Overview report

SaferCentral

Community Safety Partnership

A Domestic Homicide Review concerning the death of Dorothy (pseudonym)

(January 2023)

Author – Jackie Dadd

Date completed – September 2023

The Domestic Homicide Review Panel and the members of the Central Bedfordshire Community Safety Partnership would like to offer their sincere condolences to the family of Dorothy, who have lost a member of their family in tragic circumstances, and which has caused this review to take place.

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Preface

The key purpose of any Domestic Homicide Review (DHR) is to examine agency responses and support given to a victim of domestic abuse prior to their death and to enable lessons to be learnt where there may be links with domestic abuse. For these lessons to be learnt as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each death, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future. The victim's death in this case met the criteria for conducting a DHR according to Statutory Guidance1 under Section 9 (3)(1) of the Domestic Violence, Crime, and Victims Act 2004. The Act states that there should be a "review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death".

The Home Office defines domestic violence as:

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

Controlling behaviour is:

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

Coercive behaviour is:

An act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. The term domestic abuse will be used throughout this review as it reflects the range of behaviours encapsulated within the above definition and avoids the inclination to view domestic abuse in terms of physical assault only.

Recommendations will be made at the end of this report, however, there has been an ongoing action plan introduced by the panel, parallel to this review to ensure that the areas that can be immediately addressed have not incurred unnecessary delay.

Section 1 - Introduction

1.1 The commissioning of the review

1.1.1 This review is into the death of Dorothy, a 58-year-old female, who was found deceased at her home address by Police and ambulance following Dorothy making threats to kill herself over the phone to the Safeguarding Adults Team earlier that day. The Police have investigated the circumstances and have submitted a report to the Coroner with a finding that the death was non-suspicious and the cause was suspected overdose of prescribed drugs. The Coroner's inquest has been opened and adjourned awaiting the completion of this review.

Due to the husband of Dorothy being on bail for Domestic Abuse (DA) related offences at the time and previous history through a number of years of DA, Bedfordshire Police made a referral to the Central Bedfordshire Community Safety Partnership (CSP) on 9th January 2023 and following a meeting held on 25th January 2023 with representatives from a number of authorities and voluntary sector, a decision was made to undertake a Domestic Homicide Review as the definition in Section 9 of the Domestic Violence Crime and Victims Act (2004) had been met.

1.1.2 Contributors to the review

Agency	Contribution
Bedfordshire Police	IMR, Panel member
East London Foundation Trust (ELFT)	IMR, Panel member
Central Beds Community Safety Partnership	Oversight
Housing Department, Central Beds	Summary report, Panel member
Bedfordshire Integrated Care Board	Panel member
Bedfordshire Adult Social Care	IMR, Panel member
GP practice	IMR
Bedfordshire Hospitals NHS Foundation Trust	Panel member, Summary report
Bedfordshire Probation Service	Scoping, Panel member
Bedfordshire IDVA service/Victim Support	Summary report, Panel member
Carers in Bedfordshire	Panel member, Summary report
Path 2 Recovery (P2R)	Summary report, Panel member
Central Beds Domestic Abuse Service	Scoping, Panel member
BLMK Public Health	Panel member

1.1.3 Review Panel

The following agencies/organisations/voluntary bodies have contributed to the Domestic Homicide Review by the provision of reports and chronology. Individual Management Reviews (IMRs) have been requested and supplied:

1.1.4 – The panel comprised of the following: -

Name	Area of responsibility	Organisation
Lisa Scott	Safer Communities & Partnership Manager	Central Bedfordshire Council
Nina Page	Team Manager	Central Beds Domestic Abuse Service
Susan Childerhouse	Assistant Director of Public Protection & Transport	Central Bedfordshire Council
Jeanette Keyte	Head of Community Safety, Parking and Programmes	Central Bedfordshire Council
Rachael Clifford	Public Health Principal	Public Health Department (BLMK)
Joy Leighton	Senior Operations Manager	Victim Support/IDVA Bedfordshire
Anna Bruce	Deputy Head of Service	Bedfordshire Probation Service
Leire Agirre	Head of Safeguarding and Quality Improvement	Adult Social Care – Central Bedfordshire Council
Toni Doherty	Head of Safeguarding	Bedfordshire Hospitals NHS Foundation Trust
Anthony Orekogbe	Accommodation Services Manager	Housing Operations, Central Bedfordshire Council
Nadean Marsh	Designated Nurse – Safeguarding Adults	BLMK Integrated Care Board (ICB)
Marie Gresswell	DCI – Safeguarding Reviews	Bedfordshire Police
Darryl Springer	General Manager – Specialist Addictions Service	Path 2 Recovery – ELFT
Dr Abdullah Khan	GP practice Representative - Doctor	Medical Centre of Dorothy
Jodie Flynn	Safeguarding Specialist Nurse	Bedfordshire Hospitals NHS Foundation Trust

1.1.5 - All members of the panel and authors of the IMRs have complete independence from any subject in this review. The Review Chair and Panel gave due consideration for the content of the DHR and it was agreed that reports, chronologies, IMRs and other supplementary details would form the basis of the information provided. Thanks goes to all who have assisted and contributed to this review with their valued time and cooperation.

1.1.6 – Author of the Overview report

The chair of the review panel and author of this report is Mrs Jackie Dadd, an independent consultant who is independent of the organisation and agencies contributing to this report. She has no knowledge or association with any of the subjects in this report prior to the commissioning of this review and has not overseen or had any involvement with any investigations involving any parties. She is a retired Detective Chief Inspector with Bedfordshire Police since January 2021 with vast experience of safeguarding and domestic abuse related issues and has been involved in the DHR process since its inception in 2011. She has completed the Home Office online training, the Continuous Professional Development accredited AAFDA DHR Chair training and the Domestic Abuse and Suicide: Research, Risks and Reviews course. She is a member of the AAFDA DHR network, regularly attending the monthly forums for CPD and discussion. Mrs Dadd has completed several DHRs.

The independency of Mrs Dadd was thoroughly explored prior to her undertaking this work due to her previous links with Bedfordshire and Mrs Dadd, Central Bedfordshire CSP and the review panel were all satisfied that the transparency, independent nature and integrity of this report was assured from its outset. Central Bedfordshire CSP have experienced issues with securing available authors in previous DHRs and have negated a considerable delay in conducting the review that they have experienced previously.

1.2 Purpose of the review

1.2.1 - The purposes of a DHR are to:

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.

1.2.2 - DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for coroners' and criminal courts, respectively, to determine as appropriate. DHRs

are not specifically part of any disciplinary inquiry or process. Part of the rationale for the review is to ensure that agencies are responding appropriately to victims of domestic abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and domestic abuse. The review also assesses whether agencies have sufficient and effective procedures and protocols in place which were understood and adhered to by their staff.

