DHR 2016 H

Domestic Homicide Review Executive Summary On Behalf of Safer Lincolnshire Partnership

in respect of:

Zara

Age 33 years

Died May 2016

Marion Wright

Independent Overview Author

Date: April 2018

1. The Review Process

1.1 This summary outlines the process undertaken by Safer Lincolnshire Partnership Domestic Homicide Review Panel in reviewing the death of Zara, who was a resident in their area.

1.2 Pseudonyms have been used in this review for the victim, perpetrator and their daughter to protect their identities and those of their family members. The victim, Zara, was aged 33 years at the time of the fatal incident. She was a Latvian national who had settled in Lincolnshire in 2007. Stefan, the perpetrator was aged 32 years and was from Lithuania. The couple met in Lincolnshire in 2008 and married in 2010, their daughter and only child was born later that year.

1.3 Criminal proceedings were completed in May 2017, the perpetrator was found guilty of murder following trial and was sentenced to life imprisonment to serve a minimum of 23 years.

1.4 The Domestic Homicide Review (DHR) process began with an initial meeting in November 2016 where it was confirmed that a DHR would be undertaken. However, at that stage, Stefan was denying the murder and proceedings were postponed until March 2017. All agencies that potentially had contact with Zara, Stefan and Basia, their daughter, were contacted. Eleven agencies confirmed contact and were asked to contribute to the DHR.

2. Contribution to the DHR Process.

2.1 The agencies completing IMRs and the profile of their involvement with the individuals were as follow :-

Organisation	Author	Involvement
Lincolnshire Police	Steve Bell Regional Review Unit	Responded to telephone calls and visits from the victim and the perpetrator Attended home addresses in response to alleged offences and concerns. Attended the scene of the murder and made an arrest and prosecuted the

		murder case.
United Lincolnshire Hospitals NHS Trust	Elaine Todd Named Nurse for Safeguarding Children and Young People	Provided care for Zara between January 2011 and November 2013 via three separate attendances to the A and E Department
GP Practice Lincolnshire Clinical Commissioning Group	David Hardy Practice Manager and Practice Deputy Safeguarding Lead at the Medical Centre	Provided GP services and healthcare between 2008 until 2016 for the victim and 2010 to 2016 for the perpetrator and their daughter.
Lincolnshire Community Health Services	Jill Anderson Head of Safeguarding	Provided Health Visiting and School Nurse Service to victim and daughter between November 2010 and May 2016.
Education Services Lincolnshire County Council	Jill Chandar-Nair Inclusion and Attendance Manager Senior Liaison Manager for Education with Children's Services	Provided Pre-School and School Services from September 2014 to May 2016
Lincolnshire County Council Children's Services	Johan Hague Consultant for Lincolnshire County Council Children's Services since 2014	Provided a response to 13 contacts between January 2011 and 2016.

CAFCASS	Helen Abbotts	Provided the Family Court with reports and advice concerning a Child Arrangements Order for court hearings in March and May 2016.

2.2 A summary report was received from West Lincolnshire Domestic Abuse service (WLDAS) in relation to the IDVA Service provided in connection with a Multi-Agency Risk Assessment Conference (MARAC) in August 2011 where Zara was injured. The abusers were her brother-in-law and his brother. WLDAS manages the IDVA Service. The MARAC is organised under the auspices of Lincolnshire County Council and MARAC information was considered and agreed by Lincolnshire County Council Safer Communities Lead.

2.3 A summary report was received from EMAS who provided ambulance response to the victim on four occasions between 2011 and May 2016. There was one telephone response to Stefan.

2.4 A summary report was also received from The Borough Council in relation to Council Tax and two contacts with Stefan in May 2016. Contact was made with the letting agency who rented the property to Stefan. Liaison took place with the Cambridgeshire Prison Intelligence Officer regarding the 5 weeks Zara was remanded in custody at HMP Peterborough in September 2015. However, there is no intelligence regarding Zara making any disclosures regarding suffering Domestic Abuse.

2.5 Children and Family Court Advisory Support Services (CAFCASS) were contacted and a request made via The Family Court Judge to provide disclosure of the private law papers detailing information about their contact with Zara and Stefan. These were provided in August 2017 and an IMR was submitted in November 2017.

2.6 Information was provided by Lincolnshire Fire and Rescue Service. Having been called to the scene of the murder in May 2016, on arrival a female casualty was found to be deceased. The post mortem has since determined it was not a fire related death. In these circumstances, no further involvement was required in the DHR.

