Lincolnshire Community Safety Partnership

Domestic Homicide Review

The Homicide of Michael

8th May 2017

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CONTENTS

DOMESTIC HOMICIDE REVIEW REPORT (DHR)

1. INTRODUCTION

Anonymity: The details relating to the family and individuals are anonymised where possible. Some specific dates and dates of birth are omitted to aid anonymity. Agency names are included, other than the specific GP Practice, to avoid the identification of the family.

1.1 Summary of the circumstances leading to Domestic Homicide Review

In May 2015, Lincolnshire Police received a call from a local taxi driver[1] who noted that he had received a call from one of his customers, who reported that she had just killed her husband. This incident led to the death of Michael, with his long term partner, Melanie, subsequently charged with the offence of murder. In September 2015, at Lincoln Crown Court, Melanie pleaded guilty to murder and received a sentence of life imprisonment and is to serve a minimum of 12 years of this in custody. The nature of agency involvement with this couple was typical in respect of addressing their presenting needs, mostly Michael's physical needs.

1.2 Context to the Domestic Homicide Review

Reflecting on the context of Michael and Melanie's lives, there is limited history of inter-agency involvement with this couple, and a general lack of evidence from records of the nature of their relationship together. Michael and Melanie essentially present as an isolated couple, with limited friends or family living in the local community, with only his sister and brother living locally.

Michael was a 68 year old, White/British male, a widower, who had no children. He lived with his partner, Melanie, a 66 years old, White/British woman, with whom he had been in a relationship with for approximately 20 years, with approximately 15 years of their relationship spent living in Lincolnshire. Despite the length of their relationship, there is limited record of in-depth knowledge of the nature of their relationship. It is felt that not enough is known about the victim independently from what the perpetrator has said about him and about their relationship.

[1] During an interview with Melanie, she explained that she had panicked and phoned the first number that came to mind, which was the local taxi firm number. She was in regular contact with this taxi firm and knew the drivers well.

There is limited information of the wider family histories of Melanie and Michael. However, there are several references to the significant loss experienced by Melanie following the death of two of her daughters. Also, it would appear that Michael's attitude and negative reference to Melanie's family was upsetting for her and often a trigger for their arguments. Both had experienced physical health concerns, with Michael experiencing several episodes of chronic physical illnesses. His health issues were complex; further perpetuated by his persistent and chronic alcohol misuse. Despite several attempts by Health practitioners to provide lifestyle advice and support to change his behaviour, Michael was unable to cease his alcohol misuse, which fluctuated, but remained high throughout. During the course of their relationship there is evidence of Melanie's fluctuating mental well-being, caused by the loss of both her daughters and the stress and strain of her caring role for Michael. However, the impact of their relationship, Michael's health needs, Melanie's loss and her subsequent caring role were left generally unexplored by the agencies coming into contact with them.

Michael presented as isolated, with increasing complex health concerns, partly caused by his alcohol misuse and self-neglect. Therefore, he was increasingly vulnerable. Despite these concerns, there is limited knowledge of the exact nature of his relationship with Melanie, which cannot be fully deciphered from the agency records. Official statistics demonstrate the high prevalence rate of domestic violence and abuse; however, there continues to be evidence and concerns around domestic violence and abuse presenting as a 'hidden' issue. This 'hidden' element of domestic violence and abuse presents as a barrier to reporting incidents, which is challenging when attempting to identify and address this issue. As research reflects, little is known about the perpetrators and victims of homicides involving older adults (Bows, 2016), with limited known information about the dynamics of violence and abuse in later life. This would have further functioned as a barrier to reporting any domestic violence, abuse and coercive control experienced. Michael's isolation, his age, his deteriorating physical health and his physical disabilities would have functioned as a significant barrier to his ability to independently contact a professional agency or indeed any informal network that he had for support.

Melanie has criminal offences dating back to 1973, ranging from theft to a wounding offence to a previous intimate partner in 1988. In 2005 she was cautioned by the police for an assault on Michael. Evidence reflects episodes of physical violence; as an outcome of these incidents Michael suffered minor injuries on several occasions, including burn marks to his face, heavy bruising and minor burn marks to his left arm. Michael had no previous convictions, although

Melanie asserts that he had assaulted her several times. Information gathered directly from Melanie suggests the burden of her caring role, specifically Michael's deteriorating eyesight and his chronic alcohol dependency. She also self-reported the impact on her well-being of his alleged verbal abuse of her, and admitted that she was prone to losing her temper. Whilst a holistic assessment of their needs may have identified the practicalities of Melanie's caring role, information from the observation of the couple together for one hospital appointment describes them as supportive of each other. Despite this, information from police records and attendance at A&E indicates that their relationship was mutually destructive.

There was limited opportunity for multi-agency working and no requirement identified to trigger the MARAC[2] or any other multi-agency process. During the course of their relationship a DASH assessment[3] was completed on one occasion in 2012 (on Melanie as the victim. With the exception of the police contact, the role of East Lindsey District Council (ELDC) to support both their housing needs, the couple accessed services on an individual basis. Michael had received assessment and support from Lincolnshire County Council's (LCC) Adult Social Care (ASC), from SILCS (Adult Care & Sensory Impairment Lincolnshire County Services) and Occupational Therapy, whilst Melanie accessed support from Lincolnshire Partnership NHS Foundation Trust (LPFT) for her mental health needs. There was an overall lack of professional curiosity from ASC and LPFT to consider and complete holistic assessments, which may have provided further information to indicate the signs and symptoms of domestic violence and abuse. LPFT were the only agency with whom Melanie directly shared her concerns about her relationship with Michael; this information was shared with the GP. LPFT did not complete a DASH risk assessment or a Carer assessment with Melanie, which may have provided the opportunity to undertake an analysis of her needs and offer support to address the concerns she raised during her contact with this service.

Linking this to the current context of the Care Act 2014, it appears that there was a general lack of agency curiosity to explore Michael and Melanie's needs, with reference to 'what mattered' to them and their perspective of their needs, outcomes and requirement for support. The context of this case was within the planning and initial implementation stages of the Care Act 2014. This Act now puts safeguarding adults into law; established a national eligibility threshold for access

[2] A MARAC, or multi-agency risk assessment conference, is a meeting where information is shared on the highest risk domestic violence and abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors.
[3] DASH: The Domestic Abuse, Stalking and Honour Based Violence Risk Identification, Assessment and Management Model

to care; introduced rights to advocacy for people who would otherwise struggle to be involved in assessments and other processes and gave new rights to carers to assessment and support. The implementation of legislation has shifted the landscape to focus on well-being, outcome-focused support and enabling adults to live the life they want to live, therefore, making safeguarding personal, which is person-led and outcome-focused. Also, the actual definition of abuse and neglect has now evolved to have a broader context, which will help practitioners to identify a broader spectrum of behaviours as abusive to the adult at risk of harm. The revised cross-government definition of domestic violence and abuse is also broader, and considers the pattern of behaviour, including controlling and coercive behaviour, which was reinforced by the new offence of coercive and controlling behaviour in intimate and familial relationships introduced into the Serious Crime Act 2015. The Care Act 2014 now reinforces the rights and needs of carers and the requirement to offer care and support to meet the well-being needs of carers. This reinvigorated agenda provides the ideal platform for agencies to address safeguarding concerns in a fluid, rather than a static manner.

Several attempts were made to gather the voice and views of family members in order to inform the context of this report, with 18 letters sent to relevant family members during the review period. Friends and family often hold vital information and it would have been beneficial to gather the views of family members. Unfortunately, none of the family members elected to participate in this review. The author visited Melanie twice in prison, in July and August 2016, and was permitted a 50 minute slot on both occasions. As a result, the only voice gathered to inform the context of this report is that of the perpetrator's view of her relationship with the victim. During the process of attempting to engage this couple's family or friends in this review process, it became evident that this couple was isolated and had limited contact with friends, family, the wider community and professional agencies and services. This isolation could have been a symptom of domestic violence, abuse and coercive control. A key component of coercive control is the ongoing pattern of oppressive behaviour that facilitates the surveillance and social isolation of the victim.

There were limited opportunities to draw upon wider information to contextualise the information from the Internal Management Reports (IMRs).

1.3 Domestic Homicide Review Process

In June 2015, following the notification by Lincolnshire Police, the Chair of the Lincolnshire Community Safety Partnership considered the case in conjunction with other key agencies that had contact with the family, and concluded that the case did meet the criteria and justification for a Domestic Homicide Review; the Home Office was notified accordingly.

In June 2015 information was sent to partner agencies in order to explore which agencies were involved with this family.

In July 2015 the first panel meeting was held, the Independent Author and Chair were appointed, the Terms of Reference were agreed and Chronology template was issued to the IMR authors. Various attempts were made at different points of the review process to engage Melanie and wider family members but without success until, at a later stage in the review process, Melanie agreed to meet with the Author. A number of further panel meetings were held and some unavoidable delays occurred during the latter part of the review. During early 2017 the final report was presented to the panel which required minor amendments for accuracy, and the final report was completed by the End of April 2017.

The Terms of Reference outlined that the period of this review should commence from September 1997. As part of the Terms of Reference, the following were identified as 'key issues' for consideration:-

a) *Identification of domestic abuse;*
b) *Information sharing and cross-border working/information sharing/communication;*
c) *Risk Identification, analysis and management;*
d) *Competencies, Training and Management accountability;*
e) *Consideration and compliance with agency and multi-agency domestic abuse policies and procedures;*
f) *Impact of alcohol use on domestic abuse;*
g) *Varying engagement and the impact on domestic abuse victims/perpetrators/family;*
h) *Victims as perpetrators – the complexity of counter allegations of abuse.*

A Domestic Homicide Review (DHR) is a locally conducted multi-agency review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

- a person to whom he or she was related, or with whom he or she was or had been in an intimate personal relationship; or,
- A member of the same household as himself or herself.
- DHRs were introduced by section 9 of the Domestic Violence, Crime and Victims Act 2004 (DVCA 2004) and came into force on 13 April 2011. Their purpose is not to reinvestigate the death or apportion blame, but 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 they will be acted on, within what timescales, and what is expected to change as a result;
  - apply these lessons to service responses, including changes to policies and procedures as appropriate; and to,
  - prevent domestic violence homicide and improve service responses for all domestic violence victims and their children, through improved intra- and inter-agency working.

(CPS, http://www.cps.gov.uk & Home Office Guidance, 2013).

1.4 Independent Panel and Independent Overview Author & Chair

1.4.1 Independent Overview Author & Chair

The Independent Overview Author is Ceryl Teleri Davies, who has compiled the Overview Report, the Executive Summary and has contributed to the Integrated Action Plan produced by the Domestic Homicide Review Panel. The author is a qualified Solicitor and Social Worker, with Postgraduate degrees in both work areas and qualifications in Mental Health. She has extensive practice-based experience across social care, criminal justice and mental health services, including work on a multi-agency basis to support children, young people and vulnerable adults

at practitioner, middle and senior management level. Ceryl has completed several Serious Case Reviews, Adult Practice Reviews, Complaints Reviews and Service Evaluations. Ceryl specialises in domestic violence and abuse within young intimate relationships and child to parent abuse. Ceryl completed her Doctorate Thesis and related Service Evaluations on Preventative Services focused to changing attitudes towards abuse within young intimate relationships. Ceryl has taught at several Universities on the topic of domestic abuse.

Ceryl Teleri Davies is not employed by any of the Lincolnshire based agencies participating in this review.

The review was initially chaired by the Head of Safeguarding for Lincolnshire Community Health Services NHS Trust (LCHS). However, part-way through the review she left the employment of LCHS and her replacement in that role seamlessly took over the chairing role to the review until its conclusion. This agency had been identified as appropriate to chair this review, as the individuals put forward were experienced in chairing roles, and had a wealth of knowledge in relation to domestic violence and abuse and the wider safeguarding agenda. In addition, LCHS had no agency involvement with the subjects of this review, enhancing their suitability to act as independent chair for this review.

1.4.2 The Domestic Homicide Review Panel members were:-

The membership of the DHR Panel was agreed by the Domestic Abuse Strategic Management Board on the 14th July, 2015, which consisted of senior managers and/or designated professionals from the key statutory agencies as outlined in Table 1.