1.2.3 - The death of Dorothy has been presented to the Coroner as potential suicide. This review will ascertain whether domestic abuse could have been the cause or a contributory factor to this. It is not to apportion blame, but to view the circumstances through the eyes of Dorothy.

1.3 Timescales

1.3.1 Bedfordshire Police made a referral for a DHR to Central Bedfordshire CSP on the 9th of January 2023 due to history through the years being recorded involving Dorothy and Bill. Also, at that time, Bill was on bail not to contact Dorothy having been arrested for domestic abuse related offences against her.

1.3.2 - On 25th January 2023, the Central Bedfordshire CSP, in accordance with the December 2016 Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews commissioned this Domestic Homicide Review. The Home Office were notified the same day.

1.3.3 - Mrs Jackie Dadd was commissioned to provide an independent chair and author for this DHR on 27th February 2023. Three separate panel meetings then took place. The completed report was handed to the Central Bedfordshire CSP on 1st September 2023.

1.3.4 – Table outlining timeline of review

January 2023	Dorothy was found deceased at her home address
09/01/23	Police referred incident for consideration of DHR to Central Bedfordshire CSP
25/01/23	Decision to commission a DHR made by Central Beds CSP and partners
25/01/23	Home Office notified of decision to commission DHR
27/02/23	Mrs Jackie Dadd commissioned as Chair and Author
31/03/23	First panel meeting
08/06/23	Second panel meeting
18/08/23	Third panel meeting
01/09/23	Completed report handed to Central Beds CSP by Author

1.3.5 Home Office guidance states that the review should be completed within six months of the initial decision to establish one. The completion of this report was significantly

delayed due to more than one agency submitting their information substantially later than the set timeline. Recommendations at the end of this report address this.

1.4 Confidentiality

This report has been treated as Official Sensitive and dissemination kept to those outlined at 1.9.

Pseudonyms have been used in this report to protect the identity of those referred to throughout the report. The domestic abuse reviewed relates to the two persons below:

Dorothy – Deceased. White British female aged 58 years.

Bill – Husband of Dorothy. White British male aged 59 years.

The CSP and Author have ensured that the collation of information and the information contained within this report complies with the Data Protection Act 2018 and the General Data Protection Regulation (GDPR).

1.5 Terms of Reference

1.5.1 The full Terms of Reference can be found in Appendix A at the conclusion of this report. The Terms of reference were discussed and agreed upon during the first panel meeting on 31st March 2023.

1.5.2 - It was agreed that the main areas of focus would be based on:

a) Has domestic abuse in any form been the causation or a contributory factor to Dorothy taking her own life?
b) Are processes and communication between agencies sufficiently effective in order to respond to those with multi complex needs in a timely manner?
c) How effective are services and agencies provisions and responses within Bedfordshire for when identifying the correlation between Carers and domestic abuse
d) How effective are processes when the victim has also been a perpetrator and neither party wish to engage with agencies.

1.5.3 It was agreed by the panel that the scoping dates would take place from 2016 up to January 2023, however, if relevant information was held prior to this, a summary was to be provided to provide context.

1.6 Subjects of the review/Family and friends' involvement

1.6.1 - In accordance with Home Office guidelines to ensure confidentiality, pseudonyms have been utilised throughout this report for the following: (Age is taken at the time of death)

Dorothy – Deceased. White British female aged 58 years.

Bill – Husband of Dorothy. White British male aged 59 years.

Susan – Sister of Dorothy.

Address – Name of area is referred to as Central Bedfordshire/Beds.

1.6.2 The pseudonyms were chosen by the author and approved by Susan, Dorothy's sister. Susan was identified as a relative very late in the review and contacted by phone by the author as that was the only means of communication available. Susan kindly provided as much background information and assistance as she could to the review of which the author would like to express her gratitude. Susan did not wish to participate any further in the review by attending a panel meeting or receiving a copy of the report and declined AAFDA support when verbally offered. No other contact methods were provided by Susan who stated that she trusted the process and only wanted contact from the Author to inform her that the report had been published.

1.6.3 The author contacted Bill via email as this was the only means of contact to ask if he wished to partake in the review. Bill responded via email and the Author outlined to him the purposes of a DHR as requested and no further contact was received by Bill. Due to his initial response, it was felt it was appropriate not to make any further contact as it appeared clear that he did not wish to contribute.

1.7 Parallel reviews

1.7.1 - The Coronial process is taking place parallel to this review.

Dorothy's death was reported to the Coroner by the Police in which the report submitted stated that the death was considered to be suicide by way of overdose of prescribed drugs and was deemed to be non-suspicious. The result of that post-mortem examination was that the death was due to: -

1a) Tramadol toxicity

External examination revealed multiple abrasions, bruises and scars as follows: A 10 mm abrasion to the central part of the forehead, 10 mm abrasion to the posterior aspect of the right arm and a similar abrasion seen on the dorsal aspect of the left arm. There were bruises present as follow: 30 mm bruise to the anterior aspect of the right arm, irregular area of bruising to the anterior aspect of the right upper thigh, 45 mm bruise to the anterior

aspect of the right foot and 50 mm bruise to the anterior aspect of the left foot. It is not commented on as to whether these were in keeping with attempts at resuscitation.

Toxicology results found a number of different prescribed drugs within the blood that may have been a contribution but the blood tramadol concentration was very high and well within the range encountered in deaths attributed to tramadol use alone.

The coroner has suspended the coronial investigation pending the outcome of this review.

1.8 Equality and Diversity

1.8.1 The review gave due consideration to each of the protected characteristics under Section 149 of the Equality Act 2010. The relevant legislation that provided the context for the panel was The Disability Act 2016, The Care Act 2014 and The Equality Act 2010.

Throughout this review process the Panel has considered the issues of equality in particular the nine protective characteristics under the Equality Act 2010. These are:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership (in employment only)
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

Key considerations for the panel were whether sex, disability and age had any relevant impact on the available services and response that Dorothy and Bill received.

It was considered that Dorothy's sex was relevant to the review as 3-10 women a week die of suicide where they have suffered domestic abuse and in 2017, eighty-three per cent of victims reporting coercive control to the police were female[1]

1.8.2 - Age and disability were a consideration for the panel as although Dorothy had not quite reached the age of an elder person, she had suffered for around forty years with chronic back pain which caused her restricted movement, depression and reliance on her abusive husband for necessities such as assistance with toileting. Her age may also have had an impact on her lack of knowledge of technical devices which provided her husband with an additional means of control and manipulation by utilising CCTV and technology within the home to be able to monitor her movements and also utilise them with appropriate

[1] Office for National Statistics, 2017

editing to provide the police with evidence of his version of events. The use of technology as a means of controlling behaviour is on the rise in domestic abuse, and Bill's use of CCTV is an example of how a perpetrator can use this to their benefit.

