DOMESTIC HOMICIDE REVIEW

Susan

Died late - summer 2018

OVERVIEW REPORT

February 2022

Chair David Hunter
Author Carol Ellwood

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CONTENTS

1. INTRODUCTION

1.1 This report of a domestic homicide review examines how agencies responded to, and supported, Susan, a resident of Lincolnshire prior to her death in late-summer 2018.

1.2 Susan died as a result of a head injury sustained in a road traffic incident. Ben, Susan's partner of four years, was driving the car in which Susan was travelling at the time of the incident. Ben was arrested at the scene. A criminal investigation was undertaken surrounding the circumstances of Susan's death. The investigation has now concluded; there has been no criminal prosecution directly related to the death of Susan.

1.3 An inquest into the death of Susan was heard in March 2019. HM Coroner recorded the following narrative verdict - 'The deceased was travelling in the front passenger seat of a vehicle being driven by her partner. The pair were arguing; the deceased expressed some concern as to the manner in which the vehicle was being driven and asked him to stop or slow down. When this did not happen, she opened the door and threw herself from the vehicle which at that point was travelling at a minimum speed of 36 mph. There is no evidence that she sought to end her own life and it is not clear whether she appreciated the risks involved in what she did'.

1.4 Whilst there have been no criminal charges directly related to the death of Susan, Safer Lincolnshire Partnership, determined the death met other elements of the domestic homicide review criteria and, commissioned this Domestic Homicide Review to analyse agency involvement, in order to identify if domestic abuse was known to agencies before the death of Susan, and, where known, to review how those agencies responded to those concerns in order to identify any learning within the Safer Lincolnshire Partnership.

1.5 The panel offers its sincere condolences to Susan's family.

1.6 The report was seen by Susan's family who provided the following tribute – 'Susan was a loving Mum, daughter and sister, who was tragically taken from the world too soon. Although a very private and reserved person, she cared for everyone and was always willing to do her best and help others. She will not see her children grow up, especially her youngest child who was so young at the time of Mum's death. It has been hard on the family to come to terms with the loss of Mum and leaves so many questions that we cannot answer. As a family we think about Mum every day and miss her so much'.

2. TIMESCALES

2.1 On 19 October 2018 Safer Lincolnshire Partnership determined the death of Susan met the criteria for a domestic homicide review [DHR].

2.2 The review commenced after Ben's court case in January 2019, and the inquest which was held in March 2019. The first meeting of the review panel took place on 5 April 2019. Thereafter the panel met five times.

2.3 The domestic homicide review was presented to Safer Lincolnshire Partnership on 15 May 2020 and on 18 March 2021 when it was sent to the Home Office.

3. CONFIDENTIALITY

3.1 Until the report is published it is marked: Official Sensitive Government Security Classifications May 2018.

3.2 The names of any key professionals involved in the review are disguised using an agreed pseudonym.

3.3 This table shows the age and ethnicity of Susan and her partner at time of her death and other key individuals. The pseudonyms were agreed with Susan's family.

Name[1]	Relationship	Age	Ethnicity
Susan	Partner of Ben	47	White British female
Ben	Partner at time of death	33	White British male
Child 1	Susan's eldest child	n/a	White British
Child 2	Susan's second child	n/a	White British
Child 3	Susan and Ben's child	n/a	White British

[1] The DHR panel agreed to include Child 1 and Child 2 in the table even though they are not subject of the review but have contributed to the review and had access to the Overview Report.

4. TERMS OF REFERENCE

4.1 The Panel settled on the following terms of reference at its first meeting on 5 April 2019. They were shared with Susan's family who were invited to comment on them.

4.2 The review covers the period 1 March 2015 [which was the date Susan booked for ante-natal care for Child 3] until 19 September 2018.

The purpose of a DHR is to:[2]

a] 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;

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

c] Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

d] Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

e] Contribute to a better understanding of the nature of domestic violence and abuse; and

f] Highlight good practice.

SPECIFIC TERMS

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

[2] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews [2016] Section 2 Paragraph 7

2. When and in what way were practitioners sensitive to the needs of the subjects? Were they, knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about Susan, Child 3 or Ben? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

3. When, and in what way, were the subject's wishes and feelings ascertained and considered? Were the subjects informed of options/choices to make informed decisions? Were they signposted to other agencies and how accessible were these services to the subjects?

4. 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?

5. Was appropriate professional curiosity exercised by those professionals and agencies working with the individuals in the case, this includes whether professionals analysed any relevant historical information and acted upon it?

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

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

8. 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?

9. Were any issues of disability, diversity, culture or identity relevant?

10. To consider whether there are training needs arising from this case?

11. To consider the management oversight and supervision provided to workers involved?

12. Was any restructuring during the period under review likely to have had an impact on the quality of the service delivered?

5. METHOD

5.1 Lincolnshire Police notified Safer Lincolnshire Partnership on 13 September 2018 of the death of Susan and that the case potentially met the criteria for a domestic homicide review. A meeting held on 19 October 2018 determined the criteria had been met for a Domestic Homicide Review to be undertaken.

5.2 The first meeting of the DHR panel determined the period the review would cover. The review panel determined which agencies were required to submit written information and in what format. Those agencies with substantial contact were asked to produce individual management reviews and the others, short reports. Some agencies interviewed staff involved in the case to gain a better understanding of how and why decisions were made.

5.3 The DHR panel made the decision to include information within the overview report relating to Ben, that the panel deemed to be necessary in order to discharge their responsibilities within the DHR process.

5.4 The Chair and Independent Author met with Susan's family at their home in the summer 2019. Thereafter, they exchanged e-mails and telephone calls. They provided valuable background information on the relationship between Susan and Ben, the details of which are included within Paragraph 14.1.

5.5 The DHR Author contacted a close friend of Susan's but they did not respond to several requests to meet with the DHR Chair and Author.

5.6 The DHR Chair saw Ben's mother in October 2019 as she was reported to be close to Susan. That attributed contribution appears as necessary.

5.7 The DHR Chair met with Ben and relevant information has been included within the report. Advice to DHR panels on the involvement of partners and their family is contained within Home Office Guidance – Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews'. https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews.

5.8 The DHR Chair and Author also had access to the Coroner's file which assisted with background information in relation to Susan.

5.9 During the Covid-19 pandemic panel members remained in contact via email and electronic forums. The family were also kept updated on the progress of the report by the Author during email and telephone contact.

5.10 Thereafter a draft overview report was produced which was discussed and refined at panel meetings before being agreed. The draft report was shared with Susan's family who were invited to make any additional contributions or corrections.

6. CONTRIBUTORS TO THE REVIEW.

6.1 This table show the agencies who provided information to the review.

Agency	IMR[3]	Chronology	Report
Addaction (now named We Are With You)	✓	✓	
East Midlands Ambulance Service	✓	✓	
GP[4]	✓	✓	
Humberside, Lincolnshire and North Yorkshire Community Rehabilitation Company	✓	✓	
Lincolnshire Children's Services	✓	✓	
Lincolnshire Police	✓	✓	
Lincoln Partnership NHS Foundation Trust		✓	
North Kesteven District Council [Housing]	✓	✓	
United Lincolnshire Hospitals NHS Trust	✓	✓	
West Lindsey District Council			✓

6.2 The individual management reviews contained a declaration of independence by their authors and the style and content of the material indicated an open and self-analytical approach together with a willingness to learn. All the authors explained they had no management of the case or

[3] Individual Management Review: a templated document setting out the agency's involvement with the subjects of the review.

[4] Chronologies were received from two GP Practices and an IMR, incorporating a chronology from a third GP Practice. There was no requirement for the two GP Practices to produce an IMR.

direct managerial responsibility for the staff involved with this case. All panel members saw all the individual management reviews.

7. THE REVIEW PANEL MEMBERS

7.1 This table shows the review panel members.

Review Panel Members		
Name	**Job Title**	**Organisation**
Tracy Aldrich	Housing Services Manager	North Kesteven District Council
Liz Bainbridge	Consultant Nurse Safeguarding Children & Mental Capacity	Lincolnshire Partnership Foundation Trust
Carol Ellwood	Author	Independent
David Hunter	DHR Chair	Independent
Jane Keenlyside	Senior Management Team	EDAN[5] Lincolnshire
Barbara Mitchell	Head of Safeguarding	Lincolnshire Community Health Services (Attended first two panel meetings).
Matthew Morrissey	Interchange Manager and Lead for Safeguarding Children and Adults	Humberside, Lincolnshire and North Yorkshire Community Rehabilitation Company
Sarah Norburn (Deputising for Jon McAdam – Head of Protecting	Domestic Abuse Co-ordinator	Lincolnshire Police

[5] https://edanlincs.org.uk/
EDAN Lincs (Ending Domestic Abuse Now in Lincolnshire) Domestic Abuse Service (formerly West Lincolnshire Domestic Abuse Service) is a registered charity; we provide support and assistance to women, men and children suffering, or fleeing from domestic abuse. EDAN Lincs Domestic Abuse Service (EDAN Lincs) provides safe, emergency, temporary accommodation and support to any male or female – with or without children – experiencing domestic abuse. Whilst we do not have accommodation for males in our multi-occupancy refuge, we do offer support to men experiencing domestic abuse in our dispersed properties and via Outreach Support.

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Vulnerable People)		
Karen Ratcliff	Lincolnshire Service Manager	Addaction now named We Are With You
Claire Saggiorato	Lead Nurse Safeguarding	Lincolnshire Children's Health
Yvonne Shearwood	Head of Service	Lincolnshire Children's Services
Elaine Todd	Named Nurse for Safeguarding Children and Young People	United Lincolnshire Hospitals NHS Trust
Claire Tozer	Safeguarding Adults and Children Lead	Lincolnshire Clinical Commissioning Group
Natalie Watkinson	Domestic Abuse Project Officer	Lincolnshire County Council
Safer Lincolnshire Partnership Support		
Toni Geraghty	Legal Advisor	Legal Services Lincolnshire
Jade Thursby	Community Safety Strategic Co-ordinator with a lead in Domestic Abuse	Lincolnshire County Council
Teresa Tennant	DHR Administrator	Lincolnshire County Council
Observers[6]		
Lara Iggulden	IDVA Manager	EDAN Lincolnshire
	GP Practice Manager	

7.2 The chair of Safer Lincolnshire Partnership was satisfied that the panel chair was independent. In turn, the panel chair believed there was sufficient independence and expertise on the panel to safely and impartially examine the events and prepare an unbiased report.