AGENCY	ROLE
United Lincolnshire Hospitals NHS Trust (ULHT)	Named Nurse for Safeguarding
Lincolnshire, Nottinghamshire, Leicestershire Police (representative as Lincolnshire Police)	Domestic Abuse Co-ordinator
Clinical Commissioning Group (CCG)	Consultant Nurse Safeguarding Children and Adults
Lincolnshire Partnership NHS Foundation Trust (LPFT)	Consultant Nurse Safeguarding & Mental Capacity
Lincolnshire County Council: Adult Social Care	Adults Safeguarding Lead
East Lindsey District Council	Housing and Well-being Service Manager
Domestic violence and Abuse specialist	Domestic Violence and Abuse Co-ordinator, Lincolnshire County Council

Table 1

2. FAMILY INVOLVEMENT & CHRONOLOGY

2.1 Information from the family

As mentioned, several offers were made to Melanie's family members to contribute their views as part of this review. This review would have benefitted from the perspective of both their family members, but this offer was declined and it was only Melanie herself who wished to share her views. Melanie was visited and interviewed in prison for 50 mins in July and August 2016 in order to gather her perspective on her relationship with Michael. The discussion with Melanie indicated that Michael was isolated and did not have any specific friends, or family members who could contribute to this review. Melanie described that Michael only had a positive relationship with his sister. Her participation in the review was considered, but due to health reasons, she did not wish to participate. There were limited visits to their home, with the exception of Michael's sister

and her husband, who visited around 3 to 4 times a year. Beyond the information in the IMRs and Melanie's self-reporting there is limited information about Michael, his life and his perspectives.

Melanie explained that their relationship spanned 20 years, and had been 'alright' for the first 6 years, but had later declined into a routine focused on the completion of daily chores. She described how she would have to get up at 4.30 a.m. to complete the housework, with the exception of the hoovering. Due to the noise, she described how she was tasked with this chore after Michael had woken. There was an expectation that Melanie would prepare a cup of tea with rum for Michael as he was waking up around 10 a.m. She felt as if she had a strict daily routine, focused on Michael's demands and his caring requirements. In the later stages of their relationship, Michael required a greater degree of personal care, primarily due to his increased drinking and the decline in his physical health.

Melanie described how she felt controlled within their relationship; in particular, due to her limited freedom to leave the house. Melanie reported that Michael kept the house keys and would lock the front and back doors. Melanie also reported that there was also a padlock on the back gate and he would often say that he did not want her to leave the house as he was worried that she would not return. He would voice his concerns and question that if she left, "*who would care for me?*". She was only allowed to leave the house to attend the shop; in particular, to buy alcohol and cigarettes. She was required first thing each morning to go to the shop, and he would time the period it would take her to go to the shop and return home. She was also permitted for up to 1 hour to visit Michael's sister who lived in the same street in order to provide her with personal care assistance. She was not allowed to visit her daughter when she was unwell, and her brother stopped visiting their home, as she described that he was 'disgusted' with how Michael spoke to her. Melanie had managed to leave a couple of times, and reflected upon a holiday she had in Wales. She described how she had to climb out of the upstairs window down a ladder and then over the wall so she could leave the house to attend a funeral with her brother.

Melanie provided several self-reported examples of how Michael would ridicule her. In the earlier days, Melanie would often care for her grandchildren. She described Michael's attitude towards the children as being offensive. During the children's last visit to the home, Michael had slapped one of the children across the face and buttocks. She was upset by this and had challenged him. As a result, Melanie described how Michael locked her and the children in the

garden and refused them access to the house until after 9 p.m. As a result, the children and her daughter stopped visiting in 2001.

Melanie explained that, in the earlier period of their relationship, Michael would often become physically abusive towards her. This perspective is contrary to her earlier comment that their relationship was 'alright' during the first 6 years. She described that, as his health declined and his strength deteriorated, his ability to inflict physical abuse was limited. It was at this stage that Melanie would physically retaliate. The relationship had often escalated to become violent and abusive. Melanie described that she had *"chucked him out once*" and had "*locked him out of the house*". She had also left the property and their relationship a "*few times"*; on her return he would then be "*alright*" for 2-3 days, but would return "*back to himself*". She also acknowledged that she had assaulted him by throwing a bucket of coal on him. She described the build up to this incident and his constant ridicule and offensive comments towards her children. She had "snapped" and thrown the bucket of coal on him, later having to clean all the mess and coal, which was everywhere in the living room. She outlined that she did not remember the build up to Michael's death in detail, but recalled that he had been calling her derogatory names. He had also reiterated that she "*only thought of herself"*.

Melanie described that they had been on the housing list for 12 years and felt they would have benefitted from having a bungalow; she noted that their housing bids were unsuccessful. However, the ELDC IMR indicates that they had only made 3 bids and were not regularly bidding for a new property.

Melanie felt unable to share her life experiences or her concerns with the GP.

She described the support offered by LPFT as "*pushed from pillar to post*". Possibly she held this belief as she was seen by two different services within LPFT. Melanie reported that she felt aggrieved that, despite her explicit request for LPFT not to write to her directly at her home address, they had done this; Michael had opened the letter and had later refused to allow her to attend future appointments. She had felt upset, as this had been the one thing for her. Information held by LPFT reflect a contrary perspective, specifically that all staff members who engaged with Melanie were clear that there was no request from her not to receive information, letters or appointments in the post. Melanie signed a confidentiality statement on the 20th January, 2015, to note that she would receive information via post.

She had told LPFT that she had no intention of harming herself or others, but felt that they "*didn't seem to listen*". Melanie reflected that, with the exception of her brothers, she had only told LPFT about the abuse, and reiterated that the appointment time was not long enough to have a detailed and personal discussion. She had also wanted to reflect on her history, her childhood and her relationship with her father, but felt that the focus was specifically on her bereavement due to the loss of both her daughters. Melanie felt that they did not listen to her views or want to consider what was important to her.

Melanie described that Michael was "*good as gold*" when the SILCS worker visited. He refused to talk to the SILCS worker and noted, "*You know I don't talk to people*", but Melanie looked forward to these visits and enjoyed talking to this worker. Despite receiving equipment to assist with his sight impairment, Melanie reported that Michael refused to use the equipment, which remained unused. Melanie was granted approximately £130 for afternoon breaks, but due to her limited social engagement was unable to use this money. She struggled to understand the purpose of this money, as she was not allowed by Michael to have her own money. She also felt that the SILCS worker had gathered that Michael was drinking heavily; however, this matter was not discussed further.

The perspective described by Melanie was of an isolated couple, who occupied the same space, but lived in a mutually abusive and oppressive environment. The housing records illustrate that the couple had bid for properties on three occasions. Their isolation escalated over the years, resulting in limited social networks or support. The contact they had with agencies was limited and focused on their presenting needs rather than the key issues and pressures that mattered or impacted on them. The sentencing comments noted that the presented information reflected that Melanie had also been a victim of domestic violence and abuse and had often been the victim of vicious and hurtful verbal abuse by Michael.

2.2 Summary of the Integrated Chronology

The aim of this section is not to reproduce the full integrated chronology, but to highlight significant events in order to illustrate an account of what is known in agency records. The following extracts from the integrated chronology are the Independent author's view of the significant events which occurred prior to Michael's death. An outline of the key fringe learning is summarised in section 5.

The Terms of Reference stipulated the time frame to be examined as from September 1997 onwards, essentially the approximate period of their relationship. The merging of all known contact into the integrated Chronology has provided an overview of agency involvement.

In summary, the emerging picture revealed:-

- Overall there was limited agency involvement with them as a couple and on an individual basis. There were three key periods of agency involvement, in 2002, 2005 and 2015;
- There is limited information available of in-depth assessment of their needs;
- There is limited information available on their presentation as a couple;
- There is limited professional analysis of the exact nature of their relationship;
- The evidence from police records suggests a mutual pattern of violence and abuse in their relationship;
- Melanie made direct disclosures of domestic violence and abuse to LPFT;
- Agency records reflect Michael's deteriorating health needs and the extent of his alcohol misuse;
- During the interview with Melanie, she self-reported the strain of her caring role for Michael and the pressures this presented on her well-being. Despite this self-report, there is no information gathered from the agency records of the exact nature of her caring role, and the expectations on her as a carer, and how this had changed as Michael's health deteriorated;
- The impact of Melanie's loss and bereavement, for both her daughters;
- Their general isolation as a couple.
- At the time of Michael's death, they had limited contact with agencies, as Melanie had been discharged by LPFT and had not had face to face contact with ASC since September 2014.

Further scrutiny of the information within the merged chronology indicates that the couple were seen together by Health professionals (GP & hospital based consultants, to address various issues regarding their physical health needs), police and SILCS. With the exception of historical or minor police incidents, the police responded to domestic incidents involving both parties on the 18/02/2004, 16/03/2005 and 20/01/2012. SILCS saw the couple on three occasions, during home visits on the 27/05/14, 27/08/14 and 08/10/14. Therefore, there were limited opportunities for agencies to observe, assess and understand the dynamics and nature of their relationship. Despite this limited face to face contact with them as a couple, there are two aspects that warranted further assessment and analysis of their needs:-

a) *The quality of the adult social care assessments, the lack of focus on face to face contact with Michael and the limited professional curiosity to gather a holistic picture of their care and support requirements beyond a superficial presentation of needs.*

b) *Despite examples of responding well to Melanie's needs, there was an overall lack of professional curiosity by LPFT clinicians to complete a risk and carer assessment with Melanie. Melanie openly voiced her concerns to LPFT of the 'issues' relating to her partner which impacted on her low mood and her ability to cope in this relationship. The completion of these holistic assessments may have provided further information to indicate the nature of their relationships and assist in the identification of the signs and symptoms of abuse. LPFT generally did not recognise the opportunities to complete a DASH risk assessment or a Carer assessment.*

To summarise, there is a lack of information of Michael and Melanie as a couple and a general lack of assessment of their holistic needs as individuals and as a couple. There was a lack of opportunity for multi-agency interface, primarily due to the limited degree of agency involvement with them as a couple, the focus on their presenting needs and the lack of assessment of Melanie as a carer.

3. ANALYSIS: THE INTERNAL MANAGEMENT REPORTS (IMRs)

This section will explain the role of each agency, outline an analysis of involvement and offer a summary of each agency involvement. The key themes of the Terms of Reference will be explored throughout.

3.1 EAST LINDSEY DISTRICT COUNCIL (ELDC)

East Lindsey District Council (ELDC) provides a range of services to its residents, including refuse collection, housing benefit, council tax, planning and building control, environmental health and housing and homelessness services. In respect of Michael and Melanie, ELDC's involvement mainly consisted of managing their joint application for social housing via the Housing Register. There is no record of Melanie or Michael being offered a property from 2004 to 2010. In 2010, ELDC contracted Waterloo Housing Group to manage the housing register on its behalf.

During the review period, the key role of ELDC was in relation to the assessment of their housing application. When they first applied for housing in 2004, the applicants completed a paper-based housing application form. This form asked whether there were any unspent convictions which may have highlighted a safeguarding concern, but none were listed. The application form did not specifically ask whether an applicant or family member is a victim or perpetrator of abuse or has already fled abuse. In August 2014 the process of applying for inclusion onto the housing register changed solely to a web-based system. Applicants who were on the register prior to this time were asked to update their applications on the new web-based system, which was completed by Melanie, Michael or both together on the 8th October, 2014. There are questions asking whether the applicants or members of the household are suffering from harassment, domestic abuse or racial harassment and none of these boxes were ticked on their application. However, there is no way of knowing whether they completed this form together or separately. There was no information received during this period to suggest concerns of domestic violence and abuse.

The couple had been living in privately rented accommodation. Their housing application was managed in accordance with the Housing Allocation Scheme and was placed into band 2 (medium) as the property was unsuitable for them, but possibly it should have been placed in band 1 (high). Whilst Waterloo may have made an error in banding, the couple would still not have met the criteria for rehousing. Supporting letters were received from Michael's

Occupational Therapist and from SILCS (Sensory Impairment Lincolnshire County Service). They were not regularly bidding for properties, but were aware of the process, as they had done so in April 2012 and in October and December 2014. We know that their home was unsuitable due to their level of needs, health and disability, and despite Melanie's perspective that living in a bungalow would have been beneficial, with hindsight we cannot predict how this impacted on their relationship.