In England, women with a disability were more likely to be victims of domestic abuse in the year ending March 2020 (10.3%), compared with those without a disability (4.0%).[2]

Mental health issues manifested themselves through self-harming, alcohol abuse and suicidal ideations with attempts to take her own life on several occasions. These could be seen as coping mechanisms of the stress and abuse she had suffered over the years. It is to be considered as to whether agencies recognised the increased control and exploitation of vulnerability that this gave Bill.

Although not listed within the Equality Act 2010 as a 'protected characteristic,' questions have to be asked in relation to the role of Bill as a carer. Although it is not officially recorded that Bill was her full-time carer, he was accepted as such when either Bill or Dorothy told this to professional. It is to be examined by this panel as to whether Dorothy was provided support that would have lessened her reliance on him and whether the correlation between domestic abuse and carers was recognised.

1.8.3 Equality is about ensuring everybody has an equal opportunity and is not treated differently or discriminated against because of their characteristics. **Diversity** is about taking account of the differences between people and groups of people and placing a positive value on those differences.

1.9 Dissemination

Recipients who will receive copies of this report:

Panel Members (listed in 1.1)

Coroner's office

Members of Central Bedfordshire CSP

The family did not wish to have a copy

Bedfordshire Police and Crime Commissioner

[2] ONS data 2022

1.10 Contextual background

1.10.1 - Central Bedfordshire is a unitary authority serving a growing population of around 294,000, with 10,700 of these being females between the ages of 55-60 years. The increase in population within this area is twice as high as the overall increase in England which increases demand on services.[3]. It is a largely rural area with over half the population living in the countryside and the rest in a number of market towns.

Central Bedfordshire Community Safety Partnership (CSP) have the legal responsibility for DHRs within their area. They have commissioned six DHRs of which three are suicides thus far.

1.10.2 - This report will refer to Situational couple violence (SCV) (situationally provoked violence). This is violence that occurs where the couple has conflict which turns into arguments that can escalate into emotional aggression and possibly physical violence. SCV often involves both partners.[4]

1.10.3 The term 'carer' relates to both those who are in a paid profession and those who care for relatives or friends due to circumstance. This report will ensure it is clear when the term is used as to who it refers to.

The Care Act 2014 put in place significant new rights for carers in England including:

- A focus on promoting wellbeing
- A duty on local authorities to prevent, reduce and delay need for support, including the needs of carers.
- A right to a carer's assessment based on the appearance of need.
- A right for carers' eligible needs to be met.
- A duty on local authorities to provide information and advice to carers in relation to their caring role and their own needs.
- A duty on NHS bodies (NHS England, clinical commissioning groups, NHS trusts and NHS foundation trusts) to co-operate with local authorities in delivering the Care Act functions.

1.10.4 The first academic research in the UK has been completed that finds a very close link between 'Intimate Partner Violence (IPV) and suicidal ideation among women. Findings show:[5]

- Women who suffer domestic abuse are three times more likely than their peers to try and take their own life

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[3] Ref: ONS 2021 Survey

[4] ref: Johnson [A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and ... - Michael P. Johnson - Google Books]

[5] Ref: Sally McManus – Research for Agenda Alliance 2023

- Those who have experienced sexual abuse within a relationship have an even higher risk of suicide and are seven times more likely to have attempted to end their life.
- Victims of abuse by a partner are also more than three times as likely to self-harm and at more than double the risk of having suicidal thoughts.
- More than a quarter (27%) of women are estimated to suffer IPV during their lifetime.

Section 2 – The Facts

2.1 Background information

2.1.1 The early years of Dorothy have been provided by her sister, Susan and are in her words.

Dorothy was born in Bedfordshire and was one of five siblings. She grew up in the north of the county with her parents divorcing when she was young. As she grew into her teens, Susan states that Dorothy had issues with alcohol and drugs and was 'always getting in trouble.' She had been diagnosed with schizophrenia and went to live in a children's home in Luton. Because of the lack of the ability to travel, her family did not go to visit and they lost touch.

Dorothy met Bill and began a relationship with him when she was sixteen years old. Susan remembers that they argued from the very start as Bill also had issues with alcohol. Doctors' notes state that in 1980, which would have been the year they met, Dorothy took her first overdose following an argument with her boyfriend. There was a further overdose a year later. During this year, Dorothy had a car accident which caused reactive depression and caused severe back ache throughout the remainder of her life.

Dorothy and Bill were married when Dorothy was 18 years old.

2.1.2 Between 1980 and 2011, the Doctor's notes record five separate overdoses by Dorothy who it states worked for her husband. There are also four separate disclosures of her relationship with her husband which include being verbally bullied and violent towards her, finding fault all the time and making her feel useless, unsympathetic to her pain making her do 'heavy work' at home and in the garden and doesn't like her phoning her father. Dorothy stated that she was unable to perform well sexually due to her back pain.

Dorothy would have two terminations within five years in which Dorothy stated to professionals the reason for this was that her husband did not want a child and told her to choose between him or the baby. Dorothy told nurses that she had wanted the baby. This happened on both occasions. Doctor and hospital notes conflict as to the years this occurred as doctor states 1986 and 1991 with hospital records stating 1991 and 1995. These events were to stay with Dorothy for the rest of her life as she frequently referred to them with health professionals right up until a few days before her death.

In 1995, Dorothy and Bill became joint owners of the house that Dorothy would live in for the rest of her life. This was the year that Dorothy fell out with her sister as Susan had become pregnant and Dorothy could not cope with it and began arguments with her for no reason.

2.1.3 In 2006, Dorothy and Bill first came to police notice for a domestic incident following an argument over a spilt Chinese takeaway on the new carpet. Dorothy had called the police in which it was recorded pushing and shoving from both parties. The police report details Dorothy as being 'very intoxicated and was on medication'. Bill is described as being of sound mind who stated his wife is an alcoholic, who, after so many drinks, starts to pick fights with him. There was a further incident later on that year that was regarded as an argument.

Due to Dorothy's disclosure years later, she would have left Bill for a period of eight months in 2008 following her losing her job as he had hit her round the head whilst she was at work. This does not appear to have been reported at the time.

In 2011 there are three lengthy entries following a referral for psychology for the back pain in which Dorothy discloses being forced to have the two abortions and stating her husband controlled every domain in her life. The doctor comments: It is without doubt that this lady has suffered extreme domestic violence for the last 28 years. Even though she expressed doubt about attending the assessment, the extent of her disclosure was felt as a cry for help. However, her need to keep expressing her love for her husband and denying she would want to leave him suggests fear for repercussions for her actions and disclosures. When I reflected that her extreme emotional suffering would have an impact on her levels of pain, she readily agreed.

Referrals were made to Safeguarding of vulnerable Adults (SOVA) and Dorothy was offered a community care assessment but declined. She did however accept further support from an IDVA.

She later disclosed a rape by her husband but feared she would not be believed and stated he had been controlling ever since she had an affair 20 years ago. She said that her husband can be very kind to her and buys her expensive presents at times. Contact continued through SOVA over the next year in which they had a SIG marker on her phone number by the police as she said that if Bill molested her again, she would kill him and accepted their marriage was over.

