide support over six month duration

5.9.2 C&O has no record of involvement or intervention with the victim MA 1. MA 2 accessed advice and support as a victim of domestic abuse perpetrated by MA 1.

5.9.3 RDaSH referred MA 2 to C&O on 26.05.2011 and 31.05.2011. The first referral said MA 2 had bleach thrown on him by MA 1 who had also set fire to the settee. MA 2 did not want a visit but spoke to C&O on the telephone. He had been with MA 1 for 30 years and wanted nothing more to do with him. MA 2 was given advice on safety planning but declined the suggestion that MA 1 should not be allowed in the house. The DHR Panel felt RDaSH should have completed a domestic abuse risk assessment referred MA 2 to the IDVA service if the assessed risk was high, or to Adult Safeguarding, rather than C&O.

5.9.4 The second referral from RDaSH [31.05.2011] said MA 2 had been stabbed in the chest, had a knife injury to his eye and an attempt had been made to steal his money. MA 1 was the perpetrator. C&O spoke to MA 2 on the telephone and completed a DASH risk assessment which showed MA 2 was at high risk of suffering serious harm from MA 1. MA 2 agreed his case could go to MARAC but thought: “it would not make any difference”. MA 2 said he received support from Action Housing and did not want any from C&O. MA 2 spoke of moving to Sheffield and C&O sign-posted MA 2 to the relevant accommodation services. That was the end of C&O’s involvement with MA 2. C&O should also have referred the case to Adult Safeguarding. The DHR Panel thought that MA 2’s lack of engagement may have resulted from the poor responses he received from services concerning his domestic abuse victimisation.

5.9.5 On 19.08.2013 SYP referred MA 2 to C&O saying they had attended an incident at MA 2’s house and he and MA 1 were present and drunk. MA 2 reported that MA 1 had threatened to stab him and that he feared for his life. However, that information was not passed to C&O and SYP wrongly told C&O that there were no threats; an inaccurate statement. C&O made four unanswered telephone calls to MA 2. The last call was made on 19.09.2013 and a message was left saying that the case would be closed if no response was made within seven days. That response never came. MA 1 died on 06.10.2013.

**5.10 Lifeline and South Yorkshire Probation Trust [SYPT]**

5.10.1 Turning Point held the contract for the tier two alcohol services until September 2009 and thereafter it was Lifeline. Services were provided at its premises and outreach work was delivered by staff in the community. Lifeline is a non-medical service. Any medical intervention or specialised interventions required are referred to RDaSH.

5.10.2 Lifeline saw MA 2 on 09.07.2009 who stated he wanted to become a social drinker. He was offered one to one support but did not attend any appointments. MA 2 attended a lifeline drop in service on 10.09.2009 wanting help with his alcohol misuse. He was offered brief advice and declined any further intervention. That was the last contact Lifeline had with MA 2. He did not disclose any domestic abuse to Lifeline during his two periods of contact.

5.10.3 The Lifeline Commissioners consider that the response from Lifeline was appropriate for the two contacts and that at that stage no further information could have been gleaned. They add that a client accessing a drop in service is generally seen briefly, offered advice and information, then offered and encouraged to attend a follow up appointment where a more detailed assessment would be made. MA 2 did not attend any follow up appointments.

5.10.4 On 03.11.2010 MA 1 was sentenced to a Suspended Sentence Order with 12 months supervision requirement and 6 month Alcohol Treatment Requirement [ATR] for assaulting his niece when drunk. Alcohol was noted as the offending trigger. SYPT assessed MA 1 as posing a medium risk to known adults.

5.10.5 SYPT referred MA 1 to Lifeline on 12.11.2010. He told them during an assessment that he wanted to become a social drinker; the same aim recorded for MA 2 eighteen months earlier. That was an unrealistic ambition for MA 2 and MA 1 given their level of dependency.

5.10.6 SYPT noted that MA 1 commenced his supervision and ATR – he complied with his order and maintained 32 appointments out of 36 offered. Work completed throughout this period included:

* Completed work with Lifeline on his ATR
* Relationship advice and how to avoid conflict.
* Understanding triggers to conflict and violent reactions.
* Crisis management and keeping himself safe – managing his lifestyle.
* Self-esteem building
* Alcohol reduction
* Home visits to encourage MA 1 doing some home improvements.
* Multi-agency meetings between SYPT, Lifeline and Action Housing

5.10.7 03.05.2011 Lifeline and the SYPT offender manager [OM] met with MA 1 who disclosed he had verbal and physically abused MA 2. These acts of domestic abuse were committed when MA 1 was in drink, however, MA 1 saw himself as a low risk of committing serious harm to MA 2. This differs from SYPT OASys which found that MA 1 presented a medium risk to known adults. A perpetrator’s view of the risk they present is very likely to be understated. Additionally SYPT used its domestic abuse risk assessment tool, SARA [Spousal Assault Risk Assessment] which concluded that MA 1 presented a medium risk of causing serious harm to known partners and family members and a low risk to others. The DHR Panel felt it was reasonable to say that SYPT should have referred MA 2 to a domestic abuse support agency. SYPT’s focus was on MA 1 as an offender. The focus of a domestic abuse support agency would have been MA 2 as a victim. His risk would have been assessed and a risk management plan drawn up.

5.10.8 SYPT risk levels are defined as:

 **Low Risk of Serious Harm: [ROSH]**

 Current evidence does not indicate likelihood of serious harm.

 **Medium Risk of Serious Harm:**

 There are identifiable indicators of ROSH. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change of circumstances, for example failure to take medication, loss of accommodation, relationship breakdown, and drug or alcohol misuse.

 **High Risk of Serious Harm:**

 There are identifiable indicators of ROSH. The potential event could happen at any time and the impact would be serious.

 Source: OASys template Section R10.6 and Section 7.3 MAPPA Guidance 2009

5.10.9 Lifeline did not complete a risk assessment or make a referral to MARAC for MA 1, believing that it was the agreed responsibility of SYPT to refer joint clients to MARAC. This has now changed and Lifeline can act independently of other agencies and make their own referrals to MARAC. He was signposted to counselling organisations for his depression and to debt management for his financial problems.

5.10.10 In August 2011 the OM conducted a home visit and saw MA 1’s mother who said he could be loud and this could be intimidating, but added he gave her a lot of support. MA 1 was concerned that MA 2 was not receiving enough support. The OM passed MA 1’s information to those agencies supporting MA 2. The DHR Panel felt SYPT could have convened a multi-agency meeting to discuss the domestic abuse issues and coordinated a plan that tackled the problem from the victim’s perspective.

5.10.11 The SYPT IMR author notes that the OM missed two opportunities to increase the level of risk posed by MA 1 from medium to high. The first was when the OM learned that MA 1 had assaulted his mother and the second when MA 1 appeared in court for assaulting MA 2. However, the IMR argues that the level of supervision already being provided by the OM was above that required for a medium risk offender and therefore the mistake was not compounded by poor practice. However, a high risk assessment should have prompted SYPT to refer MA 2 to MARAC. Information was shared with relevant agencies and MA 1 completed his order on 27.10.2011.

**5.11 Rotherham Doncaster and South Humber NHS Foundation Trust [RDaSH]**

5.11.1 RDaSH is an NHS health care provider commissioned to provide a range of health care services to the communities that it serves. This includes the provision of Mental Health and Drug and Alcohol Treatment Services.

 Note:

 MA 2 and MA 1 both had contact with Drug and Alcohol Services in the 6 months prior to the incident occurring.

A separate serious incident report has to be submitted by RDaSH to the Clinical Commissioning Group. In this instance the serious incident [SI] process is being undertaken by RDaSH to look at individual agency and individual professional care provision. This will identify what lessons there are for staff, services and the wider organisation. The findings informed RDaSH’s DHR IMR.

 **Drug and Alcohol Services [DAS]**

5.11.2 MA 1 and MA 2 were known to RDaSH DAS; MA 2 from December 2007 and MA 1 from September 2009. Both were referred by their GPs. Their last contacts with DAS were in May 2013 and July 2013 respectively. DAS knew MA 1 and MA 2 had partners but did not establish their identities and therefore failed to establish they were in the same relationship.

5.11.3 They knew that MA 1 was a carer for his mother and had been in a relationship for 33 years but did not probe behind those facts. DAS did not know that MA 1 was a perpetrator and victim of domestic abuse.

5.11.4 MA 2 told DAS that he was living with his partner but leaving the relationship. He disclosed that he was stabbed by his partner in 1996 [the incident took place in 1985 and MA 1 was sentenced for it in 1986]. MA 2 said he was frightened of him.

5.11.5 MA 1 and MA 2 had patchy attendance at DAS. MA 2 was alcohol free for a short period in January 2008.

5.11.6 On 29.05.2013 MA 1 attended DAS for an assessment having been prompted by Action Housing and Support [AH&S]. DAS noted MA 1, “Has a history of alcohol related anger with violence”. It was also noted that MA 1 was a carer for his elderly mother and had a partner who he did not live with. The DAS worker recalls that MA 1 disclosed that the relationship had been volatile but that there had been an impression from MA 1 that in the past this had often been precipitated by him but more recently had become a “six of one – half a dozen of the other”. MA 1 stated that his partner was accessing alcohol treatment and did not want to have appointments or group activities provided at the same time as his partner. DAS could only avoid this clash if it established the name of MA 1’s partner; it did not and therefore the wishes and feelings of MA 1 were not fully considered. AH&S knew of the relationship and should have flagged it to DAS when referring.

5.11.7 MA 1 did not attend two appointments and failed to respond to a letter. He was discharged from DAS on 21.08.2013 and notified of the decision by letter.

5.11.8 On 01.07.13AH&S referred MA 2 to DAS. He attended a DAS appointment with his AH&S worker on 08.07.13. The assessment focused on the alcohol and physical health difficulties presented by MA 2. DAS recorded, “Notes no previous mental health issues or dual diagnosis”. It is known that RDaSH Mental health had a long history of involvement with MA 2, primarily supporting him after his head injury but also treating him for depression. The record also shows that MA 2 had problems with “hoarding” but there were no other difficulties or concerns recorded. Thereafter MA 2 failed to attend two appointments and did not respond to a letter; he was discharged from DAS on 09.08.2013.

5.11.9 The RDaSH IMR says there was no information with which staff could reasonably have put MA 1 and MA 2 as partners. The only direct information on domestic violence was the disclosure made in December 2007 by MA 2 that he was stabbed in 1996 and was frightened of “him”. There is nothing recorded on who “him” was and whether MA 2’s expression of fright was historical or current. The disclosure was not followed up by DAS and an opportunity was missed to complete its internal risk assessment. MA 1 and MA 2 were open with several agencies about their relationship and the abuse within it. The DHR Panel believed that DAS should have asked MA 2 who his partner was. The use of the pronoun “him” flagged that MA 2 was in a same sex relationship. Once in possession of that information RDaSH could have quickly put the pieces together and been in a stronger position to support MA 2 and MA 1.

5.11.10 MA 1 made disclosures that he had a history of alcohol related anger with violence and that at one point he was the perpetrator in the partnership and more recently, a victim. There is no evidence that this was explored or that any questions were asked to discover who MA 1’s partner was. RDaSH should have undertaken a domestic abuse risk assessment on MA 1 following his disclosure that he was a victim. That would have identified MA 2 and that the domestic abuse took place within a same sex partnership.

 **Mental Health Services [MHS]**

5.11.11 The MHS element of the RDaSH IMR identifies that MA 1 and MA 2 were in a longstanding relationship of over 30 years, which had at times been mutually abusive. All MHS staff who worked with MA 1 and MA 2 describe a caring and supportive relationship when sober, but aggressive and abusive when drinking or intoxicated.

5.11.12 Prior to April 2007 MA 1 was seen on three occasions for depression and MA 2 was seen on several occasions after deliberate overdosing on pain killers.Thereafter support was provided to MA 2 by a MHS physiotherapist following his head injury but MA 2’s response and take up was sporadic. MHS knew from their contacts with MA 2 that he was in a tense relationship with MA 1 and that both abused alcohol.

5.11.13 On 09.05.2011 AH&S referred MA 2 to MHS for a full needs assessment. The work was undertaken by a student social worker and the product is described by the IMR authoras very thorough and of a good standard. The assessment concluded:

* some low mood
* impaired concentration
* memory loss that impacted on some areas of his activities of daily living
* low self-confidence linked to abusive relationship with MA 1
* some self-neglect, positive about the future
* Anxiety about the risk of physical violence from MA 1
* MA 1’s niece and her partner had financially exploited him
* MA 2’s preoccupation of the relationship with MA 1 dominated the assessment as he described a 30 year history of domestic violence.
* MA 2 wants to end the relationship
* No psychotic presentation
* History of suicide attempts
* Physically unwell at time of assessment
* Supported by Headway
* Smoker and heavy drinker no illicit substances
* Does not see his drinking as problematic and has reduced slightly since trying to distance himself from MA 1
* Domestic violence well documented; FA 1 also victim by MA 1 and MA 2
* Accommodation settled but MA 1 makes MA 2 feel unsafe in his own home Relies on MA 1 to help with daily living tasks
* Does not want any support coming into his home
* No other family involvement and 30 year relationship with MA 1 means that they are both highly dependent on each other despite the violence in the relationship.
	+ 1. Following the assessment, MHS shared theinformation with:
* MA 2’s GP *requesting* *a medication review and a referral to a memory clinic*. There is no evidence that these two points were followed up
* C&O for domestic violence support
* Lifeline and RMBC adult safeguarding for financial abuse and domestic violence support.

Note: The assessment also suggested that MA 2 re-engages with alcohol services. It is clear from MA 2’s recorded comments that he did not think alcohol was an issue for him and he did not want to address it.

5.11.15 The student social worker [SSW] referred the case to C&O who in turn involved an IDVA. The SSW should have referred it directly to MARAC, but thought that C&O would do it. IDVA contacted the SSW after receiving the referral from C&O. The SSW told IDVA that the case was closed to MHS, but offered to attend a meeting with IDVA if required. IDVA and C&O worked together for six weeks trying to engage MA 2. Thereafter IDVA told the SSW that they would not be taking the case on as the relationship was too co-dependent and it was felt that MA 2 would not be capable of withdrawing from the relationship and was also perpetrating abuse onMA 1. As noted earlier this is not IDVA’s position; that will be explored later. The important point is that the student social worker interpreted what was said as: ‘no IDVA involvement with MA 2 as long as he remained in the relationship with MA 1’.

5.11.16 On 27.07.2011 MA 1 was taken to A&E by ambulance. He repeated his domestic abuse history but said he was no longer in a relationship with MA 2. MA 1 voiced suicidal thoughts, threatened to cut his wrists and thought he may have taken an overdose. MA 1 was very drunk with no recollection of getting to A&E. The mental health crisis team assessed MA 1 but he was not sober. He denied suicidal thoughts and had no plans to harm self or to harm anyone else. The main concerns were relationship issues and he wanted to speak to someone about them. There was no psychosis, thought disorder or delusional presentation. He had capacity [was competent] to make decisions.