3.2 UNITED LINCOLNSHIRE HOSPITALS NHS TRUST (ULHT)

United Lincolnshire Hospitals NHS Trust is one of the largest Trusts in the country, providing services from 3 acute hospitals in Lincolnshire. The Trust also provides a wide variety of outpatient, day case and inpatient services from a range of other community hospitals operated by Lincolnshire Community Health Services or local GP clusters. The Trust provides a wide range of healthcare services delivered by over 7,500 trained staff.

Melanie accessed ULHT services from May 2002 until February 2013. Apart from three A&E attendances (in May 2002, October 2002 and March 2005), and one episode of care from the Orthopaedic Team, Melanie's main association with ULHT was via the Gastrointestinal Department. On the 22nd October, 2002, Melanie attended A&E following an episode of self-harm and reported that she was feeling depressed as she could not *"get along with her partner"*. As a result, Melanie was admitted to Hospital pending a Psychiatric review. There was no evidence to suggest that Melanie's comments regarding her difficulties with her partner were explored further by A&E staff. Michael accessed ULHT services from March 2005 until January 2015. He was not open to ULHT services at the time of his death. During this time, the main association with ULHT was via the Gastrointestinal and Ophthalmology Departments, with the exception of one visit to A&E. There were several references to Michael's alcohol use throughout his hospital appointments, with constant advice given of the need to reduce his alcohol intake, but limited support was offered to assist him to achieve this aim. On the 25th April, 2013, an Ophthalmology review was undertaken; with the Consultant Ophthalmologist documenting that Michael was "well supported by partner". The analysis of this information would suggest that there was evidence of the impact of this relationship on Melanie's low mood and ability to cope, whilst she had later presented as capable and supportive.

A key incident occurred on the 16th March, 2005, when Michael attended A&E following an assault by Melanie, during which he sustained burns to his left forearm and face. He disclosed that Melanie had assaulted him with a hot poker, resulting in line markings and blisters, with the wound dressed and advice provided. Safety was considered as part of the discharge planning; with information noting that Melanie had been arrested. There was no wider consideration given to Michael as a victim of domestic violence and abuse, his safety planning beyond the discharge process or any requirement that he may benefit from the offer of wider support services. This presented an opportunity to gather Michael's perspective on the assault and to gain a sense of the nature of their relationship. Consideration does need to be given to the historical context, the knowledge and understanding of domestic violence and abuse and the processes at the time. Despite this, the Domestic Violence, Crime & Victims Act 2004, the biggest piece of legislation on domestic violence in over 30 years, was newly implemented; the National Domestic Violence report of 2005 reflects that March was designated the domestic violence month and there was a National Domestic Violence delivery plan. Therefore, despite the ever growing knowledge on domestic violence and abuse, during this particular period there were several National endeavours to raise the profile of domestic violence and abuse, including the publishing of good practice guidance on how to implement strategies to encourage and enable disclosure of domestic violence in a range of Health settings**.**

The information reflects that Melanie and Michael attended A&E with concerning signs and symptoms of vulnerability, harm and abuse. Michael attended with a physical injury caused by a domestic assault; however no further exploration, advice or support was offered to him as a victim of domestic violence. Equally so, on Melanie's attendance at A&E when she openly voiced her difficulties with her partner at home, were not explored further. Revised policies have now been implemented, with the concepts of professional curiosity and 'Think Family' extensively shared with all staff. Despite the concerns raised regarding Michael's alcohol misuse, no professional ownership was taken to explore this further and offer support. There was an over-reliance by ULHT to depend on the GP to arrange services to support Michael with his alcohol use, rather than referring Michael directly for support. The requirement of ULHT staff to explore potential support pathways directly with patients struggling with substance misuse has now been communicated to staff via the Weekly Bulletin and through the Trust intranet, and will be explored further within a review of the ULHT Safeguarding policy.

3.3 CLINICAL COMMISSIONING GROUP (CCG)

South West Lincolnshire CCG is one of the commissioning organisations for health services across Lincolnshire. It is one of four commissioning organisations within the area created following the abolition of Primary Care Trusts in April 2013, and works closely with the neighbouring CCGs. The four CCGs operate a federated model of safeguarding, with the roles and responsibilities of the Designated Doctor and Nurse for Safeguarding being hosted within South West Lincolnshire CCG, but delivering the functions, as defined in national guidance, across the whole health economy. Co-commissioning arrangements between CCGs and NHS England of primary medical care are being put in place from 2015/16 with the implications for safeguarding clearly set out.

From September 1997 to May 2015 there are frequent recorded visits by Michael to the GP (he changed GP in 1998). The key theme from the GP visits is the continual lifestyle advice provided regarding his alcohol misuse and smoking. Michael's recorded alcohol intake fluctuated over the years, but remained high throughout, with no genuine attempts noted of his working to reduce his alcohol intake, despite concerns raised. There is evidence of the smell of alcohol on Michael's breath during several appointments, with a clear record of his alcoholism. In 1999 a referral was made to the specialist alcohol intake service, with an alcohol treatment programme devised following an assessment of his needs. However, Michael failed to attend two appointments with the Alcohol services and, as a result; his case was closed to this service. In 1999 Michael was registered with the Department of Social Security as '*incapable of work'*. In February 2002 the GP documents that Michael had an alcohol dependence syndrome '*which had gone on for years'*, which he generally appeared unmotivated to change. Despite this, continued offers of support were made, including the offer to access to specialist services. There is also evidence of the provision of lifestyle advice on several occasions.

Nothing from the records suggests that Michael did not have the capacity to make his own decisions; therefore the GP could not have done anything further at this point to assist Michael to address his substance misuse and lifestyle choices. However, there was limited exploration of the impact of Michael's needs or substance misuse on Melanie's well-being. It is not possible to know whether a further assessment of Michael's needs would have assisted in identifying the triggers for his alcohol dependency or provide the opportunity for him to disclose any domestic violence and abuse suffered.

In March 2006 it is noted that Michael had severe health issues due to his chronic alcohol misuse for more than ten years. In the interim period, there were several noted GP appointments to address a plethora of health issues. In 2012 there is evidence of Melanie contacting the GP to request changes to his prescription and to note her concerns for his health. From June 2013 onwards, Michael experienced significantly reduced vision, which was possibly due to toxic or nutritional influences. In July 2013 an item of note from the records is that Melanie spoke with the GP and stated that Michael continued to drink six to seven cans of lager per day, reflecting continued alcohol misuse and the general neglect of his well-being. She informed the GP that Michael would be unable to attend the Practice on that particular day. The following day both attended for a consultation, with Melanie advising the GP that "*Michael had become yellow in colour a week ago but it had now cleared up*". Michael informed the GP that he felt "*his life was not worth living as he was losing his eyesight".* In August 2013 the GP advised Michael that his "*liver was enlarged due to alcohol*" the records go on to state that Michael "*refused to cut down and would not take advice"*. This information reflects the impact of Michael's physical health on his emotional well-being and motivations to change his lifestyle.

In August 2014 the GP received a letter from Michael's Optician, which stated that Michael was "*well supported by his partner and due to his difficulty with near vision tasks, had been supplied with an illuminated hand magnifier"*.

On the 16th of March, 2015, Michael failed to attend an appointment with the GP. Two days later the Practice staff attempted to make contact with him on both his home and mobile numbers for a medication review. At this point, the GP changed his prescription to weekly until he had undergone a medication review. A further attempt to contact Michael was made two days later with no success, and the weekly prescription subsequently remained in place. On the 8th April, 2015, the Practice staff documented a message which had been received from a person phoning on Michael's behalf regarding his medication review, but who did not leave a contact number. On the 15th April, 2015, Michael gave permission for his medication to be reviewed by his partner with the Practice staff, and is noted as *"feeling well with no other issues"*. However, the context of these visits to the GP illustrates Michael's complex and continual health needs, with a record of a degree of care and support offered by Melanie. They also evidence the challenges and frustration she felt in attempting to offer support, advice and guidance in order to assist him to manage his substance misuse, which had a continued negative impact on his health and well-being.

Despite falling within a period prior to this review's scoping timeframe, the GP records detail that Melanie has been admitted to hospital following medication overdoses on four occasions and had previously reported that her ex-husband was abusive towards her. Over the years, Melanie attended the GP on several occasions with physical pain, but the GP also referred her to LPFT due to presenting low mood and feeling tearful. The referral letter dated the 7th October, 2002, detailed;

"the underlying cause appears to be a relationship with a chronic alcoholic who has no insight into his illnesses' and goes onto state, 'She has left him on several occasions, but has always returned for various reasons. Currently she is struggling to cope, feeling low and tearful and tending to lose patience with her partner, especially at night. She denies alcohol abuse and I have discussed the need for her to consider changing her own situation if her partner is not able to do so, Melanie feels she is lacking assertiveness for this"

An update was sent to the Mental Health Service on the 30th October, 2002, advising that Melanie had been admitted to Hospital nine days earlier and an urgent assessment was requested. On the 14th November, 2002, the initial report forwarded to the GP from Community Mental Health Services advised of the planned treatment to refer to primary care for short-term counselling and commented that;

"*Melanie appears to be suffering from reactive depression due to difficulties in her home life which include her partner drinking to excess and making her feel inadequate, which in turn has affected her confidence in life. Melanie identified herself that her partner is her main problem and things will remain the same whilst she remains in this abusive relationship. It may be beneficial to start Melanie on some anti-depressant medication".*

The next visit of interest to the GP was on the 10th October, 2005, when Melanie attended for smoking cessation support and advice. During the consultation the GP Practice records state "*Lots of issues at home but feels this is the right time. Smokes 30 per day".* During the following consultation the records go on to state "*Still hasn't had a cigarette. Feels isolated at home. Life not good with partner so feels support needed at the moment"*. In July 2006 it noted that Melanie "*had given up [smoking] but had problems with her family so started again"*.

In August 2007 Melanie raised concerns regarding a "*thumping in her throat most nights"*, with queries regarding anxiety. In June 2008 she attended her GP complaining of palpitations and was also advised to reduce her alcohol intake. She continues to attempt to stop smoking; however, in January 2013 it is noted that she continued to smoke 40 a day and had lost two daughters, five years ago and again in 2011. In June 2013 it is noted that Melanie is "worried *about partner who drinks heavily and has a cough, eating very little and states is yellow, also not bathed or shaved since November and refuses any help. Partner states would not talk to a doctor if they rang – advised to try*". The advice provided by the practice nurse was for Michael to talk with his doctor, despite Melanie noting that he would not select to take this action. A more proactive approach, focused on considering Melanie's role as carer, may have assisted in assessing these concerns holistically and in completing a DASH assessment, which may have highlighted his vulnerability as a victim of domestic violence and abuse.

On the 22nd August, 2014, (approx. 10 months prior to Michael's death) Melanie contacted the GP noting that she had cut her arms, "*couldn't switch off"* and lived with a partner who is an alcoholic. She presented as talking loudly, shouting and noted that she would "*jump in the river*". She did not attend for a late GP session. On the 29th August, 2014, following a letter from the Community Mental Health Nurse, the GP made contact with Melanie regarding prescribing an anti-depressant. Melanie was described as "*willing to start medication and the side effects and precautions explained".* In August 2014 the GP Practice received a letter from the Community Mental Health Nurse requesting an increase in the dosage. The letter details;

"On assessment today her mood has slightly improved, but she continues to struggle at times, her sleep pattern is variable. We discussed ways to try and reduce her responsibilities at home with regard to her caring role for various family members and taking some time for herself. We discussed positive activity scheduling and exercise which she has agreed to try".