2.7 Both the agency review panel members and the Individual Management Review (IMR) report authors who have provided agency evidence considered by the review are independent from any direct involvement in the case or direct line management of those involved in providing the service.

3. The Review Panel Members

3.1 DHR 2016H Review Panel Members

Marion Wright	Independent Overview Report Author / Chair
Karen Shooter	Lincolnshire County Council Domestic Abuse Manager
Rick Hatton	Lincolnshire Police
Sarah Norburn	Lincolnshire Police
Roz Cordy	Lincolnshire County Council Children's Services
Elaine Todd	United Lincolnshire Hospital Trust
Claire Tozer	South West Lincolnshire Clinical Commissioning Group
John O'Connor	Lincolnshire County Council, Children's Services (Education)
Barbara Mitchell	Lincolnshire Community Health Service
Donna Brewer	The Borough Council
David Harding	GP Representative
Jane Keenlyside	West Lincolnshire Domestic Abuse Service
Zoe Rodger-Fox	East Midlands Ambulance Service
Pat Armitage	CAFCASS

<u>Panel Support Members.</u>

Toni Geraghty	Legal Services, Lincolnshire Advisor to the Panel
Ben Rush	Panel Administrator, Lincolnshire County Council

Teresa Tennant	Panel Administrator Lincolnshire County Council

3.2 A total of five meetings were held with the Review Panel. The first was to consider information available, to agree that a DHR was appropriate and to consider the Terms of Reference. The second was to commission the IMR's. The third meeting was to consider information contained in the IMRs, to identify gaps and to seek further information as appropriate. The third meeting was also attended by the report authors and enabled agencies to present their information and give time for others to ask questions and make comment. The fourth and fifth meeting considered the draft overview report and ensured that it fairly and accurately represented the information of those agencies that contributed.

4. Chair and Author of the Overview Report

4.1 To reinforce the impartiality of this report it is confirmed that the Independent Chair / Independent Overview Author, referred to as The Author, is not employed by any Lincolnshire agency in any other capacity and has not previously had any direct involvement in this case. Neither has she had any line management responsibility for those who have been providing services or for those managing the provision of those services. The Independent Chair / Author is a retired Assistant Chief Officer of Probation with 33 years' experience. She had strategic lead for Public Protection including Domestic Abuse and had been involved in working with offenders who commit crimes of D.A. both through individual and group work. The Author was responsible for the management of the introduction of MARAC, in 2009, into the area in which she worked. The Author has undertaken many training courses in relation to Domestic Abuse and the pattern of behaviour this involved. The most recent event attended was the Domestic Homicide Review Workshop developed by AAFDA (Advocacy After Fatal Domestic Abuse) and Standing Together in May 2017. She has experience of providing Serious Case Reviews for MAPPA (Multi Agency Public Protection Arrangements) and writing numerous Domestic Homicide Reviews. The Author has had a special interest in Domestic Abuse throughout her career having first undertaken a placement with Erin Pizzey at Chiswick Women's Aid in 1975.

5. Terms of Reference for the Review.

5.1 In order to address the key issues, agencies were charged with answering the questions set out below and providing analysis for their answers.

Issues to be addressed :-

a) To examine whether there were any previous concerns, incidents, significant life events or indications which might have signalled the risk of violence to any of the subjects, or given rise to other concerns or instigated other interventions.

b) When and in what way were practitioners sensitive to the needs of the subjects, knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

c) When, and in what way, were the subject's wishes and feelings ascertained and considered? Were the subjects informed of options/choices to make informed decisions? Were they signposted to other agencies and how accessible were these services to the subjects? Was the victim's perception of danger canvassed?

d) Did the agency assess the risk they posed to each other in light of the separation (because as we know people are more at risk when they are separating/have separated and there is a loss of children/custody issues)?

e) What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

f) Was appropriate professional curiosity exercised by those professionals and agencies working with the individuals in the case, this includes whether professionals analysed any relevant historical information or patterns of behaviour and whether they were acted upon it?

g) Were the actions of agencies in contact with all subjects appropriate, relevant and effective to the individual and collective family needs and risks identified at the time and continually monitored and reviewed?

h) Did the agency have policies and procedures for Domestic Abuse and Safeguarding and were any assessments correctly used in the case of the subjects? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC or other multi-agency fora?

i) Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

j) Were any issues of disability, diversity, culture or identity relevant?

k) To consider whether there are training needs arising from this case

l) To consider the management oversight and supervision provided to workers involved

m) Did any restructuring during the period under review likely to have had an impact on the quality of the service delivered?