[6] Observers were present during a number of the DHR Panel meetings for their continuing professional development.

7.3 The panel met five times and matters were freely and robustly considered. Outside of the meetings the chair's queries were answered promptly and in full.

8. CHAIR AND AUTHOR OF THE OVERVIEW REPORT

8.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 sets out the requirements for review chairs and authors. In this case the chair and author were separate persons.

8.2 David Hunter was appointed as the Domestic Homicide Review Chair. David is an independent practitioner who has chaired and written previous Domestic Homicide Reviews, Child Serious Case Reviews, Multi-Agency Public Protection Reviews and Safeguarding Adults Reviews and was judged to have the experience and skills for the task. Before retiring from full time work in 2007 he served in the armed forces and police service.

8.3 The Chair was supported by Carol Ellwood as the Independent Author for the review. Carol retired from thirty years public service [British policing] during which she gained experience of writing independent management reviews, as well as being a panel member for Domestic Homicide Reviews, Child Serious Case Reviews and Safeguarding Adults Reviews. In January 2017 Carol Ellwood was awarded the Queens Police Medical (QPM) for her policing services to Safeguarding and Family Liaison. Carol is also an Associate Trainer for Safelives[7].

8.4 Between them they have undertaken the following types of reviews: child serious case reviews, safeguarding adult reviews, multi-agency public protection arrangements [MAPPA] serious case reviews, domestic homicide reviews and have completed the Home Office online training for undertaking Domestic Homicide Reviews. They have also attended AAFDA[8] training for DHR chair and authors.

8.5 Neither the Chair nor Author have worked for any agency providing information to the review.

[7] http://www.safelives.org.uk/ The UK-wide charity dedicated to ending domestic abuse, for everyone and for good.
[8] Advocacy After Fatal Domestic Abuse Register Charity No: 1125973 www.aafda.org.uk

9. PARALLEL REVIEWS

9.1 Her Majesty's Coroner for Lincolnshire opened and adjourned an inquest into Susan's death on 1 October 2018. In March 2019 an inquest was held. The medical cause of death was recorded as – 'head injury sustained in a road traffic incident'. The inquest did not establish that Susan intended to take her own life. A narrative verdict was recorded

9.2 Lincolnshire Police completed a criminal investigation into the circumstances surrounding the death of Susan. A decision was made by the Senior Investigating Officer that no criminal charges would be made in relation to Susan's death. See paragraph 12.10.

9.3 In January 2019 Ben appeared at Lincoln District Magistrates' Court charged with motoring offences which occurred at the time of the road traffic incident resulting in Susan's death. Ben pleaded guilty to those offences and was disqualified from driving.

9.4 Following the death of Susan Lincolnshire Police referred the case to the Independent Office for Police Conduct [IOPC][9]. This is a statutory process when someone has had direct or indirect contact with the police when, or shortly before, (in this case 31 August 2018), they were seriously injured or died, and the contact, may have caused or contributed to the death or injury. The IOPC determined – 'no person serving with the police or contractor may have committed a criminal offence or behaved in a manner which would justify the bringing of disciplinary proceedings.'

9.5 The chair is not aware that any other agency has conducted a review or investigation into Susan's death.

[9] https://policeconduct.gov.uk/complaints-and-appeals/statutory-guidance

10. EQUALITY AND DIVERSITY

10.1 Section 4 of the Equality Act 2010 defines protected characteristics as:

- **age** [for example an age group would include “over fifties” or twenty-one year olds. A person aged twenty-one does not share the same characteristic of age with “people in their forties”. However, a person aged twenty-one and people in their forties can share the characteristic of being in the “under fifty” age range].
- **disability** [for example a man works in a warehouse, loading and unloading heavy stock. He develops a long-term heart condition and no longer has the ability to lift or move heavy items of stock at work. Lifting and moving such heavy items is not a normal day-to-day activity. However, he is also unable to lift, carry or move moderately heavy everyday objects such as chairs, at work or around the home. This is an adverse effect on a normal day-to-day activity. He is likely to be considered a disabled person for the purposes of the Act].
- **gender reassignment** [for example a person who was born physically female decides to spend the rest of her life as a man. He starts and continues to live as a man. He decides not to seek medical advice as he successfully ‘passes’ as a man without the need for any medical intervention. He would have the protected characteristic of gender reassignment for the purposes of the Act].
- **marriage and civil partnership** [for example a person who is engaged to be married is not married and therefore does not have this protected characteristic. A divorcee or a person whose civil partnership has been dissolved is not married or in a civil partnership and therefore does not have this protected characteristic].
- **pregnancy and maternity**
- **race** [for example colour includes being black or white. Nationality includes being a British, Australian or Swiss citizen. Ethnic or national origins include being from a Roma background or of Chinese heritage. A racial group could be “black Britons” which would encompass those people who are both black and who are British citizens].
- **religion or belief** [for example the Baha’i faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism are all religions for the purposes of this provision. Beliefs such as humanism and atheism would be beliefs for the purposes of this provision but adherence to a particular football team would not be].
- **sex**
  sexual orientation [for example a man who experiences sexual attraction towards both men and women is “bisexual” in terms of

sexual orientation even if he has only had relationships with women. A man and a woman who are both attracted only to people of the opposite sex from them share a sexual orientation. A man who is attracted only to other men is a gay man. A woman who is attracted only to other women is a lesbian. So, a gay man and a lesbian share a sexual orientation].

10.2 The Panel considered if Susan and Ben had any of the relevant protected characteristics and wider diversity issues but concluded they did not. There were some issues relating to depression for both Susan and Ben but based on the available information were not considered to be within the definition of disability.

10.3 Susan and Ben were both white British with English being their first language. There is ample evidence that they carried out day-to-day activities. They both worked and ran a home while looking after a young child. The same information can be used to infer they had capacity to make all their decisions.

11. DISSEMINATION

11.1 The following organisations/people will receive a copy of the report after any amendment following the Home Office's quality assurance process.

- The Family
- North Kesteven District Council
- Lincolnshire Partnership NHS Foundation Trust
- EDAN
- Lincolnshire Community Health Services
- Humberside, Lincolnshire and North Yorkshire Community Rehabilitation Company
- Lincolnshire Police
- Addaction now named We Are With You
- Lincolnshire Children's Services
- United Lincolnshire Hospitals Trust
- Lincolnshire Clinical Commissioning Group
- Safer Lincolnshire Partnership
- Lincolnshire County Council
- Lincolnshire Police and Crime Commissioner

12. BACKGROUND INFORMATION [THE FACTS]

12.1 Susan and Ben met in the summer of 2014 and lived together in several different rental properties. Child 3 was born during their relationship. Both Susan and Ben have children from previous relationships. At the start of their relationship Ben moved into Susan's rented property.

12.2 After a few years, Susan and Ben moved into a small touring caravan in the same village before settling in a static home on a remote site. Just a few weeks before Susan's death the couple moved into a flat above the closed down public house on the same site.

12.3 The location of the latter properties is in a rural part of Lincolnshire, approximately 15 miles from Lincoln city centre. The area has a small community and is located at the end of a single track road, 7 miles from a main road.

12.4 On 30 June 2018 Lincolnshire Police attended a domestic abuse incident reported by Susan, during which she stated she had been head butted by Ben. Child 3 was woken by the incident. Susan had a visible mark to her face. Ben was arrested and interviewed. No civil or criminal proceedings were progressed in relation to this incident. Details of the incident were shared with Lincolnshire Children's Services on 5 July 2018, who allocated the referral for a social care assessment.

12.5 On 31 August 2018 Susan made a same day appointment for Ben to attend and see a GP in relation to his mental health, Ben was seen at 1544 hours. Susan, and their child accompanied Ben to this appointment. Susan is not registered at this GP Practice. During the appointment Susan became upset and left the room. Susan was found in a corridor by a practice nurse in a distressed state. Susan informed the practice nurse that Ben was verbally abusive towards her and her eldest child, she also disclosed the incident from June 2018. When asked, Susan stated that she feared for her safety if she went home. Susan was provided with leaflets and contact details for support as well as being offered the privacy of a room to make contact. Susan declined this offer and informed the practice nurse that she would make contact herself. A safeguarding referral was made in respect of Child 3, the same day to Lincolnshire Children's Services, which was responded to appropriately and identified as in need of further assessment.

12.6 At 1635 hours, on 31 August 2018, following the incident at the GP practice, the Police responded to a 999 call from Susan during which she stated that Ben was being violent, and that he had 'kicked off'. The incident occurred at his Mother's address. Susan was reported as being distressed but uninjured. Susan stated that Ben had left the property and that she was concerned about his behaviour, mood and manner of driving. Susan described his mental health as uncontrollable. Child 3 had been present during the incident. The Police were not aware of the earlier incident at the GP practice.

12.7 Police visited Ben and during the contact he stated that he was seeking help from his G.P. and that he had an appointment on 3 September 2018. Police completed a mental health form[10]. Susan was also seen, and a DASH[11] form completed. It was recorded that Susan and Ben would be staying at separate locations. Details of the incident were shared with Lincolnshire Children's Services on 6 September 2018, after the death of Susan.

12.8 On 3 September Ben visited his GP, who made a telephone referral to the Crisis Team. The GP followed up this telephone referral by sending a fax patient summary to the Crisis Team. This action was completed within 15 minutes of the telephone referral being made. The Crisis Team made two attempts to contact Ben upon receipt of the referral at 1722 hours and 1910 hours, these were unsuccessful.

12.9 On 4 September 2018 the Crisis Team attempted further telephone contact for triage with Ben at 1600 hours, which was unsuccessful. The GP information was reviewed by the Crisis Team which identified a risk of aggression, suspected acute mental illness, as well as a child within the family. It was agreed for two Lincoln Partnership NHS Foundation Trust (LPFT) staff to visit Ben on 5 September 2018.