Contact continued through SOVA over the next year in which they had a SIG marker on her phone number by the police as she said that if Bill molested her again, she would kill him and accepted their marriage was over.

In 2012, Dorothy was made redundant, suffered with agoraphobia and there were two further overdose entries on her medical records with an entry stating it was following an argument with her husband and that he was the primary problem. She also disclosed she was not allowed to have her own bank account and that Bill had hidden the cash they had and took her mobile phone and keys.

2.1.4 In 2014, Dorothy's physical condition was such that Bill had to assist her with toileting as she was not able to reach and clean herself. In later years, Dorothy would disclose in later years how Bill would go into the bathroom and make her wait for the toilet when she had taken constipation relieving medication and would leave her days without assisting her to shower so she was unwashed.

In 2015, further domestic incidents occurred for which the Police were called for the first time in nine years. Dorothy reported being assaulted by Bill in which he grabbed her by the back of the head and threw her on a wooden chair. Bill told the police that Dorothy was threatening to throw his phone out of the window. Both were intoxicated. Bill was arrested the following day and in interview, gave accounts of Dorothy abusing him but stated that he does everything for her.

Two further incidents occurred that year in which the police attended with alcohol consumption, bi-directional violence and counter allegations being present in both.

In 2016, a number of entries were made by health professionals where Dorothy disclosed to the Doctor and to ELFT (Mental health) that she was struggling in her marriage and couldn't leave due to financial dependence. This was the first occasion that Dorothy disclosed that Bill had CCTV installed around the house and records everything.

In January, a referral was received from the GP to South Bedfordshire Crisis team. Following a phone call where Dorothy informed them of the CCTV, a taxi was arranged to allow her to attend the surgery for privacy. A safeguarding referral was completed to Adult Services and she was subsequently discharged from the Crisis team when Dorothy declined an assessment at home or at the office and said she would contact the police if she needed help.

In March, Dorothy was brought to Luton and Dunstable hospital after she had stabbed herself in the neck. This required some minor treatment with butterfly tape.
The Psychiatric Liaison Team reviewed Dorothy. She reported she had done this after an argument with her husband and friend. Dorothy disclosed physical assault and verbal abuse and psychological control, including the use of CCTV cameras in the house to monitor her movements. Bill had broken some of her things and so she had thrown his seeds across the room.

The assessment records that this would suggest that Dorothy may have a diagnosis of personality disorder.

2.1.5 Dorothy declined informal admission and due to level of risks, an assessment was discussed with on call Doctor who agreed for MHA referral to EDT. EDT were contacted, however there were a lot of referrals so the social worker requested to speak to Dorothy and see if she will agree informal admission. Dorothy refused to talk to the social worker stating that it was her choice to end her life and that she does not want to talk to anyone. Dorothy dropped the phone and was requesting to leave EAU. Staff nurse in charge was informed of the plan and delay in getting EDT to come out for assessment, current risks was shared with the nursed in charge and that Dorothy was to be admitted to EAU and if she tries to leave for the ward doctor to assess under section 5(2) MHA whilst she waits to be

seen by EDT. Advised the nurse in charge to arrange 1:1 observation due to risk of absconding and self-harm. This was discussed with the Doctor who saw Dorothy in A &E and he advised a Safeguarding referral due to reported domestic violence. The assessment was discussed with the on-call Manager for psychiatry who agreed with plan and for the Liaison nurse to complete a safeguarding referral.

Staff liaised with the Police to find out the outcome of her husband's custody as he was on bail not to contact her. When the staff spoke to Dorothy, she informed them she would not be pressing charges against him.

Whilst on the ward, Dorothy disclosed the following (copied directly from the record as it provides in depth sight into the marriage):

Dorothy says her husband has been suffering with depression and also suffers from OCD as well, and he will get angry. Dorothy says she starts to get comfortable and then he will "knock me down again". Dorothy's husband has bathed and showered her for a long time now. Her husband calls her lazy (she has problems with her back) and really pushes her to do things.

2.1.6 Dorothy says her husband was first violent to her early in her marriage and would throw her around, jumped on her spine and seriously assaulted her. Then for 14 years there was very little aggression but he continued to be verbally aggressive to Dorothy calling her a "piece of shit", "slut", "slag" "fat", "Lazy" – Dorothy had a brief affair 25 years ago and he still brings this up. Dorothy is very tearful and upset about this and says that her husband has smashed things up that belong to her with regularity.

Dorothy says she has told her mother she was scared she'd kill him, and her mother said to do it and she would stand up in court with her. Dorothy has found it difficult to leave as her husband is "genuinely sorry" and is a "lovely man" – Dr asks what he has done to change his behaviour. Dr explains about saying sorry but continuing to do the same thing again and again, without evidence about being genuinely sorry and judging people on their words and their behaviour. Dorothy says she always ends up having to say sorry. Dorothy says that her husband changes very quickly.

Dorothy has previously been in a position where she had to get very drunk and he would have sex with her and video the sexual activity. Dr explains that this is criminal behaviour and Dorothy says she consented as she wants to make him happy.

Dorothy says that she wants to go home, and she wants to be with her husband and loves him very much. Dorothy says she isn't afraid to be by herself and isn't afraid that he will kill her if she leaves him.

Dorothy has said her husband won't accept any additional help to care for her. Dr says that her husband has not changed and has not made any attempts to change. Dorothy believes that he will changed as he is now terrified, and she doesn't want to hurt him – and it wouldn't make any difference if he went to prison. Dorothy says she wants to make herself

feel good. Asked whether being at home with her husband makes her feel good, she says most of the time unless he “kicks off”.

2.1.7 Dorothy values herself and doesn’t believe him when he says she’s fat. Dorothy says if he does anymore, she will leave him. She last left him 22 years ago for 8-9 months and she wanted him to prove himself. Dorothy lost her job as he punched her in the head whilst she was at work and lied to Dorothy’s sister about the conditions she was staying with her sister. Her husband eventually moved into her sister’s place and they got back together. Dorothy says that everyone has their moments.

Her husband has spent the last four years being verbally abusive, and once in a blue moon would physically assault her. In the last twelve months he has physically assaulted her five times – one time he nearly killed her. Something got taken out of the oven at the wrong time, and he was beating her in a motorhome and he was trying to suffocate her by covering her nose and her mouth, she didn’t end up going into hospital. He has also hit her with numerous objects before, like a clothes horse. Dorothy says that he says it’s because of her drinking alcohol.

On this occasion she was banged on the head, by having it hit on the floor. Dr asks whether Dorothy thinks he could kill her, she says that he wouldn’t and she isn’t scared of him. Dr explains that domestic violence over a long period of time can become brain washed. Dorothy says she says sorry to keep the peace but she knows that she is right.