6. Background Information.

6.1 Information suggests that Zara and Stefan met in Lincolnshire in 2008. Both had come to the UK to find work and improve their life opportunities. Zara was from Latvia and Stefan was from Lithuania. These two countries are neighbouring Baltic States. There is a significant Eastern European Community in Lincolnshire to which they belonged.

6.2 Zara's sister and family also live in Lincolnshire and it is reported that they were very close and supportive of each other. Zara's parents continue to live in Latvia and Stefan's mother resides in his home country of Lithuania. His father is no longer alive.

6.3 The couple married in 2010 and their daughter, who was their only child, was born in November 2010. The couple both worked in the food industry, Zara in fruit and vegetable packing and Stefan in a bakery. The couple lived in privately rented property in Lincolnshire, moving on two or three occasions to other houses in the same vicinity.

6.4 The couple first came to the attention of agencies for a safeguarding concern in January 2011 when Zara had called an ambulance. She was distressed. The baby was seven weeks old and Zara referred to her crying a lot and that she was short of sleep. The baby had woken Stefan and this caused an argument and there was physical contact between the adults which involved pushing. The hospital observed appropriate parenting by Zara.

6.5 Zara went to stay with her sister but the couple quickly reunited. They were seen by a Health Visitor, the next day, when all was reported to be well.

6.6 There was an incident, in July 2011, where Zara had minor injuries following her brother-in law smashing a window. There was a Multi-Agency Risk Assessment Conference (MARAC) in August 2011, due to a high risk assessment of Domestic Abuse (D.A.) by the Police. However, there was no ongoing contact as Zara did not wish for involvement.

6.7 There was nothing of further significance known until May 2015, when Zara reported to her General Practitioner (GP) that she was in a new relationship. Following this disclosure, there was concern raised by Stefan via the child's Pre

School, Children's Services and the Police, relating to Zara's new boyfriend, her alcohol use and her care of Basia. Basia was living with Zara at this time. In the main, this concern was considered to be malicious and without supporting evidence. The couple had separated and it was acrimonious.

6.8 In September 2015, two males were seriously assaulted. Zara's boyfriend was one of the individuals arrested and later convicted of the assault. A few days later, Zara, herself, was arrested and remanded in custody charged with perverting the course of justice in that she assisted the offenders. She was remanded in custody for five weeks. She was acquitted of the charges in May 2016. Her remand in custody meant that her daughter went to live with her father, Zara's estranged husband. On her release on bail, Stefan would not let Zara have custody or contact with their daughter.

6.9 The school were concerned for Basia's well-being, given the conflict between the parents, and there were various communications between the School, Children's Services and the Police. There were allegations and counter allegations by the couple about the quality of care for Basia.

6.10 During April and early May 2016, Zara made five calls to the Police complaining of alleged offences including theft, criminal damage and of stalking and harassment she thought had been committed by Stefan. She disclosed he had been violent, previously, and she was afraid of him. There were no charges brought. He was spoken to by the Police on one occasion.

6.11 Zara had initiated proceedings via the Family Court to resolve the conflict over care and custody of their child. There was a Court hearing seven days before Zara was murdered, with custody granted to the father and indirect contact by Zara. She had been acquitted of all criminal charges four days before.

6.12 The following week a workman reported a fire at a multi-occupancy block of flats. The Ambulance and the Police were called. Zara's body was found in the bath. Stefan reported that he had been with her the night before, (this was his birthday), but he insisted he had left her safe and well. Discrepancies in his reporting of events were found. He was charged and, following trial, was convicted of Zara's murder, in April 2017, and sentenced to 23 years imprisonment.

7. Summary Chronology.

7.1 The chronology of contact and services provided spans a six year period, covering the length of time from the first identification of any concerns about this family. This was in January 2011, when Zara was distressed following an argument with and pushing by Stefan. There was some limited contact, later, in 2011 and then no relevant information from agencies until the breakup of the marriage in the summer of 2015. Following this there is information from Education, Children's Services and

the Police. Other than the referral to MARAC relating to an incident involving family members and not Stefan in 2011, there was no contact with D.A. agencies.