12.10 In September 2018 Police and East Midlands Ambulance Service responded to a single vehicle road traffic incident. Ben had been the driver of the vehicle and Susan the passenger at the time of the incident. Susan was

[10] This is a Lincolnshire Police generated form completed by officers and used to gather information concerning mental health incidents. The information is only shared with the Crisis Team (LPFT) when individuals are detained under S136 or S135 Mental Health Act.
[11] Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) risk identification, assessment and management model.

brought to A&E at Lincoln County Hospital, before being transferred to Queens Medical Centre[12], Nottingham, where she later died from her injuries.

12.11 Ben was arrested at the scene. A Police investigation was undertaken into the circumstances of Susan's death. The investigation concluded with no evidence to indicate that there had been any sort of violent or physical struggle. The post mortem examination found no evidence of alcohol, other therapeutic or illicit drug having been used by Susan. The cause of death was determined as 'head injury sustained in a road traffic incident'. There were no other injuries to suggest historical injuries caused by another party and no injuries to suggest she had been the victim of a blunt or sharp trauma assault. There was also no evidence to indicate that she had been gripped with sufficient force to cause an injury or that she had left the vehicle against her will.

12.12 Ben was charged with an offence of driving whilst unfit through drink/drugs. In January 2019 Ben pleaded guilty to the offence and was disqualified from driving for 18 months.

12.13 In March 2019 an inquest was held in relation to Susan's death. H.M. Coroner recorded a narrative verdict. See paragraph 1.3.

[12] The Queens Medical Centre is part of Nottingham University Hospitals NHS Trust

13. CHRONOLOGY

13.1 Background

13.1.1 The following section is a summary of information that has been provided to the DHR by family members on their knowledge and understanding of Susan and Ben, and their relationship together. The section also contains information provided following contact with Ben and access to the Coroner's file.

Susan
Susan was the eldest of two children born to her parents. During her childhood Susan lived in villages surrounding Lincoln where she attended local schools. Upon leaving school Susan had several jobs within the catering industry and progressed within this area to undertake roles at Assistant Manager level for several years. Susan was also known to have a domestic cleaning job, which had been gained through contact with Ben's Mother. Susan had two children from a previous relationship. These children lived with their father following the separation of the relationship. The eldest of these children lived with Susan and Ben in the months prior to her death. Susan was described by her family as a very private and reserved person. Susan's family stated that prior to her meeting Ben; she always took pride in her personal appearance and ensured that her house was spotlessly clean and tidy. A position that deteriorated as her relationship developed with Ben. This change was described, by a family member, to the Chair and Author as if Susan had done a complete '360' degrees.

Ben
Ben is the youngest of five children. Ben worked on road building/repairs and more latterly he qualified to drive lorries. Information within some agency contacts indicated that Ben worked long hours and often worked away from home. Ben confirmed this when seen. Ben informed the DHR Chair that he had used drugs since about the age of 15 and that he was aware of the effect on his mental health with this long-term use. Ben stated that for the first two years of his relationship with Susan she was not aware of his drug use. Ben stated he did not drink much alcohol, other than an occasional bottle of beer. Susan's family described Ben as someone who very rarely consumed alcohol, but when he did, he went over-the-top.

Susan's family described Ben as a jealous person, who could easily change his behaviour and that he presented with an aggressive stance and had no respect for statutory authorities. Ben acknowledged to the DHR Chair that he had a short temper and could easily 'blow up' and in doing so he recalled the incident with the road worker and taxi driver when describing his short temper. However, he minimised his part.

Ben has several convictions that are relevant for this review; the details are in Section 14.

Susan and Ben's Relationship

Relationship

Susan and Ben are understood to have met around July/September 2014 and on seeing each other they formed an immediate attraction.

Ben informed the DHR Chair that he wasn't in a good place when he met Susan and had had a diagnosis of depression, however; this soon lifted after he met Susan and found work. Ben described their relationship as 'Spot on' and that they got on really well, which continued after Child 3 was born.

Ben's mother stated there was verbal and physical aggression (pushing and shoving) between them both and she described this as being 'six of one and half a dozen of the other'.

Ben stated that up to Child 1 moving in, there was never a cross word between him and Susan. After Child 1 moved in the dynamics changed and Ben began niggling at Susan and wanted Child 1 to move out so they could be alone again.

Child 1 informed the Chair and Author that in the 2-3 weeks prior to Susan's death, she appeared to be quiet and that she had asked Child 1 not to disclose to the family the arguments that were happening and how things were in the home between Ben and Susan. This information, including Child 1 seeing an injury to Susan in July 2018 is covered further in the report.

Accommodation

Ben stated he moved into Susan's private rental property straightaway after meeting her; however; when repairs were not carried out on the house, they stopped paying the rental fee which resulted in a court case relating to the outstanding rent owed.

At this time, Ben and Susan moved from the property into a touring caravan within the village, before moving to a static home in rural Lincolnshire.

Child 1 informed the Chair and Author that he moved into the static home to live with Susan and Ben in May 2018 following Ben offering him a job. The job did not materialise as planned, but he continued to live with Ben, Susan and Child 3 until Susan's death.

In the two weeks before Susan's death, Susan and Ben moved into a flat above the disused pub on the site, in which they were living.

Susan's family felt that although the move out of the village was due to the condition of their rental property, on reflection since Susan's death, it may have been a way of Ben isolating Susan from her family.

<u>Finances</u>

Ben explained how his salary was paid into Susan's bank account as he did not have one, and Susan provided him with an allowance. However, he also said he used her bank card at times. Susan's family believed that it was Ben who controlled the finances.

Ben informed the Chair that he believed Susan may have been in some financial difficulty, and although Susan never confided in him, he gave an example of money that was leaving the bank account to pay for a car no longer owned by Susan. This provides further evidence that Ben knew something about the family's finances.

Ben's Mother informed the Chair that when they were living in the touring caravan, Susan and Ben's mail was re-directed to her property, during which she received letters for Susan relating to financial matters. The Chair was shown a copy of one such letter which was received after Susan's death. The letter from a firm of solicitors revealed Susan was being formally pursued for a substantial debt after defaulting on an Independent Voluntary Agreement.

Ben's Mother lent Ben and Susan money to secure their move to the static home. Some of this money had been repaid by Susan prior to her death.

Susan's father informed the Chair and Author that there was a financial issue within their relationship surrounding a lack of money, whereby Susan would often ask him to lend her money, for which he was never repaid. Susan's father informed the review that in the few months prior to her death he had told Susan that he would not give her any more money unless she left Ben.

It is also known, from Council records, that Susan had a Council Tax debt of several hundred pounds which included some of the period when she and Ben lived together.

13.2 EVENTS TABLE

13.2.1 An events table has been produced which contains important events which help with the context of the domestic homicide review. It is drawn up from material provided by the agencies that contributed to the review and memories and recollections of Susan's family. The table is produced at Appendix A.

14. OVERVIEW

14.1 Introduction

14.1.1 This section of the report summarises what information, relevant to domestic abuse, was known to the agencies and professionals involved with Susan and Ben. The structure adopts a chronological approach in which each issue of significance is described, and the input of each agency considered. The events are cross referenced to the events table at Appendix A. The analysis of the contacts against the terms of reference appears at section 15.

14.2 Events predating the timescale of the DHR

14.2.1 Between 2009 and 2012 Ben was known to some agencies in respect of domestic abuse in previous relationships. There are four recorded incidents, with four different victims during this time period.

14.2.2 In 2009 Ben was convicted for an offence of battery. This is Ben's only conviction for a domestic abuse related crime. A DASH was completed, and the incident graded as standard.

14.3 Events within the timescale of the DHR

Criminal Justice Processes involving Ben

14.3.1 Ben came to the attention of the Police on two occasions, during early 2016. The first incident occurred in February 2016 when Ben was involved in a racially aggravated altercation with an adult male taxi driver. Susan was also present during this incident. Police enquiries identified that Ben was the aggressor. An offence of Racially Aggravated Common Assault was recorded but as the victim did not wish to support an investigation or prosecution, no further action was taken. When Ben was seen as part of the DHR he denied being the aggressor.

14.3.2 The second incident occurred approximately three weeks later, when Ben was stopped driving a car, which the Police had seen being driven erratically. Following a search of the vehicle, a small quantity of cannabis was found. Ben admitted possession of the drugs and was issued with a cannabis warning. There is no indication that Ben was screened for drug use at the time of this. Information provided by Lincolnshire Police indicated that screening kits were not as readily available in March 2016 as they are now.

14.3.3 At the time of these incidents Ben was awaiting trial at Crown Court for the offence of assault occasioning actual bodily harm, for which he was eventually sentenced in August 2016. This was not related to domestic abuse. Because neither incident resulted in formal charges the National Probation Service's report to the court, to inform sentencing for the actual bodily harm offence, did not refer to them. Therefore, the two incidents were not considered when the National Probation Service later formulated Ben's risk to others.

30 June 2018 - Domestic Abuse Incident

14.3.4 On 30 June 2018 Susan called the police to report that Ben had assaulted her and head-butted her. Child 3, who had been asleep, had been woken as a result of the incident. During the call Susan stated that Ben would lose his temper, and that he had hit her before, but this was the worst it had been. There were no previous reports of domestic abuse between Susan and Ben known to the Police. Ben was not at the property at the time of the call. Susan believed that Ben was in a nearby pub. Brief details from the Police National Computer (PNC) were recorded on the incident log in relation to Ben. These related to the incident in September 2014 and July 2011. Further checks were also completed by the Force Control Room and Custody Suite, including a check of the critical register and a check of any bookmarked incidents involving Susan and Ben, which were all negative.

14.3.5 Police Officers attended and spoke to Susan who informed them that Ben had returned to the caravan in drink, and that she would not let him in and during the incident Ben head-butted her in the forehead. Susan was seen by the Police to have an injury to her face which was captured on body worn video. Ben returned to the caravan whilst the Police were present, and he was arrested.

14.3.6 Susan provided a statement stating she did not wish to pursue a complaint and that she did not want to go to court. An Officer contacted Susan the following morning, prior to the interview of Ben, and Susan maintained that she did not want to pursue a complaint of assault.

14.3.7 Ben was interviewed by the Police and denied causing the injury to Susan. The interviewing officer did not undertake any further research, than what had already been completed by the Police as detailed in 14.3.4 and

therefore was not aware of the previous domestic abuse incidents, or other acts of violence, for which Ben was not convicted.