On the 19 November, 2014, Melanie telephoned the GP. The records detail that she complained of feeling sleepy during the day since the dosage of her anti-depressant was increased, with the dosage reduced to 15 mg with a night sedation also added to her prescription. On the 5 December, 2014, Melanie was referred for psychological therapies as, "*she has a burden of responsibility in a caring role for her partner and other family members. She has lost several close family members to cancer, which impacts on her mood greatly".* At this stage, she was not offered bereavement counselling or a carer's assessment. On the 17th December, 2014, Melanie

requested more of her night sedation medication, at which point she was advised further regarding the potential addiction. On the 23rd January, 2015 (the final GP contact prior to Michael's death), the GP notes reflect that Melanie is "*Still not mentally stable*", she was seeing two counsellors and reflected that she was definitely not addicted to her night sedation medication, as it is the only thing that will get her 2-3 hours' sleep at night.

Melanie had expressed difficulty in coping with Michael, to the point of hopelessness, but in light of the presenting complex health needs, this was not considered as a risk of harm in an abusive context. The GP records detail Melanie as presenting as feeling low and tearful, struggling to cope in her relationship with a chronic alcoholic and disclosing she was tending to lose patience with him. The records go on to detail a referral to Mental Health Services, advising a discussion had taken place with Melanie regarding the need for her to change her own situation if her partner was not able to do so. This is obviously a challenge faced by many people, with the reality of leaving unsuitable relationships often unmanageable.

The GP notes do not detail if further support was offered to Melanie to achieve this, along with managing the complexities of her relationship with Michael, particularly her ability to cope with his unwillingness to change his lifestyle, which Melanie herself disclosed as causing her to lose patience. Two weeks following this appointment, Melanie was seen in A&E having hurt herself. Following this event, the GP appropriately updated the Mental Health Services and Melanie was referred for counselling; however, there is no evidence of an offer to undertake a Carer assessment or a pro-active offer of support. This requirement of an active offer of a carer assessment has now been reinforced following the implementation of the Care Act 2014. There is limited evidence of the adoption of the professional curiosity to inform a clear analysis of the impact of Michael's behaviour on Melanie's well-being, the offer of wider support services to assist her to manage her role as a carer or an analysis of any unmet needs either may have. The GP was the only agency with sustained, regular contact with the couple over a prolonged period of time that had the overall view of their medical, physical and mental health needs. As the professional curiosity to explore the context of their relationship and what Melanie was saying was not linked or explored further, it is unknown whether the direct exploration of Melanie's wishes, feelings and the signs of anxiety (e.g. lack of sleep) would have provided her with the opportunity to share any further concerns around her relationship with Michael.

In view of the level of loss experienced by Melanie and the degree of responsibility in her role as carer for Michael, the impact on her mental well-being is understandable.

3.4 LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST (LPFT)

LPFT have also completed a root cause analysis exercise which informed their Individual Management Report (IMR) for this review. A Mental Health Homicide review was not commissioned by NHS England in this case.

LPFT was established on 1st June 2002, when social care and health services, formerly provided by Lincolnshire County Council and Lincolnshire Healthcare NHS Trust, were brought together to create a new mental health and substance misuse service for adults. LPFT provides a range of health and social care services for people of all ages and provides care and treatment for a local population of some 735,000 people within Lincolnshire. Improving Access to Psychological Therapies became Steps to Change (S2C) in April 2014. S2C is an NHS programme of talking therapies for mild to moderate common mental health problems, as underpinned by the National Institute for Health and Clinical Excellence (NICE).

Melanie was first referred to the community mental health service on the 17th October, 2002, by her GP. The GP referral stated that she was feeling low, tearful and lacking assertiveness and, "*it appears the underlying cause for this is her relationship with a chronic alcoholic"* whom Melanie reportedly had tried to leave on several occasions. Melanie was placed on a waiting list for counselling, but was again referred via her GP on the 4th November, 2002, requesting an urgent assessment after she had been admitted to hospital. An assessment was completed on the 13th November, 2002, which identified multiple factors, including "*problems directly related to the abusive relationship which she is in"* after she reported that her partner was an alcoholic and controlling which triggered anxiety and low confidence. Several symptoms were identified, including depressive symptoms, self-harm and suicidal ideation. The assessment concluded that Melanie was experiencing reactive depression due to difficulties in her home life, which included "*her partner drinking to excess and making her feel inadequate*" and "*that her partner is her main problem and things will remain the same whilst she remains in this abusive relationship"*. The outcome of the assessment noted that Melanie would benefit from anti-depressant medication and short-term counselling. Melanie was invited to discuss a course of therapy, the case was closed and there was no further contact until 2014.

Melanie was urgently referred to Older Adult's Community Mental Health Team (OACMHT)[4] by her GP on the 22nd August, 2014, as she had reported that she wanted to throw herself in the river following a stressful event and she had a partner who was "*an alcoholic and not supportive*". As a result, there was an attempt by a Community Mental Health Nurse to conduct a home visit on that same day; however, there was no reply at home. On the 26th August, 2014, a home visit was conducted by a Community Mental Health Nurse and Occupational therapist, during which Melanie denied suicidal thoughts, but disclosed maladaptive coping in response to multiple stressors including; bereavement of her daughter, a diagnosis of cancer in another daughter and lack of support from her partner, whom she described as having alcohol issues. As an outcome, anti-depressants and a follow-up appointment were agreed for the 2nd October, 2014. However, Melanie cancelled by telephone and stated that she "*needs to be with her husband whom she reports to need supervision due to his alcohol issues*". She confirmed that she had commenced anti-depressant medication and "*feels that her mood has improved"* and noted that there were no current thoughts of self-harm and that she could only attend appointments on Wednesdays or Thursdays due to "*her caring role for people*".

Melanie attended a 'face to face' appointment on the 17th October, 2014; she reported that her mood was improved but her sleep pattern continued to be poor. She explained that she was upset due to the forthcoming anniversary of the death of her daughter and the burden of her role as a carer. It was recommended that she should focus on positive activities and that her anti-depressant dosage should be increased. Melanie cancelled her next scheduled appointment and was next seen on the 1st December, 2014. Melanie reported that she had independently reduced her medication, as she was not tolerating the increased dose as prescribed by her GP, but there is no evidence that this matter was referred to the GP. A referral was completed for counselling with S2C[5]. Melanie failed to attend her appointment on the 2nd January, 2015, and did not respond to attempts to contact her via telephone. Melanie contacted the team on 14th January 2015 in a "*state of distress"* and "*unable to cope*", it is noted in this contact that Melanie

[4] The aim of the Older Adult's Community Mental Health Team (OACMHT) service is to enable people to remain within their own homes and work with the patient, families and other agencies to achieve this. The OACMHT delivers holistic clinical interventions including; talking therapy, medication management, relapse prevention, risk assessment and management alongside helping with accessing personal budgets, good physical healthcare and social integration.

[5] The S2C service is for anyone in Lincolnshire over the age of 16, who is feeling stressed, anxious, low in mood or depressed. The S2C service offers directed self-help at step one, Psychological Well-being Practitioners (PWP) at step two offering guided self-help in groups or 1:1, and Cognitive Behavioural Therapists, Counsellors at step 3.

reported to "*be having thoughts around events which happened in her childhood"* and feeling desperate. A face to face contact was arranged for the following day. Records reflect that Melanie spent time "*venting her feelings around her relationship with her partner*" and had sought support from the Blind Society to speak with him, and that she had "*taken herself to Wales to have time away from him"*. Within the recorded contact for this visit, it is noted that plans to resolve the situation had been discussed and a decision to contact the council for rehousing if she felt the situation was unresolvable. The details of this visit were not shared with the S2C service, or support for housing assistance discussed.

Melanie attended her initial triage assessment with S2C on 20th January, 2015. The risk assessment noted verbal abuse from her partner and some thoughts of self-harm with no intent, but the documents were incomplete. A second appointment to complete the triage assessment was arranged for 2nd February, 2015, which Melanie cancelled, with another appointment scheduled for the 10th February, 2015, which Melanie did not attend. As she had disclosed some risks, another appointment was offered to complete the triage process; this was completed on 18th February 2015. Within the triage assessment, Melanie is recorded as a carer for her partner, grandson and daughter and she was experiencing verbal and psychological abuse from her partner and was grieving for her daughters. On the 20th February, 2015, Melanie was again seen face to face. Records state that she "*can't tolerate her husband*"; but that her medication was keeping her mood stable and she had applied for separate housing from the council, which was information reported by Melanie to LPFT; however, there is no record of this housing application.

On the 20th March, 2015, following three further attempts to contact her via telephone, Melanie attended a face to face appointment for review with OACMHT, when she noted that she had increased her anti-depressant medication and tolerated it, and had reduced her time at home to avoid her partner. Despite several signs and symptoms of abuse and two visits to complete the assessment, no further analysis was undertaken of the potential risk of harm or the need to signpost to other services. Explicitly asking key safeguarding questions in a transparent manner, as per the Trust practice, would potentially have assisted Melanie to further disclose the nature and pattern of any form of abuse within her relationship with Michael. The required degree of professional curiosity and interest would have allowed the conversation to be started with Melanie. There were opportunities to complete a DASH risk assessment and respond to direct disclosure of domestic violence and abuse. Firstly, on the 15th January, 2015, when she reported some "*issues*" relating to her partner that impacted on her mood, resulting in her having to

remove herself from the home. Secondly, on the 18th February 2015, when Melanie reported verbal and psychological abuse by her partner. Finally, on the 1st April, 2015, when Melanie had made a clear request to discuss her feelings about her relationship. As the DASH, adult safeguarding screening tools or risk assessment were not completed, the exact nature and pattern of abuse within their relationship remains unknown. There was a general lack of analysis of the presenting concerns, including a void in considering the actual stresses and strains. Melanie had indicated low mood and stress in undertaking a demanding caring role and strain in living with a chronic alcoholic. The presenting situation was that of a patient noting concerns around her intimate relationship, indicating emotional harm and her tendency to lose her temper, but no wider consideration was given to the family dynamics as a whole. The lack of analysis of Melanie's needs outside of the care and treatment for mental health needs is further reflected in the referral letter to S2C, which omitted to outline key information, such as Melanie's difficulties in her relationship with Michael and her poor engagement with services. It also raises the issue of whether some of the questions in the DASH assessment form are suitable for evaluating the risk within the intimate relationships of older adults[6]. The Older People's Commissioner for Wales has now suggested that risk assessment tools should be used differently for older adults, including having a focus on different factors (for example, social isolation).

On the 1st April, 2015, Melanie attended her first counselling session with the S2C service. A review of the risk assessment did not identify any current risks and the risk assessment was not updated following this contact. Melanie is noted as requesting support with coming to terms with the loss of her daughter and "*to discuss her current relationship and the way she feels about it*". A further appointment was mutually agreed; however, as she did not attend her planned appointment on the 15th April, 2015, and did not contact the service, she was discharged as per the S2C Therapy Contract.

The LPFT's IMR explicitly outlines the presenting challenges and limitations in information sharing when patients are open to two teams working with different clinical systems. Not only did this impact on the quality of information sharing, but also caused challenges when implementing treatment plans. There was a lack of robust and proactive liaison with other healthcare professionals, including a review of previous clinical records or evidence, which could have identified domestic violence and abuse. It is good practice to liaise with other healthcare

[6] For example, see questions 7, 9, 14,18, 23 of the DASH assessment form.

professionals and work collaboratively with service users when considering their plan of care. Information sharing between Health professionals between the different services within the Trust was ineffective in assessing risks, particularly that of domestic abuse and poor engagement. The quality of information sharing, particularly regarding planned care and assessed risk, between all LPFT professionals was generally poor. The discharge letter to the GP did not offer details of Melanie's progress or detail recommendations regarding any ongoing care and treatment needs. This lack of information did not enable the GP to make a judgement regarding potential risks.

Melanie's involvement ended with S2C on 15th April, 2015, with the OACMHT on 20th March, 2015. There were 11 contacts with Melanie, 9 of which were face to face contacts as follows:-

2002 – 1 contact
2014 – 1 telephone call and 4 face to face
2015 – 5 face to face

All the face to face contacts occurred within a concentrated time span, from August 2014 until April 2015, with contact ceasing approximately a month prior to Michael's death. The following was known by LPFT regarding Melanie and Michael's relationship:-

26/8/14: The impact of Michael alcohol misuse on Melanie's well-being.
15/01/15: Melanie reported "issues" related to her partner and that she had gone to Wales for some time away. She reported that she was going to go to the Council to request a house move and was also intending on requesting additional support from the Blind Society.
18/02/15: Melanie reported verbal and psychological abuse from partner in S2C second assessment; this was a direct disclosure of domestic abuse.
20/02/15: Melanie raised issues to the OACMHT relating to her partner and applying to the Council for a house move (this staff member would not have been able to see the disclosure from the 18/02/12, as the information was recorded on different systems).
01/04/15: Melanie asked the counsellor if they could discuss her relationship and the way she feels about it. However, she then failed to attend subsequent appointments.