8. Key Issues Arising from the Review / Lessons Learned

8.1 Whilst there were two recorded incidents of D.A. in 2011, this family remained below the radar for agency involvement, other than in a very limited way, until four years later in 2015. They then came to the attention of the agencies following the breakdown of their relationship, separation and conflict over custody of their daughter. It is recognised that in January 2011 and May 2016, there was a lack of professional curiosity to explore with Zara the nature of the allegations she made of abuse, to undertake a full assessment based on her perceptions of fear and danger, to consider her safety and signpost her on to D.A. agencies for support as appropriate. There was also a lack of professional curiosity at other times, including from the GP when Zara requested a blood test to prove to her estranged husband that she was not using drugs, as he would not let her have contact with her daughter without this proof. There were no exploratory questions on the underlying problem in their relationship and the response focused on the presenting issues of the drug test

8.2 The first of three DASH risk assessments was completed in June 2015, the other two were in May 2016. They were all considered standard risk and related to verbal harassment and malicious allegations by Stefan. The danger surrounding the non-physical coercive controlling behaviour and intimidation went, largely, unrecognised and the risks remained below the threshold for intervention. Stefan used his custody of their daughter to control Zara and used false allegations of her poor parenting and behaviour to discredit and undermine her in the eyes of professionals e.g. Zara was unable to have regular contact with her daughter, only seeing her twice between September 2015 and her death in May 2016. It is critical to recognise the risk factors associated with coercive control and take steps to ensure victims are aware of the dangers and for agencies to refer to specialist D.A. services for intervention.

8.3 Generally, agencies did not see the relationship as abusive. Whilst certain behaviour exhibited by Stefan was seen as malicious e.g. ringing The Ambulance Service and Police in June 2015, when he could not get his daughter to answer the door, there was little consideration of the risk this non-violent behaviour presented. In the main, the risks to their daughter were seen as a result of Zara's behaviour and her new relationship which were the subject of Stefan's allegations. Stefan was seen, by the School and potentially Children's Services and the Police, as providing the more consistent and appropriate parenting. It is important agencies are aware that for perpetrators to make false allegations against victims, in relation to care of children, is a recognised pattern of behaviour in abusive relationships and should be considered as such.

8.4 In April 2016, the Police did not recognise the three offences, of theft of the cycle and criminal damage to Zara's car, were linked and amounted to a pattern of escalating risk behaviour. Whilst Zara indicated that she suspected that her estranged husband was responsible for the offences, she had no proof. Stefan was not seen in relation to four of the five allegations made in April and May 2016. Had he been seen, the concerns regarding the risk he presented may have been more fully explored and further action taken.

8.5 Events were, largely, viewed in isolation and the emerging pattern of escalation in Stefan's abusive behaviour was not seen. Had the links been made, this may have increased the identified risk assessed via the two DASH completed in May 2016.

8.6 In 2015, there was activity with a variety of agencies following the breakdown of their marriage and separation. As a result, their child was placed on the Vulnerable Child Register by the School to monitor her well-being. This was seen as good practice. However, despite the activity between Education, CSC and the Police, there was a lack of joined up working between these agencies to fully understand the dynamics of the family and Zara was never seen in relation to the many concerns regarding the care of their daughter, until the Child Arrangement Order in April 2016.

8.7 Despite three referrals from Education to CSC asking for a Social Care Assessment, this case did not meet the threshold for such an assessment. It was considered the concerns were related to the dispute over custody of the couple's daughter and an Early Help Assessment and a TAC intervention were offered but not proceeded with. It should be recognised that where there is an abusive relationship, separation and potential loss of the child, the risk to the victim is significantly increased.

8.8 There was a communication difficulty between the School and CSC in relation to the TAC. CSC were under the impression the TAC was in place from October 2015 to May 2016. However, the TAC never started as Stefan did not consider it necessary. Had CSC been aware there was no ongoing help and support involved with the family, they may have viewed the allegation by Stefan of his daughter witnessing her mother's inappropriate behaviour differently and become involved in undertaking an assessment.

8.9 Consistent and comprehensive record keeping is crucial in ensuring appropriate continuity of care and an integrated response. This is a recommendation in relation to the recording and communication in connection with the TAC.

8.10 In the circumstance of her being unable to have contact with her daughter due to Stefan's controlling behaviour, Zara asked School to keep her, regularly informed of

her daughter's attendance and progress. It was agreed the School would ring her to do this. When contacted, the School found Zara's curt response inappropriate and discontinued the arrangement. An alternative form of communication, via text or letter, could have been considered to enable an ongoing and important link with her daughter.