14.3.8 Ben was released from custody. No further action was taken in relation to the assault because there were no independent witnesses. As no other lines of enquiry were pursued, there was insufficient evidence to proceed with the offence of assault.

14.3.9 The Public Protection Notice PPN[13] that was completed for the incident graded the risk as 'standard'. The Officer described the matter as a one-off incident and that Susan did not think Ben would do it again. The incident was shared with Lincolnshire Children's Services on 5 July 2019, as a notification. No other safeguarding measures were progressed, such as Domestic Violence Protection Notice (DVPN)[14], Domestic Violence Disclosure Scheme (DVDS)[15] or consideration of an evidence-based prosecution[16].

14.3.10 Lincolnshire Children's Services undertook a social care assessment following this incident which commenced on 13 July 2018 and concluded on 19 July 2018. The assessment included a visit to the caravan to see Susan and her child, contact with the nursery and a discussion with Susan around her perception of domestic abuse. Ben was not seen as part of the assessment. The Social Worker developed a safety plan with Susan which included the neighbours assisting in providing a safe place in the event of a further incident of domestic abuse. That safety plan was implemented on 30 August 2018 and provided evidence of the fact that the strategy enabled safety of child and Mother. See 14.3.13.

Events on Friday 31 August 2018

[13] The PPN process was introduced in Lincolnshire Police on 23rd May 2018. The PPN is a tool for all officers and staff to submit their concerns about risk, including domestic abuse cases, to a supervisor for review, or to a specialist team for consideration of onward referral to Social Care and other partner agencies. This process is part of the Niche system and in relation to standard and medium risk Domestic Abuse cases there is a requirement for a Sergeant to review the incident. Cases of high-risk cases are automatically sent for Inspectors to review.

[14] https://www.gov.uk/government/publications/domestic-violence-protection-orders

[15] https://www.gov.uk/government/publications/domestic-violence-disclosure-scheme-pilot-guidance

[16] https://www.cps.gov.uk/legal-guidance/domestic-abuse-guidelines-prosecutors

14.3.11 At 1544 hours on 31 August 2018 Ben attended his GP practice with Susan and Child 3. The appointment had been made by Susan for Ben that day. Ben and Susan travelled separately to the appointment. Ben, accompanied by Susan and Child 3 was seen by an Advanced Nurse Practitioner during which he stated that he needed help with his mental health, that he was very stressed, depressed and couldn't cope. Ben stated that his work and family life were very stressful, the close community were causing him stress and that he was losing his temper and shouting all the time. Ben denied any thoughts of harming himself or any others and it was recorded that Child 3 was a protective factor.

14.3.12 Part way through the consultation Susan left the room in tears and was found in the corridor by a Practice Nurse, who described her as being in a distressed state. Susan was taken to a separate room. Child 3 remained with Ben. Susan told the Practice Nurse that she'd had enough and could not take any more of Ben's behaviour. Susan explained that she felt Ben's mental health was deteriorating and that he was now frequently verbally abusive to her and Child 1, but never towards Child 3.

14.3.13 Susan informed the Practice Nurse of the incident in June 2018 when Ben had assaulted her, but that she had not pressed any charges and that Lincolnshire Children's Services had been involved. The Practice Nurse informed Susan that she could still press charges retrospectively. Susan also informed the Practice Nurse that only the day before her neighbours had taken her and her youngest child into their house as they were worried by the amount of shouting coming from the house. The Practice Nurse sent an e-message to the Advanced Nurse Practitioner that she was with Susan who was in a very distressed state.

14.3.14 Ben was offered a prescription for antidepressants, provided telephone numbers for Relate[17], the mental health 24-hour access line[18] and details of Steps 2 Change[19]. Upon completing the consultation, the Advanced Nurse

[17] https://www.relate.org.uk/find-my-nearest-relate/centre/lincolnshire-relate-centre

[18] http://www.lincsshine.co.uk/component/sobipro/?pid=81&sid=386:LPFT-Single-Point-of-Access&Itemid=0
The Single Point of Access (SPA) service provides a first point of contact for people aged 18 and over who wish to access mental health and disability services in Lincolnshire.

[19] http://www.lpft.nhs.uk/steps2change/
Steps2change is a free NHS service that provides a range of evidence based talking therapies for problems such as depression, anxiety, post-trauma reaction, panic, phobia

Practitioner advised Ben that she was going to see Susan as she was aware she was with her colleague and was upset.

14.3.15 The Advanced Nurse Practitioner asked Susan "If she feared for her safety if she went home now" to which she replied "Yes". The Advanced Nurse Practitioner left Susan and sought advice from the surgery safeguarding lead. Susan was provided with various numbers for Domestic Abuse Helplines and advised she could return to the surgery anytime if she needed support or a place of safety to make her calls. Susan was asked if she wanted to contact any of the helplines from the safety of the treatment room but she declined. She stated she would ring them from her mobile in the car park next to the surgery or she might go to Ben's mother's house. The Practice Nurse offered to contact Susan's surgery to make an appointment, but she declined at the time and said she would do it later.

14.3.16 Susan left the room stating she was going to collect Child 3. Ben had already left the surgery with Child 3 to collect his prescription. A short time after a male and female could be heard shouting from the nearby public car park. A car was heard to be driven away, but staff at the surgery were not able to identify who was driving this car. Susan had earlier informed staff that her and Ben had travelled in separate cars. Ben's Mother informed the DHR Chair that Susan had borrowed her car to go to the surgery and returned to Ben's Mother's home with Child 3 after Ben was seen at the surgery.

14.3.17 The Advanced Nurse Practitioner contacted Lincolnshire Children's Services by telephone that same day at 1646 hours and made a referral due to concerns for the environment she understood Child 3 to be living in. Lincolnshire Children's Services sent the referral to the area team for allocation on 3 September 2018. The referral was processed in accordance with Working Together 2018[20] and local safeguarding children policies[21].

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and Obsessive Compulsive Disorder (OCD). Steps2change consists of qualified Cognitive Behavioural Therapists, Counsellors, Interpersonal Therapists, Psychological Wellbeing Practitioners and Employment Advisors; all employed by Lincolnshire Partnership NHS Foundation Trust to provide psychological treatment on behalf of Lincolnshire Clinical Commissioning Groups. We offer information and guidance in a variety of locations across the county. Our aim is to provide the help you need, in convenient locations, within easy reach of where you live and work.

[20] https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

[21] https://lincolnshirescb.proceduresonline.com/chapters/contents.html

Contact was not made with Susan prior to her death, albeit there were plans to undertake a further assessment.

14.3.18 The following text is contained within the referral – 'Susan told caller that Ben has been verbally abusive and has been hitting her. Susan said 2 months ago Ben head butted her, she called police but did not press charges. Susan also said her, and Ben were having a row the other day and neighbours had come round and took Child 3 away and locked Ben in another room. Ben is also verbally aggressive to the older son (details not known) who lives in the house. Susan asked caller to get Child 3 back to her but when caller went into Ben again he got annoyed and said 'No he is staying with me'. Ben then went off with Child 3 to the pharmacy next-door. Before he left Ben told caller that where he is living stresses him out and he is losing his temper. Caller stated that Ben has a history of depression and seemed agitated when he was with her, she has started him on new medication and requested a review for him in 2 weeks. Caller stated Child 3 seemed a bit upset when parents are shouting, he looked well-kept and was happy to go to both parents'.

14.3.19 At 1635 hours on 31 August 2018, following the incident at the GP practice, the Police received a 999 call from Susan who reported that Ben was being violent. Susan was distressed but uninjured. The incident had occurred at Ben's mother's address and Susan informed the Police that Ben had left alone in his vehicle, but that she was concerned about his behaviour, his mood and style of driving and that Ben's mental health was uncontrollable. Susan informed the Police that Ben's outbursts were more verbal but included that Child 3 had been present during the incident. Child 3 was reported to be staying with Susan.

14.3.20 At 2302 hours the Police attended at Ben and Susan's home to see Susan. The attending Officers completed a PPN form, grading the risk as standard. The form recorded that the incident was a verbal argument, the couple were staying in separate locations. Susan was frightened for Ben's welfare and concerned for his mental health and that Ben was going to seek help from his GP the following Monday. No offences were disclosed.

14.3.21 After the call the Police attended at another property on the same site as Ben and Susan's home. Ben informed the Police that he had a good support network around him and that he was due to see his GP on Monday

morning. A Mental Health Form was completed in respect of Ben[22]. Details of the incident were shared with Lincolnshire Children's Services – this information was received at 1404 hours on 6 September 2018. The Police were not aware of the earlier incident at the GP surgery.

Events on 3 September 2018

14.3.22 Ben attended his GP surgery on 3 September 2018 at 1521 hours. During the consultation Ben informed the GP how he was currently feeling which included that he felt that Susan wanted him out of the house. When asked, he stated he had no urge to harm others, no more than pointing a finger or raised voices.

14.3.23 The GP made an immediate telephone referral direct to the Crisis Team, who informed the GP that they would contact Ben directly. No timescales were given for this contact. The GP requested a patient summary be faxed to the Crisis Team; this was completed within 15 minutes of the telephone referral.

14.3.24 The Crisis Team attempted to contact Ben on two occasions via his mobile on 3 September 2018 – both were unsuccessful at 1722 and 1910 hours.

Events on 4 September 2018 and beyond.

14.3.25 At 1600 hours on 4 September 2018 the Crisis Team attempted to contact Ben and again were unsuccessful. A review was undertaken of the initial referral and which identified a risk of aggression, suspected acute mental illness and the presence of a child in the situation. A decision was made for two members of staff to undertake a cold call the following day as well as take contact letters.

14.3.26 In September 2018 Police and East Midlands Ambulance Service received a call regarding a single vehicle incident in a rural area of Lincolnshire resulting in Susan's death.

[22] This is a Lincolnshire Police generated form completed by officers and used to gather information concerning mental health incidents. The information is only shared with the Crisis Team (LPFT) when individuals are detained under S136 or S135 Mental Health Act.