5.11.17 The crisis team contacted AH&S to support him and referred MA 1 to his GP to access a counsellor for his relationship issues. MA 1 told the crisis team that he did not want to stop drinking and did not view it as a problem. This is exactly the position taken by MA 2 a few weeks earlier and makes effective treatment almost impossible. MA 1 was advised to self-refer to alcohol services if necessary.

5.11.18 MA 1 and MA 2 ended their involvement with RDaSH MHS in the summer of 2011 and re-started it in the summer of 2013.

5.11.19 On 10.05.2013 a manager from RDaSH Access Services wrote to MA 2 saying H&NS were concerned for his mental health and he should contact RDASH if he wanted an assessment. This was a poor response and given the known history of MA 2. A better response would have been for RDaSH to see MA 2 or at least attempt to do so. MA 2 did not make contact with RDaSH and there was no follow up. That was RDaSH’s last dealings with MA 2.

5.11.20 On 31.05.2013 H&NS contacted RDaSH Access Services expressing concern about MA 1 and MA 2’s excessive use of alcohol and continuing arguments. The RDaSH Access Services worker told a H&NS worker to complete a vulnerable adult’s form and re-contact them. The RDaSH MHS IMR author says that it is unclear why RDaSH Access Services could not take the details over the telephone. There is no evidence that a vulnerable adult’s form was completed. RDaSH heard no more from MA 1.

**5.12 The Rotherham NHS Foundation Trust [TRFT]**

5.12.1 TRFT provides a wide range of health services to the people of Rotherham [population approximately 252,000] and to patients from further afield. TRFT was developed from the Rotherham General Hospitals NHS Trust and since April 2011 included Community Health Services. Rotherham Hospital is the main site and has a large accident and emergency department.

5.12.2 In April 2011 MA 1 received treatment in accident and emergency for injuries sustained during an assault by MA 2. The process followed in the department is that patients are triaged initially, and an assessment is made on the urgency of their presentation. MA 1 reported he was hit on the head with a bottle and that his hand hurt. TRFT identified the incident as domestic abuse and noted the perpetrator was MA 1’s male partner. MA 1 was alert and had been drinking vodka. He was offered a referral to a domestic abuse support agency, telephone numbers and signposting but declined them all. Clinical signs indicated no urgent need for treatment, so MA 1 was then asked to stay in the waiting room until staff were available to treat his injuries. He left the department before a DASH risk assessment was considered and because he had mental capacity it was judged unnecessary to begin the missing person policy. The DHR Panel judged that it was not necessary for TRFT to undertake a DASH risk assessment even though they can be completed in the absence of the victim.

5.12.3 MA 1 returned the following day and was treated for fractures to two fingers. MA 1 said a friend hit him with a mug. He did not disclose domestic abuse nor does it appear that the staff considered the injuries might have resulted from domestic violence as evidenced by the absence questioning. The TRFT Panel member felt it was reasonable that the nurse who spoke with MA 1 did not ask him about domestic violence because he said a friend had caused the injuries and there was nothing to suggest the real nature of the relationship. The DHR Panel felt that with hindsight, the nurse could have probed further, and asked whether the injuries resulted from domestic abuse.

5.12.4 In 2001 MA 2 was admitted to Rotherham hospital on four occasions following overdoses. On 17.02.2007 MA 2 was admitted to accident and emergency for a significant injury to his left lower eyelid. He was accompanied by his partner who smelt of drink. MA 2 said he had fallen over and cut his eye. MA 1 had then cut away a piece of loose skin from the resulting wound. MA 2 was admitted for corrective surgery.

5.12.5 This incident predates the start of the DHR review period and is included in some detail because the “cutting eyelid” reference appears in several agency IMRs and the explanation provides context.

5.12.6 On 02.02.2007 MA 2 was admitted to Rotherham hospital following a fall at home. He was diagnosed with a cerebral bleed and transferred to the Royal Hallamshire Hospital [Sheffield]. Thereafter MA 2 was transferred to TRFT Oakwood Centre for Rehabilitation Medicine. The records indicate that assessments were done of his home circumstances at that time and a section 5 referral [Community Care Act 2003] was faxed to Social Services for a social care assessment.

5.12.7 MA 2 reported that he had given up alcohol and smoking. He was assessed as being independent with all daily living activities and no concerns were raised regarding his mental capacity. He shared with staff that his partner was unsupportive and there were strains within the relationship. This did not raise enough concerns at that time to prevent his discharge to his partner’s home. MA 2 was noted to have low motivation and underwent a psychiatric review which determined there was insufficient evidence for clinical depression. The DHR Panel thought staff should have probed MA 2 for more information about his relationship to determine if he required support from other services.

5.12.8 Throughout the DHR there are many references to MA 2’s head injury and how it may have impacted on his needs. The injury was a significant episode in his life. There was no suspicion that it was connected with domestic abuse; it was accepted that the fall and injury was a medical event.

5.12.9 In 2008 MA 2 was admitted twice to Rotherham hospital with drink induced conditions. He did not identify any domestic abuse; the presenting issues were excessive alcohol consumption. In 2009 MA 2 received treatment for a cut knee having fallen on glass. Again there was no disclosure of domestic abuse.

5.12.10 MA 2 was admitted to Rotherham hospital in August 2011 having fallen over in an intoxicated state causing abrasions to his face. He underwent detoxification and was discharged home with advice to stop drinking. He left the department before seeing alcohol services.

5.12.11 On 15.03.2013 MA 2 attended accident and emergency complaining of persistent coughing for three days. It was noted he drank a little bottle of vodka daily [the equivalent of 280 units of alcohol weekly against the Government advice of not more than 21 units for a man]. YAS had found him in very poor living conditions. MA 2 was admitted and remained in hospital for several days. Staff discussed his social needs with him but the issue of domestic abuse was not raised. MA 2 did not identify MA 1 as his carer and the conditions MA 2 lived in [lived alone, gave his mother as next of kin] indicated he was not being cared for. The ward identified that MA 2 needed a cleaner, but when they informed him that he would need to pay for that service, MA 2 told staff he would ‘sort it out’ himself.

5.12.12 Missed appointments can be a sign of a chaotic lifestyle. During the period under review MA 1 missed two hospital appointments and MA 2 missed twelve.

5.12.13 The DHR Panel felt that TRFT had limited direct knowledge of the domestic abuse between MA 1 and MA 2 and that staff should have been more inquisitive about what was happening in MA 2’s life. MA 2 often disclosed his history of domestic abuse to professionals and a little more probing by TRFT staff may have resulted in a disclosure.

**5.13 Sheffield Teaching Hospitals NHS Foundation Trust [STHFT]**

5.13.1 STHFT consists of adult community services and five hospitals, including accident and emergency services. They had two contacts with MA 2. The first was in April 2007 when MA 2 underwent emergency brain surgery and the second in April 2012 when he was taken by ambulance to accident and emergency with a chest infection. MA 2 said he lived alone.

5.13.2 STHFT knew MA 2’s history of alcohol abuse but had no indication that he was involved in domestic abuse. STHFT does not screen routinely for domestic abuse; staff rely on additional factors or suspicions being present before probing.

**5.14 Stag Medical Centre [GP for MA 1]**

5.14.1 The Stag Medical Centre provides primary medical services and referrals to secondary care and other external agencies for over 11,000 patients. There are seven GP’s and five nurses. The Practice also has counsellors, alcohol and drug specialists who work from the premises.

5.14.2 MA 1 was a patient at the practice from September 1999 to his death. He had nine consultations with three GPs. The main presenting issues were:

* Anxiety
* Depression
* Alcohol misuse

5.14.3 MA 1 did not disclosure domestic abuse but on one occasion said he had domestic problems. He was referred to the community mental health team twice and also to alcohol services. There was one missed opportunity to refer MA 1 to alcohol services. On that occasion MA 1 understated his alcohol consumption but the GP said his symptoms were attributable to drinking alcohol. At one consultation MA 1 said he drank a bottle of vodka a day [280 units a week] but did not want to stop.

 Note: Higher-risk drinking is regularly drinking more than 8 units a day or 50 units a week if you're a man. Source www.nhs.uk

5.14.4 The practice is often informed that a patient has not attended for an appointment and the GP will then decide on what action needs to be taken. Sometimes services do not inform GP’s of missed appointments. In this case the GP did not know MA 1 had not attended his February 2010 appointment with alcohol services.

5.14.5 The GP IMR identifies that only one agency asked MA 1’s GP to review his case. This was TRFT Accident and Emergency in a letter dated 27.07.2011, when following MA 1’s attendance with suicidal thoughts, the hospital suggested to the GP that MA 1 could be referred to a primary care team counsellor for support and therapy. The letter added that MA 1 was no longer in his 35 year relationship and had a charge of assaulting his partner pending.

5.14.6 MA 1 went to his GP the next day; 28.07.2011. The letter from TRFT had not arrived and therefore the concerns of TRFT, including domestic abuse, were not known before the consultation. The GP established from MA 1 that the mental health crisis team would follow up his case.

5.14.7 MA 1 next went to his GP in March 2012 some nine months later declaring he was a chronic alcoholic. This was an opportunity for the GP to discuss domestic abuse with MA 1 but there is nothing in the records or from the interview with the GP to say it was.

5.14.8 The IMR does not mention what the domestic abuse training programme is at the medical centre or whether literature on the subject is available within the public areas and consultation rooms.

5.14.9 In June 2008 and March 2009 MA 1 disclosed domestic problems to his GP. The DHR Panel felt it was reasonable to expect the GP to have explored what MA 1 meant by domestic problems. It is not possible to tell from the GP notes the gender of MA 1’s partner. The DHR Panel thought that many agencies missed opportunities to refer or inform MA 1’s GP of his alcohol dependency and domestic abuse. GP’s hold patients universal health records and in MA 1’s case there was a significant gap in the GP’s knowledge of the domestic abuse MA 1 faced and perpetrated.

**5.15 St Ann’s Medical Centre [GP for MA 2]**

5.15.1 St Ann’s Medical Centre is a large, town centre GP practice providing primary GP care for its registered population. Its involvement with MA 2 was to provide primary medical services and refer to secondary care and other external agencies as required.

5.15.2 MA 2 was a patient at St Ann’s Medical Centre from 01.05.2009, having transferred from the Stag Medical Centre. He was last seen by them in December 2012. In between times he was treated and/or referred to other services for; alcohol dependency, depression and a respiratory condition.

5.15.3 St Ann’s Medical Centre sent MA 2 twenty one letters inviting him for appointments; he responded to just three. There were no alerts on his GP records and MA 2 never disclosed his domestic abuse history.

5.15.4 On two occasions old bruising was seen on MA 2’s body but there is no record of any questions being asked about its origins. This indicates that domestic abuse was probablynot considered by those clinicians who saw MA 2. Additionally the medical practice was unaware of MA 2’s social circumstances despite a home visit in July 2009.

5.15.5 The IMR does not mention what the domestic abuse training programme is at St Ann’s Medical Centre or whether literature on the subject is available within the public areas and consultation rooms. There is no explanation of why MA 2 was not asked about his bruising. It is remarkable that MA 2’s extensive involvement with domestic abuse was not known to his GP.

**5.16 Multi Agency Risk Assessment Conference [MARAC] Structure Aims**

5.16.1 The following information is drawn from Safer Rotherham Partnership MARAC Operating Protocol February 2013.

5.16.2 The Rotherham MARAC has been in operation since 2007. To date the MARAC has operated according to the guidance provided by CAADA [Co-ordinated Action Against Domestic Abuse], the charity commissioned by the Home Office to establish/develop MARACS.

5.16.3 Rotherham completed the CAADA MARAC accreditation process in 2009, one of the first 20 areas in the country to do so. Production of a MARAC Protocol was one of the recommendations of the accreditation report. The Rotherham MARAC is steered by the Domestic Abuse Priority Group [DAPG] on behalf of the SRP who developed the MARAC Operating Protocol.

5.16.4 The purpose of a Multi-Agency Risk Assessment Conference [MARAC] is to reduce the risk of further assault, injury and homicide, to victims of domestic violence who have been assessed as at high risk of further abuse. The MARAC is designed to enhance, not replace, existing arrangements for public protection, including safeguarding children and adults, and has a specific focus on the safety of the victim and any children. The MARAC forms part of a package of measures which also includes the Independent Domestic Violence Advocacy Service.

 **Aims of the MARAC**

 The over-arching aims of the MARAC are to:

* Protect high risk victims of domestic abuse and their children
* Reduce serious harm and risk of homicide as a result of domestic abuse
* Improve multi agencyeffectiveness by enabling agencies to work together
* Improve single and multi-agency accountability through focused action planning
* Provide support for staff working with “high risk” cases of Domestic Abuse
* Reduce the risk of further victimisation of victims of Domestic Abuse
* Enhanced information sharing between agencies, to ensure that a full picture of the risk can be identified and appropriate measures implemented to reduce the risk
* The Rotherham MARAC brings agencies together, fortnightly, to consider cases of domestic abuse where the victim has been assessed as at high risk of serious harm, with the aim of reducing that risk, and promoting safety.

This includes:

* Accepting referrals from any agency whose staff are trained to use the ACPO [Association of Chief Police officers] DASH 2009 Risk Assessment Model, and who have assessed the case as High Risk.
* Ensuring the victim’s voice is heard, through representation by the Independent Domestic Violence Advocate.
* Sharing information to provide a full picture to enable appropriate action to be agreed.
* Agreeing actions to reduce risk and promote the safety and well-being of the victim and any children.
* Providing professional support to reduce the risk of further harm.

**5.17 Independent Domestic Violence Advocacy and MA 2’s MARAC**

5.17.1 The Rotherham IDVA Service comprises of two full time independent domestic violence advocates, a part time Business Support Assistant and a Part Time Manager. The IDVA Service was developed in line with Coordinated Action Against Domestic Abuse [CAADA] guidance and is currently managed within the Safeguarding Adults Service, Neighbourhoods and Adult Services Directorate. It has operational in Rotherham since 2007/2008.

5.17.2 This Service is specifically for victims of domestic abuse who have been assessed as being at high risk of imminent harm. High risk domestic abuse is usually a pattern of abuse which presents a risk of serious harm or homicide, but in some cases there is a minimal history and it is a “one off” incident that triggers the high risk assessment.