Dr says that he says sorry but has not changed and has not tried to get any help. Dorothy says that she is also verbally abusive to him. Dorothy says she wants to go back to her husband but if he continues to be like this, she doesn’t want to be with him. Dr says that her husband says he has been exonerated by the police and that there will be no alcohol in the house. Dr is concerned this will happen again if she goes back to the house.

When Dorothy stabbed herself in the neck, she wasn’t sure whether she wanted to die or whether she wanted to hurt him as well, so he is not powerful. Dorothy drank some alcohol and her husband found the bottle, and said she was an alcoholic and pretended to throw the alcohol away. Her husband then started drinking himself and was hiding the alcohol. Dorothy confronted her husband about the fact he had been drinking alcohol. The next morning her husband ignored her and then a few days later he told Dorothy she had an attitude problem and said she couldn’t go to a service for a dead friend. She doesn’t go anywhere without him. Her husband made her come back from a friend’s house for making a scene about it. Dorothy drank one third of a bottle of vodka and looked up at the CCTV camera in the dining room saying she couldn’t forgive him for a number of things and he “kicked off”. He started to call her names, and talking about her affair and she couldn’t take it so went into the shower and stabbed herself in the next three times. She isn’t sure whether she was trying to die or what – she was very angry. Her husband didn’t know about this and started smashing things in the kitchen. Dorothy threw a number of seedling trays into the kitchen; her husband saw blood on her neck and “went ballistic”. Her husband then went out and called the police whilst Dorothy was calling an ambulance. She was screaming down the phone that he was coming up the stairs – she says she didn’t know what he was going to do.

2.1.8 Dr asks whether Dorothy has ever sought support from a domestic violence group and she said "yes, and I ended up in here" – this was the Crisis Team. She has not tried anyone else. She previously tried to kill herself by taking a medication overdose. Prior to admission she was having suicidal thoughts but she wants to live. Dorothy says she is more "elated" now than she has been for the last six months because she does not have to be with him. Dorothy agrees that she has had thoughts about leaving her husband but she does love him. She reports no maltreatment form her family, but she was sexually assaulted in foster care in Leighton Buzzard aged 15. She was walking through a park and four males grabbed her and raped her. She told the police what had happened and she didn't want anyone to touch her, the police said because she wouldn't cooperate it didn't happen. Dorothy says she was stupid to go out in the dark on her own and not to cooperate with the police.

Dorothy got pregnant when younger and she was told "it's him or the child" and so she had a termination – this has happened twice with her husband. With the third pregnancy he didn't believe she was pregnant and so he ran her down with the car and she miscarried. Now she is 51 he wants to have a baby and says, "you can't give them to me, you murdered my babies". Dr states that her husband seems not to take any responsibility and Dorothy says that he says he's sorry. But now he says it's her fault as she is mentally ill. Dorothy feels that she does need help.

The hospital had to apply safeguarding measures whilst she was on the ward that 'her husband was not allowed access' although she was then discharged to his care when she left the hospital. Dorothy had started to walk with the assistance of a stick.

The ward Occupational Therapist contacted the Central Bedfordshire Safeguarding Team to share concerns around coercion from her husband and were informed of an upcoming MARAC. This information was also shared with the medical team and a domestic abuse worker was allocated.

Over the next few years, there were to be further incidents of domestic abuse between Dorothy and Bill in which on one occasion, Bill was arrested for assault and Dorothy was Dorothy was detained under S2 MHA and admitted to a Mental Health unit having stabbed herself in the neck and legs due to the way he treated her. Referrals were made to SOVA, IDVA and MARAC (Glossary at appx B). Bill stated in interview that CCTV was installed to protect himself from accusations and that he wasn't drunk but Dorothy had been and again, insinuated the incident was of Dorothy's making. The police did not consider controlling and coercive behaviour.

2.1.9 There were two more incidents involving the police that year and a further MARAC hearing. The Psychiatric Liaison Team recorded that Dorothy had received talking therapies for several years at the Disability Resource Centre, most likely the Complex Needs Service, but she stopped working with them when she found it too difficult to talk.

During June 2017, Bill made redundant from job after 23 years. Following an incident in 2018, Bill received a fine and a community order with a Rehabilitation Activity Requirement (RAR) following a victimless prosecution for assault in which Bill pleaded guilty.

In 2020, Bill had an affair and moved out of the home to his new partners address in Woburn for a short time, leaving Dorothy with no care. He then lived at the end of the garden in his motorhome with his new partner. The police were called on numerous occasions, including when Dorothy had lost her key and couldn't get in the house and he refused to let her in with his key so she slept in the conservatory. Dorothy was reliant on crutches to get about and her mobility was extremely poor. This was one of four incidents the police attended that year in which one of them, Dorothy was arrested for shutting his foot in the patio door but detention was not authorised on arrival at the police station.

Dorothy was seen by the crisis team in which she said she was struggling to cope with him living at the bottom of the garden with his new partner, took an overdose of morphine and was detained under s2 MHA. Referrals were made to P2R for her alcohol abuse and she was discharged to the crisis team.

Towards the end of 2021, Dorothy called the police whilst intoxicated and had locked herself in the shed. On arrival, Bill made allegations of assault and Dorothy was arrested. On release from custody, she had bail conditions not to contact Bill and was place in temporary accommodation in Luton with no care needs package.

2.1.10 At the beginning of 2023, Dorothy informed the police that Bill had punched her several times, also, a number of allegations concerning their domestic situation stating he was controlling, won't let her go out without him or let her see her friends. Dorothy also reported that on an unknown date several years ago her husband had put an item into her vagina without her consent. Bill was arrested and remained in custody until being bailed not to contact Dorothy. An Adult Risk Assessment was completed stating that she required extra help for her needs. This was raised to a safeguarding enquiry and after ascertaining Dorothy was not open to CMHT, an urgent welfare visit took place.

They visited in the evening, staying for some time, addressing her immediate physical and practical need that they could. They offered differing support mechanisms to which Dorothy declined them all stating that she would kill herself if Bill was not allowed to come home. She outlined all of the emotional, physical and sexual abuse she had endured over the years. When options were discussed with Dorothy re domestic abuse support services and fleeing, she advised that this is all she has known. She stated she met Bill when she was 16 years old and married him at 18 years old. That they've been married forty years and it appears she is now dependent on him.

On leaving, they noted a vehicle possibly belonging to Bill in the car park close to Dorothy's home. Due to concerns of risk involving this and Dorothy not eating with suicidal ideations, police were contacted and asked to complete a welfare check which was completed with no further risks identified.

Communication between the police and Adult Safeguarding continued the following day. Contact was made with Dorothy over the phone in which ASC offered carers to visit but Dorothy declined. The worker thought she heard a male voice in the background and when asked about this, Dorothy said it was a neighbour. Dorothy again re-iterated that she needed Bill to come home.

2.2 Circumstances of the death of Dorothy

2.2.1 Two days after Bill's arrest, a safeguarding support worker picked up a voicemail message late in the day from Dorothy in which she was crying and sobbing and asking for help. Unable to get hold of her on the phone, the worker contacted the Police to ask for a welfare check. Conversations took place in relation to whether there was immediate risk.