This summary reflects that there was a direct disclosure of domestic abuse and three opportunities for exploring this concern with Melanie, but there was a general lack of

professional curiosity to explore this further. The combination of sporadic engagement and two different clinical systems meant that information and risks were not addressed in a holistic and live manner. A greater degree of professional curiosity could have been employed in order to evaluate the identified risks and inform effective risk management. All Trust staff involved in the nine face to face contacts had a clear understanding of domestic abuse definitions, but failed to effectively assimilate this knowledge into practice. Recent research indicates that alcohol and mental health concerns have emerged as areas of concern for both victim and perpetrator, which should be recognised as an alert for domestic abuse (Sharp-Jeffs & Kelly, 2016). During assessment, other safeguarding concerns relating to historical abuse, having an unpaid carer role and risks to children were also not recorded in risk assessments or safeguarding adult or child screening tools in accordance with Trust policy. As a consequence, this information was not shared appropriately within the organisation or with other professionals involved with Melanie's care, including her GP.

The IMR identified poor quality risk management in that Melanie's care plan and risk assessment was incomplete and not reviewed throughout the term of her contact with the OACMHT. Further actions to address Melanie's care needs could have been undertaken following her face to face appointment on the 28th August, 2014, telephone contact on the 2nd October, 2014 and face to face contacts on the 17th October 2014, 15th January 2015, 18th February 2015 and the 20th February 2015. Risks to others were not analysed following Melanie's disclosure during consultation with the S2C service that she could lose her temper and smash things. Therefore, information was not shared effectively between both services, and risk was seen as static, rather than dynamic and responsive. Whilst there is evidence of effective responses to address her presenting needs and concerns, and good use of management supervision and effective clinical judgement based on assessed unmet needs, there was a general lack of analysis of her role as carer, her feelings and difficulties, shared about her relationship with Michael.

3.5 POLICE

Lincolnshire Police is one of the largest forces in the United Kingdom in terms of geographic area, covering 2,284 square miles. The population of the force area is currently approximately 731,500. The force currently employs 1110 police officers, 155 Police Community Support Officers (PCSO), 299 police staff and 569 G4S staff. Also working on a voluntary basis are 216 Special Constables, 142 Volunteer Police Cadets, 19 Volunteer PCSO's and 160 Police Support Volunteers. The

majority of back-office and some mid-office functions of the force are now provided by the force's strategic partner, G4S.

Under collaborative arrangements with other forces in the East Midlands, most homicide investigations are now undertaken by the East Midlands Special Operations Unit, Major Crime (EMSOU MC), and a Senior Investigating Officer (SIO) from that unit will be appointed to lead the enquiry; however, the early stages of such a crime are initially responded to and managed by local officers. The period of this review includes police incidents in Leicestershire, Nottinghamshire and Lincolnshire. The East Midlands Special Operations Unit, Regional Review Unit completed the IMR on behalf of Leicestershire, Nottinghamshire and Lincolnshire Police. The Reviewing Officer reviewed all the available recorded details of the incidents, including Command and Control incident logs, crime reports and custody records that feature either of the subjects of this review, and has included details, irrespective of the nature of the incident, on the chronology.

During the time period of this review there were a total of 25 separate police incidents involving the victim and/or the perpetrator, with 12 of these incidents of relevance to this review. The first relevant incident occurred in Nottingham in 1988, which involved an assault by Melanie on a previous partner and resulted in Melanie receiving a 3 month prison sentence, suspended for 12 months. The only circumstances known and recorded about this offence are contained within microfiche records, which state, *"after argument with partner the offender stabbed victim with knife and threatened to kill".* It is known that Melanie was initially charged with offences of Section 18 'Wounding with Intent' and 'Threats to Kill'; however, she later pleaded guilty to a lesser offence of Section 20 'Wounding' and the 'Threats to Kill' offence was ordered to lie on file. There is no further information available regarding this incident; this incident reflects Melanie's pattern of violence and abuse within her intimate relationship.

The remaining incidents all occurred during the review period, between September 1997 and prior to the incident on the 15th May, 2015. They include incidents of criminal damage or domestic violence and abuse. Out of these 12 identified domestic abuse incidents, 5 occurred within Leicestershire between 6th September 1997 and 20th January 2000; 3 occurred in Nottinghamshire, on 7th February 1988 and two on 18th November 2000 and 4 occurred in Lincolnshire between 15th August 2002 and 20th January 2012. Therefore, the first of these was reported to Leicestershire Police on 6th September 1997 and the last one was reported to

Lincolnshire Police on 20th January, 2012. In each of these incidents, there was no resulting prosecution, as there were no official complaints made from either party, or their complaints were withdrawn soon afterwards. However, following an incident on 16th March, 2005, Melanie received an official police caution for assaulting Michael.

Outlined within this section are the police incidents reported to Leicestershire Police. On the 6th September, 1997, Melanie reported criminal damage to their caravan. It is recorded that arguments between Melanie and Michael had begun on the previous evening and continued after they had both been drinking, and damage was caused to the caravan. There are no further recorded details of this incident regarding the nature of the argument or the type of damage caused. Michael was arrested but, on his arrival at the police station, Melanie telephoned the police to state that she was not making a complaint and gave no reason for withdrawing her complaint. On the 17th October, 1997, Melanie rang the Police, as she and Michael had been arguing and she had left to stay with her daughter. No crime or other offences were disclosed by either party, and the incident was recorded as domestic violence; however, it is unclear whether Michael was spoken to by the police about this matter. On the 2nd February, 1998, it is recorded that both had been drinking during the daytime and later in the evening a quarrel erupted resulting in several items of furniture being damaged. Michael was arrested; he was interviewed the following day and charged with an offence of causing criminal damage but, on 4th February, Melanie contacted the police stating she wanted to withdraw her complaint. On the 26th May, 1999, Michael reported that he had been assaulted by Melanie, causing minor scratches to his face. It is noted that this assault was triggered when he became jealous. Michael did not make an official complaint, and there is no record that any further police action was taken. On 20th February, 2000, Michael reported that there had been an argument between him and Melanie, resulting in Melanie wishing to leave the address. The incident was filed as a domestic incident, there was a record of no offences and no further police action was taken.

Outlined within this section are the police incidents reported to Nottinghamshire Police. On the 1st November, 2000, it is recorded that a 'known' person had smashed items of furniture following a verbal argument, but that Melanie refused to provide a statement and did not wish to pursue a complaint. Records reflect limited information about this incident, and it cannot be established who the 'known' person referred to was. A further two crimes were recorded on the 18th November, 2000. Firstly, when Melanie's daughter kicked her in the ribs and secondly, when Michael attempted to intervene and was assaulted, resulting in a minor cut above his left eye.

Melanie and Michael refused to provide a statement, and declined to make any official complaint about this matter.

Outlined within this section are the police incidents reported to Lincolnshire Police. On 15th August, 2002, Lincolnshire Ambulance Control contacted Lincolnshire Police as Melanie had alleged that Michael had punched her in the face with a clenched fist. The police officers dealing with this alleged crime reported that this was an alcohol-related domestic incident. Michael was arrested and removed from their home; however, after he was interviewed the alleged assault was reassessed. The report states that there were no visible injuries to Melanie's face and she had no pain as a result of the alleged punch. However, during the interview with Michael, he alleged that it was Melanie who had attacked him. He had several visible injuries including cuts to his forehead, a bite mark to his ear and bruising and scratching to both his arms. Despite this, Michael did not make any counter allegation of assault, and Melanie declined to make any statement of complaint regarding the alleged punch to her face. As it appeared that Melanie was the aggressor, the complaint of alleged assault on her was believed to be malicious and recorded as a 'No Crime', as she had no visible injuries. This incident occurred in 2002 and there is no record of a force Domestic Abuse Policy for this period.

On 18th February, 2004, Michael rang the police reporting that he had been hit in the face by Melanie. He declined any medical assistance and stated that they had been drinking and stated that '*things were only going to get worse'*. The incident was graded as an urgent response and officers arrived at the scene within 10 minutes. Melanie was arrested for assault occasioning actual bodily harm (AOABH), as Michael had received a 1" laceration to his left cheek. The officers reported that both parties were very drunk and, as a result, Michael was deemed incapable of providing a witness statement that evening. Melanie was detained in custody overnight to be dealt with the following day. The following day Michael declined to make a complaint and was unwilling to have photographs taken of his injuries. The incident log states that a domestic violence form was to be submitted; however, there is no record that the form was actually submitted, or of any subsequent involvement by the Domestic Abuse Officer (DAO). However, it should be borne in mind that paper forms would have been completed at this time.

On the 16th March, 2005, the police were contacted by a family member to say that Melanie had assaulted Michael with a red poker whilst both were heavily intoxicated. Melanie was arrested and bailed by the police. Michael had minor bruising, burn marks to his face, and heavy bruising

and minor burn marks to his left arm. The following day, Michael declined to make any formal complaint of assault as he had been intoxicated when he was assaulted. However, Melanie fully admitted the offence stating she had "*just flipped".* She received a formal police caution for assault occasioning actual bodily harm (AOABH). There is no record that this incident was considered by the DAO's.

On 20th January, 2012, Melanie contacted the police to state that she had just thrown a bucket of coal at her partner who had complained that he was injured. Melanie sounded as if she was in drink on the telephone, and she also noted that Michael had been drinking. Melanie also stated that she had held a knife to his throat, but had put it down and did not intend using it again. She said that her daughter had just died, another daughter had died three years beforehand and Michael had been *"slagging them off",* and she had had enough. During the call with the operator, Melanie was heard asking Michael if he was injured but she said he was ignoring her. When asked if she thought he was injured, she replied that he soon would be if he did not leave her alone. On attendance at their home the officer reported that both were spoken to separately, that it was clear that there had been a verbal altercation and that both parties had consumed alcohol, although they did not appear to be heavily intoxicated. Neither wanted to make further complaints, but Melanie noted that she wanted Michael to leave for the night as he had made hurtful remarks about her children. Melanie noted that her remarks to the police operator were made in the "*heat of the moment"* and were untrue. Michael agreed to go and stay with his sister for the night, and noted that he did not want her to get "*into trouble"*. There was no further mention or allegation by either party about a knife having been used during this altercation. The attending officer completed a DASH risk assessment in respect of Melanie and not Michael; with the rationale given that Michael did not say anything or make a complaint, whilst Melanie presented herself as the victim. There was no analysis of the presenting information to the operator, specifically that Michael was the victim and had received injury to his arm. The completed risk assessment outlines that Michael was an alcoholic, had assaulted Melanie previously and she was afraid he may cause her further injury or violence. She said that he phoned her constantly during the day when she goes shopping and that he always controlled her.

She added that, during those 15 years beforehand whilst in Leicester, Michael used a weapon to hurt her but it is not specified what weapon was used and no other details were given. The risk assessment shows that when Melanie was asked if her abuser, Michael tried to control everything she does and/or was excessively jealous; she replied "*always has"*. She told the officer

that Michael had problems in the past year with alcohol and mental health, and had been in trouble with the police in the past for "*drink driving"*. The officer then commented *"Melanie did not appear scared of Michael; upon police arrival to this incident she was still arguing with him, she did not appear shaken but angry".* The risk was recorded as 'medium'; it was recorded that no offences were disclosed and that this was a verbal altercation only. Due to the lack of retained comprehensive records, it has been difficult to establish what, if any follow up action was taken in many of the above incidents.