5.17.3 On 08.06.2011 Choices and Options [C&O] faxed a fully completed MARAC referral form [DASH risk assessment] for MA 2 and a C&O referral form to IDVA 1 who accepted it as an appropriate referral. The DASH noted that MA 2:

* was experiencing physical and emotional abuse and social isolation
* acknowledged feelings of depression and suicidal thoughts
* stated he and MA 1 have attempted to separate on a number of occasions,
* said MA 1 keeps coming back
* felt harassed by MA 1 visiting his property and telephoning him
* disclosed a history of domestic violence MA 1 exhibited controlling behaviour
* says weapons have been used previously saying that he has been ‘stabbed’
* stated that MA 1 ‘has tried to kill me several times’
* said MA 1 had attempted strangulation
* had been assaulted by a family member of MA 1 and had financial issues with them
* misused drugs and alcohol and has mental health issues. It is not clear from the form whether this refers to MA 1 or MA 2
* said MA 1 has had criminal activityconcerning domestic violence and other violent offences

5.17.4 IDVA 1 requested information from: SYPT, mental health worker [MHW] [organisation not specified] AH&S, the Housing Champion and SYP. A joint visit with MHW to MA 2 at his home was arranged for 16.06.2011. The venue was altered to a Public Service Centre to minimise the risk to staff. However the meeting of the 16th was cancelled because it could not be confirmed with MA 2.

5.17.5 A new appointment was made for IDVA 2 and an AH&S worker to see MA 2 on 23.06.2011 after his GP’s consultation. However on 23.06.2011 the AH&S worker told IDVA 2 that MA 2 was intoxicated and the appointment was cancelled. IDVA 2 noted that MA 2 and MA 1 were still separated.

5.17.6 On 30.06.2011 IDVA 2 telephoned the MHW seeking information on MA 2’s whereabouts and was told that the MHW no longer works with MA 2. The MHW agreed to attend any visit to MA 2 if needed. Later that day the AH&S worker told IDVA 2:

 ...Had to break into MA 2’s property this Monday with help of Police and Ambulance. There were 5 empty bottles of vodka, bruising to his [MA 2] face and evidence of him having been in Hospital. MA 2 said that MA 1, his ex, had been there but there was no evidence of a break in and so he had let him in. The AH&S worker said that this is a pattern, MA 2 was verbally very abusive to her and she has not seen this before. She is not allowed to visit him on her own now... The IDVA advised C&O that it was not safe for any lone workers to go to house. The entry states that AH&S worker will inform IDVA when it is safe for her to see MA 2.

5.17.7 On 04.07.2011 IDVA 2 summarised the case thus: ‘Client on a drinking binge, not safe to visit, support been done via Action Housing, possibly still in relationship, Choices and Options close, been unable to visit as drunk every time we have arranged a visit’. A recommendation was made by IDVA 2 that the case should be pended because IDVA 2 was unable to engage with the MA 2.

5.17.8 On 07.07.2011 IDVA 2 was told by a housing officer [AHO 3] from N&HS that ‘MA 2 is back in a relationship with MA 1, who is a very violent, unpredictable person. They are getting to the point where they may have to evict if the violence continues. MA 2 is back heavily in drink’.

5.17.9 IDVA 2 informed AHO 3 that MA 2 was being discussed at MARAC that day [07.07.2011] and that her feeling is that there will be no further action for IDVA 2 as the client is choosing to be in that relationship. MA 2’s safety could not be addressed by IDVA as MA 2 was not engaging.

5.17.10 IDVA 2 suggested to an Action Housing and Support worker that s/he calls a meeting of all workers involved with MA 1 and MA 2 to discuss a plan of action. IDVA 2 agreed to support MA 2 if he wanted to leave the relationship and would participate in a meeting to discuss a way forward. IDVA 2 added that the Action Housing Support worker was asked to consider contacting a mental health worker to discuss whether MA 2 was a “No Secrets” vulnerable adult due to his poor physical and mental health. IDVA 2’s notes record that the Action Housing Support Worker would inform IDVA 2 if a “way forward” meeting, or an appointment with MA 2, was arranged.

 Note: Action Housing Support has no record of this contact from IDVA 2 and the Action Housing Support worker has no recollection of being asked. Action Housing Support accepts that it was made. Therefore it cannot explain why IDVA 2’s suggestion to organise a multi-agency meeting was not progressed.

5.17.11 MA 2’s case was considered by MARAC on 07.07.2011 and three actions arose from it:

1. Make the victim aware of the outcome of the MARAC
2. Try and offer support to MA 2
3. Ensure Agency files are flagged

5.17.12 Actions 1 and 2 were allocated to IDVA. The IDVA manager told the DHR Panel that it was unusual for an IDVA to be allocated actions when it was known the victim had reconciled with the perpetrator. This is because IDVAs avoid coming into direct contact with perpetrators and seeing MA 2 was likely to bring the IDVA into such direct contact. The task of updating MA 2 in these circumstances was normally left to the police. Action 1 has a target date of 04.08.2011 and there is no evidence that it has been completed by IDVA. Action 2 is shown as complete and there is evidence that IDVA tried to contact MA 2, but to no avail. Action 3 was for all agencies to complete by 04.08.2011.

5.17.13 There is no definition of “all agencies”, however the assumption that it refers to all MARAC agencies is reasonable. It is known that MA 2’s GP did not have any flags on his medical notes.

 Note: GPs are not directly represented at MARACs, despite the potential they have to be part of an effective multi-agency response for victims and perpetrators. The DHR Panel recommends that a piece of work is undertaken to determine how best to connect GPs and MARAC.

5.17.14 IDVA 4 reviewed MA 2’s case and required a number of actions undertaken before it could be pended. IDVA 4 explained the need to screen male referrals to ensure they are not also perpetrators in line with Respect UK guidance and that all male victims should not be met face to face without a manager’s agreement. This was necessary to ensure an IDVA’s safety.

5.17.15 There was substantial information sharing between IDVA 2 and SYPT, the mental health worker, Headway, Action Housing and Support. IDVA 2 made an unsuccessful attempt to contact MA 2 and was unable to send a letter as MA 2 was back in a relationship with MA 1. IDVA Worker 4 discussed the case IDVA 5 [a senior manager] expressing concerns that MA 2’s behaviour had resulted in his disengagement from agency support.

5.17.16 The alcohol work had been withdrawn because of verbal abuse and MA 2 faced eviction. IDVA Worker 4 said there was further information that indicated MA 2 may be a perpetrator when he is in drink. IDVA 4 and 5 agreed the case should be referred to safeguarding adults and that the mental health and addiction issues may require community care support. IDVA 2 established that mental health was referring the case to safeguarding adults and therefore she did not need to do it.

5.17.17 Following consultation with SYP, the IDVA services stopped work on MA 2’s case because IDVA could not engage with MA 2.

5.17.18 Several agencies thought IDVA had declined to work with MA 2 because he was still in a relationship with MA 1. IDVA say this is not the case, the issue was they were unable to gain safe access to him. IDVA’s notes as recorded in the IMR are summarised above.

5.17.19 The DHR Panel recommends that IDVA should clarify its position on whether IDVAs will work with victims still in a relationship and through the Domestic Abuse Priority Group inform its MARAC partners in writing what their position is. The action was completed in March 2014.

5.17.20 The complex issues between MA 1 and MA 2 demanded a more radical approach than the one employed for so many years. On 07.07.2011 IDVA 2 suggested to a support worker from Action for Housing that she arrange a meeting of those agencies involved with MA 1 and MA 2 to find a way forward. That was the only time such a suggestion was made, but unfortunately a meeting did not take place. It would have been helpful if this excellent suggestion had been raised at MARAC and appeared in the minutes.

5.17.21 Another away forward was through a referral to Adult Safeguarding. In this case MA 2 was a vulnerable adult who met the “No Secrets” definition and there was a perpetrator [MA 1]. A referral would have led to a strategy meeting which would have considered a safeguarding investigation and ensured that a safeguarding plan was in place.

5.17.22 IDVA’s suggestion to SYPT to refer MA 2 to Respect [www.respect.uk.net: domestic violence support] appears sound apart from the fact that MA 2 was not under SYPT’s supervision; MA 1 was. IDVA recorded that SYPT agreed to the task but there is no mention of it in SYPT’s IMR. There is however an entry in SYPT’s chronology to say it took a call from IDVA on the 18.07.2011 which coincides with IDVA’s record. However, in interview IDVA said that SYPT agreed to refer MA 2 as part of its management of MA 1.

5.17.23 SYP make several recommendations around MARAC minutes. The DHR Panel believed that MARAC should review its minute template to ensure it provides for systematic and consistent recording of risk and risk management plans.

5.17.24 In 2013 Rotherham MARAC completed a CAADA Self-Assessment template which resulted in an action plan that included recommendations from a previous DHR. When that Action Plan is completed MARAC should be in a stronger position to protect victims of domestic violence. The DHR Panel recommends that the Safer Rotherham Partnership invites CAADA back to review progress on the action plan and to determine whether it adequately deals with same sex relationships.

**6. ANALYSIS AGAINST THE TERMS OF REFERENCE**

Each term appears in ***bold italics***andis examined separately. Commentary is made using the material in the IMRs and the DHR Panel’s debates. Some material would fit into more than one terms and where that happens a best fit approach has been taken.

**6.1 Term 1**

 ***Were the risk indicators for domestic abuse present in this case recognised, properly assessed and responded to in providing services to MA 1 the victim, and MA 2 the alleged perpetrator? If not, what was the reason for this?***

6.1.1 Sixteen agencies [RDaSH Drug and Alcohol Services and RDaSH Mental Health Services have been counted as two agencies] provided IMRs for the DHR.

* 13 knew that either MA 1 and/or MA 2 were victims/perpetrators of domestic abuse
* 2 missed an opportunity to find out [St Ann’s Medical Centre-RDaSH MHS]
* 1 had no opportunities [Sheffield Teaching Hospitals NHS FT]

6.1.2 Only three agencies completed domestic abuse risk assessments; they were:

* South Yorkshire Police [SPECSS+ risk assessment tool] [but not on all occasions]
* Choices and Options [DASH risk assessment tool]
* South Yorkshire Probation Trust [SARA risk assessment tool]

 SPECCS is:

 **S**eparation (child contact)

 **P**regnancy (new birth)

 **E**scalation

 **C**ommunity isolation

 **S**talking/harassment

 **S**exual abuse

6.1.3 Rotherham NHS Foundation Trust wanted to complete a DASH risk assessment but MA 2 left before it happened. However, he returned the next day but the opportunity to complete a DASH was not taken. The general lack of domestic abuse risk assessments in this case indicates that the practice of completing them for same sex relationships is not fully embedded in Rotherham. This is a lesson learned for the DHR Panel and will form a recommendation. The ACPO/DASH domestic abuse risk assessment is now used within Rotherham.

6.1.4 On two occasions MA 2’s GP noted bruising but did not ask MA 2 its origins. This is a simple example of a domestic abuse risk indicator not being recognised. RDaSH DAS knew that MA 1 was in a volatile relationship but did not pursue with whom or its nature. They also knew that MA 2 had been stabbed and was frightened. This should have been explored with MA 2 but was not. Since December 2013 GPs in Rotherham have had access to a Domestic Abuse flow chart developed by the Safer Rotherham Partnership. This should help GPs with decision making once they are told of or suspect domestic abuse.

6.1.5 Agencies had different levels of knowledge about the extent and nature of the domestic abuse. SYP held the most information but did not know of every incident of domestic abuse because either MA 1 or MA 2 did not want them informing. An early multi-agency meeting would have provided a framework for sharing information but no agency thought to do it before the 2011 MARAC and even then it did not happen.

6.1.6 H&NS received several complaints from neighbours that MA 1 and/or MA 2’s were shouting and swearing in the street. H&NS approached the problem from an anti-social behaviour perspective and never really appreciated that MA 1 and MA 2 were in an abusive relationship, despite having some knowledge that domestic abuse was happening in their homes. In September 2013 H&NS wanted MA 1 and MA 2 to sign an “acceptable behaviour contract”, thereby perpetuating the anti-social behaviour route. H&NS did not recognise the domestic abuse indicators because they appeared within a same sex relationship. However, when domestic abuse encroaches into the peace of a neighbourhood, as it did on several occasions in this case, it also becomes an anti-social behaviour matter. H&NS tackled the complex problem from one angle; that of their expertise. H&NS routinely see family members together when dealing anti-social behaviour, which is the opposite of what happens in domestic abuse cases where people are generally seen separately.

6.1.7 In April 2009 Headway saw MA 1 and MA 2 together. MA 2 had two black eyes caused by MA 1. They agreed at Headways’ prompting to report the matter to the police and also consented to a referral to adult safeguarding. There is no corresponding record in SYP’s chronology; there is an entry in adult services chronology. Headway’s identification of domestic abuse risk factors [the black eyes] was straightforward and the referral to adult safeguarding appropriate. MA 1 and MA 2 agreed to report the assault to the police. There is no evidence that Headway checked with MA 1 or MA 2 that they had reported the assault to the police. Going to the police would have been a risk control factor and by not checking it has been done Headway did not spread the risk beyond adult safeguarding.

6.1.8 SYP knew that MA 1 presented a risk of domestic abuse to his mother and acknowledged their error in taking MA 1 to his mother’s house when resolving a crisis between MA 1 and MA 2. It did not occur to the officers that by “solving” one problem they were potentially creating another. On reflection the staff can see the point and have learned.

6.1.9 This case had many domestic abuse primary risk factors some of which were acted on and others not. A more subtle risk factor was the fire risk presented by MA 2’s propensity to cook while drunk. Primarily this was more of a generic risk to himself, his neighbours and MA 1. Potentially it is a weapon that could be used by MA 1 or MA 2 in their domestic battles. However, only South Yorkshire Probation Trust considered this aspect. The IMR notes on 01.08.2011:

 “Adult safeguarding had contacted MA 1’s mother to assess risk. MA 2 had disclosed to safeguarding adults that MA 1 had stabbed him, cut his eyelid, poured bleach on him and set light to the bedding whilst he was in bed”.

6.1.10 On 13.09.2011 South Yorkshire Fire and Rescue Services undertook a Home Safety Check at MA 2’s property and provided smoke alarms and other materials. On 09.05.2013 Adult Services undertook a general assessment and identified fire as a risk. [Cooking when drunk and smoking cigarettes]

6.1.11 A trainee social worker at RDaSH Mental Health completed an assessment following a referral from Action Housing and Support. The domestic abuse risk factors were recognised and the trainee social worker referred the case to Choices and Options who completed a DASH risk assessment on 07.06.2011. The DASH showed that MA 2 was at high risk of suffering serious harm from MA 1. C&O made an appropriate referral to IDVA and MARAC.

6.1.12 MA 2 did not meet the MAPPA criteria. A case could be made out that MA 1 met the MAPPA criteria for a Category 3 Offender as set out in MAPPA Guidance 2012 Version 4 sections 6.10 to 6.14. The decision is that of the SYP MAPPA Co-ordination Unit. However, there is no evidence that MAPPA was considered and that was a missed opportunity.

6.1.13On balance the DHR Panel felt that the risk indicators for domestic abuse were sufficiently recognised by enough agencies for an effective response to have been provided; the fact that an effective response was not provided, is examined under the next term of reference.