The Police went to Dorothy's home address a couple of hours later and went round the back when there was no answer to the front door. It was here they saw Dorothy laying on the floor and smashed the two sets of glass doors to gain entry. They began CPR which was continued when the paramedics arrived until they pronounced Dorothy as dead sometime later. Multiple notes from Dorothy in relation to her death were found at the house. These indicated that she still loved Bill and couldn't live without him but made mention of how he had told her he hadn't loved her in decades and that he didn't mean to do things, it was the alcohol.

Multiple empty weekly pill boxes were found on her bed and a discarded tramadol tablet was on the floor. There were multiple internal 'Alexa' cameras and wall mounted cameras located in every room except the bathroom. These appeared to be active and the hard drive for these cameras has not been located.

2.3 Individual management reviews (IMRs)

2.3.1 – Dorothy and Bill had contact with numerous agencies throughout their lives. IMRs were requested from the agencies who had face to face contact with them within the last years of Dorothy's life.

2.3.2 Bedfordshire Police

The Police were requested to provide a summary of contact with Bill and Dorothy from 2006-2015, which was outside of the scoping period on the Terms of reference to provide context of the relationship over a number of years. It is noted that policies and procedures were significantly different during those years to how they are now.

SUMMARY 2006 - 2015

The two incidents in 2006 give a little insight into the domestic situation and highlight Dorothy's alcohol abuse, though it is another nine years before police are involved again on 4th July 2015. On this occasion the log states that Dorothy reports being assaulted by Bill, by hitting her around the head, bashing a chair into her throat and biting her finger. Dorothy reported Bill had been drinking heavily and had driven off in his motorhome. The log refers to Dorothy being hysterical, possibly intoxicated and is on morphine patches, anti-inflammatories and pain killers.

The crime report states Dorothy had grabbed Bill's phone and threatened to throw it out of the window unless he tells her who he was talking to. He refused and she has thrown it out

of the window. Bill has then walked away being followed by Dorothy. He then grabs her by the back of the head and throws her on top of a wooden chair.

The following day Bill attended Dunstable police station and was arrested for assault occasioning actual bodily harm. He gave a full account in interview stating he was being shouted at for not doing enough housework but states he actually does it all due to Dorothy's health. He had been doing a BBQ and Dorothy swiped the food off his plate and threw it, hitting the door frame. He then turned on the TV and played a game on his phone. Dorothy then snatched his phone throwing it out of the window. Bill went and retrieved his phone, swore at Dorothy and left in his motor home. He stated Dorothy causes these incidents frequently. No physical abuse had occurred by either party and he was able to account for all the old wounds he had. He stated Dorothy self-harms but was unsure if she had recently. There are no other references to self-harming and unknown if this was further explored.

2.3.3 On 18th December 2015 Bill called police to say during an argument he had been slapped very hard around the face and had barricaded himself in the bathroom. Due to previous false allegations of assault against him, he had installed 10 cameras throughout the house. Dorothy was arrested and after seeing the CCTV admitted the assault. She was cautioned for the offence.

On 20th December 2015 an abandoned 999 call was made and on returning the call Dorothy answered and in what is described as a sarcastic voice said her husband had called us and he was frightened for his life. On speaking to Bill, he said there was a domestic situation and he couldn't say anything further but needed the police to come immediately. It was established a verbal argument had occurred over Dorothy being arrested the day before and that she had an affair 30 years ago. Bill decided he would stay elsewhere that night.

In the incidents prior to 2016, each incident involved at least one of the parties having consumed alcohol. The incidents show a level of bi-directional violence with both being accused of being the perpetrator by the other.

All the incidents have safeguarding references documented according to policy and procedure at the time and (the police state), appropriate DASH risk assessments were made. Consideration should have been given for referrals to alcohol abuse agencies. It is documented that Dorothy was registered as disabled but there is no information as to what specific disability she suffered with. When detained the custody records states she suffered from numerous medical conditions. A medical examination was carried and the custody record endorsed 'no recommended observations. She was fit to be detained and required Ventolin puffs. She stated she had consumed a ¼ bottle of vodka. Until this point there is nothing documented to suggest Bill was classed as a 'carer'. Bill and Dorothy had been together for over 30 years and this appeared to be the start of regular domestic incidents where the consumption of alcohol was present by either or both parties. Although the police response to these incidents was appropriate, both were suffering with their physical health and this must have been a burden on them both, possibly impacting on their mental

health and using alcohol to cope. Consideration could have been given to seek further support through referrals.

2.3.4 2016

Following two domestic disputes in January 2016 in which alcohol abuse by both parties was a factor and Dorothy's mental health was mentioned for the first time, the police were called by Dorothy in March 2016.

Dorothy reported that Bill had punched her and that she was going to run away with all the money. There was £100,000 in plastic containers. Dorothy stated she was going to kill herself and had punctured her leg three times with a knife. She said she punctured her neck but has stopped the bleeding. She was upset and said, 'she got the wrong place again'. She stated she did this as Bill doesn't love her anymore. She said he has been violent to her lots of times. Police called for an ambulance who after arrival conveyed Dorothy to hospital. She had a superficial cut to her neck, grazes to her cheek and forehead and no other injuries, other than scratches to her legs which she says are self-inflicted. Bill was arrested for assault. On 19/03/2016 Dorothy was detained under S2 MHA and admitted to a Mental Health unit.

A DASH risk assessment of high was correctly recorded and a vulnerable adult report was completed and submitted to the Public Protection Unit Support Team detailing:

'Dorothy is a vulnerable female who is suffering domestic violence from her husband Bill. She has stated that he is regularly verbally abusive to her, swearing at her and telling her she is useless. On top of this he has assaulted her on multiple occasions in the past. Police have been called this evening as he has punched her to the face, head and jumped on her back. This female suffers chronic back pain due to a damaged disc and also has hip pain as a result. She is not hugely mobile.

2.3.5 On top of this Dorothy also suffers depression and is actively seeking to kill herself, at the time of writing this she is at Luton and Dunstable hospital with officers and the mental health team are aware. She has today attempted to stab herself in the neck twice with a kitchen knife. She has a history of self-harm with scars visible on her arms. Whilst with Dorothy, she stated she was so unhappy that she doesn't want to live anymore and was visibly upset that her suicide attempt had failed. Dorothy had drunk 1/3 of a bottle of vodka but had stated that she is not an alcoholic.