This was the first risk assessment completed, with the DASH assessment completed with Melanie rather than Michael. The police did not identify the risks and vulnerability to Michael, either due to his gender or because they did not adequately recognise that instances of mutual violence may have been retaliatory and therefore identify the risks to both parties. From the information, it is unclear what factors made Melanie the victim in this scenario; whether it was her views on his control in their relationship or her statement that he had been in trouble in the past. As outlined above, she continued to argue with him and appeared angry. The prospect of collecting any information about the incident from both perspectives, including the context of their relationship and the nature and patterns of abuse within their relationship, was potentially lost. Had this information been gathered, it is unlikely that the actions taken would have been different, or that the full details of the nature of their relationship would have been shared.

Based on the presenting historical context, it is unlikely that an alternative outcome would have been achieved had the DASH been completed with Michael rather than Melanie. It should also be reiterated that any officer dealing with this couple at this time would not have been aware of Melanie's previous conviction for wounding or the circumstances, as this information was not contained within her records. The back record conversion of previous convictions is only usually completed after an individual's microfiche records have been obtained, and normally are only requested during major or serious crime investigations. Therefore, in this case, the information only became known to the Police during the murder investigation.

To summarise, from September 1997 and January 2012 there were 12 identified domestic related incidents involving Melanie and Michael. Over the course of this review period, there have been changes to the domestic violence and abuse procedures adopted by the police, with the initial procedure adopted in Leicestershire in 2004, Nottinghamshire in 2005 and Lincolnshire in 2003. The limited records of some of these historical incidents means that the audit trail of actions

undertaken is vague, but it would appear that, beyond the incident in 2012, limited further action was undertaken. Melanie refused consent for her information to be shared with partner agencies, and she was given information regarding the availability of domestic abuse services. Across all incidents, there is a clear pattern reflecting that neither Melanie nor Michael wanted any continued police action following their attendance to deal with a reported incident, which is not uncommon, but can function as a barrier to deconstructing the actual sequence of events in order to inform further safety and support planning.

3.6 ADULT CARE & SENSORY IMPAIRMENT LINCOLNSHIRE COUNTY SERVICES (SILCS)

The primary purpose of Adult Care is to empower and enable adults requiring support to live independently, by assessing needs, gathering the views of those citizens accessing services and via the delivery of a range of services and interventions designed to maximize independence, promote choice and support adults to live safe from abuse. This is further reinforced by the Care Act 2014 which attempts to rebalance the focus of social care on preventing and delaying needs, rather than only intervening at a point of crisis. Adult Care is responsible for Occupational Therapy and the commissioning of SILCS, a service for adults with visual and hearing impairment. SILCS is primarily a rehabilitation and enablement service that seeks to provide registration, advice and support and training in mobility and independent living skills including Braille, Moon, handwriting, typing and keyboard skills. SILCS is part of an umbrella organization, BID Services. There were no delivery or performance issues with this contract delivered on behalf of Adult Care.

During the review period, occupational therapy conducted an assessment of Michael's needs following receipt of a referral from SILCS. SILCS had also completed an initial assessment of Michael, and concluded that he needed an occupational therapy assessment to support his mobility at home, which is outside the remit of their service. SILCS also supported Melanie in the completion of an online carer's assessment. This is a self-service online assessment provided by Adult Care. The SILCS Assessor supported Melanie in the completion of this carer's assessment; this was done in her role as trusted assessor. This system was devised in response to carers wanting easier access to and choice of who assesses them, and a speedy response to their enquiries. Lincolnshire Adult Care has developed a training system for partners in the voluntary sector to act as trusted assessors. In this case the SILCS Assessor conducted a face to face interview with Melanie.

On the 27th May, 2014, the initial home visit was completed by the Team Leader and Assessor for SILCS. As an outcome of the assessment, it was agreed that a referral to Low Vision Clinic and Occupational Therapy Assessment be completed and various visual aids be provided. During this period, the SILCS Assessor completed a referral to Occupational Health and provided support regarding re-housing needs. On the 12th September, 2014, the assessment of needs was completed by the OT; however this assessment was undertaken without seeing Michael. Also on this date, Melanie completed the online Carer's assessment form.

The records reflect a lack of critical reflection, assessment, risk management and analysis when working with this couple, from both the OT and SILCS. ASC developed 15 quality standards to ensure the core aspects of the Care Act 2014 were operationalized and embedded into practice in readiness for the implementation of the Act in April 2015. These quality standards include a focus on seeing customers alone and considering relationship dynamics, assessing needs, assessing risk, a focus on safeguarding adults and children from risk of harm, person-centered care and support planning, personalization, reviewing care needs, effective recording, the value of carers and the consideration of any wider diverse needs. Whilst it is recognised that the assessments took place prior to the implementation of the Act, the standards are comprehensive and clear, yet there is limited evidence within this case that they informed the assessment process or the services delivered to Michael and Melanie. Evidence also suggests that there was a lack of assessment, analysis and professional curiosity of their presenting needs, individually and jointly. This is contextualized by Melanie's views shared with the SILCS assessor that Michael was able to do more tasks then he currently undertook. There was no further discussion around the rationale of her comment, or indeed any exploration of how this fitted in as part of his assessment, which should have focused on his strengths. There was limited consideration of the support plan to assist Michael achieve his well-being outcomes, which would support Melanie in her role as his carer. Therefore, there was a lack of professional curiosity to trigger a conversation about 'what mattered' to them as a couple and what support would enable/empower them to lead a fuller life.

The involvement of ASC in this case was minimal, with only one home visit conducted by the Occupational Therapist (OT) and three home visits by the SILCS assessor. Despite the subsequent provision of equipment for Michael, during the OT home visit, Michael was not seen and neither was his direct views gathered in order to inform the assessment of his needs. Policies and

procedures pre and post the Care Act 2014 note that adults should be seen in order to enable the assessor to complete a full assessment of their needs. Instead, the views of his carer were gathered, with this information added to the initial referral information received from SILCS. Therefore, the collection of this degree of information does not equate to a full assessment of needs or consider the impact of Michael's needs, the role of Melanie as his carer or the nature of their relationship, in particular their alcohol intake and history of domestic violence and abuse. The analysis of their needs appeared static, focused on environmental factors and superficial needs, rather than deconstructing the pattern of their daily lives. When completing the carer's assessment with Melanie, opportunities were presented to further unpick her wishes and feelings around the nature of their relationships, the pressures of caring and also her views on any support, guidance or services that may have assisted her in her caring role. Rather than engaging in a meaningful conversation around 'what mattered' to her, the focus was on providing her with a personal budget for leisure activities, with no clear picture of the well-being outcomes this would achieve. Again, there was a general lack of professional curiosity or consideration given to the core quality standards for ASC, in particular the standard of seeing a customer on their own.

This case reflects the need for person-centered reviews in order to ensure that cases are kept in focus and to avoid 'drift', and also to encourage the closure of cases when the work has been completed or personal well-being outcomes have been achieved. In addition, as a matter of course, and indeed good practice, all service users and carers should have the opportunity to review the content of their assessment, sign the documentation and receive a copy. When tracking information from case files, a clear picture should emerge of individual needs, the outcomes to be achieved through the delivery of their support plan and the review process. This cannot be achieved if the case recording lacks analysis and clarity. Therefore, insufficient information was gathered from both Michael and Melanie in order to inform a comprehensive assessment of both their needs and to understand the historical context or nature of their relationship. It is a professional and reasonable expectation that family relationships and domestic abuse be considered as key aspects of all social care assessments.

4. MULTI-AGENCY ANALYSIS OF THE TERMS OF REFERENCE

4.1 ***Did the agency have policies and procedures for (DASH) risk assessment and risk management for domestic violence victims or perpetrators, and were those assessments***

correctly used in the case of this victim/alleged perpetrator? Did the agency have policies and procedures in place for dealing with concerns about domestic violence? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC?

4.1.1 All the agencies have implemented the necessary policies and procedures for domestic violence victims and perpetrators. Agencies are fully aware of the requirement to complete a DASH assessment when a disclosure of domestic violence and abuse is made. The relevant policy and procedures took account of and reflected national guidance and recommended good practice at the time that they were introduced and implemented and have been professionally accepted as being effective.

4.1.2 During LPFT's contact with Melanie there was one explicit disclosure of domestic abuse made, and three opportunities to adopt an approach focused on professional curiosity. There were three opportunities to complete a DASH risk assessment. Firstly, on the 15th January, 2015, when she reported some "*issues*" relating to her partner that impacted on her mood, resulting in her having to remove herself from the home. Secondly, on the 18th February 2015, when Melanie reported verbal and psychological abuse by her partner. Finally, on the 1st April, 2014, when Melanie had made a clear request to discuss her feelings about her relationship. As the DASH, adult safeguarding screening tools or risk assessment were not completed, the exact nature and pattern of abuse within their relationship remains unknown and was not thoroughly assessed. There was a general lack of analysis of the presenting concerns, including a void in considering the actual stresses and strains.

4.1.3 A DASH risk assessment was completed by the police in respect of the incident on the 20th January, 2012; however, it was only completed in respect of the alleged perpetrator, Melanie. Although the incident was reported by her, it did concern the alleged assault by her on the victim, Michael. The circumstances of this incident would not have resulted in any further action, as the threshold for further action is normally when the risk is assessed as high, therefore there was no referral to MARAC. Where the risk is assessed as medium or standard, then there is an expectation that any safeguarding issues are considered by the officer attending the incident, which may include making a referral to an external agency who specialise in domestic abuse. The officer who dealt with this police incident would not have been aware of Melanie's previous

conviction for wounding or the circumstances of it, because at that time it was not contained within the relevant records.

4.2 ***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?***

4.2.1 There were opportunities for assessment and decision-making:-

a) *The SILCS Assessor attended the couple's home on three occasions, primarily to gather information regarding Michael's disability and Melanie's caring role. It appears that no specific questions were asked about their relationship, and therefore domestic abuse was not considered. If information about the couple's relationship had been sought, it may have elicited information about co-dependent alcohol use and domestic abuse. When Melanie was supported to complete the carer's assessment, she clearly states she is depressed, not sleeping, unwell herself and feeling as if she had no life of her own. It would have been appropriate here for the assessor to unpick this further with Melanie in order to explore the nature of their relationship. It is positive that the SILCS Assessor recognised the need for a referral to ASC for an occupational therapy assessment, acknowledging the limitations of their involvement and supporting the couple to achieve a better quality of living.*

b) *When the Occupational Therapist visited the couple's home, Michael was not seen or included as part of the assessment of his needs, with the focus on his presenting physical needs. Therefore, contrary to good practice, the expectations outlined with the Care Act 2014 and a person-centred approach of seeing adults alone, Michael was not included as part of the assessment of his needs.*

c) *Both presented to the GP regarding their long term health issues and appropriate actions were taken in response upon contact. During the period prior to Michael's murder, Melanie was advised of the potential dangers of taking her medication, and was engaged with the mental health services, who communicated that it was the burden of caring and bereavement that was impacting upon her mental well-being. During the period prior to the homicide, Melanie presented issues to the GP seen in other perpetrators, for example,*

mental health issues, depression, stress, difficulty in sleeping, substance misuse and self-harm (Sharp-Jeffs & Kelly, 2016). In view of the level of loss, and the degree of caring, the analysis fitted with the situation Melanie was experiencing. From Michael's perspective, it was the impact of long term chronic alcoholic addiction and his resistance to altering his lifestyle, whilst knowing the long term outcome of failing to change. There is no evidence that either lacked capacity to make those decisions, and therefore it would appear that the GP acted in a professional manner and offered care, support and advice as required.

4.3 ***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?***

4.3.1 With the exception of Melanie's assault on a previous partner in 1988, there were 11 other identified domestic related incidents involving the victim and alleged perpetrator between September 1997 and January 2012. None of those incidents resulted in serious harm or injury to either party, and in all cases the aggrieved person either refused to make an official complaint or withdrew it shortly afterwards. Of the four incidents in Lincolnshire, the last one recorded prior to the murder was in January 2012.

4.3.2 The assessment and actions of the SILCS assessor and the Occupational Therapist were responsive to Michael's presenting physical needs. As discussed, there was no further questioning or analysis of Melanie's statement of how she felt at this time and her belief that she had no life of her own. Limited professional curiosity was demonstrated regarding the dynamics of this household, their general well-being and the overall holistic and historical context in order to shape the assessment of their needs and the plan to support these needs.