**6.2 Term 2**

 **Were the services provided for MA 1 and MA 2 timely, proportionate and ‘fit for purpose’ in relation to the levels of risk and need that were identified?**

6.2.1 The DHR Panel thought the following issues for MA 1 and/or MA 2 required a response.

* Alcohol dependency
* Domestic abuse
* Depression
* Thoughts of self-harm
* General health issues
* Motivation to change
* Their general acceptance of their lifestyle.
* Independent living
* Financial exploitation
* Risk of abuse to MA 1’s mother
* Lack of effective engagement/positive resistance with/to services

6.2.2 The complex problems between MA 1 and MA 2 were largely tackled from each agency’s discipline and in isolation of a long term coordinated plan. That is not saying agencies did not share information, they did, and that is looked at under term of reference four. Agencies responses to the risk indicators were mixed. Many worked very hard, but in isolation, to try and solve their element of the problem. For example SYP attended many incidents and where appropriate, made arrests and brought charges.

6.2.3 Adult Services completed several assessments but judged the “No Secrets” vulnerable adult threshold was not met. On 21.07.201 a social care assessment was undertaken and it was noted that MA 1 was the registered carer for MA 2. Adult Services also undertook a carer’s assessment on MA 1. Some small issues were identified and support provided. However, the core issue of domestic abuse was not assessed.

6.2.4 The prevailing view of agencies was that MA 1 and MA 2 were adults who had the capacity to make rational decisions. The DHR Panel thought many agencies were in a good position to initiate a coordinated response to the “couple’s” complex needs. It seems the focus of agencies was on their speciality. Agencies did not always ask, nor were they always told, of what other support was in place for MA 1 and MA 2.

6.2.5 Several agencies tried to help MA 1 and MA 2 with their alcohol dependency. MA 2 had a brief period of abstinence in 2008, but neither partner wanted to stop drinking and at times did not see it as a problem. Both of them told the same agency on separate occasions that their aim was to become social drinkers. That was an unrealistic outcome for MA 1 and MA 2 and the general advice for people dependent on alcohol is abstinence. That is a difficult journey and even motivated people require significant support. The DHR Panel judged that the couple probably used alcohol as a coping mechanism but it was also linked to their domestic abuse.

6.2.6 IDVA tried hard to engage with MA 2 following the DASH risk assessment by C&O in July 2011. The IDVA service responded promptly and gathered information from several agencies. IDVA never saw or spoke with MA 2 because he would not engage or keep appointments. Mention has already been made that some agencies perceived that IDVA would not provide a service to couples still in a relationship.

6.2.7 It was an IDVA who suggested to an Action Housing worker on 07.07.2011 that s/he could call a meeting of all the workers involved with MA 1 and MA 2 to plan a “way forward”. That was a good suggestion and probably the only realistic way of identifying the problems and progressing towards a solution. However, it did not happen and was never considered again by any agency. The DHR Panel felt the suggestion was not followed through because it was made outside of MARAC.

6.2.8 At various times two or three agencies worked together to support MA 1 and MA 2, and identified actions from their narrow stances. Individual actions were agreed but there was never a settled multi-agency plan.

6.2.9 MARAC had a role to play and provided a framework for a multi-agency response. The MARAC minutes of 07.07.2011 identified several of the issues, but not mental health. This oversight probably came about because RDaSH was not present for that part of the discussion. The minuted actions were ineffective against a case of such complexity and did not address the risk factors. The volume of cases dealt with at MARAC in 2011 [and now] meant there was limited time spent on each one. MA 2’s case was very complex and need far more time allocating to it than was available at MARAC.

6.2.10 MA 1’s GP knew he had domestic problems. There is no record of what they were or that services were offered to support him from that perspective. While MA 1 was treated appropriately for his diagnoses, the service he received was in isolation of the complete picture. MA 1 could have shared his domestic abuse experiences with his GP and ask for help.

6.2.11 MA 2’s GP missed two opportunities to provide domestic abuse services when s/he noted bruising to MA 2. He could also have disclosed that he was the victim/perpetrator of domestic abuse. There are many barriers to victims making disclosures and MA 2 was selective in who he told.

6.2.12 The DHR Panel believed that agencies worked in good faith and were faced with an almost insolvable problem. Neither MA 1 nor MA 2 were motivated to change and were reluctant to accept help or sustain their contact with agencies. The lesson arising from this term of reference is that, one person apart, [IDVA], no agency thought to tackle MA 1 and MA 2’s needs through a coordinated multi-agency response.

6.2.13 There was a missed opportunity to influence and support MA 1 and MA 2 through adult safeguarding. However, most agencies did not recognise that MA 1 and MA 2’s situation was at times, suitable for adult safeguarding intervention.

**6.3** **Term 3**

 ***How did agencies ascertain the wishes and feelings of MA 1 and MA 2 about their victimisation/position and were their views taken into account when providing services or support?***

6.3.1 There is evidence that the wishes and to a lesser extent the feelings of MA 1 and MA 2 were taken into account. When it became apparent that MA 1 and MA 2 could no longer cohabitate arrangements were made to re-house them and temporary accommodation was found for MA 2. They asked for help and received it.

6.3.2 C&O listened to MA 2 and that resulted in a DASH risk assessment and referral to MARAC and an IDVA. That was a supportive act as was SYP’s response when they arrested MA 1 and MA 2 for separate incidents of domestic abuse. There were other occasions when either, or both MA 1 and MA 2, told SYP that they did not want them to pursue incidents of domestic abuse.

6.3.3 On separate occasions MA 1 and MA 2 expressed to Lifeline that they wanted to be social drinkers. As stated earlier that is not a realistic outcome for chronic dependency. It is not clear whether Lifeline’s services to MA 1 and MA 2 took account of their stated aims or whether the pair’s unrealistic wishes were challenged.

6.3.4 SYPT explored with MA 1 his feelings around his relationship and asked him to examine what might trigger his actions. MA 1 felt he was the victim in the relationship and the offender manager formed a view that at times his engagement, while compliant, was superficial.

6.3.5 MA 1 and MA 2 varied in what they disclosed to whom. On occasions they were frank, but other times they were not. For example RDaSH DAS never knew they were in a relationship and only had glimpses of the domestic abuse. MA 1 disclosed a volatile relationship to RDaSH DAS but did not volunteer any further information. MA 2 told RDaSH DAS that he had been stabbed in 1996 and was frightened of “him”. There is no evidence that this clearly expressed feeling was picked up and pursued.

6.3.6 The following is an extract from Adults Services IMR which specifically addresses term 3.

 “It is clear from the interventions that MA 2 did not have the opportunity to discuss his views with regard to his relationship with MA 1 other than very briefly, during points of crisis i.e. when police attended. From the chronology in RMBC’s electronic social care record for MA 2 his assessment visits concentrated on practical issues around daily living”.

6.3.7 Other agencies report a similar theme in that they got on with the day to day support but could not effectively engage MA 1 or MA 2 in meaningful discussions about what the real issues might be and what they wanted. At one point [07.06.2011] MA 2 told C&O that he wanted to move to Sheffield to get away from MA 1, but then rejected their offer to facilitate it. MA 2 quickly changed his mind thereby sending mixed messages of what his true wishes and feelings were. He may not have known and the DHR Panel understood how they may fluctuated. The DHR Panel felt that MA 2 and MA 1 did not have a stable goal and their chaotic lifestyle and inconsistent views were a barrier to professionals engaging them in long term planning.

**6.4 Term 4**

 ***How effective was inter-agency information sharing and cooperation in response to MA 1 and MA 2 situation? What consideration was given to sharing information between agencies from different authorities in support of MA 1 and MA 2 and was it effective?***

6.4.1 Save for one major exception [6.4.3] there is ample evidence that agencies shared information and cooperated in their response to MA 1 and MA 2’s needs. For example IDVA contacted several agencies when preparing for MARAC; SYPT had close links with Lifeline in support of MA 1’s period of supervision and Action Housing and Support exchanged information with RDaSH, Adult Services and Lifeline. It would be fair to say that information sharing was substantial.

6.4.2 Internal communication between RDaSH MHS and RDaSH DAS was not effective in that neither part of the organisation knew the other was also dealing with the same people. RDaSH MHS knew that MA 1 and MA 2 were partners but RDaSH DAS did not.

6.4.3 The major exception was that information sharing between non-medical agencies and MA 1 and MA 2’s GPs was poor. MA 1’s GP had a note [from TRFT] saying MA 1 was involved in domestic abuse. The note did not say whether MA 1 was a victim or perpetrator. RDaSH shared its 2011 assessment of MA 2 [including domestic abuse] with his GP. MA 1 and MA 2 had regular contact with their GPs and as such may have benefitted from their doctors’ perspective and advice. MA 1 and MA 2 could have initiated a domestic abuse conversation with their GPs.

6.4.4 The Royal College of General Practitioners [RCGP] says domestic violence is an abuse of human rights and a major public health problem because of the long-term health consequences for people who have experienced it. Many people experiencing abuse believe that their GP can be trusted with disclosure and GPs can offer practical support to protect people who disclose abuse.  Responding to Domestic Abuse: Guidance for General Practices [www.rcgp.org.uk](http://www.rcgp.org.uk)

6.4.5 The DHR Panel thought there was a significant gap in the GPs’ knowledge of the domestic abuse suffered and committed by MA 1 and MA 2. This gap resulted largely because agencies did not recognise the importance of sharing information with the couple’s GPs. The lesson is that GPs are denied an opportunity to support victims and perpetrators of domestic abuse if they do not have the relevant information.

6.4.6 Therefore, the DHR Panel recommends that all agencies who work with high risk victims and perpetrators of domestic abuse have systems in place to notify GPs when their patients are engaged with services. The DHR Panel further recommends that the SRP explores how GPs can support high risk victims and perpetrators of domestic abuse through MARAC or other processes.

6.4.7 Additionally the DHR Panel recommends that GPs use the SRP GP domestic abuse flow chart to help support victims; additionally, GPs should complete the online GP domestic abuse training available through the Home Office.

***6.5 Term 5***

***How do agencies with the Partnership support victims from LGBT [lesbian gay bisexual and transgender] and other minority groups who disclose domestic abuse?***

6.5.1 The percentage of gay or bi-sexual men [6.2%] who suffered partner abuse in 2008/09 is nearly double the number for heterosexual men [3.3%]. Lesbian women [12.4%] as a percentage also suffered far more partner abuse compared to heterosexual women [4.3%].

 British Crime Survey 2008/09 Table 3.07 [page 76]

6.5.2 In a survey, more than a third of respondents [38.4%, 266/692] said that they had experienced domestic abuse at some time in a same sex relationship. This included 40.1% [169/421] of the female and 35.2% [94/258] of the male respondents.

 It has to be remembered that the questionnaire sample was not random, nor necessarily representative of the same sex community. Therefore the levels of domestic abuse experienced do not represent the prevalence of such abuse within same sex relationships. What the figures do indicate, however, is that domestic abuse is an issue for a considerable number of people in same sex relationships in the UK.

 Comparing domestic abuse in Same Sex and Heterosexual Relationships: Donovan, Hester, Holmes and McCarry University Bristol and Sunderland: November 2006

6.5.3 Prior to 2008 Rotherham did not have any commissioned services for male victims of domestic violence whether they were in same sex or heterosexual partnerships.

6.5.4 In 2011 Rotherham re-commissioned domestic abuse services from Choices and Options, Apna Haq and Rotherham Women’s Refuge. An appendix to the tender document required those agencies to ensure that MARAC referral and domestic abuse risk assessment was a contractual obligation. Choices and Options was additionally required to provide telephone support for male victims where it was safe for them to do so.

6.5.5 In 2011/12, Victim Support also began to provide face to face support to male victims of domestic abuse.

6.5.6 The three services mentioned above support LGBT women, but LGBT males are supported by Choices and Options or Victim support from 2011.  Where appropriate, LGBT victims would be signposted to Broken Rainbow UK [an LGBT national service] for specialist support.  Rotherham does not have a LGBT specific service, but has a group chaired by the RMBC Diversity Manager, The IDVA service will support high risk males through the MARAC process. The Sexual Assault Referral Centre and Independent Sexual Violence Adviser provide services for LGBT victims.

6.5.7 All agencies that provided domestic abuse services to MA 1 and MA 2 recognised they were in a same sex relationship. Many professionals approached the task of supporting MA 1 and MA 2 from their agency’s experience of dealing with mixed gender domestic abuse. In brief, MA 1 and MA 2’s circumstances were outside of many agencies general experience; particularly before LGBT domestic abuse services for males were commissioned in 2011.

6.5.8 The support offered to MA 2 by Choices and Options was designed to meet his needs, e.g. home or neutral venue visits and/or telephone support. MA 2 was also offered a referral to Broken Rainbow but declined.

6.5.9 On 14.07.2011 IDVA 2 was asked by her manager to discuss with MA 1’s Offender Manager whether he should be referred to Respect**. \*** On 18.07.2011 the OM confirmed that she would give MA 1 Respect’s telephone number.

 **\* Respect:** men and women working together to end domestic violence:

Respect develops, delivers and supports effective services for:

* male and female perpetrators of domestic violence
* young people who use violence and abuse at home and in relationships
* men who are victims of domestic violence

 [www.respect.uk.net](http://www.respect.uk.net)

6.5.10 There is no evidence that MA 1 or MA 2 sought the help from a LGBT domestic abuse organisation. However, MA 1 and MA 2’s interaction and lack of consistent engagement with the agencies who wanted to support them, suggests that they were not committed to, or were incapable of, making changes in their lives. Whether a LGBT organisation would have made progress with them cannot fairly be judged.

6.5.11 There is no evidence that any other organisation referred MA 1 or MA 2 to a LGBT domestic abuse organisation. Therefore, the lesson is that without the help and expertise of LGBT domestic abuse services, victims of same sex domestic abuse may not be supported as effectively as they could be.

6.5.12 The DHR Panel recommends that the SRP determines how best to ensure that professionals working with same sex victims of domestic abuse are aware of what LGBT services are available and how make referrals.

**6.6** **Term 6**

 ***How were any racial, cultural; linguistic; faith or other diversity issues, taken into account during assessments and provision of services to MA 1 and MA 2?***

6.6.1 MA 1 and MA 2 were white British with English as their first language. There is no indication from any of the IMRs what, if any, their faith was. There was nothing recorded to suggest they sought support from a faith group. Their sexual orientation was recognised and as seen under term of reference 5, taken account of when providing services. However, there is some indirect evidence that because the domestic abuse was between two males it was considered differently than domestic abuse between a male and female. For example euphemisms such as, bickering, arguing, disagreement and anti-social behaviour, were used to describe MA 1 and MA 2’s behaviour. The DHR Panel recognised that such descriptions while not inaccurate, contributed to masking what was essential domestic abuse.