8.11 Whilst the family's first language of Russian was not seen as a barrier to accessing services, the potential cultural barrier in this minority community of victim blaming attitudes and the expectations of the stereotypical role of women may have been. Fear concerning immigration status, shame and embarrassment and the fear of the child being removed from the parents may all have played their part in restricting disclosure and accessing services.

8.12 Although there were some concerns of varying degrees felt by Education, CSC, CAFCASS and the Police, none met the threshold for intervention and Zara was not recognised as a victim of D.A. in the form of jealous surveillance, coercive control and harassment. As concerns did not meet threshold for current multi agency involvement there was an absence of a co-ordinated response to fully understand the risk involved and to provide an intervention to protect her and her daughter.

8.13 The impending separation of the father from his child, caused by the mother's application to the Court for contact, was a piece of information that should have heightened the awareness of practitioners to her vulnerability and an increase in risk.

9. Conclusions.

9.1 Both Zara and Stefan, independently, came to the UK from Latvia and Lithuania to pursue a better life with new opportunities. They met in 2009 and married in 2010, with their first and only child being born later that year. The first allegation of abuse was recorded in January 2011 when there was limited involvement with statutory agencies that fell short of an assessment and intervention and the couple appeared to resolve their difficulties. Prior to 2015, the contact with HVs suggested the couple had a close and effective relationship and that Zara was a caring and appropriate mother.

9.2 Zara's sister lived near to her in Lincolnshire and they provided each other with help and support reportedly having a close and caring relationship. Zara kept in touch with her parents in Latvia visiting in the holidays. Locally, she had a network of friends who also came from Eastern Europe. It is considered that D.A. is more prevalent in Latvia and Lithuania and it is, generally, considered more acceptable. The legislation to condemn it and support networks to manage it being less developed than in the UK.

9.3 The couple both worked in the food industry, working shifts and long hours. They rented houses and moved on a couple of occasions but within the same Eastern European community.

9.4 The relationship ended in the spring of 2015, according to Zara, in part, due to violence in the relationship. Zara met a new boyfriend. Initially, she retained custody of her daughter, although there was conflict with Stefan from the outset as he wanted sole custody of Basia. As a result, Stefan made what were viewed as malicious allegations to the School, CSC CAFCASS and the Police, about Zara's inappropriate parenting. These allegations are not uncommon in disputed custody cases the Police did undertake safe and well checks in relation to the child and there were no concerns. The School placed the child on the Vulnerable Child Register. Agencies saw the problem as one of conflict over custody arrangements and did not consider that D.A. may have been an issue.

9.5 Zara's new partner and others were involved in a serious assault on two men. In May 2016, he was convicted and sentenced to 18 years imprisonment. Zara was arrested and charged with perverting the course of justice in that she assisted the offenders by giving them a lift in her car from the crime scene. She was remanded in custody for five weeks which presented Stefan with the opportunity to take control of the custody of their daughter. Although Zara was remanded on bail in October 2015, Stefan would not return their daughter to her or let her have any contact.

9.6 Unable to see her daughter, Zara took legal proceedings to try and gain access and custody of Basia. As the Court date of the 13th May 2016 neared, there became a pattern of her becoming the victim of crime and harassment from Stefan. Whilst Zara told the Police that she thought Stefan was responsible for the offence of theft and an offence of criminal damage, the Police consider there was no evidence to make him a suspect in their enquiries. They were seen in isolation, even though they happened within an eight-day period, and they were finalised without Stefan being interviewed.

9.7 In early May 2016, Zara reported to the Police that Stefan was following her and taking video recordings and that he called at her home uninvited. She disclosed that she was frightened by his actions and that he had been violent towards her in the past and she feared he may be violent again. There were two DASH risk assessment s which were both considered standard risk. Zara was advised about a non-molestation order but no D.A. support services information was given and there was no evidence of exploration of her fears or the previous violence to fully understand the risks presented.

9.8 On the 9th May 2016, she was acquitted of the charges against her and on the 13th May 2016, there was a Family Court hearing regarding the custody arrangements for Basia. The allegations Zara made to CAFCASS about her being the victim of DA were not fully investigated and were seen as allegations and counter allegations not

unusual in contested child arrangements orders. The outcome was custody to Stefan and only indirect contact to Zara. This must have been a terrible blow to Zara and a reinforcement of the success of the controlling behaviour by Stefan.