14.3.27 The following table shows the date and time of events from 31 August to 4 September.

Date	Time	Event
31.08.18	1544	Ben, Susan and Child 3 attend GP Practice.
31.08.18	1635	Police received 999 call from Susan who is at Ben's Mothers.
31.08.18	1646	Advanced Nurse Practitioner makes referral to Lincolnshire Children's Services.
31.08.18	1647 (This is the time they spoke to the GP)	Lincolnshire Children's Services sent referral to area team on 31 August 2018, which was allocated on 3 September 2018 in accordance with policies and procedures.
31.08.18	2302	Police attend Ben and Susan's home and speak with Susan. After this Ben is seen at a different property but on the same site.
03.09.18	1521	Ben and his cousin attend appointment with GP. Referral made to Crisis Team.
03.09.18	1722	Crisis Team attempted to contact Ben.
03.09.18	1910	Crisis Team attempted to contact Ben.
04.09.18	1600	Crisis Team attempted to contact Ben.

15. ANALYSIS USING THE TERMS OF REFERENCE

Introduction to Analysis

The information available to the panel, and its discussions of the case, would fit into more than one term of reference. Therefore, to avoid duplication the DHR panel has taken a best fit approach in its analysis.

15.1 Term 1

To examine whether there were any previous concerns, incidents, significant life events or indications which might have signalled the risk of violence to Susan, Ben and Child 3 or given rise to other concerns or instigated other interventions.

15.1.1 The DHR panel have identified that Ben was known to some agencies as a perpetrator of domestic abuse prior to his relationship with Susan. This included Ben having a conviction for a domestic related assault from 2009. The DHR panel felt that this information, along with Ben's previous criminal history, indicated to professionals that there was a risk of violence towards Susan from Ben in their relationship and by association Child 3.

15.1.2 There were opportunities identified within the timescales of the review when the DHR panel felt that professionals could have considered utilising the DVDS. These opportunities included: following the domestic abuse incident on 30 June 2018 and the subsequent social care assessment by Lincolnshire Children's Services. Susan had informed the Police on 30 June 2018 that Ben had been involved in domestic abuse with a previous partner, but this was not explored further. The DHR panel felt that although Susan had informed professionals that she was aware of Ben's history this was never fully tested with Susan to confirm her knowledge and understanding of the risks that were posed.

15.1.3 The review established that at the time Ben was in custody and being interviewed for the assault on Susan, Ben's previous criminal history was not fully reviewed, this was contrary to policy and procedure that was in place at that time. Therefore, the police officers dealing with the case had no knowledge of Ben's previous criminal history. This was also identified in a previous Police IMR[23] and the Domestic Homicide Review for that case is currently with the Home Office for verification. Since the incident in June 2018 Police have updated systems and processes which now provide officers with a prompt to undertake research and record the outcome.

[23] DHR2017N

15.1.4 When Ben was released from Police custody in June 2018 with no criminal charges and did not instigate any other safeguarding interventions, the Police could have considered applying for a Domestic Violence Protection Notice (DVPN) having considered Ben's previous domestic abuse history. A DVPN is a short-term measure, which if utilised, could have provided an opportunity for support services to engage with Susan. The custody system now has a prompt for officers to consider the DVPN scheme.

15.1.5 The College of Policing[24] says: 'Officers have a duty to take or initiate steps to make a victim as safe as possible. Officers should consider Domestic Violence Protection Notices (DVPN) and Domestic Violence Protection Orders (DVPO) at an early stage following a domestic abuse incident as part of this duty. These Notices and Orders may be used following a domestic incident to provide short-term protection to the victim, when an arrest has not been made but positive action is required. Or where an arrest has taken place, but the investigation is in progress. This could be where a decision is made to caution the perpetrator or take no further action (NFA), or when the suspect is bailed without conditions.'

15.1.6 The opportunity to consider utilising the DVDS for potential victims of domestic abuse is the responsibility of all agencies. The DHR panel agreed that had Susan been provided with information through this scheme it may have provided her with an understanding of any potential risk that Ben posed for her and her child which she could then think about when deciding what to do.

15.1.7 The DHR panel have had access to the number of applications Lincolnshire Police have received in relation to DVDS since 2016 up to October 2019, which show an increase in applications year on year.

Year	Right to Ask	Right to Know	Number
April 16 – March 17	31	34	65
April 17 – March 18	87	49	136
April 18 – March 19	142	75	217
April 19 – end of Nov 19 (year not ended)	139	71	210

Term 2

15.2 When and in what way were practitioners sensitive to the needs of the subjects, knowledgeable about potential indicators of

[24] The College of Policing is a professional body for the police in England and Wales. It was established in 2012 to take over a number of training and development roles that were the responsibility of the National Policing Improvement Agency

domestic violence and abuse and aware of what to do if they had concerns about Susan, Ben or Child 3? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

15.2.1 The DHR panel have identified that practitioners were sensitive to the needs of the subjects and knowledgeable about the indicators of domestic abuse. However, the review has identified some incidents where the level of staff training did not provide them with the knowledge to consider alternative safeguarding options for Susan. These are covered within Section 15.10 of the report under Term 10.

15.2.2 The Police identified the risk to Susan during the two domestic abuse incidents and provided Susan with information on support agencies and actions she could undertake for her safety. Within Lincolnshire Police this is known as 'stay safe advice.' The officers did recognise the impact that domestic abuse has on a child who is witnessing or living in that environment and shared details of both incidents with Lincolnshire Children's Services, one of these was received after the death of Susan.

15.2.3 However, the Police did not consider all the safeguarding options available such as the consideration of a DVPN, following the incident in June 2018 and utilising the DVDS. This has been identified by the Police IMR Author as learning and the DHR panel have made an appropriate recommendation in this respect. Since the incident Lincolnshire Police have amended relevant forms and computer systems to ensure that these areas are available as prompts for staff when dealing with domestic abuse.

15.2.4 The Health Visitor had a clear understanding of the issues pertaining to domestic abuse and appropriately reviewed family records following the primary birth visit with Susan. This identified that Ben had a previous history of domestic abuse and was known to Lincolnshire Children's Services and the Criminal Justice System. The records detailed that this information was to be followed up with Susan, however; it was not evident within the records that this action was undertaken. When speaking with staff for the review, it was reported to the IMR Author, that further discussions had taken place with Susan despite there being no clear record. During these conversations it was reported that Susan provided positive information in respect of her relationship with Ben. The DHR panel agreed there should have been detailed recording on this matter.

15.2.5 A clear example of professionals' understanding of domestic abuse is that of the actions of the Advanced Nurse Practitioner and Nurse Practitioner during their contact with Susan on 31 August 2018. The actions of these staff members ensured a co-ordinated response to the disclosure and

safety of Susan and their child, without jeopardising the consultation appointment with Ben.

15.2.6 During the incident on 31 August 2018, Susan was provided with information for support agencies and an option of being able to contact the agencies directly from the GP surgery in a safe and secure environment. Consideration was also given, with the consent of Susan, to contacting her GP surgery for further support. The staff also identified the impact of domestic abuse on children and made a telephone referral directly to Lincolnshire Children's Services identifying those concerns.

15.2.7 During the consultation with Ben on 3 September 2018 he stated that he had no urge to harm others, no more than pointing a finger or raised voices. If these actions had been aimed towards Susan, then this would have been classified as domestic abuse and should have prompted further clarification and questioning by the GP.

15.2.8 Despite these actions the staff did not complete a DASH with Susan. The DHR panel agreed that a DASH should have been completed in these circumstances, regardless of the fact, that Susan was not a patient at that GP practice.

15.2.9 The DHR panel identified that all agencies should have a working knowledge of civil orders available to protect victims of domestic abuse, alongside the DVDS process. The DHR panel acknowledged that assurances needed to be obtained and that training and staff knowledge were in place and has made a recommendation to this effect.

Term 3

15.3 When, and in what way, were Susan, Ben and Child 3's wishes and feelings ascertained and considered? Were Susan, Ben and Child 3 informed of options/choices to make informed decisions? Were they signposted to other agencies and how accessible were these services to the subjects?

15.3.1 The DHR panel have identified that Susan was provided with information on her options, and details of other agencies during key events; these included the Police response to two domestic abuse incidents and the actions by the Nursing staff on 31 August 2018.

15.3.2 The DHR panel have been unable to find any record which identified that Susan had been provided with the information as to how she could apply for consideration of disclosure under the DVDS.

15.3.3 There are entries within some agency contacts which identified that Susan had knowledge about domestic abuse, and which indicated, that she knew

of Ben's history of domestic abuse. This information was never challenged or tested with Susan and therefore the true extent of what she knew was not known by professionals. The DHR panel agreed that when Susan informed the Police that she knew of domestic abuse between Ben and a previous partner, this should have been probed further which would then have allowed them to consider instigating a DVDS application. The DHR panel recognised that all agencies should be alert and proactive when responding to service users' knowledge around domestic abuse history within previous relationships.

15.3.4 The DHR panel acknowledged the findings of the published report undertaken by National Rural Crime Network 'Captive and Controlled'[25]. The DHR Author also had access to the report of Lincolnshire Police and Crime Commissioner in response to this report[26].

15.3.5 Ben was referred to the Crisis Team following the visit to the GP on 3 September 2019. The DHR panel have seen evidence of the attempts that were made by the Crisis Team to contact Ben via telephone. These calls were not answered by Ben, the reasons why are not known and the Crisis Team made the decision to visit Ben in person to progress the referral; this visit did not occur due to the death of Susan and following criminal investigation.

Term 4

15.4 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?

15.4.1 There were several opportunities for assessment and decision making on this case. The first of these was the actions by the Police to the domestic abuse incident in June 2018. The decision by the Police to take no further action for the assault on Susan was made without the knowledge of Ben's previous domestic abuse history or his wider proclivity for violence. Had this information been known, it would have provided the decision maker with an opportunity to consider charging Ben with an offence of assault, which given Susan's position of not wanting to pursue a complaint, could have resulted in an evidence-based prosecution, or consideration of an

[25] https://www.ruralabuse.co.uk/wp-content/uploads/2019/07/Domestic-Abuse-in-Rural-Areas-National-Rural-Crime-Network.pdf

[26] Lincolnshire Summary to the National Report on Understanding Domestic Abuse in Rural Areas

application for a DVPN to be issued. Any of these actions would have to be supported by a safety plan for Susan and Child 3.