4.3.3 Michael's alcohol dependency was the main consideration for the majority of his consultations with the GP. Between February 1999 to December 2000 two referrals were made by the GP to the Alcohol services. On both occasions he did not engage with the service, and several attempts were made to explore referral for support for Michael to address his alcohol dependency, with continual lifestyle advice provided.

4.3.4 LPFT had nine face to face contacts with Melanie in the months prior to Michael's death; a greater degree of professional curiosity could have been employed in order to evaluate the

identified risks and to inform effective risk management relating to domestic violence and abuse. The IMR identified poor quality risk management; in that Melanie's risk assessment was incomplete and not reviewed throughout the term of her contact with the OACMHT.

4.4 ***Is there evidence that historical information was analysed in order to provide a holistic assessment of risk?***

4.4.1 With regards to the GP, Melanie had expressed difficulty in coping with Michael, to the point of hopelessness on one occasion, but this was not considered in the context of risk of harm or abuse. The issues presenting were the chronic ongoing complex health care needs of Michael, which the carer found overwhelming. However, their established histories of ongoing physical health needs, and their presenting concerns as a vulnerable couple, were not uncommon.

4.4.2 From a police perspective, only minimal paper-based records have been retained for some of the historical incidents, and therefore it is not always known if any further action was taken. With the exception of the incident on 18th February, 2004, in which it is recorded that a domestic violence form was submitted, there is no record or indication that any other action was taken, or risk management plan formulated, as a result of the incidents that occurred in 2002 and 2005. As most of the police incidents and/or any alleged crimes dealt with were of a minor nature, and no further police action resulted from them, any historical information would not have affected any assessment of risk at that time. The circumstances and nature of these incidents would not have triggered the necessity for officers to have requested Melanie's microfiche records, and details about the 1988 offence would not have been considered. Following the incident on 21st January 2012, it is known that, because the DASH risk assessment categorised the risk as medium, Melanie was offered information, but no other services were offered as she did not give her consent for information about the incident to be shared with partner agencies.

4.4.3 From an ASC perspective, there is indication that limited historical information was sought or used in order to inform the assessment of needs or to inform a risk assessment. With regards to LPFT, again, there is limited evidence to suggest that the historical information from their contact with Melanie in 2002 was used as context to their contact with her in 2014/15.

4.5 ***Did the agency comply with domestic violence protocols agreed with other agencies, including any information sharing protocols? Was inter- and intra-agency communication efficient and effective?***

4.5.1 Since the implementation of the DASH form, the use of the term 'abusive' would be explored further. However, the primary concern from a Health and Social Care perspective were their presenting health and physical needs. There was limited opportunity for inter-agency communication and information sharing specifically relating to any of the domestic abuse incidents. Overall, domestic violence and abuse was not considered to be a concern in this case, as no explicit disclosure of harm was made by Michael.

4.5.2 The information relating to Melanie's previous engagement with LPFT in 2002, was not archived onto the clinical systems at the time of her second referral in 2014. This resulted in clinicians not having access to this information, and no attempt to access this information was made as Melanie, denied previous contact with mental health services. Additionally, the two separate clinical systems used by the 2 services do not share recorded information, reducing the opportunity for clinicians to freely access all relative data.

4.6 ***Were practitioners sensitive to the needs of the victim and the alleged perpetrator, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect practitioners, given their level of training and knowledge, to fulfil these expectations?***

4.6.1. Following a Police incident on the 21st January 2012, a risk assessment was completed in respect of Melanie, who did not give her permission for information to be shared with partner agencies, and the circumstances of this incident were not so severe as to allow the information to be shared under a public interest test.

4.6.2 From an ASC and LPFT perspective, the key focus was solely on the presenting needs, rather than on exploring the couple's relationship. Melanie did indicate the impact their relationship was having on her well-being; however, the required professional curiosity to pursue and evaluate this information further was not adopted. It would have been reasonable to expect that this information would have been explored further with Melanie, not only to identify the trigger for her perspective, but also to identify any risks or additional care and support needs.

4.7 ***Did the practitioners seek, and were they given, appropriate levels of supervision, advice and guidance during the decision making process? Was there sufficient management accountability for decision making? Were senior managers or other organisations and professionals involved at points in the case where they should have been?***

4.7.1 From an ASC, both practitioners felt that no additional supervision, advice or guidance was required. Professional interaction with vulnerable adults requires the ability of practitioners to be able to consider the unthinkable, and be open to the possibility of abuse, and then be skilled enough to have that difficult conversation with the adult concerned. A wider questioning/appreciative inquiry approach that examined the couples support networks, history and relationship would have given a fuller picture of their everyday experiences, which would have been more individualised and person-centered. No further supervision issues were identified within the agency IMRs.

4.8 ***When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options or choices in order to make informed decisions? Were they signposted to other agencies? Had the victim disclosed to anyone, and if so, was the response appropriate?***

4.8.1 During the time period of this review, from September 1997 to May 2015, excluding the murder incident, there were a total of 25 other incidents involving the victim and/or the alleged perpetrator. Eleven of these incidents have been identified as falling within the definition of domestic violence and abuse, of which nine involve conflict between the victim and the alleged perpetrator, as some of these cases were recorded as being domestic abuse and others recorded as offences of assault or criminal damage. In every case, neither party made any official complaint or withdrew their initial complaint shortly afterwards, and in many cases either or both parties did not divulge to the officers what had occurred. Out of the nine incidents, there were three occasions when Michael was arrested and two occasions when Melanie was arrested. At times, their relationship was mutually abusive and there were occasions when Melanie presented herself as the victim, even when Michael had significant physical injuries.

4.8.2 Beyond this police contact, there was limited face to face contact with Michael. Michael was only spoken to by the SILCS assessor with regards to his physical needs, mobility and visual

impairment. As previously outlined, he was not seen by the OT; was not incorporated as part of the OT assessment process. There is evidence from his GP records that his views were ascertained regarding his physical health and well-being.

4.9 ***What was known about the alleged perpetrator? Had MAPPA been considered?***

There were no identified triggers to consider the MAPPA process.

4.10 ***Was the information recorded and shared, where appropriate?***

4.10.1 There were limited opportunities to share information or to work on a multi-agency perspective to address their needs as a couple.

4.10.2 The SILCS Assessor supported Melanie to complete the online Carer's Assessment; the outstanding issue is that no-one had a conversation with her about her comments in this assessment regarding her caring role and her difficulties at the time. In relation to the Adult Care Assessments, Melanie was sent a copy of her online self-service Carer's Assessment and the emergency plan. Michael was not included in the Occupational Therapy Assessment process and did not receive a copy of the assessment. Also, there is no record that a review was completed, either face to face or over the telephone.

4.10.3 The LPFT's IMR explicitly outlines the presenting challenges and limitations in information sharing when patients are open to two teams working with different clinical systems. Not only did this impact on the quality of information sharing, but also caused challenges when implementing treatment plans.

4.11 ***Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the alleged perpetrator and their families? Was consideration for vulnerability and disability necessary? How accessible were the services for the victim and alleged perpetrator?***

4.11.1 There is no indication that the ethnic, cultural, linguistic or religious identity of the victim, alleged perpetrator or their families was not considered.

4.11.2 Domestic violence and abuse is not always recognised as an issue that occurs within intimate relationships for older adults. Research reflects the link between domestic violence and

abuse and caring responsibilities, with the potential for violence and abuse within these caring relationships greater, specifically when in an intimate relationship and attempting to support a partner with problematic substance misuse (Sharp-Jeffs & Kelly, 2016). The completion of a holistic carer assessment may have assisted in facilitating a conversation with Melanie on the pressures she faced and how this facilitated the abuse in their relationship. Whilst this should be considered here, it is not by any means a justification of Melanie's actions; however, caring circumstances should be carefully considered in relation to the stresses that carers encounter, and how such context can facilitate abuse. The key issue is primarily around adopting the required professional curiosity in order to consider needs and well-being beyond the presenting information.

4.12 ***Have there been any other similar cases in recent years, and are there any lessons that could have been learnt?***

No, there has not been a similar DHR.

4.13 ***To what degree could the homicide have been accurately predicted and prevented?***

Based on the multi-agency information, this homicide could not have been accurately predicted or prevented.

4.14 ***What effective practice can be passed on to other organisations?***

None specifically identified

5. LEARNING ON THE FRINGE

There were several domestic violence and abuse incidents; due to the historical nature of some of these incidents there is limited information available. What the information does reflect is the limited opportunities to modify behaviour and influence change. The information indicates that there were no real warranted opportunities for a referral to MARAC. When an opportunity arose in 2012 for the Police to complete a DASH risk assessment the assessment was completed on the alleged perpetrator rather than the victim. Any confusion around the perpetration of the violence and abuse could have been averted through the completion of a DASH risk assessment with both parties. LPFT did not complete a DASH risk assessment or a Carer assessment, which may have

provided the opportunity to undertake an analysis of her needs and offer support to address the concerns Melanie raised with them.

The records indicate a lack of an overall agency oversight of them as a couple; therefore there are voids in gathering a sense of their everyday life, in particular during the social care assessment. However, the GP had seen the couple together and offered support in a preventative manner, primarily in an attempt to address Michael's alcohol misuse. There is limited reference to Melanie as a grandparent, with no real sense of her contact, relationship and any caring role she may have undertaken for her grandchildren. The opportunities to see them together mostly arose as part of their medical appointments, SILCS visits and during contact with the Police (the 3 forces) to address their domestic violence and abuse complaints. The social care records present limited opportunity for further consideration of Michael's physical needs and the actual degree of daily maintenance, care and support required. Therefore, there is no real picture of the extent of his disability, his mobility, the deterioration in his eyesight and how these needs were managed and supported. In addition, there is no sense of whether his alcohol misuse continued to fluctuate. The degree of caring that Michael required and the stresses and strains this may have placed on Melanie are unclear beyond the view she is now expressing. Whilst this may be unclear, there are some key opportunities for further learning identified:-

- The requirement to promote a more robust and proactive approach focused on professional curiosity and 'Think Family' (holistic assessment in a collaborative manner with all agencies).
- The requirement to actively promote the role of carers from a social care and health perspective, in particular when considering the quality of the LCC'S social care assessment and the lack of evaluation by LPFT of Melanie's caring role. The pattern of her behaviour was not known to ASC, but some of this information was held by LPFT, the Police and the GP. There was little opportunity in this case for multi-agency working, which limited the opportunity for information sharing. The Care Act 2014 will assist in promoting the rights, needs and offer of support for carers.
- The requirement for Care plans to be outcome-focused and flow from the assessments. Again, the Care Act 2014 will drive the requirement for assessment which focuses on a 'what matters' conversation and targeted care and support plan which are focused on well-being outcomes.
- The requirement to discuss domestic violence and abuse as a core aspect of assessments.

- The consideration of the visibility of victims of domestic violence and abuse, irrespective of their gender, which requires analysis prior to the completion of the DASH assessment. Therefore, this assessment process at the outset needs to be open-minded and questioning. Adopting the required professional curiosity needs in order to focus on routinely asking questions about the nature of relationships. Probing further about the nature of relationships and the existence of domestic violence and abuse may overcome pre-conceived ideas; for example, domestic abuse within older adult relationships. When considering the complex needs of this couple, the focus was on their mental health or substance misuse rather than identifying the risk of violence and abuse in their relationship.

There was also presenting self-neglect, which is a challenge to manage pre the Care Act 2014, and also when the adult in question presents as having the required capacity to make decisions perceived to be in his or her best interest, or indeed unwise. The Care Act 2014 clearly outlines the aims of adult safeguarding to focus on preventing and reducing the risk of harm of abuse to adults who have care and support needs. The focus is on establishing clear roles and responsibilities, effective partnership working and on delivering person-centred care focused on promoting well-being outcomes. This is a positive step forward, as it reinforces the focus on seeing adults on their own to assess their care and support needs.