9.9 The 19th May 2016 was Stefan's birthday. In the evening the couple were seen together, on CCTV footage. The next day, Zara's body was found in the bath at her home following a report of a fire which had been set on the stairwell of her property. Zara had multiple injuries and had been drowned. Stefan was interviewed in connection with her death and was later charged and convicted of murder. In 10th April 2017, following the trial, he was sentenced to 23 years imprisonment.

9.10 Agencies, in general, did not recognise D.A. in the form of Stefan's controlling behaviour and stalking and harassment and the risks it presented to Zara and, in turn, Basia. There was a clear escalation in Stefan targeting Zara prior to her death, with five incidents in a four-week period. Whilst it was not reasonable for any agency to predict the tragic events that were to occur, had there been some co-ordinated intervention, there may have been the opportunity to manage and reduce the risks.

10. Recommendations.

10.1 <u>EMAS</u>

10.1.1 From April 2017, all staff will be required to complete an E Learning Package and self-assessment around safeguarding and D.A. This will be used as a training needs analysis. Themes will be taken from this review and used in the assessment during 2017 / 2018.

10.1.2 EMAS will implement the lessons learned from this review as part of a continuing engagement with the safeguarding agenda.

10.2 <u>The General Practice.</u>

10.2.1 Clinical staff are to record the name and relationship of people attending with the patient.

10.2.2 The General Practice to agree an icon or symbol for safeguarding concerns to be included on the top right of the medical record. This will be added to all medical records where there is a safeguarding concern by the end of October 2017.

10.3 Community Safety Partnership

10.3.1 Ensure all staff in lead agencies are able to understand the power and control dynamics of D.A. and are able to recognise coercive control.

10.3.2 All relevant agencies to be informed of the learning from this review in relation to the risk associated with D.A. perpetrators making false accusations about their ex partners ability to parent and using child contact arrangements as a means to further control and abuse their ex-partner.

10.3.3 In line with the agreed process, all lead agencies to be reminded to inform the TAC Administration Support Team within Children's Social Care when a TAC ends.

10.3.4 To approach NHS England to request that the National Medical Computer System includes a nationally agreed icon or symbol for safeguarding concerns that would appear on every page of the medical record rather than the front page alone.

10.4 Lincolnshire Police

10.4.1 Lincolnshire Police should consider using the reported pattern of events in this case, (theft of a cycle and two offences of criminal damage) as a learning exercise during any future force wide training, particularly Domestic Abuse, Harassment and Stalking training and wider vulnerability training to evidence the importance of looking at the pattern of offending rather than viewing incidents in isolation.

10.5 CAFCASS

10.5.1 To ensure all staff assess allegations of D.A. thoroughly in line with agency Domestic Abuse Practice Pathway guidance provided.

Marion Wright
Independent Author.

10. Glossary of Terms

A&E	Accident and Emergency Department
CAF	Community Assessment Framework
CAFCASS	Children and Family Court Advisory Support Services
CCGs	Clinical Commissioning Groups
CRU	Central Referral Unit (Police)
CSC	Children's Social Care
CSE	Child Sexual Exploitation
SLP	Safer Lincolnshire Partnership
DA	Domestic Abuse
DAO	Police Domestic Abuse Officer
DASH	Domestic Abuse Stalking and Harassment and Honour Based Violence
DHR	Domestic Homicide Review
DV	Domestic Violence
DVA	Domestic Violence and Abuse
EHA	Early Help Assessment
EMAS	East Midlands Ambulance Service
GP	General Practitioner
HMIC	Her Majesty's Inspectorate of Constabulary
HMICFRS	Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services
HMP	Her Majesty's Prison
HV	Health Visitor
IDVA	Independent Domestic Violence Advisor

IMR	Individual Management Report
LCHS	Lincolnshire Community Health Service
MAPPA	Multi Agency Public Protection Arrangements
MARAC	Multi Agency Risk Assessment Conference
MDT	Mobile Data Terminal
NHS	National Health Service
PD	Practice Direction
PPU	Police Public Protection Unit
TAC	Team Around the Child
THRIVE	Threat Harm Risk Investigation Vulnerability and Engagement
TOR	Terms of Reference
ULHT	United Lincolnshire Hospital Trust
VISOR	Violent and Sex Offenders Register
WLDAS	West Lincolnshire Domestic Abuse service