Bill was arrested for ABH. In interview he provided an account and stated he and Dorothy were having dinner and everything was fine. He went to a widow's house, which he does every day and a while later Dorothy followed but started causing problems and he realised she was drunk. She left and then he followed her home. On-going through the door, she punched him causing a cut to his lip. She then grabbed his glasses and crunched them in her hand. He grabbed her wrists and tried to calm her down. He has then gone upstairs, collected the money which was his and left the house. At no point did he cause any injuries and she had none when he left the house. He knew she would call the police and, on his return, he didn't see her. He was not drunk and can remember everything. He stated she

suffers from mental health at the moment and needs help. He stays in the house to be her carer. They are not in a physical relationship and live in separate rooms. He stated he put the CCTV in the house for his own protection and she threatens him to sleep with one eye open and she will have him sent to jail for hurting her. He sleeps with a chair under the door handle. A witness corroborated the fact Dorothy arrived at her house drunk and caused problems and left before Bill, who then followed. Bill also had a cut lip and was bailed with conditions not to contact or communicate directly or indirectly with Dorothy unless requested by persons involved in her treatment.

On 22/03/2016 the case was finalised with no further action [NFA] being taken. Referrals were made to Safeguarding of Vulnerable Adults [SOVA], Independent Domestic Violence Advisor [IDVA] and MARAC. The occupational therapist shared information at the MARAC whereby Dorothy had recordings on her phone of Bill being abusive to her. There were 15 in existence but she only had three as he had deleted the rest. These came from the cameras within the house. She reported that Bill was over caring, preventing Dorothy from completing activities of daily living so that she was completely dependent on him.

There were two more incidents involving the police that year and a further MARAC hearing. Following an incident in 2018, Bill received a fine and a community order with a Rehabilitation Activity Requirement (RAR) following a victimless prosecution for assault in which Bill pleaded guilty.

2.3.6 2020

09/08/2020- Domestic dispute – Common assault - Bill contacted the police and reported Dorothy had locked him out. She had been drinking and was aggressive. She had shut his foot in the patio door and picked up his air rifle and hit his foot with it. Dorothy stated the row was over Bill cheating on her. Dorothy was arrested but on arrival at the police station her detention was not authorised, and a decision was made for the matter to be dealt with out of custody. Dorothy was contemporaneously interviewed. Bill subsequently withdrew support for any police action and was living in Woburn with his new partner.

The officer recorded their concerns for Dorothy who had discovered that Bill was cheating on her. Bill was her primary carer and Dorothy stated on several occasions that she barely leaves the house without him and hadn't showered in days as he was not there to assist.

Dorothy was reliant on crutches to get about and her mobility was extremely poor. She was on several different medications as she suffered from depression and severe back pain, some of which were not prescribed.

2.3.7 Reflective considerations: Safeguarding advice was given. No referrals were made but due to the previous incidents and referrals information should have been shared. The information that Dorothy may be taking unprescribed medication should have also been included and investigated.

1/09/2020- Domestic dispute Criminal Damage - Dorothy left her home with what was believed to be a sharp object, she went into the street and slashed all four wheels of Bill's

vehicle which was left parked outside of the location. A DASH risk assessment was completed as medium risk and an adult referral made.

23/10/2021 Assault without injury – Dorothy contacted the Police stating ''get the police ''I'm fucking hurting' 'husband has taken all the keys' 'he's trying to stop me' 'I'm going to do something stupid'. A further call was received from Bill stating that she had locked herself in in his workshop at the bottom of the garden, was drunk and accusing him of all sorts of things. On arrival he told them that whilst sitting at the dining room table he had been assaulted by Dorothy who slapped and punched him. Dorothy was arrested and replied no comment in interview. The duty nurse and the Emergency Duty team (EDT) were contacted to assess her. The CPS made the decision to refuse charge as although the CCTV captured the incident, as Bill was not supporting, they stated they couldn't use it.

2.3.8 Reflective considerations: This domestic assault was alleged by Bill following Dorothy contacting the Police and the focus turned to his narrative on attendance. His retraction statement said that he only reported the assault that day as he was in fear of Dorothy making a false allegation against him. It is stated that this was a difficult case as they had been married nearly 38 years, they did not want to prosecute each other and Bill was her carer. Referrals were sent to ELFT for both and Bill was referred to the National Centre for Domestic Violence (NCDV) with a view to obtaining a non-molestation order. The custody record for Dorothy states that there was no trace of her on the computer system so no previous risk assessments were available which is incorrect.

28/10/2021 - Adult protection incident - Dorothy was found in the early hours heavily intoxicated and couldn't remember where she lived. She had recently moved to an address in Luton. Referrals sent to SOVA and ELFT.

03/01/2023 - Sexual Assault by Penetration – Dorothy contacted police reporting that Bill was being violent and had punched her several times, also, a number of allegations concerning their domestic situation stating he was controlling, won't let her go out without him or let her see her friends. Dorothy also reported that on an unknown date several years ago her husband had put an item into her vagina without her consent. She refused to provide any further details in relation to this and would not tell officers anymore. Officers described Bill as feigning unconsciousness and he was conveyed to hospital. He was subsequently arrested for assault and criminal damage to Dorothy's mobile phone. The adult risk assessment is assessed as medium with comments:

'I feel that Dorothy would benefit from extra support as she is disabled and is currently not receiving any help from any care providers or health care. I feel that she would further benefit from further support and care if Bill is placed with bail conditions that prevent him from contacting her. I feel extra help would help to manage Dorothy's level of care and her needs'.

During interview, Bill said that he is the main carer for Dorothy who is disabled, has schizophrenia and issues with alcohol. He denied assaulting Dorothy and that the phone is his. The officer recorded that it was clear that Bill was struggling to cope to look after Dorothy on his own and it was having a detrimental impact on his own health and possible

mental health. Bill would live in his motor home whilst on bail. They felt that when they were both reunited there could be the demands and pressure of trying to care for Dorothy and felt that Bill would benefit from the added support to help him with his medical conditions and to help him with the pressures of trying to be main the carer for Dorothy.

Dorothy provided a negative statement not supporting any police action. Referrals made to Adult Safeguarding and to Central Beds MARAC rep.

2.3.9 04/01/2023 – The Police received a call from Adult social services who had visited Dorothy who is refusing any care, has not eaten or cleaned herself and made a statement to the workers stating she will kill herself if Bill does not return. Dorothy had stated that she would not call the police if he returned even if he was angry. During the visit the Alexa system went red and Dorothy stated that meant Bill would be watching. The concern was Bill may be back at the location and a second concern of self-harm. Bill has full control of the money and will shut off the gas and electricity. The Social worker stated it was some of the worst things she had ever heard and had left Dorothy only half an hour before. The Police attended at 21.47hrs that evening but were unable to get a reply until 22.01hrs. Dorothy was emotional but officers recorded she was safe and well and did not want to harm herself and felt she need a full-time carer.

The following day, a Safeguarding Adults and MARAC representative sent an email to the Police stating: 'I have spent most of the day gathering information and writing up the recommendations for S42 enquiry. I have a lot more information from the workers that visited Dorothy in relation to assaults and sexual abuse. I have spoken to her myself this morning and I believe that Bill has returned to the property as there was a man talking to her in the background during our call. This is very complex and I had intended to refer to MARAC as I feel a multi-agency approach is required in this case. The risks are very high. When completed, I will send the SV1b over to you and the officers dealing with the ongoing investigation for review'.