6.6.2 There is a reference in H&NS’s IMR that in July 2010 an anti-social behaviour officer formed the impression during a visit to MA 1 that his neighbours did not like him because he was homosexual. There is no information on whether this aspect was followed up or additional support offered.

6.6.3 MA 1 and MA 2 had mental health needs which were recognised and services provided. MA 2 had a significant head injury in 2007 and there is substantial evidence that agencies responded to this by assessing his needs and providing support. MA 2’s head injury made it more difficult for agencies to support MA 2 because it was not known how much of his behaviour and thinking was influenced by the trauma. The DHR Panel thought that if referrals had been made to Adult Safeguarding when opportunities arose, it would have increased the opportunities to sift through the complex issues.

**6.7 Term 7**

***Were the reasons for MA 2’s abusive behaviour properly understood and addressed? Was there sufficient focus on reducing the impact of MA 2’s abusive behaviours towards MA 1 by applying an appropriate mix of sanctions [arrest/charge] and treatment interventions?***

6.7.1 Since the terms of reference were set it has been established that MA 1 and MA 2 were victims and perpetrators.

6.7.2 The Panel noted that MA 1 and MA 2 were mutual victims and perpetrators in a volatile relationship. No-one under took any screening to determine in individual cases who was the victim and who was the perpetrator. This was a missed opportunity to ensure the primary victim has been identified and that the response to the domestic abuse occurring in the relationship was victim focused. The Panel agreed that domestic abuse training should ensure there is clear guidance on screening where relationships are apparently co-responsively violent in line with national guidance established by Respect.

<http://respect.uk.net/work/male-victims-of-domestic-violence/toolkit-wor>k-male-victims-domestic-violence/

6.7.3 This DHR examined matters from 01.04.2007 by which time much of the pattern of behaviour between MA 1 and MA 2 appeared set. It was never established whether the domestic abuse was the result of alcohol misuse or if the domestic abuse was independent of the alcohol misuse. It is known that on many of the occasions when the police attended incidents one or both of the couple had been drinking.

6.7.4 The same hypothesis can be put forward for alcohol use and mental health; was there a causal link between MA 1 and MA 2’s alcohol use and their mental health?

6.7.5 RDaSH Mental Health Services IMR helpfully notes:

 “There is a complex relationship between alcohol use and mental health issues. Each case has to be judged individually in accordance to the presentation, needs and willingness of the service user to engage with services. It is the opinion of Author 2 that the links between the presentation, past depression and current presentations were overshadowed by the alcohol use and therefore were not fully explored, with the exception of the student social worker. The way services were set up in 2007 probably met the needs as presented at the time, albeit in a fragmented way, although it is possible more consideration could have been given to domestic violence. However, on interviewing the staff of that time they believed that the services offered were proportionate to the information they had and the presenting issues of MA 2. More consideration could have been given to MA 1 as a carer [for MA 2] and the risks he posed when drunk, although it is acknowledged that both men were at risk from each other and both were supportive of each other in their chosen lifestyle, making safeguarding referral a complex consideration. The student social worker went to great lengths to communicate with many agencies to try to secure the best services to offer the most appropriate care and did consider the risks and identified needs”.

6.7.6 On 03.11.2010 a court imposed a six month Alcohol Treatment Requirement on MA 1 for assaulting his niece. An OASys revealed that:

 “MA 1 has more than 10 years use of excessive alcohol and that the relationship with his Partner MA 2 is often volatile”.

6.7.7 South Yorkshire Probation Service Trust and Lifeline worked with MA 1 on his alcohol abuse and how it impacted on his offending. His Offender Manager recognised that lowering MA 1’s alcohol consumption would also lower his risk of offending. This judgement ties MA 1’s alcohol use to his propensity for violence and should be considered with the information in the next paragraph.

6.7.8 RDaSH MHS IMR has the following passage which illustrates interlinks between alcohol misuse and domestic abuse and the difficulty it presented in this case.

 “Generally the abuse as recorded is more as MA 1 as the victim rather than the abuser, this may have been because he was the person the services had the most contact and therefore had his version of events. There is acknowledgement throughout the text that there was abuse on both sides. It is author 2’s impression from speaking to the physiotherapist that there was not a wholly acknowledged context of an abusive relationship and this tended to be boxed as linking to alcohol abuse and that if they were helped with the alcohol then there would not be the abuse. It is difficult to say if this would have been the case or not but a greater understanding of the links and exploration of the whole relationship rather that the superficial understanding may have been useful, but this would have required greater engagement with both MA 1 and MA 2 and an understanding of the impact on their presentation and wellbeing. In 2011 the student social worker had a much greater understanding of the impact of the abuse on MA 2 and tried to assist with this with signposting to appropriate agencies for help. Given that they did not particularly present with symptoms of mental illness further exploration of the domestic violence within the mental health services is somewhat limited than if they did have a mental illness and were part of a treatment team. However latterly in 2013 the links were not considered in any great depth and the history of alcohol use appeared to overshadow and therefore minimise the potential for reducing the impact of the abuse”.

**6.8 Term 8**

 ***Were single and multi-agency policies and procedures, including the MARAC protocols, followed and are they embedded in practice and were any gaps identified?***

6.8.1 At the time of the events unfolding in this DHR agencies in general had domestic abuse policies and by October 2013 there were in advance of the position in April 2007. The Royal College of General Practitioners in conjunction with IRIS [Identification and Referral to Improve Safety] and CAADA issued “Responding to Domestic Abuse: Guidance for General Practice 2012” which provides excellent information for clinicians including national help lines for same sex victims.

6.8.2 Several agencies report that while their domestic abuse policies are generic they seem to be written from a female victim stance. An example of this is taken from RDaSH IMR.

 “The RDaSH policy on domestic abuse is very female centred with only passing reference to abuse of males. Also the domestic violence training in the Trust tends to focus very heavily on female abuse victims with some acknowledgment of men as the abused. Due to this there may be some practitioners who don’t readily pick up on male abuse and therefore the training and the policy need to be more explicit. However Author 2 believes in this case, certainly in 2011, the abuse was picked up and dealt with appropriately by the worker involved”.

6.8.3 The lesson from the DHR is that professionals should be aware that their domestic abuse policies and procedures could be seen as not applying to same sex domestic abuse, meaning that victims from those groupings may not be recognised and/or appropriate services provided. The DHR Panel recommends that all member agencies of the SRP review their domestic abuse policies to ensure they cater for same sex relationship abuse, including male victims.

6.8.4 Several agencies believed that IDVA would not support victims if they were still in a relationship with the perpetrator. As a bald statement it is not true. However, some professionals felt that IDVA had disengaged from the case for this reason. This removed an avenue of support for MA 2 and professionals supporting him. A recommendation supporting this lesson was made earlier in the report.

6.8.5 The DHR Panel heard from its members that outside of the criminal justice system there were no programmes for perpetrators of domestic abuse. Therefore, the DHR Panel recommends that the SRP consider commissioning perpetrator courses which include services for same sex perpetrators.

6.8.6 The SRP Domestic Abuse Coordinator Adult Services, is responsible for domestic abuse training. All professionals working in Rotherham or linked to Rotherham services are able to access domestic abuse training which consists of ten face to face sessions based on three modules:

1. A one day awareness raising course
2. A one day course for ACPO DASH risk assessment
3. A two day course delivered by Rotherham Safeguarding Children Board which builds on module 2 and explores domestic violence and child protection

6.8.7 Adult Services is leading a review of domestic abuse training. It is anticipated that the domestic abuse training will follow the Bronze to Platinum training framework that Safeguarding Adults Board agencies work to. Modules will be mandatory for those member agencies and will be accessed according to role in line with this framework. There is also an aspiration to develop e-learning domestic abuse training. The DHR Panel feel that all domestic abuse training should include same sex relationship abuse.

**6.9 Term 9**

 ***How effective was the supervision and management of practitioners involved with the response to needs of MA 1 and MA 2. Did managers have effective oversight and control of the case?***

6.9.1 There is evidence in the IMRs that professionals referred many aspects of their work with MA 1 and MA 2 to managers and the lessons and recommendations from this DHR do not reflect a lack of oversight and control. However, the DHR Panel thought it disappointing that no manager considered an alternative approach to tackling the issues between MA 1 and MA 2. An IDVA suggested this approach but it was never pursued after the MARAC. Nevertheless the DHR Panel acknowledged that many people and agencies worked hard to support MA 1 and MA 2 in challenging circumstances.

6.9.2 The DHR Panel felt there is a lesson for agencies managers and the SRP about why this case continued for many years without effective coordinated action. It required a manager to recognise that a different approach was needed and to call a multi-agency meeting and agree a lead professional. Had a lead professional been in place, RDaSH DAS would have been better connected to their colleagues in RDaSH MHS. The DHR Panel recommends that managers from all agencies, who supervise staff involved with domestic abuse, receive training in MARAC so they can more effectively support their front line professionals.

**6.10 Term 10**

 ***Were there any issues in relation to capacity or resources within the Partnership and its agencies that affected your ability to provide services to MA 1 and MA 2 or to work with other agencies?***

6.10.1 No agency reported any resourcing issues nor did the DHR Panel observe any. The DHR Panel felt that the volume of cases meeting the MARAC referral criteria was in excess of the IDVA resources available to effectively deal with them and that time pressures within MARAC meetings further constrained the amount of work that could be done in each case. The DHR Panel judged from its collective knowledge that Rotherham was not unique in this respect.

**6.11 Term 11**

 ***Was the risk to family members of MA 1 and MA 2, in particular their mothers, recognised as Domestic Abuse?***

6.11.1 MA 1 and MA 2’s mothers faced risks from them in that they witnessed arguments between their sons and were subjected to verbal abuse through being shouted at. Adult Services recognised that MA 1 was financially abusing his mother and responded positively to stop it. Beyond that no other agency appreciated either mother was exposed to the domestic abuse between their sons.

6.11.2 On one occasion SYP took MA 1 to his mother’s house after they intervened in a domestic abuse incident between MA 1 and MA 2. MA 1’s mother [over 80 years of age] had already been identified as vulnerable because of MA 1’s behaviour towards her. SYP acknowledged that it was an error to have done this, noting the officers unwittingly displaced the problem to a different address.

**6.12 Term 12**

 ***When risks to family members were identified, was risk to either MA 1 or MA 2 as immediate partners considered?***

6.12.1There is some evidence that MA 1 financially exploited MA 2 when access to his mother’s money was stopped. He simply found another victim a fact not recognised by agencies. It would have been excellent practice if adult services had considered whether MA 2 was at risk of financial exploitation once MA 1 was stopped from accessing his mother’s money. The DHR Panel recommends that adult services consider whether its domestic abuse training adequately explores financial exploitation. This should include the dangers of perpetrators transferring their financial abuse from one person to another.

**7. LESSONS IDENTIFIED**

7.1 The IMR agencies lessons are not repeated here because they appear as actions in the Action Plan at Appendix A.

7.2 The DHR Lessons Identified are:

|  |
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| 1. Only three organisations completed domestic abuse risk assessment. South Yorkshire Police and South Yorkshire Probation Trust used the domestic abuse risk assessments current to them and Choices and Options completed a DASH Risk Assessment. Other agencies had opportunities to complete risk assessments but did not. A reasonable conclusion is that risk assessment in domestic abuse cases is not embedded within all relevant agencies in Rotherham.

**Lesson**If domestic abuse risk assessments are not completed, victims are denied the opportunity to have the risks they face from perpetrators systematically scrutinised and protective measures put in place. In brief victims continue to be exposed to unknown and therefore uncontrolled risks. |

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| 1. The domestic abuse between MA 1 and MA 2 continued unabated and peaked in 2011 and 2013. Many agencies knew of the situation but no one took responsibility for organising a multi-agency response and appointing a lead professional, thereby relying on a more ad-hoc approach organised by professionals working in ones or twos.

**Lesson**Repeat victims who do not meet the qualifying criteria to receive support from MARAC, MAPPA or Vulnerable Adult processes have no framework within which their cases can be considered, thereby leaving them without effective coordinated services.  |

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| 3. The DHR Panel was unable to tell from the IMRs or its debates exactly what it was that MA 1 and MA 2 wanted from their lives. MA 1 and MA 2 moved from one crisis to another and were inconsistent in asking for and accepting help and support; additionally they sometimes actively resisted the offers made to them. Therefore, it is reasonable to say that professionals would also struggle to know what the couple required. Professionals also overlooked the Respect screening tool for determining who the victim/perpetrator was. Overall professionals had no clear idea what is was that MA 1 and MA 2 wanted from them and this made planning and delivering life changing outcomes so much harder. **Lesson**Professionals working complex domestic abuse cases should establish who the victim/perpetrator is and want they want and then agree aims and objectives with them. This will provide professionals with a clear operating framework. |

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| 4. Sometimes GPs are the only agency to know when a patient is the victim or perpetrator of domestic abuse and therefore they have an important role to play in supporting their patients. In this case, most agencies did not tell either MA 1 or MA 2’s GPs, about the domestic abuse. The information that was shared was not pursued by the GPs and the earlier recommendation for GPs to adopt the SRP GP flow chart should help them to support victims and perpetrators. **Lesson**If professionals do not share information with GPs about their patients who are involved in domestic abuse it leaves a gap in the resources available to support victims and perpetrators.  |

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| 5. For much of the review period agencies had very limited experience of dealing with domestic abuse in a male same sex relationship and probably less experience or knowledge of what bespoke services were available. That improved from 2012 but by then the pattern and depth of abuse between MA 1 and MA 2 was firmly set.  **Lesson**Professionals should recognise that domestic abuse features in same sex relationships as it does in heterosexual ones, and requires specialist support for victims and perpetrators.  |

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| 6. MA 1 and MA 2’s abusive relationship was widely known about. Many professionals approached it from a male/female model of dealing with domestic abuse, overlooking the fact that it was male same sex domestic violence. **Lesson**The traditional male/female model of dealing with domestic abuse does not necessarily suit male on male long term domestic abuse. Professionals should be mindful of this point and tailor their methods accordingly.  |

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| 7. The limited experience of professionals in dealing with male same sex domestic abuse and the paucity of specialist resources, particularly before 2012, meant that the reason for MA 1 and MA 2’s behaviour was not fully understood. Part of an effective plan for dealing with domestic abuse is to establish and deal with the causes. **Lesson**Without understanding the reasons for MA 1 and MA 2’s mutually abusive relationship, the likelihood of success in reducing or eliminating it was significantly reduced.  |

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| 8. Not understanding what drove the domestic abuse meant that professionals had a lesser chance of reducing or eliminating it. Individual professionals working with MA 1 and MA 2 received supervision and management, but the need for strategic direction of the case was never identified or pursued by managers or MARAC.**Lesson**Failing to recognise that this case required strategic direction meant that the chance of a successful outcome was significantly reduced. |

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| 9. Adult services acted promptly and stopped MA 1 financially exploiting his mother. They did not consider that MA 1 might transfer his exploitation to another person, in this case MA 2.**Lesson**Professionals should be mindful that people, who have been stopped from financially exploiting one person, may look for others to exploit and take action to prevent or minimise it happening. |

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| 10. The DHR Panel felt that in general agencies domestic abuse policies could be seen as focussing on heterosexual domestic abuse. **Lesson** Operating within a heterosexual domestic abuse model makes it more difficult to identify same sex domestic abuse and provide appropriate support.  |

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| 11. There was significant confusion in many agencies on when and how to refer MA 1 and/or MA 2 to adult safeguarding and several agencies missed opportunities to do so.**Lesson**Without referrals adult safeguarding is unable to support victims of domestic violence and lessen the risks they face. |

**8. CONCLUSIONS**

8.1 MA 1 and MA 2 were in a long term abusive relationship. The first recorded incident was in 1985when MA 1 stabbed MA 2. The incident was serious as reflected by the two year prison sentence MA 1 received on 17.01.1986. While the case papers are no longer available, it is probably fair to say that MA 2 made a complaint and supported the prosecution; the actions of a person who was not prepared to tolerate domestic abuse. It is noteworthy that on 05.12.2005 MA 1’s GP received a request from his solicitor for a letter explaining the impact of alcohol /drugs on MA 1. The GP declined. This is the first recorded incident of alcohol featuring in MA 1 and MA 2’s domestic abuse.