15.4.2 The College of Policing website provides detailed guidance regarding the DVPN/DVPO process[27] in addition to Lincolnshire Police's website[28]. The DHR has identified that had Ben been issued with a DVPN, following which if granted by the court, a DVPO, then it could have provided an opportunity for support agencies to have made contact with Susan to discuss the circumstances of the case and the options available to her and Child 3 for future safeguarding.

15.4.3 The social care assessment undertaken by Lincolnshire Children's Services provided an opportunity for professionals to engage with Ben. Ben was not seen during the interview and therefore there was no opportunity to gain an understanding of his perception in order to make an informed decision about risk which might have been evident. The assessment focused on Susan and her role as the principal carer for Child 3.

15.4.4 There was no formal supervision on the social care assessment given the limited time that the family were engaged with Children's services. There was managerial oversight which is evidenced by the fact that a Manager signed the report off. The oversight was not effective as it did not pick up and/or challenge the fact that Ben was not seen as required by policy and procedure.

Term 5

15.5 Was appropriate professional curiosity exercised by those professionals and agencies working with the individuals in the case? This includes whether professionals analysed any relevant historical information and acted upon it?

15.5.1 The Health Visiting service did exercise professional curiosity about Ben; however, there was no written record that this information was followed up with Susan or other agencies.

15.5.2 The review has already identified and detailed how the Police did not review or take into consideration the historical information when they responded to the domestic abuse incident in June 2018.

[27] https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/domestic-abuse/arrest-and-other-positive-approaches/domestic-violence-protection-notices-and-domestic-violence-protection-orders/
[28] https://www.lincs.police.uk/reporting-advice/domestic-abuse/

15.5.3 During the social care assessment period (July 2018), there was not the level of professional curiosity that would have been expected in accordance with the policies and procedures for the completion of the social care assessment, in particular the lack of engagement with Ben. The Social Worker did not have the opportunity to go back to the office to review the information which was held by the Local Authority prior to the safe and well visit on 12 July 2018. However, there was an expectation that the Social Worker would ensure that they had been able to review the whole file prior to undertaking a further visit to gather more information. As the visit was urgent and the Social Worker was already out in the field it was appropriate for the initial contact to be undertaken with Susan without the additional information being known.

Term 6

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

15.6.1 Part of Lincolnshire Children's Services planning was to develop a safety plan in conjunction with Susan, and Child 3, which included to seek refuge in a neighbour's caravan should she feel threatened or be assaulted by Ben. This advice was understood by Susan who did exactly that when faced with a threat from Ben. The safety planning also extended to informing Child 3's nursery of the domestic abuse within the family. The plan that was agreed with Susan was achievable and acceptable to professionals involved in the case.

15.6.2 Mental health services were persistent in trying to contact Ben in order to complete an assessment of his needs, including any threat he may pose to his family or other people.

Term 7

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

15.7.1 All agencies involved in the case had policies and procedures in respect of domestic abuse and safeguarding.

15.7.2 The Police completed a PPN form for both incidents. These forms were reviewed by a Supervisor, in line with a change of policy in May 2018 and shared with Lincolnshire Children's Services. The DHR Author has had access to the current protocol between Lincolnshire Children's Services and Lincolnshire Police[29] in respect of information sharing which confirmed that the information was shared in the agreed timescales.

15.7.3 The Social Worker had access to the DASH assessment completed by the Police in June 2018. The Social Worker used the DASH to compare against responses given by Susan during the social care assessment, in doing so, the Social Worker completed a separate and updated DASH which did not highlight any additional concerns.

15.7.4 The IMR Author identified that the social care assessment would have been more robust had there been engagement with Ben within the assessment and subsequent safety plan, and that there was a lack of challenge when the assessment was concluded and signed off. The IMR Author has raised this with those involved in this assessment.

15.7.5 The DHR panel acknowledged that the actions of the staff within the GP practice on 31 August 2018 were in response to an emerging situation, and their response was one of 'crisis management' which included, separation of Susan and Ben, a referral to Lincolnshire Children's Services, details of support agencies being provided to Susan, the offer of contact with her own GP and a further appointment being made for Ben.

15.7.6 The DHR panel agreed that a DASH should have been completed for the incident at the GP practice even with Susan not being a patient at the practice. The fact that a DASH was not completed is contrary to policies and safeguarding training. However, in reaching this conclusion the DHR panel acknowledged that had a DASH been completed, this would not have been received by the Police prior to their attendance at an incident a short time later. Nor would it have identified that the case reached the criteria for an emergency MARAC to have been held.

15.7.7 Susan was not subject to a MARAC or any other multi-agency fora[30]. The DHR panel agreed that neither of the two incidents, reported to Lincolnshire Police met the criteria for the case to have been heard at MARAC. The weaknesses in not considering a DVPN and DVDS have already been covered within the report.

[29] Protocol between Lincolnshire Police and Lincolnshire Children's Services on Managing Domestic Abuse Notifications & Referrals where Children are involved/resident in the Household. 2016.

[30] Fora is a multiple of forum.

Term 8

15.8 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?

15.8.1 The Police graded both domestic abuse incidents as 'standard' risk. This was based upon the information provided to them whilst dealing with the incident and their professional judgement. Standard risk is defined as – 'current evidence does not indicate likelihood of serious harm'. The DHR panel discussed if this was an appropriate risk assessment following the incident in June, given the fact that Ben had been arrested and therefore at the time of completion of the PPN he was not in contact or likely to be in contact with Susan. The DHR panel concluded that the grading of 'standard' risk was appropriate in these circumstances.

15.8.2 When the Police responded to the incident on 31 August 2018, they were not aware that Ben had seen an Advanced Nurse Practitioner a short time earlier in respect of mental health issues, nor were they aware of the disclosures that Susan had made to staff. The DHR panel agreed that the incident was correctly graded as standard risk.

15.8.3 The DHR panel discussed the availability of support services and information sharing between agencies where incidents have been graded as standard or medium. The Safer Lincolnshire Partnership is exploring the development of a system of information sharing that captures all DASH forms that are completed, in order to support the identification of patterns of abuse and coercive and controlling behaviour.

Term 9

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

15.9.1 The DHR panel did not identify any other issues in relation to disability, diversity, culture or identity during the review. All of the agencies in the Safer Lincolnshire Partnership have well developed policies on a wide range of diversity issues.

15.9.2 Research acknowledges that women are more likely to experience domestic abuse then men[31]. Women experience higher rates of repeated victimisation and are much more likely to be seriously hurt (Walby &

[31] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/domestic-abuse-is-a-gendered-crime/

Towers, 2017; Walby & Allen, 2004) or killed than male victims of domestic abuse (ONS[32], 2017). Further to that, women are more likely to experience higher levels of fear and are more likely to be subjected to coercive and controlling behaviours (Dobash & Dobash, 2004; Hester, 2013; Myhill, 2015; Myhill, 2017).

15.9.3 According to the Crime Survey for England and Wales (CSEW) year ending March 2019[33] -

- an estimated 7.5% of women (1.6 million) and 3.8% of men (786,000) experienced domestic abuse in the last year,
- women aged 20 to 24 years were more likely to be victims of any domestic abuse in the last year than women aged 25 years and over
- adults who were separated or divorced were more likely to have experienced domestic abuse compared with those who were married or civil partnered, cohabiting, single or widowed
- adults who lived in urban areas were more likely to have experienced domestic abuse in the last year (6.0%) than those who lived in rural areas (4.2%)
- in 75% of the domestic abuse related crimes recorded by the police in the year ending March 2019, the victim was female.

15.9.4 The DHR panel established that rurality did not seem to operate as a barrier in Susan's case as she did access support and was provided with information on available services within her locality.

Term 10

15.10 To consider whether there are training needs arising from this case?

15.10.1 Lincolnshire Police have delivered training to new Police Officers since 2014 in relation to key elements of domestic abuse such as DVDS, DVPN and DVPO. DASH training has been delivered since March 2010 and the Force has undertaken a programme of Vulnerability and Risk training since October 2018.

15.10.2 Lincolnshire Police had a DVDS action plan for 2019/2020 which included the delivery of training to operational Police Officers who have not yet received training in this area. This action plan is now completed. The

[32] Office of National Statistics

[33] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2019

learning from this review will be incorporated in the Forces 2020/21 action plan. In addition, Lincolnshire Police will review training requirements on this area on a yearly basis. The IMR Author for Lincolnshire Police identified that the Police Officers involved during this review had not yet received this training and measures have already been taken to address the training needs of those staff.

15.10.3 In addition during the timescales of this review Lincolnshire Police delivered specific briefings, which included basic information on the DVDS, to specialist Domestic Abuse service workers and Neighbourhood Police Officers to ensure that officers were more informed when signposting and referring victims of domestic abuse. The panel heard that multi-agency briefings and training have included information on the DVDS.

15.10.4 The GP who saw Ben at the surgery on 3 September 2018 did have access to the previous incident on 31 August 2018 contained within the medical records and did make a direct referral to the Crisis Team the same day.

15.10.5 It was unclear to the DHR Independent Author and Chair whether non-police agencies have a functional understanding of the DVDS and are equipped to either advise people about the 'Right to ask' element or request the police to consider undertaking a 'Right to know'.

15.10.6 The DHR panel recognised that the partnership have already undertaken a number of activities to communicate and raise awareness of the DVDS. However, it is recognised that this work needs to be ongoing and included at all levels of communication. This is a point and recommendation.

Term 11

15.11 To consider the management oversight and supervision provided to workers involved?

15.11.1 The social care assessment undertaken in July 2019 was open to the Lincolnshire Children's Social Care team for less than a week. The IMR Author for Lincolnshire Children's Services identified that no formal supervision took place in respect of the assessment. However during contact with the Practice Supervisor, for the completion of the review, they stated that they did have discussions with the Social Worker prior to the final authorisation of the assessment. However these were not recorded on the MOSAIC[34] electronic system. The IMR Author for Lincolnshire Children's Services has discussed this with practitioners involved in this case prior to the commencement of the review.

[34] Children's Services electronic records system

15.11.2 A formal review of the assessment would have identified the lack of engagement with Ben in the completion of the assessment, and the role of Ben in relation to the development of the safety plan. This lack of engagement is contrary to LSCB procedures[35]. It is accepted that Ben worked long hours which would have created some challenges in arranging the meeting and alternative contact could have been considered such as a telephone interview with Ben. Given the very short time that the case was opened indicates that alternative contact was not considered.