Due to the nature of domestic violence and abuse as a 'hidden' issue, and this couple's position on the periphery of services, the exact nature of their relationship cannot be gathered from agency records. Melanie's views do go some way in describing her perspective of their relationship; however, due to the circumstances and the limited family involvement in this review, Michael's perspective remains unknown. The review of the IMRs indicates a degree of hopelessness by Melanie, but this was not necessarily presenting as severe, complex or beyond the norm of the lives of many adults. A robust professional curiosity may have assisted in identifying the depth of her despair, the nature of their co-dependency and the extent of support required to address their actual, rather than their presenting needs.

6. CONCLUSION

There was sporadic evidence to reflect the degree of acrimony and abuse within their relationship, with pieces of information shared with the Police and Health regarding the abuse.

From the information it would appear that the key triggers to the abuse within their relationship were their alcohol misuse, the pressure of the caring responsibility on Melanie and the verbal abuse within the relationship. Michael was registered disabled, and had a range of physical, mobility and personal needs. Their relationship was volatile and shaped by a history of domestic violence and abuse, with the police called on several occasions and allegations made by both parties, but neither pursued the complaints further. At the time of Michael's death, the police had attended several previous incidents of domestic violence and abuse involving him, the earliest of which occurred more than 13 years beforehand (2002, 2004, 2005 and 2012). Michael was arrested by the police during two of those cases and Melanie was arrested on another. Neither the victim nor the perpetrator was subject of a MARAC. There have been a total of 12 domestic abuse incidents recorded by the Police over almost a 27 year period, and the last recorded incident prior to the murder occurred more than 3 years beforehand, in January 2012. In that case the risk was correctly assessed as being medium, and it was the only domestic abuse related incident brought to the attention of the police for nearly 7 years. The most serious incident referred to in this IMR was the wounding offence committed by Melanie against a previous partner in 1988. The existence of that offence, however, was not known to the officers who dealt with the incidents during this review period, and details of Melanie's previous convictions did not materialise on her record until after the murder investigation commenced.

The issues were further compounded by the environmental factors, Michael's continued chronic substance misuse and Melanie's fluctuating depression and self-harm. There are several examples of Melanie physically assaulting Michael, venting her anger and threatening harm. There was a general sense that she was reaching her threshold regarding her tolerance of him, in particular her description of his verbal abuse and derogatory remarks about her family. The sentencing comments also note that the presented information reflected that Melanie had also been a victim of domestic abuse, often involving vicious and hurtful verbal abuse by Michael. However, due to the lack of comprehensive assessments of their needs the actual dynamics of their relationships from both perspectives remains unknown. This highlights the function and value of comprehensive assessment, focused on the holistic needs of the family as a whole.

Not only was the information about the unhealthy nature of their relationship sporadic, there was no real opportunity for multi-agency working in order to merge the overlapping information across agencies. Whilst there were opportunities to complete a DASH assessment, there were no presenting opportunities to consider MARAC. As recent research indicates, the completion of

robust risk assessments is a key emerging theme in DHRs, in particular around the completion of two DASH forms when the victim or perpetrator is unclear (Home Office, 2016). In conclusion, from the information reviewed, it would not have been possible for any agency to predict or prevent Michael's death. However, LPFT and LCC ASC were in a position to access or offer comprehensive assessments, which may have assisted in offering support in order to alleviate the emerging stress, strain and anxiety within their relationship.

7. IMPLEMENTING THE LEARNING

The IMRs have provided evidence of actions already undertaken in response to individual agency recommendation. These recommendations have been identified by each IMR author in their own reports and have been signed off at a senior level within the respective agency. The Board accepts responsibility for overseeing and ensuring their implementation (see: Appendix 1).

8. RECOMMENDATIONS

Overview Author's Recommendations:

Recommendation 1: LCC ASC to review compliance with their assessment and review procedures, including some QA of OT Assessments in order to confirm that this case is an isolated incident of non- face to face practice with immediate effect.

Recommendation 2: LCC ASC to review their performance or contract review methods for external providers, in particular around the quality of assessments and recording, with a key focus on their quality standards principles.

Recommendation 3: All relevant agencies to undertake a dip audit sample of the quality of Domestic Abuse Incidents and the completion of DASH risk assessments, ensuring it captures a review of the DASH assessment being completed on the right person (victim) or both (in cases of dual reporting). The results should inform the need to issue further guidance to the relevant professionals where appropriate. Following the outcome of this audit by agencies, the Domestic Abuse Strategic Management Board to consider a review of the process around the dual reporting of domestic violence and abuse.

Recommendation 4: In line with the principles of the Care Act 2014, LCC ASC to produce a briefing note to be circulated to all agencies on the definition of carers, their roles and responsibilities and how they can access services.

Recommendation 5: LPFT and CCG to review and align their practice of addressing the needs of carers, including arranging assessments for carers which address their own substance misuse or mental health needs.

Recommendation 6: As part of the domestic violence and abuse training, all agencies to be alerted to the particular attention to older people's experiences and the increased risk for abuse in a caring relationship when the carer is a partner.

9. REFERENCES

Bows, H. (2016) 'Why elderly deaths from abuse are part of wider pattern of violence against women'. *The Conversation.* Available from: https://theconversation.com/why-elderly-deaths-from-abuse-are-part-of-wider-pattern-of-violence-against-women-57529

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Home Office (2016). *Domestic Homicide Reviews: KEY FINDINGS FROM ANALYSIS OF DOMESTIC HOMICIDE REVIEWS*. [Online] Available from: *https://www.gov.uk/...data/.../HO-**Domestic-Homicide-Review-Analysis**-161206.pdf* Accessed on the 10th December, 2016.

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Sharp-Jeffs, N. & Kelly, L. (2016). *Domestic Homicide Review (DHR): Case Analysis.* [Online] Available from: *www.endviolenceagainstwomen.org.uk/.../64848_STADV_Report_v1b_proof3.pdf* Accessed on the 10th December, 2016.

APPENDIX 1: IMR RECOMMENDATIONS

1. ELDC

There are a number of minor recommendations which will be completed by the individual agency author.

Recommendation 1: Ensure Waterloo Housing group are complying with the housing register contract including ensuring their staff are competent to identify and report safeguarding concerns and have appropriate policies.

Recommendation 2: To advise and assist Waterloo with reviewing their safeguarding policy, which is due for review in January 2016. A copy of ELDC's safeguarding policy has already been forwarded to them.

Recommendation 3: To review the process for assessing housing applicant's medical need and ensure those staff making the assessments are competent. Waterloo have already been contacted about this.

Recommendation 4: Review whether the Council is doing enough to advise its residents of Domestic Abuse services for victims and perpetrators and how this information can be communicated.

2. ULHT

Recommendation 1: ULHT's Safeguarding Adults Lead will update the Trust's Safeguarding Adults Policy to reinforce the need for consideration to be given to referring a patient directly into drug and alcohol support services. Timescale for completion – end of March 2016.

3. CCG

The only recommendation to emerge from this report from the CCG IMR coincides with the increasing acknowledgement of the impact of caring roles within family groupings which have been placed on a statutory footing within guidance for implementing the Care Act 2014.

Recommendation 1: For GPs to assess the needs of, and impact upon the adult or child carer within families that include individuals within complex health issues and record their assessment and actions.

NB: The Level 3 Safeguarding Children and Adult Programme commencing March 2016 includes the requirement for GP's to assess the needs of the carer and the adult or child. The joint assessment must include consideration of both individuals' well-being, alongside any referral and support mechanisms triggered from the assessment.

4. LPFT

Recommendation 1: In response to findings 3 & 4: More focused work is required to ensure clinicians are aware of and implement their responsibilities within the Trust Safeguarding Policy (Policy 11) and Multi-agency Domestic Abuse Policy to correctly identify, record and respond to disclosures of historical and domestic abuse, embedding the domestic abuse risk assessment and referral process across all areas of the Trust. The Older Adults division particularly should implement, and assure the Trust boards of the implementation, of the Safeguarding Screening tools, effective risk management and associated actions upon suspicion or disclosure of domestic abuse, with an action plan to assure this recommendation is implemented within six months.

Recommendation 2: With reference to points 2 and 4, an audit of risk assessments and care planning throughout the Trust, in order to analyse the quality of record keeping upon appointment and discharge of patients and review following disclosure of a risk event. Improved record keeping in line with Trust guidelines, in particular within risk assessment, care planning and robust information-sharing with internal and external agencies, would increase the potential for decisions made being based on comprehensive knowledge of the risks, patient's wishes and

expectations and collaboratively-established unmet needs. This should be implemented within six months.

Recommendation 3: During the Trust-wide audit of risk assessments and care planning as detailed above, analysis of the extent of the recording of children being a protective factor in risk assessments, as per finding 5 above.

Recommendation 4: In relation to finding 6, there should be an immediate Trust-wide review of patient service contracts and policies in how they engage patients who present with risks to self, to others and from others, who are unwilling or unable to attend planned appointments. An action plan in response to this review should be implemented within 6 months.

Recommendation 5: Regarding point 7 above, the Trust will roll out the clinical system portal in 2 phases, commencing in June 2016. This will allow clinical staff to access records from all Trust electronic clinical systems. In order to improve access to all clinical systems and to promote staff accessing historical information held in paper form, information will be shared in the Trust's lesson learned bulletin about administration staff having access to all systems and how to request paper records with historical information.

5. POLICE

The Reviewing Officer has not identified any recommendations emanating from this IMR.

6. ADULT SOCIAL CARE

Recommendation 1: Domestic abuse needs to have a higher profile in the Local Authority's work with Adults and their families. This needs to be supported by a dynamic approach that encapsulates good practice, excellent training and the tools to do the job effectively, e.g., a proficient system including IT and good articulation, and promotion of domestic abuse as an issue that affects all communities.

Recommendation 2: In order to ensure that practice is good, Adult Care needs to give consideration to a range of measures, checks and balances that support practitioners in delivering good quality work across a range of services.

Recommendation 3: Consideration needs to be given to strengthening the management oversight, particularly at the principal practitioner level. This could be achieved by incorporating robust risk assessment at the allocation stage of case management, in particular the use of the family histories and chronologies in identifying patterns and themes of behaviour in order to enable professional judgements about level of risk to be made confidently. In reflecting on this case, it would be timely to also consider reviewing the 'complex' case definition and deciding if a 'complex' case needs to be managed in a different way from a more straight forward request.

Recommendation 4: In order to support a strengthened management oversight, Adult Care may wish to consider revisiting the current Quality assurance regime, to put in quality checks of cases at points such as review and closure, or all cases open for 6 months plus, for example, which could also cross reference with practitioner supervision and development. This would support the development of high level assessment skills and start to help identify what 'good' looks like.

Recommendation 5: The practice standards need to be revisited in terms of how these are articulated to the staff and how Adult Care ensures they are adhered to. This would provide a base-line standard of practice that could be tested with a more robust approach to auditing cases.

Recommendation 6: Adult Care and LCC needs to ensure there is a robust approach to Making Safeguarding Personal. In focusing on this developmental area, the implementation of the new Domestic Abuse protocol for the Local Authority as a whole needs to be supported in a systematic and dynamic way. This also needs to be articulated well to multi-agency partners who are also engaged in working with Adults and their families. This would ensure that all staff working with the citizens of Lincolnshire have safeguarding at the forefront of their practice, encourage relationship-based practice and so that the best person to have the 'conversation' about difficult issues would be equipped to do this and be clear about their accountabilities.

Recommendation 7: Adult Care may wish to commission a training strategy for Adult Care and those services which are commissioned by it, with strong performance measurements underpinning it, which are reported on a regular basis, and action taken if these standards are not met. This training strategy should also consider the multi-agency training that is hosted by the Adult Safeguarding Board and how this can be offered to partners in the future in order to

ensure there is a suite of core training, including safeguarding issues, such as domestic abuse, drug and alcohol use and mental health.

Recommendation 8: Adult Care may need to consider changes to AIS that ask a domestic abuse question as part of all assessments as a mandatory field. This would raise awareness and at least provide a prompt to staff to ask these questions. There would need to be consideration to review what is asked in the Carer's Assessment in order to ensure an in-depth assessment is undertaken that focuses beyond the presenting issues. These changes would need to be articulated to the Mosaic team to ensure this is factored into the build of the new system.

Ceryl Teleri Davies

Independent Overview Author

8th May, 2017