8.2 In the time between then and the start of the DHR period [01.04.2007] there is evidence within the combined chronology that MA 1 and MA 2 had periods of depression, abused alcohol and that MA 2 was the victim of domestic abuse perpetrated by MA 1. Therefore by 01.04.2007 a significant number of corrosive factors were present in their relationship. Added to this was the head injury suffered by MA 2 when he fell in February 2007.

8.3 Agencies were involved in assessing and supporting MA 1 and MA 2 for a variety of medical and non-medical needs. Following MA 2’s head injury, MA 1 was noted as his carer and at times was also a carer for his own mother. There is some suspicion, fuelled by MA 2 that MA 1 was financially exploiting his mother and MA 2. Adult services took effective action and stopped the exploitation of his mother, but not the believed exploitation of MA 2. MA 1’s mother was recognised by some agencies as being vulnerable and she also witnessed abusive behaviour between her son and MA 2. The pair were verbally abusive towards her but she always supported MA 1 and decline to initiate any action against him.

8.4 South Yorkshire Police had extensive involvement with MA 1 and MA 2. Officers attended over 50 incidents between the couple. MA 1 was arrested three times for assaulting MA 2 and MA 2 was arrested twice for assaulting MA 1. Despite the imposition of sanctions the domestic abuse continued.

8.5 The pattern of abuse altered from MA 1 being the aggressor to MA 2 retaliating. The longer the relationship lasted the less tolerant MA 2 appears to have been of MA 1’s behaviour. The escalation in domestic abuse appears to have coincided with an increase in their alcohol consumption, although it is very difficult to be precise. It also appears that MA 1 was the more able and dominant of the pair. There was also a suspicion in some agencies that MA 1 stayed with MA 2 because of the financial benefits it brought to MA 1.

8.6 Their alcohol abuse turned into chronic dependency and agencies never established whether there was a link to the domestic abuse. The DHR Panel felt that from a lay person’s perspective the link was clear. MA 1’s period under statutory supervision and an Alcohol Treatment Requirement did not alter his behaviour. He complied with the letter of the engagement but not the spirit.

8.7 The quality of the domestic abuse risk assessments undertaken was variable and limited to three agencies. On the one occasion a DASH risk assessment was completed it revealed that MA 1 presented a high risk of causing serious harm to MA 2. That initiated the MARAC process, the outcome of which was not helpful in addressing MA 1 and MA 2’s problems. The cumulative effect of domestic abuse on MA 2 in particular, does not seem to have been properly considered when assessing risk. During the timeframe under review not all practitioners from all agencies had the training/knowledge/awareness to pass on their concerns to an appropriate person who could have completed a risk assessment.

8.8 Apart from the MARAC process and that was limited, no other framework for dealing with the complex domestic abuse issues between MA 1 and MA 2 was considered. Agencies should have explored the adult safeguarding route which may well have provided a model within which to support the couple. In this case, MA 2 met the “No Secrets” definition of a vulnerable adult and the case should have progressed to a vulnerable adult strategy meeting. Another option was for a manager within one of the agencies involved with MA 1 and MA 2 to have used their influence and drawn together a multi-agency meeting to respond to the matters. The outcome of such a meeting would have included: the appointment of a lead professional; establishing aims and objectives; developing and implementing a practical plan together with a separate written safety plan for MA 1 and MA 2. A more remote possibility was to have the case screened for access to MAPPA.

8.9 Nevertheless professionals worked hard to effect change in MA 1 and MA 2 and there was some good collaboration; there was certainly lots of information exchanged, save with their GPs.

8.10 MA 1 and MA 2’s unpredictable response to offers of help and support did not instil confidence in professionals. One summed it up by saying, “I felt a bit deflated, I was encouraged by all the interagency work” and “MA 2’s drinking was out of control but nobody appears to be supporting him. I felt if all these specialist agencies could not help him, how could I”?

8.11 2011 saw a spike in the reported domestic abuse between MA 1 and MA 2 which tapered off during mid-2012. In late 2012 the abuse increased continuing into 2013 and on to the fatal incident. As late as 19.08.2013 MA 2 said he feared for his life as MA 1 might stab him.

8.12 Whether the problems of MA 1 and MA 2 were solvable or controllable will never been known for a fact. The barriers they faced and erected effectively kept professionals at bay. The DHR Panel thought that given both men were adults with the mental capacity to make their decisions, it was not, perhaps, for others to impose a moral judgement about their behaviour; rather it was to try and keep them safe from harm within the restrictions of their choices and the law. The ability of agencies to safeguard adults who have mental capacity contrasts sharply with children’s safeguarding where the legislative framework enables professionals to take effective action without consent.

8.13 The DHR Panel’s overall conclusion was that the complexities of MA 1 and MA 2’s long established relationship and their variable tolerance of professionals, coupled with their dependency on alcohol, made it very difficult to provide them with help and support in a way that had an enduring and positive impact on their lives.

**9. PREDICTABILITY/PREVENTABILITY**

9.1 It was known that MA 1 caused serious harm to MA 2 as evidenced by his conviction and imprisonment in 1986 for stabbing him. The DHR Panel assessed that MA 1 continued to pose a high risk of causing serious harm to MA 2.

9.2 However, no risk assessment was completed that suggested MA 2 posed a risk of causing serious harm to MA 1 and in that context his action in killing MA 1 was not predictable.

9.3 The DHR Panel [and MA 1’s sister] observed a change in the dynamics of the relationship after MA 2’s brain injury in 2007. MA 1 continued to abuse MA 2, but MA 2 began to retaliate and became a perpetrator. For example in April 2011 MA 1 received treatment in hospital for two fracture fingers which he said were inflicted by MA 2. That incident and another assault on MA 1 by MA 2 in August 2012 were risked assessed by SYP who determined that MA 2 posed a medium risk of causing serious harm to MA 1.

9.4 The increase in violence between MA 1 and MA 2 took place in an environment where both men were dependent on alcohol. They had mental health needs but were not suffering from a mental disorder. However the risk assessments did not reflect the actual dangers each posed to the other.

9.5 It was MA 2 who took MA 1’s life and the Crown’s decision to accept MA 2’s plea to manslaughter reflects the DHR Panel’s view that MA 2 probably responded to his long term victimisation and momentarily lost control with fatal consequences.

9.6 Therefore, the DHR Panel believed the death of MA 1 was not predictable nor was it preventable.

**10. RECOMMENDATIONS**

**10.1 Single Agency**

10.1.1 The single agency recommendations appear in the Action Plan and are not repeated here.

**10.2 DHR Panel**

10.2.1 The DHR Panel recommends that the Safer Rotherham Partnership:

1. Satisfies itself that its constituent agencies domestic abuse policies explicitly cater for abuse within LGBT relationships.
2. Establishes a common domestic abuse risk assessment model across it constituent agencies
3. Ensures that professionals in its constituent agencies are fully conversant with the services available to LGBT victims and perpetrators and how and when to make referrals.
4. Identifies what services are available for LGBT victims and perpetrators of domestic abuse and if there is a gap, how best new services can be commissioned.
5. Reviews the current domestic abuse framework to ensure it includes a mechanism to identify those complex cases which are not supported by the current domestic abuse framework and thereafter satisfies itself that services are available for such victims and perpetrators.
6. Considers the benefits of its constituent agencies having a common understanding of the various definitions associated with vulnerable adults and how to apply them to individual cases, including on when and how to make safeguarding referrals.
7. Determines whether there are benefits in its constituent agencies using the same documentation for making safeguarding referrals.
8. Determines whether its constituent agencies understand the adult safeguarding procedures and how they relate to domestic violence processes including MARAC.
9. Ensures its domestic abuse training includes: LGBT domestic abuse as a substantive element and the Relate “Male victims of domestic violence screening tool kit”. Additionally, supervisors should receive training in the MAPAC process.
10. Includes in its domestic abuse training the phenomenon of transfer of risk [including financial risk] from one victim to another.
11. Encourages its constituent agencies to share domestic abuse information with the victims and perpetrators’ GPs.
12. Establishes how best GPs can contribute to supporting victims and perpetrators of domestic abuse, including supporting MARAC and using the SRP GP domestic abuse Flow Chart.
13. Reviews the MARAC Minute template against the CAADA minute template to ensure the former incorporates the key features of the latter.
14. Invite CAAADA to audit the SRP 2013 CAADA self-assessment Action Plan.
15. Supports Headway in developing and introducing its domestic abuse policy and support training.