15.11.3 There is evidence that appropriate levels of supervision, advice and guidance was given to officers who attended the two domestic abuse incidents. The incident logs show the involvement of a Duty Sergeant who recorded their own observations and comments within the PPN. This process was in line with a new policy implemented in May 2018. In addition, a trained member of the Force Control Room finalised and closed each police incident log. However, there is no evidence that any supervisor who saw the log considered either a DVPN or the DVDS.

Term 12

15.12 Was any restructuring, during the period under review, likely to have had an impact on the quality of the service delivered?

15.12.1 On 1 October 2017 the 0-19 Children's Health Service transitioned from Lincolnshire Community Health Service to Lincolnshire County Council. This transition did not impact on service delivery as policies, procedures and service specifications for the Health Visiting service were unchanged during that time.

15.12.2 The DHR panel have not identified any other evidence of restructuring within partner agencies that impacted on the quality of service delivered.

[35] LSCB procedures manual; domestic abuse policy 14.1.1 - If the mother is choosing not to separate, then the abusive partner will need to be involved in the assessment and intervention. Practitioners should make all reasonable efforts to engage him and refer him to an appropriate perpetrator programme"

16. CONCLUSIONS

16.1 Susan died as a result of a head injury sustained during a single vehicle road traffic incident. At the time of the incident Susan was a passenger in the vehicle in which Ben was driving. Ben was arrested at the scene of the incident, following which the Police conducted a lengthy investigation into the circumstances of Susan's death, and the relationship of Susan and Ben. The investigation did not result in any criminal charges or court case directly related to the death of Susan. The inquest recorded a narrative verdict but found no evidence that indicated that Susan intended to take her life.

16.2 Ben was known to have been involved in previous incidents of domestic abuse within other relationships. It was also known that Ben sometimes resorted to violence when in conflict with other people in a non-domestic setting. This included unprovoked attacks on strangers; one in 2014 the other in 2017. An independent witness identified Ben as the aggressor in one incident. Ben denied being the aggressor. Ben and his mother acknowledged to the DHR chair that he had a short temper and could quickly 'blow up'.

16.3 Information sharing processes between Lincolnshire Police and National Probation Service have changed and information is now shared on a wider range of Police contacts, this includes arrests, a process which was not in place at the time of this case.

16.4 The DHR panel considered if Ben's behaviour towards Susan could have amounted to control and coercion and whether the decision to move to an isolated location may have been motivated by a desire to isolate Susan from her family. Ben and Susan moved to seek better accommodation and the DHR panel considered this and evidence provided to the Coroner's inquest and these factors identified that there was an emergence of control in relation to isolation for Susan.

16.5 The DHR panel have seen evidence that Susan was experiencing financial difficulties prior to and during her relationship with Ben. This was also said during meetings between the family and DHR Chair. The family informed the DHR Chair that Susan repeatedly asked for money, it is not known who, if anyone, was behind Susan's decisions to ask her father for money. When the family were seen by the DHR Chair and Author they stated they

believed the money was being used by Ben for purposes other than supporting Susan and Child 3.

16.6 Control and Coercion, including financial exploitation are often a feature in domestic homicide reviews; however, despite known financial difficulties for Susan, the DHR panel could find no evidence that this was linked to control and coercion by Ben.

16.7 There was evidence within some agency records that there had been domestic abuse in Susan and Ben's relationship in the four months prior to Susan's death. The DHR panel recognised that research indicates that victims live with domestic abuse for a significant period of time[36] and that on average victims experience 50 incidents of abuse before they do seek effective help[37] [38]. Susan told some professionals that she knew about his history of domestic abuse. Those professionals should have checked her understanding, of what she knew from Ben, or other non-official sources, against the facts.

16.8 It was clear to the DHR panel that when Professionals have discussions on disclosure with victims this needs to be clearly documented, to include what information has been shared, what knowledge the victim has and what advice was given to the victim to obtain further information. This has been placed into recommendations and will be progressed and monitored by the Safer Lincolnshire Partnership.

16.9 The DHR Author and Chair met with Susan and Ben's family who provided valuable information on the relationship between Susan and Ben. Susan had confided in an individual family member in the months prior to her death about her poor and sometimes violent relationship with Ben and swore the person to secrecy. The family member acknowledged the difficulty that this situation placed on them. The family felt that there was a need for awareness raising in relation to all elements of domestic abuse, including how families can raise concerns with Professionals.

[36] http://www.safelives.org.uk/policy-evidence/about-domestic-abuse/how-long-do-people-live-domestic-abuse-and-when-do-they-get
[37] SafeLives (2015), Insights Idva National Dataset 2013-14. Bristol: SafeLives.
[38] Walby, S. and Allen, J. (2004), Domestic violence, sexual assault and stalking: Findings from the British Crime Survey. London: Home Office.

16.10 From reading the material supplied by HM Coroner, it is very clear that in the few months before Susan's death the relationship between her and Ben deteriorated at an escalating pace. He was continually bickering at her claiming he wanted things to be like they were before Child 1 came to live with them. Susan confided in someone she was being asked to choose between family and Ben, which the DHR panel recognised as an element of controlling behaviour.

16.11 The DHR Chair met with Ben who acknowledged he treated Susan unfairly. The DHR Chair asked Ben what could have been done to help them. Ben stated that he should have left the relationship adding that Susan had not asked him to leave, or told him that she was leaving their relationship. The panel thought that Ben's use of the phrase, 'Susan had not told him to leave' demonstrated his lack of insight into domestic abuse, his minimisation of events and victim blaming.

17. LEARNING IDENTIFIED

17.1 Agencies

There are no individual agency recommendations as learning has been embedded into practice and any relevant changes to processes undertaken prior to the completion of the review.

Addaction now We Are With You

17.1.1 Addaction identified that it did not: comply with its policy for clients who do not attend appointments; keep adequate records on its data system and gather enough information to sufficiently inform risk assessment.

Humberside, Lincolnshire and North Yorkshire Community Rehabilitation Company

17.1.2 Humberside, Lincolnshire and North Yorkshire Community Rehabilitation Company found a small number of factors relevant in this case which perhaps show the need for some improvement in the overall work of the Probation Service and these are specifically to do with pre-sentence practices that are currently exclusive to the National Probation Service.

17.1.3 The first is checking service records at the pre-sentence stage. In this case there was a failure to use recorded information to articulate clearly the link between what was previously known.

17.1.4 The IMR author has recommended that all NPS staff involved in pre-sentence report writing should receive a reminder regarding the importance of making such checks and utilising recorded information regarding risks, in their reports.

17.1.5 The second was clinical assessment rationale where the expectation that pre-sentence report authors articulate their clinical assessment of risks and not solely rely on numeric tools such as RSR (Risk of Serious Recidivism). Time elapsed between offences or types of offending should be explained clearly, especially if this is being used to inform an assessment that appears to involve a lower level of risk than is intuitive (i.e. Low as opposed to Medium)

17.1.6 The IMR author believes it is worth reiterating to all staff engaged in the writing of court reports the need to articulate their clinical assessment of risks and not solely rely on numeric tools such as RSR.

Lincolnshire Children's Services

17.1.7 Lincolnshire Children's Services noted that while the health visitor provided care in line with the children's health policies and procedures and exercised professional curiosity to explore potential risks based on information received. It is not clearly documented within the records if the health visitor fully explored concerns with Susan.

17.1.8 The social workers did not interview Ben when preparing the social care assessment as required by policy and procedure and this consequently limited the quality of the assessment. The Practice Supervisor did not raise this matter prior to the closure of the case. It is reassuring that in interview with the IMR author the social worker accepted that a meeting with Ben could have added to the assessment process. This has subsequently been addressed with the practitioner.

17.1.9 There was clearly engagement with Susan and a development of a safety plan. This positively engaged the local community. It is unfortunate that the safety plan could not be tested as a result of the family being an open case for a relatively short period of time.

17.1.10 Lincolnshire Children's services say, 'the issues raised by this matter are addressed within the internal procedures. There has been work undertaken with the individuals who were involved in this matter which took place prior to the commencement of this review. It is accepted that there is always a risk that individuals will not comply with the set procedures and when this takes place this is addressed through the internal quality assurance processes. Consequently, there are no recommendations.'

Lincolnshire Police

17.1.11 Lincolnshire Police identified that a renewed emphasis in delivering the DVDS and DVPN training was needed. DVDS has been reviewed and communications across the force have commenced in Jan 2020. DVPN/O Scheme is under review (March 2020).

17.1.12 A previous police IMR[39] identified that officers who complete the PPN/DASH risk assessments were not prompted to complete more research in respect of the parties involved or to record the level and extent of that research. It was recognised that such a prompt would particularly help officers establish more details about any potential history of abuse by the offender against the victim or other victims, including whether there were any previous incidents or convictions for domestic abuse.

17.1.13 The Force have upgraded the PPN to include a previous history search and a prompt for officers to inform victims of the DVDS. The custody system already includes a similar prompt for officers to consider the DVPN scheme.

17.2 The Domestic Homicide Review Panel's Learning

17.2.1 The DHR panel identified the following learning. The panel did not repeat the learning already identified by agencies at paragraph 17.1. Each learning point is preceded by a narrative which sets the context for the learning and recommendations which are crossed referenced.

Learning 1 [Panel recommendation 1]
Narrative
Susan informed Professionals that she was aware that Ben had been involved in domestic abuse in previous relationships and that she was aware of the signs of domestic abuse and what action could be taken. Professionals did not check Susan's level of knowledge with the facts. Therefore did not identify whether there was a gap in her knowledge that could have impacted on her decisions about keeping herself and Child 3 safe.
Learning
Professionals need to ensure that victims of domestic abuse have good quality information about keeping themselves safe and are supported in the decisions they make.

[39] DHR2017N

Learning 2 [Panel recommendation 2]
Narrative
There are processes and legislative options which allow Professionals to disclose information to victims on risks and convictions in order to safeguard themselves and their family. These include social care assessments, Section 47 and Section 17 Children Act assessments, Child Sex Offender Disclosure Scheme (CSODS)[40] and assessments within the Probation Service. In addition, there is also the option of Professionals utilising the Domestic Violence Disclosure Scheme to which any agency can make an application/refer a case.
Learning
In order to protect victims, professionals working in this field need to have a clear understanding of the availability of civil orders, different processes and legal options available to them to undertake disclosure, including accessing the DVDS.