**APPENDIX A**

Safer Rotherham Partnership Domestic Homicide Review

MA1 - Action Plan

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| Recommendation | Lead agency | Action(s) to taken | Key Milestone | Target date |
| What is the over-archingrecommendation? | Who will ensure the actions are implemented? | How exactly is the relevant agency going to make this recommendation happen?What actions need to occur? | What are the key steps thatWill enable the measuring of the recommendation to be enacted?  | When should thisrecommendationbe completed |
| THE ROTHERHAM NHS FOUNDATION TRUST |  |  |  |  |
| 1: TRFT to raise the profile of the importance of evidencing social assessments of patients at each episode of care | TRFT, Assistant Chief Nurse | The Clinical Audit plan to include an audit of record keeping, providing a baseline across the Trust demonstrating the documentation of holistic assessments (including social circumstances) for each episode of care. The action plan is to be presented to the Adult Safeguarding Operational Group.To liaise with Clinical Effectiveness to determine an appropriate audit tool to measure this. | Audit tool agreedResults of audit to be fed back to Named Nurses. | September 2014Completed |
| 2: All TRFT staff to receive information detailing Domestic Violence and Abuse, the indicators, risk factors and relevant policies to be used. Information regarding Domestic Violence and Abuse to be provided at induction for new staff.Survey to be completed three months after information distribution to assess the level of knowledge of staff regarding Domestic Violence and Abuse. | TRFT Adult Safeguarding | Information booklet placed on Trust website March 2014. All staff informed of this through the Trust ‘Comms’Adult Safeguarding Team to present information at induction sessions. To commence from 1st May 2014 | Leaflet available to all staffAgreement reached at Joint Professionals Group.Presentation agreed.Induction sessions allocated. All staff to access within three months of appointment. | April 2014 April 2014July 2014Completed |
| 3: All TRFT staff to receive information detailing Adult Safeguarding, the process and links to other policy and procedure. | Adult Safeguarding | Information leaflet placed on Trust website February 2014. All staff informed of this through the Trust ‘Comms’.Leaflet also sent out through ‘payslip drop’ |  | April 2014April 2014July 2014Completed |
| 4: The TRFT DV Policy to be updated to reflect the current processes. | TRFT Adult Safeguarding | Updated policy to be ratified.The updated Policy to be circulated to all Trust staff through Communications team. | Ratified policy put on intranet and plan developed to embed throughout the Trust. | December 2014January 2015Completed |
| 5: Record keeping standards to be included in all TRFT delivered Adult Safeguarding training.  | TRFT Adult Safeguarding | Training packages to include record keeping standards. | Already incorporated in training material. | March 2014 |
| 6: This case to be used as a tool to aid learning across the TRFT.This case to be used to illustrate the relevance of incorporating social assessments into the clinical care provided to patients and highlight how this may be evidenced. | TRFT Adult Safeguarding | Training for senior managers to take place on 21/05/14. Presentation to include reference to this case to highlight the importance of high standards of record keeping, good communication and social assessments. | Presentation developed and delivered to senior managers across the Trust. | August 2014Completed |
| 7: TRFT A&E to review their arrangements for patients who attend frequently to ensure the criteria for triggering is amended and there is consideration given to their safeguarding needs. | Matron for A&E | The assessment should include an assessment of risk and signpost to safeguarding services. | Documentation will evidence the frequency of attendances.Records will demonstrate consideration of the safeguarding needs of all frequent attendees to A&E. | August 2014Completed |
| RMBC Adult Services |  |  |  |  |
| 8: All Safeguarding Managers/frontline assessors to have mandatory Domestic Violence training.  | RMBC Adult Services | Mandatory Domestic Violence/ DASH training to be available as part of the induction programme for all relevant frontline assessors. | Training records to be updated appropriately, effective monitoring to take place to ensure timescales adhered to. | Managers by April 2014 and for the wider Service by July 2014Completed |
| 9: All Assessors complete an assessment of presenting need which is identified during their assessment process in consultation with the customer (not copied from the previous assessments).  | RMBC Adult Services | Assessment of presenting need, identified during assessment process, in consultation with the customer. To be addressed with Management Team/ Team Meetings and underpinned in supervision with Assessors. | Contemporaneous Assessments undertaken authorised by Team Managers.  | April 2014Completed |
| 10: Assessors should ensure the assessment and review process involves all the appropriate professionals’ comments and concerns (where a meeting isn’t relevant or feasible) and the assessment documents should have clearly identifiable quotes from the customer and carer, and the assessors own views should be clearly stated.  | RMBC Adult Services | Should be in place already but Senior Management to address this with the Management Team/ Team Meetings and underpinned in supervision. | Through Management Authorisation of assessment / review documentation. | April 2014Completed |
| 11: Assessors should provide case recording evidence of why a decision is taken/ not taken in the social care record to support the audit process and ensure consistency. | RMBC Adult Services | Should be in place already but Senior Management to address this with the Management Team/ Team Meetings and underpinned in supervision. | Through Management Authorisation of assessment / review documentation. | April 2014Completed |
| 12: Assessors should identify risks throughout the assessment process and ensure that all the risks are addressed in the Assessors response, clearly evidencing where the customer has capacity to take risks, what discussion have taken place. The authors feel that mandatory risk assessment training should be available to all frontline assessors and Team Managers.  | RMBC Adult Services | Mandatory risk assessment training should be available to frontline practitioners/ Managers. | Training records to be updated appropriately, effective monitoring to take place to ensure timescales adhered to. | July 2014Completed |
| 13: Assessors should use the Fair Access to Care Criteria clearly outlining why they believe the customer identified needs meets/does not meet FAC’s at this level using the narrative provided in the criteria for clarity of decision making for Team Managers/Service Managers. | RMBC Adult Services | Should be in place already but Senior Management to address this with the Management Team/ Team Meetings and underpinned in supervision. | Through Management Authorisation of assessment / review documentation. | April 2014Completed |
| 14: RMBC should implement the VARMM procedures to support working with customers with complex physical and mental health/ substance misuse needs who have capacity to make decisions (as defined under the Mental Capacity Act).  | RMBC Adult Services | Implementation of procedure to be discussed with Senior Management Team. | Agreed by Senior Management Team with implementation of Plan.  | April 2014Completed |
| 15: Assessment and Care Management to work with ICT to enable the quick identification of customers who have a DASH assessment in progress/ completed.  | RMBC Adult Services | ICT to enable the identification of customers who have a DASH assessment in progress/ completed. | Identification of customers who have a DASH assessment in progress/ completed highlighted on Social Care customer records. | April 2014Completed |
| 16: Mandatory recording training for all Social Care frontline assessing staff.  | RMBC Adult Services | RMBC to ensure recording training becomes Mandatory for all Social Care frontline assessing staff. | Training records to be updated appropriately, effective monitoring to take place to ensure timescales adhered to. | April 2014Completed |
| 17: Customers with complex social care needs should be recorded as discussed in supervision, with clear outcomes around decisions made by whom, and the rationale for this. A section in the Supervision template should be provided to facilitate/ prompt this.  | RMBC Adult Services | Supervision template amended as identified. | Monitored through Quality Assurance Audit. | April 2014Completed |
| 18: When RMBC forward Safeguarding referrals onto RDASH there needs to be some follow up from RMBC to ensure this has happened.  | RMBC Adult Services | Assessment Direct to ensure Safeguarding referrals forwarded to RDASH also provided to Safeguarding Manager/ named person responsible. | Monitoring of the outcomes from Safeguarding referrals sent to RDASH to be undertaken. | April 2014Completed |
| ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST |  |  |  |  |
| 19: The Trust clinical needs assessments and guidance should be reviewed and amended to contain a prompts or guidance to staff to ask about domestic abuse. This principle should also apply to review documentation, and should be embedded in practice.  | RDaSH | Assistant Directors for each of the business divisions will need to direct service managers across the organisation to implement review of assessment documentation and guidance and amend as necessary to incorporate prompts re domestic violence | Implementation and monitoring via Clinical Governance Groups | January 2015Completed |
| 20: The Trust Mental Health Access and Treatment teams should access System One; equally Drug and Alcohol Services should access Silverlink to enable a better flow of communication and information and therefore reduction in risk to service users, public and staff.  | RDaSH | Trust IT lead to review how this can be implemented and Assistant Directors across the trust for each relevant business division to roll out through service manager | Implementation via trust ICT board and divisional Clinical Governance Groups | January 2015Completed |
| 21: The Trust should explore how clinical staff can access electronic systems from partner agencies to establish previous and current risk assessment/management and service input by other teams and services. | RDaSH | Trust IT lead to explore options (particularly those of information Governance and Data Protection) and clarify if this is feasible  | Dissemination of information by trust IT lead | January 2015Completed |
| 22: The Trust should further consider VARM in conjunction with partner agencies. | RDaSH | Review by trust Adult Safeguarding Lead | Trust Safeguarding lead participation in multi agency (SYP led) meetings and dissemination of information | January 2015Completed |
| 23: The Trust should review the Engagement/Disengagement policies of all services/departments and consider whether to amalgamate these in to one overarching policy, with specific guidance for different circumstances/service user groups. | RDaSH | Report author has already clarified that although the possibility was being explored, decision has been made within the trust that this is not workable due to the large variance in services provided across the trust |  | Completed |
| 24: The Trust should review and update the Domestic Abuse Policy ensuring it consider all relationships regardless of gender or sexual orientation and includes relationships are/may be mutually abusive. | RDaSH | Review by trust Adult Safeguarding Lead | Dissemination of policy updated as necessary | January 2015Completed |
| 25: Training in relation to Domestic Abuse and the ‘asking the question about abuse’ training should be reviewed and updated in relation to abuse in the context of the updated policy. | RDaSH | Review by trust Adult Safeguarding Lead | Update of training programme content and circulation to staff across all divisions via Assistant Directors and Service Managers | January 2015Completed |
| 26: The Trust clinical needs assessments and guidance should be reviewed and amended to contain a prompts or guidance to staff to ask about domestic abuse. This principle should also apply to review documentation, and should be embedded in practice.  | RDaSH | Assistant Directors for each of the business divisions will need to direct service managers across the organisation to implement review of assessment documentation and guidance and amend as necessary to incorporate prompts re domestic violence | Implementation and monitoring via Clinical Governance Groups | January 2015Completed |
| 27: The Trust Mental Health Access and Treatment teams should access System One; equally Drug and Alcohol Services should access Silverlink to enable a better flow of communication and information and therefore reduction in risk to service users, public and staff.  | RDaSH | Trust IT lead to review how this can be implemented and Assistant Directors across the trust for each relevant business division to roll out through service manager | Implementation via trust ICT board and divisional Clinical Governance Groups | January 2015Completed |
| 28: The Trust should explore how clinical staff can access electronic systems from partner agencies to establish previous and current risk assessment/management and service input by other teams and services. | RDaSH | Trust IT lead to explore options (particularly those of information Governance and Data Protection) and clarify if this is feasible  | Dissemination of information by trust IT lead | January 2015Completed |
| 29: The Trust should further consider VARM in conjunction with partner agencies. | RDaSH | Review by trust Adult Safeguarding Lead | Trust Safeguarding lead participation in multi agency (SYP led) meetings and dissemination of information | January 2015Completed |
| 30: The Trust should review the Engagement/Disengagement policies of all services/departments and consider whether to amalgamate these in to one overarching policy, with specific guidance for different circumstances/service user groups. | RDaSH | Report author has already clarified that although the possibility was being explored, decision has been made within the trust that this is not workable due to the large variance in services provided across the trust |  | Completed |
| 31: The Trust should review and update the Domestic Abuse Policy ensuring it consider all relationships regardless of gender or sexual orientation and includes relationships are/may be mutually abusive. | RDaSH | Review by trust Adult Safeguarding Lead | Dissemination of policy updated as necessary | January 2015Completed |
| 32: Training in relation to Domestic Abuse and the ‘asking the question about abuse’ training should be reviewed and updated in relation to abuse in the context of the updated policy. | RDaSH | Review by trust Adult Safeguarding Lead | Update of training programme content and circulation to staff across all divisions via Assistant Directors and Service Managers | January 2015Completed |
| HOUSING AND NEIGHBOURHOOD SERVICES |  |  |  |  |
| 33: Improve the ability of visiting Housing and Neighbourhood Services Officers to identify and assess risk. | H&NS & IDVA | H&NS to Conduct an audit of those officers who have received DASH Risk Assessment training, and IDVA to provide training to those visiting officers who have not yet received it  | Improved recognition of risk and understanding of related diversity issues. Performance and Quality Unit (P&QU) to review by audit June 2014  | May 2014 Completed |
| 34: Prioritise the completion of ASB process maps prior to the implementation of the Civica ASB and Tenancy Management Module. | H&NS | Completion of process management maps for ASB and domestic abuse / Safeguarding issues  | Improved support for officers and a more effective consistent service. P&QU to review completion by audit June 2014  | May 2014Completed |
| 35: Provide refresher training on the principles of effective case management and interagency working for cases involving vulnerable perpetrators. | H&NS | Provide training including interactive case studies with partners  | Improved case management. P&QU to review completion by audit July 2014  | June 2014Completed |
| 36: Reinforce the need for timely and accurate record keeping.  | H&NS | Line Managers to deliver at Team meetings | Auditable case notes that tell the story and support effective action. P&QU to Spot check February 2014 | February 2014Completed |
| 37: Improve the supervision of ASB cases. | H&NS | * Introduce 8 week reviews of ASB cases in the following categories: Intimidation and harassment, Alcohol related, Drugs, Domestic Abuse and Violence (other)
* Review capacity to roll out to all categories of ASB and implement review
 | Earlier management intervention and decision making on the direction of the case. * Roll out February 2014
* Review April 2014

P&QU to review completion June 2014 | April 2014Completed |
| 38: Improve the joint working between Area Housing Officers and Floating Support Agencies.  | H&NS  | * An AHO representative to attend the floating support forum.
* Each case to have a recorded joint action plan identify how the two services will work together to sustain the tenancy.
 | * A protocol joint working established. April 2014
* Joined up working, better case management and improved service to the client. June 2014

Review completion by Area Housing Manager & P&Q Unit by audit, July 2014 | June 2014Completed |
| 39: Improve the sharing of information on ASB activity between AHO teams. | H&NS | Review how the IT system can be improved to more effectively tag and link third parties to tenancies  | Improved understanding of the activity of perpetrators of ASB across Area Assembly boundaries and improve collaborative working to resolve the issue P&Q Unit by audit, June 2014 | May 2014Completed |
| 40: Improve information sharing between SNT’s. | H&NS | Use this case to highlight the issue and review how information is shared across SNT boundaries | Improved understanding of ASB activity ability through collaborative working to resolve the issueP&QU to review completion by review June 2014 | May 2014Completed |
| INDEPENDENT DOMESTIC VIOLENCE ADVOCACY  |  |  |  |  |
| 41: To implement a system which ensures all case recording adheres to the principles defined by the DH Social Services Inspectorate, ‘Recording with Care’ (1999), which enhances the CAADA guidance given in their IDVA Case Management Pack. | IDVA Service | 1. To discuss the requirements and reasons with each member of the IDVA and Domestic Abuse Service.
2. Specific audit of current case work in respect of record keeping
3. Implement an audit system for ongoing monitoring
 | 1. Discussions recorded in Team 1:1s
2. IDVA Manager to undertake this audit and implement system for on- going checks
 | 1. Complete
2. March 2014

Completed1. March 2014

Completed |
| 42: Ensure the Adult Services, RMBC referral process to other agencies, is being adhered to. (Implemented February 2013).  | IDVA Service | To ensure this process is being recorded on the exit form, which is subject to audit  | Implement an audit of current cases to ensure this is occurring | March 2014Completed |
| 43: Ensure the IDVA Service understands the roles of all the Agencies it works with, as these vary and highlighted in this case as being particularly in relation to Adult Services, Vulnerable Adults and Head Injury.  | IDVA Service | The IDVA Service moved to be part of the Safeguarding Adults Service in December 2011 and therefore this particular knowledge is now embedded in the IDVA Service | To ensure this is embedded through case study, group supervision | Action complete |
| LIFELINE  |  |  |  |  |
| 44: Reporting IMR’s need to be in conjunction with the commissioners to gain support and feedback. | Lifeline | To alert commissioners when an IMR request comes in and the timescales. To include the name of the individual and the level of the report | To refresh the policies to include the reporting of DHR processes. To include timescales for reporting  | This recommendation will be completed in 4 weeks |
| SOUTH YORKSHIRE POLICE  |  |  |  |  |
| 45: The DASH tool be implemented across South Yorkshire Police [SYP] | SYP | ISD completion of system.System then used by all officers attending DV Incidents | Already implemented and in place | COMPLETED |
| 46: SYP; Addresses that have been identified as being the home of a vulnerable adult should be tagged for the information of any future calls. This practice should be adopted force-wide. This will prevent inappropriate individuals being taken to these addresses by officers. | SYP | Direct instruction to all Adult Protection Officers | Number of such tags being created | COMPLETED |
| 47: This report should be brought to attention to the SYP Communications Manager in terms of the need for safe and well checks to be carried out where there has been a history of domestic abuse. | SYP | Direct communication with Comms Manager | Audit of communication with Comms Manager.Subsequent instruction to Comms Staff | COMPLETED |
| 48: The SYP adult protection referral process will be re-launched to officers as a timely reminder of when these referrals need to be competed.  | SYP | General order item to all officers | Numbers of CID 70’s being submitted | COMPLETED |
| 49: SYP; All MARAC minutes should specifically state which agency is providing which information to the meeting. | SYP MARAC Coordinator | Minute takers record which agency provides information during the meetings. The information is typed into the minutes. | Completed during each case discussion. Minutes reviewed and audited quarterly. | COMPLETED |
| 50: SYP; Risks are specifically highlighted within the MARAC minutes document. | SYP MARAC Coordinator | Minute takers record risks identified during the meetings. The information is typed into the minutes. | Completed during each case discussion. Minutes reviewed and audited quarterly. | COMPLETED |
| 51: SYP; Wherever possible, all agencies feedback their actions by way of secure email before the action completion date and the detail of the email is copied and pasted into the minutes as a full and accurate account of the information provided. | SYP MARAC Coordinator | Action results that are emailed are copied and pasted into the minutes.Administrators to remind all members at meetings to provide action updates.MARAC action updates are requested on email each time case summaries and minutes are circulated | Completed between MARAC meetings. Minutes reviewed and audited quarterly | COMPLETED |
| 52: SYP; Wherever possible, agencies who do not have secure email report to MARAC admin about completed actions, before the action completion date, by phone or fax and a full account is recorded and typed into the minutes.  | SYP MARAC Coordinator | Action results that are faxed or phoned in are typed into the minutes. Administrators to remind all members at meetings to provide action updates.MARAC action updates are requested on email each time case summaries and minutes are circulated | Completed between MARAC meetings. Minutes reviewed and audited quarterly. | COMPLETED |
| 53: SYP; Agencies who are unable to complete actions within agreed time frames should contact MARAC admin, by email phone or fax, with a full explanation of the circumstances. The details to be cut and pasted or typed into the minutes. | SYP MARAC Coordinator | Incomplete action results that are faxed or phoned in are typed into the minutes. MARAC action updates are requested on email each time case summaries and minutes are circulated. Administrators to remind all members at meetings to provide action updates | Completed between MARAC meetings. Minutes reviewed and audited quarterly | COMPLETED |
| 54: SYP; The aim of the recommendations is to ensure that the origin of all information provided is recorded and that the detail and context of actions and action write offs is clear and comprehensive within the MARAC minutes document. | SYP MARAC Coordinator | Administrators to remind all members at meetings provide action updates.MARAC action updates are requested on email each time case summaries and minutes are circulated.All information to be recorded and embedded into the minutes | Minutes reviewed and audited quarterly. | COMPLETED |
| YORKSHIRE AMBULANCE SERVICE |  |  |  |  |
| 55: Within 6 months YAS will re-launch the domestic violence campaign for EOC & frontline staff  | YAS Head of Safeguarding  | 1. Email the EOC power point awareness campaign to the Head of EOC at Trust HQ for approval who will upload onto the system for 4 weeks. 2. Upload the awareness campaign on to the YAS intranet site via the on-line team; e-learning module on DV available & 4 week campaign, following change in Claire’s law 3. Send the 4 remaining DHR recommendations to the corporate communications team to publish in the Operational Update weekly bulletin 4. Publish information on the new NICE guidelines (if published at time of awareness campaign) 5. Q&A paper & links to regional support pathways | Email YAS EOC Head of Department and YAS Head of Corporate Communications with information. Email on-line team information for awareness campaign  | 19th Sept 2014 Completed |
| 56: Within 3 months, YAS will place a reminder in the weekly YAS Operational Update (OU) of the current definition for domestic abuse and remind staff to consider this in relation to ex-partners as well as those who actively remain in relationships. | YAS Head of Safeguarding | Send the recommendation to the corporate communications team to publish in the Operational Update weekly bulletin on week 3 |  | 19th June 2014 Completed |
| 57: Within 3 months YAS will put a bulletin in OU to remind staff of their responsibilities to refer “vulnerable adults” to social care & the police, when an assault has occurred and to document this has been offered. | YAS Head of Safeguarding | Send the recommendation to the corporate communications team to publish in the Operational Update weekly bulletin on week 3 |  | 19th June 2014 Completed |
| 58: Within 3 months YAS will put a bulletin in OU to remind staff that all adults should be offered signposting to domestic violence services when abuse is suspected or confirmed. | YAS Head of Safeguarding | Send the recommendation to the corporate communications team to publish in the Operational Update weekly bulletin on week 3 |  | 19th June 2014 Completed |
| 59: Within 3 months YAS will put a bulletin in OU to remind staff that Police presence on scene does not negate staff responsibilities to refer to external agencies when safeguarding issues are highlighted | YAS Head of Safeguarding | Send the recommendation to the corporate communications team to publish in the Operational Update weekly bulletin on week 3 |  | 19thJune 2014 Completed |
| ACTION HOUSING & SUPPORT |  |  |  |  |
| 60: All support employees to attend a domestic abuse awareness course.  | Director of Client Support Services | All staff to be booked on through local facilities | Staff will have attended training | June 2015 Completed |
| 61: Training plan to be updated to include domestic abuse awareness as mandatory. | Human Resources Manager | By updating mandatory training plan | Training plan updated | Jan 2014Completed |
| 62: Domestic Abuse policy to be finalised and re-issued, and all employees to demonstrate that they have read and understand it. | Director of Client Support Services | Policy to be reviewed, consulted on, re-issued to all staff and intranet tick box to demonstrate reading | Policy re-issued | D ecember 2013Completed |
| 63: Service Managers to attend bespoke internal training course around role and responsibilities of position, ensuring internal processes are followed appropriately. | Director of Client Support Services | Internal training course to be devised and delivered | Training delivered | April 2014Completed |
| 64: All staff to be reminded of purpose of safeguarding folder. | Area Managers | Area Managers to communicate this to teams via team meetings | Meetings held and staff reminded | January 2014Completed |
| 65: Domestic Abuse flowchart to be devised along same lines as current safeguarding flowchart utilised internally. | Director of Client Support Services | Flowchart to be devised, consulted upon and issued to all staff | Flowchart issued to all staff | June 2014Completed |
| 66: Rolling programme of safeguarding training every three years to specify that staff to have attended their local safeguarding training wherever possible. | Director of Client Support Services | In place already as per policy | All staff up-to-date on safeguarding training | April 2014Completed |
| 67: Rotherham staff to attend bespoke training course around risk and internal processes in relation to updating paperwork, including the legal nature of these documents and their responsibilities in the accuracy of the date contained within them. Course to also include reminders of importance of support delivery, consistency and need for contact. | Director of Client Support Services | Area Manager to devise bespoke course with Service Managers, and deliver to Rotherham staff. Other managers to attend and roll programme out across rest of company | All Rotherham staff attended training and display greater understanding of role and responsibilities; standards within Rotherham teams to improve – tested through file audits and commissioner checks | April 2014Completed |
| 68: Consideration to be given to capability processes for relevant staff members based on information from this process and current working practices. | Area Manager | Area Manager to work with Service Managers to identify whether practice has improved; if not performance management work to be undertaken | Staff identified through this process to demonstrate standard of work has improved significantly or undergo performance management | March 2014Completed |
| 69: Service Managers to attend bespoke internal training course around role and responsibilities of position including in relation to cover for absences. | Director of Client Support Services | Training to be sourced to address role and responsibilities of front line managers | Service Managers taking greater responsibility for teams and service delivery | April 2014Completed |
| 70: Area Manager to implement all actions from annual internal audit. | Director of Client Support Services | Annual internal audit identified safeguarding issues in September; Area Manager to address outstanding action points | Action points completed | April 2014Completed |
| 71: Area Manager to actively manage team and Team Leaders, including attendance at team meetings and thorough auditing of supervisions and files. | Area Manager | Area Manager to increase presence and rigorously supervise Service Managers to ensure front line staff are also being managed more effectively | All managers demonstrating more proactivity in management approach | January 2014Completed |
| 72: Policy and procedure is discussed at team meetings to ensure critical processes are rolled out and understood. | Director of Client Support Services | When a new policy or procedure is issued it will be discussed at team meetings to ensure staff have properly digested the content | Standard item on team meetings | April 2014Completed |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Headway |  |  |  |  |
| 73: To ensure advice and guidance is given to all staff regarding accurate recording of comprehensive case notes. | Headway Rotherham | Manger to ensure staff briefing is undertaken  | Staff briefing delivered | February 2014Completed |
| 74: To ensure appropriate DASH risk Assessment is undertaken.  | Headway UK | All staff receiving DASH risk assessment training | Staff will have attended DASH risk assessment training | June 2014Completed |
| 75: Ensure that all staff carry out joint visits with agencies where ever possible and share information contained within any assessment process. | Headway Rotherham | Staff to make arrangements for joint visits where appropriate | Arrangements for undertaking of joint visits recorded in case notesWhere joint visits have been undertaken, these are recorded in the case notes | March 2014Completed |
| 76: Ensure the role of Headway Rotherham is clearly defined to ensure the service does not compromise its independence by fulfilling roles not core to service provision. | Headway Rotherham | Manager to ensure staff briefing is undertaken | Staff briefing delivered | March 2014Completed |
| 77: Develop policy whereby follow up protocol is established when contact with clients is not made. | Headway Rotherham | Manager to develop policy | Policy developed, staff made aware of protocol and policy being adhered to is reflected in case notes | March 2014Completed |
| 78: All staff to undertake MARAC awareness training. | Headway UK | All staff receiving MARAC awareness training | Staff will have attended MARAC awareness training | June 2014Completed |
| National Probation Service  |  |  |  |  |
| 79: Offender manager to increase risk level if evidence suggests risk is increasing. | Offender Manager Team Manager | Review of risk undertaken is recorded in case in line with service policy | Decisions regarding risk will be recorded following review | March 2014Completed |
| St Anne’s Medical Centre |  |  |  |  |
| 80: The Practice to review its internal processes for dealing with DNAs from invite letters and take cognisance of National Guidance on Non-Attendance. | Practice Manager | Review of DNA policy is undertaken | DNA policy is refreshed | June 2014Completed |
| 81: The clinicians dealing with patients presenting with alcohol problems should always consider. referring them to specialist alcohol services. | Practice Manager | All clinicians within the practice to be briefed | Briefing delivered | June 2014Completed |
| Stag Surgery  |  |  |  |  |
| 82: The Stag Surgery ensures that all staff listen and record carefully the views of patients, taking their concerns seriously and referring appropriately to other services which the patient would benefit from, supporting the every interaction counts agenda. | Practice Manager | Practice staff to be briefed | Briefing delivered | June 2014Completed |
| 83: Stag surgery reviews it processes and considers the need to have a tracking system for checking whether patients with alcohol/substance misuse needs have attended their appointments at the services they have been referred to. | Practice Manager | Review of processes undertaken | Development of tracking system (if review indicates this is required) | June 2014Completed |
| 84: That Stag Surgery adopt routine practice questions and assessment about Domestic Abuse when in discussion with a patient known to have alcohol/substance misuse problems. | Practice Manager | Staff to be trained in asking the question in line with IRIS programme | Staff recording discussions about Domestic Abuse in patient’s notes | June 2014Completed |
| Choices and Options (C&O)  |  |  |  |  |
| 85: That when a C&O professional is faced with lack of engagement it should share information with other relevant agencies and engage in joint planning to support the “client”. | C&O Project Manager | Staff to be fully briefed on the need to share information about non or dis-engagement with relevant agencies | Sharing of information recorded in case notes | March 2014Completed |
| 86: That C&O should train all front line staff to develop service provision to meet the needs of service users within LGBT partnerships. | C&O Project Manager | Staff to receive training in Domestic Abuse in LGBT relationships and how to meet the needs of service users  | All staff are trained | June 2014Completed |
| 87: That C&O should keep comprehensive records of telephone calls made to clients. | C&O Project Manager | Staff to briefed on the need to keep comprehensive records of telephone calls made to clients | Telephone discussions with clients are comprehensively recorded in case notes | June 2014Completed |
| The DHR Panel |  |  |  |  |
| The DHR Panel recommends that the Safer Rotherham Partnership: |  |  |  |  |
| 88: Satisfies itself that its constituent agencies domestic abuse policies explicitly cater for abuse within LGBT relationships.  | Cherryl Henry-Leach SRP Domestic Abuse Coordinator RMBC |  |  | 31st March 2015Completed |
| 89: Establishes a common domestic abuse risk assessment model across it constituent agencies  | Cherryl Henry-Leach SRP Domestic Abuse Coordinator RMBC |  |  | 31st March 2015Completed |
| 90: Ensures that professionals in its constituent agencies are fully conversant with the services available to LGBT victims and perpetrators and how and when to make referrals. | Cherryl Henry-Leach SRP Domestic Abuse Coordinator RMBC |  |  | 31st March 2015Completed |
| 91: Identifies what services are available for LGBT victims and perpetrators of domestic abuse and if there is a gap, how best new services can be commissioned. | Cherryl Henry-Leach SRP Domestic Abuse Coordinator RMBC |  |  | 31st March 2015Completed |
| 92: Reviews the current domestic abuse framework to ensure it includes a mechanism to identify those complex cases which are not supported by the current domestic abuse framework and thereafter satisfies itself that services are available for such victims and perpetrators. | Cherryl Henry-Leach SRP Domestic Abuse Coordinator RMBC |  |  | 31st March 2015Completed |
| 93: Considers the benefits of its constituent agencies having a common understanding of the various definitions associated with vulnerable adults and how to apply them to individual cases, including on when and how to make safeguarding referrals | Cherryl Henry-Leach SRP Domestic Abuse Coordinator RMBC |  |  | 31st March 2015Completed |
| 94: Determines whether there are benefits in its constituent agencies using the same documentation for making safeguarding referrals. | Cherryl Henry-Leach SRP Domestic Abuse Coordinator RMBC |  |  | 31st March 2015Completed |
| 95: Determines whether its constituent agencies understand the adult safeguarding procedures and how they relate to domestic violence processes including MARAC. | Cherryl Henry-Leach SRP Domestic Abuse Coordinator RMBC |  |  | 31st March 2015Completed |
| 96: Ensures its domestic abuse training includes: LGBT domestic abuse as a substantive element and the Relate “Male victims of domestic violence screening tool kit”. Additionally, supervisors should receive training in the MAPAC process.  | Cherryl Henry-Leach SRP Domestic Abuse Coordinator RMBC |  |  | 31st March 2015Completed |
| 97: Includes in its domestic abuse training the phenomenon of transfer of risk [including financial risk] from one victim to another.  | Cherryl Henry-Leach SRP Domestic Abuse Coordinator RMBC |  |  | 31st March 2015Completed |
| 98: Encourages its constituent agencies to share domestic abuse information with the victims and perpetrators’ GPs. | Cherryl Henry-Leach SRP Domestic Abuse Coordinator RMBC |  |  | 31st March 2015Completed |
| 99: Establishes how best GPs can contribute to supporting victims and perpetrators of domestic abuse, including supporting MARAC and using the SRP GP domestic abuse Flow Chart. | Cherryl Henry-Leach SRP Domestic Abuse Coordinator RMBC |  |  | 31st March 2015Completed |
| 100: Reviews the MARAC Minute template against the CAADA minute template to ensure the former incorporates the key features of the latter.  | Cherryl Henry-Leach SRP Domestic Abuse Coordinator RMBC |  |  | 31st March 2015Completed |
| 101: Invite CAAADA to audit the SRP 2013 CAADA self-assessment Action Plan.  | Cherryl Henry-Leach SRP Domestic Abuse Coordinator RMBC |  |  | 31st March 2015Completed |
| 102: Supports Headway in developing and introducing its domestic abuse policy and support training. | Cherryl Henry-Leach SRP Domestic Abuse Coordinator RMBC |  |  | 31st March 2015Completed |

**Appendix B**

**Glossary of Terms**

ACPO Association of Chief Police Officers

A&E Accident and Emergency

AH&S Action Housing and Support

ASC Adult Social Care

ATR Alcohol Treatment Requirement

CAADA Co-ordinated Action Against Domestic Abuse

CID Criminal Investigation Department

C&O Choices and Options

COPD Chronic Obstructive Pulmonary Disease

DAPG Domestic Abuse Priority Group

DAS Drug and Alcohol Services

DASH Domestic Abuse, Stalking and Honour Based Violence

DHR Domestic Homicide Review

H&NS Housing and Neighbourhood Services

IDVA Independent Domestic Violence Advocate

IMR Individual Management Review

IRIS Identification and Referral to Improve Safety

LGBT Lesbian, Gay, Bisexual and Transgender

MAPPA Multi Agency Public Protection Arrangements

MARAC Multi Agency Risk Assessment Conference

MHS Mental Health Services

MHW Mental Health Worker

NHS National Health Service

OASys Offender Assessment System

OM Offender Manager

RCGP Royal College of General Practitioners

RDaSH Rotherham Doncaster and South Humber NHS Foundation Trust

RMBC Rotherham Metropolitan Borough Council

ROSH Risk of Serious Harm

SARA Spousal Assault Risk Assessment

SRP Safer Rotherham Partnership

SPECSS Separation, Pregnancy, Escalation, Community isolation, Stalking/harassment Sexual abuse

STHFT Sheffield Teaching Hospitals NHS Foundation Trust

SSW Student Social Worker

SYFRS South Yorkshire Fire and Rescue Service SYFRS

SYP South Yorkshire Police

SYPT South Yorkshire Probation Trust

THFT The Rotherham NHS Foundation Trust

YAS Yorkshire Ambulance Service