Learning 3 [Panel recommendation 3]
Narrative
Susan confided in a family member about her relationship with Ben in the months prior to her death. It was only after Susan's death that the family considered that there may have been domestic abuse within the relationship. The family informed the DHR Chair and Author that they felt that communities are not aware of what to do should they suspect domestic abuse and which agencies they can contact to raise their concerns.
Learning
Publicity campaigns on domestic abuse need to ensure that they reach all aspects of the community. Including families, friends and work colleagues and provides them with information on the stages of domestic abuse, and coercive control, how they can respond and report concerns. In addition, information also needs to detail civil options available including how information can be requested and shared under processes such as DVDS.

[40] https://www.gov.uk/government/publications/child-sex-offender-disclosure-scheme-guidance

18. RECOMMENDATIONS

18.1 Agencies Recommendation

18.1.1 No agency reporting to this DHR identified any new recommendations as any issues raised for a particular agency were already being actioned.

18.2 The Panel's Recommendations.

18.2.1 The DHR panel identified the following recommendations.

Number	Recommendation
1	That the Safer Lincolnshire Partnership obtains evidenced based assurances from its core membership that staff working in this field know the importance of checking a victim's full understanding of risk factors particular to their circumstances.
2	That the Safer Lincolnshire Partnership obtains evidenced based assurance from its core membership that staff working in this field have a clear understanding of the different processes, civil orders and legal options available to all agencies to undertake a disclosure of information to a victim.
3	That the Safer Lincolnshire Partnership reviews the existing Domestic Abuse Communications Plan to raise awareness of domestic abuse in Lincolnshire. Ensuring it is reaching all aspect of the community, including family, friends and work colleagues, on how they can respond and report concerns and options available to them, including civil orders and how they can request information to inform their safety planning.

Appendix A

Events Table

Date	Event
Events pre-dating the Terms of Reference for the DHR	
31.01.09	Ben arrested for assaulting a female partner (not Susan). Ben was charged and later convicted of battery.
26.02.10	Police received information that Ben had threatened a female partner. Victim was seen but did not want to engage with the Police. DASH completed.
2010	Susan suffered from anxiety and depression following breakdown of marriage. Medication prescribed.
31.07.11	Police attended a report of a verbal argument involving Ben and a female partner. Ben was charged and later convicted of a public order offence and criminal damage. DASH completed.
04.11.12	Police spoke to female partner of Ben who stated that he had made threats towards her. DASH completed.
26.09.14	Ben assaulted male during altercation. Ben arrested and later convicted for an offence of assault.
Events within the timescales of DHR	
March – October 15	Routine ante-natal appointments for Susan.
18.04.15	Ben charged by Lincolnshire Police with offence of Assault occasioning actual bodily harm following 'road rage' incident on 26.09.14. Bailed to Lincoln Magistrates' Court on 25.05.15.
21.05.15	Ben appeared at Lincoln Magistrates' Court. Case adjourned to Lincoln Crown Court for Plea and Case Management Hearing on 04.06.15.
04.09.15	Health Visitor conducted home visit with Susan. Routine questions around domestic abuse covered during contact.
21.10.15	Health Visitor conducted home visit with Susan. No information in the records to suggest that concerns identified with Ben's history on the 4.09.15 were explored further.
28.10.15	Health Visitor conducted home visit with Susan. Notes record potential domestic abuse by Ben in previous relationships.
25.11.15	Lincolnshire Children's Health review undertaken with Susan regarding Child 3.

27.02.16	Ben involved in racially aggravated common assault with adult male. No further action taken by Police.
18.03.16	Ben stopped by Police whilst driving motor vehicle erratically. During search of vehicle small quantity of cannabis found. Ben issued with cannabis warning.
30.06.16	Ben pleaded guilty at Lincoln Crown Court to offence of assault occasioning actual bodily harm from incident on 26.09.14. Case adjourned until 12.08.16.
12.08.16	Ben sentenced at Lincoln Crown Court to 8 months imprisonment, suspended for 24 months - 24 Month Suspended Sentence Order. One stand-alone Requirement of 150 hours Unpaid Work. Suspended Sentence Order expired on 11.08.18.
04.11.16	Lincolnshire Children's Health review undertaken with Susan regarding child of Ben and Susan.
13.01.17	Ben contacted Police regarding a traffic offence. Ben later withdrew the complaint with the Police.
25.10.17	Ben completed 150 hours unpaid work as part of Suspended Sentence Order.
01.05.18	Council Tax Records - Susan moved to a remote static caravan site.
14.05.18	Susan contacted Council Tax Records and advised that Ben did not reside at address.
22.06.18	Child 1 contacted West Lindsey District Council regarding financial matters in relation to a previous residency.
30.06.18	Susan contacted Police to report that Ben had head butted her. Ben arrested by Police. Ben later interviewed by Police and released from custody without charge.
05.07.18	Domestic incident from 30.06.18 shared with Lincolnshire Children's Services.
18.07.18	Health Visitor informed of domestic incident from 30.06.18 by Social Worker and that case is being closed to Children's Services.
20.07.18	Incident reported to Police that Ben and Child 1 had been threatened by adult male.
24.07.18	Health Visitor sent letter to Susan in relation to targeted 3 year review for Child 3 due later in 2018.
11.08.18	Ben's Suspended Sentence Order imposed on 12.08.16 expired.
31.08.18	Ben attended GP with Susan. Ben requested help with his mental health. Susan left consultation distressed and disclosed that Ben had been aggressive, verbally abusive and had been hitting her. Referral made to Lincolnshire Children's Services. Support information

	provided to Susan.
31.08.18	Susan contacted Police to report that Ben was being violent. Susan stated that Ben's mental health was uncontrollable, and she was concerned about his mood and style of driving. Ben seen by Police and welfare visit undertaken. DASH and mental health form completed. Information shared with Lincolnshire Children's Services.
03.09.18	Safeguarding incident from GP screened by Lincolnshire Children's Services and sent to Family Assessment Support Team (FAST) team to undertake further assessment.
03.09.18	Ben attended at GP surgery. GP telephoned Crisis Team to refer Ben with possible psychosis. Crisis Team agreed to contact Ben for telephone triage.
03.09.18	Crisis Team attempted to contact Ben – unsuccessful.
04.09.18	Crisis Team attempted further telephone contact for triage with Ben -unsuccessful. GP consultation reviewed and identified risk of aggression, suspected acute mental illness and a potential child. Cold Call to be completed by two staff on 05.09.18.
04.09.18	Single vehicle road traffic incident reported to Police and East Midlands Ambulance Service. Vehicle had been driven by Ben, with Susan a passenger. Ben arrested at scene of incident. Susan later died in hospital due to injuries sustained in the incident. Ben subsequently charged with the offence of driving a motor vehicle with a proportion of a specified controlled drug above the specified limit.
05.09.18	Police inform Lincolnshire Children's Services of death of Susan. Safeguarding processes commenced for Susan and Ben's child.
06.09.18	Domestic incident from 31.08.18 shared with Lincolnshire Children's Services.
07.09.18	Child 3 made subject of Interim Care Order.
10.09.18	Ben attended GP surgery. Referral made to Forensic psychiatrist.
11.09.18	Ben referred for Forensic psychiatric assessment.
13.09.18	Ben informed InfoLinks that he had moved to address with Susan in August 2018.
17.09.18	GP informed that Lincoln Partnership NHS Foundation Trust unable to progress referral to criminal investigation.
19.09.18	Ben self-referred into treatment with Addaction. We Are

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Appendix B

Definition of Domestic Abuse

Domestic violence and abuse: new definition

The cross-government definition of domestic violence and abuse is:
any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to:

- psychological
- physical
- sexual
- financial
- emotional
-

Controlling behaviour

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

Coercive behaviour

Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. This is not a legal definition.

Appendix C

Controlling or Coercive Behaviour in an Intimate or Family Relationship

A Selected Extract from Statutory Guidance Framework[41]

- The Serious Crime Act 2015 [the 2015 Act] received royal assent on 3 March 2015. The Act creates a new offence of controlling or coercive behaviour in intimate or familial relationships [section 76]. The new offence closes a gap in the law around patterns of controlling or coercive behaviour in an ongoing relationship between intimate partners or family members. The offence carries a maximum sentence of 5 years' imprisonment, a fine or both.
- Controlling or coercive behaviour does not relate to a single incident, it is a purposeful pattern of behaviour which takes place over time for one individual to exert power, control or coercion over another.
- This offence is constituted by behaviour on the part of the perpetrator which takes place "repeatedly or continuously". The victim and alleged perpetrator must be "personally connected" at the time the behaviour takes place. The behaviour must have had a "serious effect" on the victim, meaning that it has caused the victim to fear violence will be used against them on "at least two occasions", or it has had a "substantial adverse effect on the victims' day to day activities". The alleged perpetrator must have known that their behaviour would have a serious effect on the victim, or the behaviour must have been such that he or she "ought to have known" it would have that effect.

Types of behaviour

The types of behaviour associated with coercion or control may or may not constitute a criminal offence. It is important to remember that the presence of controlling or coercive behaviour does not mean that no other offence has been committed or cannot be charged. However, the perpetrator may limit space for action and exhibit a story of ownership and entitlement over the victim. Such behaviours might include:

- isolating a person from their friends and family;
- depriving them of their basic needs;
- monitoring their time;
- monitoring a person via online communication tools or using spyware;
- taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep;
- depriving them of access to support services, such as specialist support or medical services;

[41] Controlling or Coercive Behaviour in an Intimate or Family Relationship Statutory Guidance Framework. Home Office 2015

- repeatedly putting them down such as telling them they are worthless;
- enforcing rules and activity which humiliate, degrade or dehumanise the victim;
- forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities;
- financial abuse including control of finances, such as only allowing a person a punitive allowance;
- threats to hurt or kill;
- threats to a child;
- threats to reveal or publish private information [e.g. threatening to 'out' someone].
- assault;
- criminal damage [such as destruction of household goods];
- rape;
- preventing a person from having access to transport or from working.

This is not an exhaustive list