The Victim Engagement Officer (VEO) contacted Dorothy for support and Dorothy pleaded for Bills bail conditions to be dropped as she didn't think she would cope as he was her carer. The VEO spoke to her with regards to her domestic circumstances and influence Dorothy to possibly rely less on Bill and carry out some little things around the house. Dorothy agreed to work with IDVA who would help her put plans in place to help her become stronger and work on confidence and self-esteem.

2.3.10 <u>Unexplained sudden death -</u> A call was received at 16.42hrs from the Safeguarding Adults team reporting that they had received a call back today from Dorothy who was crying, sounded distressed and was asking for help. They picked the call up about 15.45hrs but do not know when Dorothy made the call. They have called her back and when spoken to, her presentation was very calm and a bit quiet but she would not engage with the informant or his team. There was some concern that when they called yesterday, they could hear a male's voice and that he was bailed (Bill) not to attend the property.

A member from their team had called yesterday following a referral from the police on 4th January 2023 regarding safeguarding and to see what social services and mental health

could do. They tried to establish what her needs were and how they could assist her as she needed care and support to be put in place. Dorothy was declining this support and demanding her husband return home to provide the care and support. During the call she said, “If my husband is not allowed to return and care for my needs, I will commit suicide”. Informant was concerned as they are not able to get in contact with her today and safeguarding adults do not do home visits as they are a triage team who take information and direct it as the difficulty was all the services shut by 16.20hrs. Dorothy had not been assessed for her level of needs but it was understood she has significant physical needs and needed physical assistance for which her husband was providing for her. Due to the nature of what had been said and now not able to contact Dorothy, they have called the police. If the police needed to get back in touch, they were to inform EDT and a telephone number was provided.

Police called Dorothy and left an answer message stating, ‘we are concerned for your welfare and call 101 with cad number or 999 in an emergency’. A THRIVE (Threat, Harm, Risk, Investigation, Vulnerability and Engagement) assessment was completed but no units were available to attend. At 18.05hrs, new staff were on duty and reviewed outstanding incidents. There were still no units available and would be allocated in line with THRIVE and unit availability. At 19.33hrs officers attended and found Dorothy deceased. Suicide notes were found at the address which referred to her love for Bill and the fact she wanted him home.

2.3.11 Best practice/Reflective considerations:

Dorothy’s call back was listened to by Safeguarding about 15.45hrs but it is not known when she made the call. Safeguarding spoke to her about fifteen minutes before phoning police and describe her as calm but quiet and said she was alright and put the phone down. She hadn’t mentioned anything that day of taking her life. Having listened to the call, the review officer’s opinion is though there has been and is concern for Dorothy’s welfare and there had been previous threats to end her life, there was not any urgency that her life may be at risk. The response, ‘prompt’, was in line with the THRIVE assessment completed and for a vehicle to be assigned when available. The police attended the address when a unit became available. The THRIVE assessment was appropriate in the circumstances. Research was carried out. The response of ‘prompt’ would have a target of attendance within 1hour and would be prioritised over scheduled incidents. Although the target is 1hour this would be subject of THRIVE reviews against other incidents and available resources to dispatch. As soon as a vehicle was available it was assigned to the incident.

2.3.12 Addressing Terms of Reference

Police have core operational duties and responsibilities one of which is protecting life and property and therefore the actions on each occasion addressed the immediate circumstances. In order to have a longer-term effect appropriate positive action by arresting either party was taken. The DVPN could have been a route to offer a break to both parties but does not appear to have been considered appropriate.

The dependency Dorothy had on Bill, as well as her feelings for him affected decision making and therefore no order was in place to assist in controlling the continuing domestics. On the one occasion Bill did appear before the magistrates, part of his sentence was a community Service Order incorporating an RAR. The conditions in relation to this were not relevant to domestic abuse.

The College of Policing, Authorised Professional Practice provides some clarity regarding counter allegations and states that officers should avoid jumping to conclusions about which party in the relationship is the victim and which is the perpetrator. They should probe the situation and be aware that the primary aggressor is not necessarily the person who was first to use force or threatening behaviour in the current incident. If both parties claim to be the victim, officers should risk assess both counter allegations.

Information was shared with the police regarding possible controlling behaviour. The occupational therapist stated Dorothy is agoraphobic, socially isolated, and may not engage with services or attend appointments after she leaves the Mental Health Unit. She stated Bill is over caring. Adult Social Services report controlling behaviour but this wasn't endorsed when Dorothy was visited by the police the same evening. The VEO did address the situation the following day by offering advice and suggesting Dorothy works with an IDVA to which she agreed.

Whether identified as victim or aggressor, safeguarding advice was given and appropriate referrals made for both parties. Where possible, collaborative evidence was sought and positive action taken by arresting and prosecuting. Consideration could have been given to make referrals regarding the alcohol abuse and possible support for Bill. Since 2018 the 'Athena' computer system allows better governance of researching and monitoring domestic abuse investigations.

2.3.13 Best practice/Reflective considerations:

On review of a number of incidents dating back over numerous years, the action taken by the Police was appropriate and relevant referrals made in relation to Adult safeguarding referrals and Mental Health referrals.

It was apparent from the initial Police contact back in 2006 that both Bill and Dorothy had alcohol abuse issues yet throughout all of the incidents they attended from 2006 onwards, no referrals were made to assist with this, which on numerous reports had been recorded as the suspected cause of the domestic disputes.

Consideration of the DVPN process is also an option for officers to consider in situations where the victim expresses reluctance to pursue any action, and it is another means of finalising incidents by taking positive action.

All domestic abuse incidents reported to Bedfordshire Police are attended by uniformed front-line intervention officers. They deal with the initial response, conduct a DASH or DARA risk assessment, implement any immediate safeguarding measures required and conduct an initial investigation, if the incident amounts to a crime. They record the incident on the

computer 'Athena' as a Crime or a Non-Crime. The Intervention Sergeant on duty will review and sign off the DASH/DARA book, and if the incident is graded as High Risk, the Intervention Inspector on duty is informed to ensure appropriate safeguarding measures and investigation are being conducted. All officers and staff are provided with a guidebook 'Domestic Abuse Toolkit' which gives detailed step by step instructions in dealing with reported domestic abuse. This includes staff dealing with initial contact, e.g., call handlers or station officers, to the officers attending or responsible for the investigation. From the commencement of each report a risk assessment is carried out using THRIVE (Threat, Harm, Risk, Investigation, Vulnerability, Engagement). This is revisited at each stage of the investigation.

2.3.14 Effective practice identified

- Response to calls by Police Control Room.
- Research of previous incidents by Police Control Room.
- Response officers dealing with incidents.
- Completion of risk assessments
- Prompt referrals to partner agencies.
- Use of SIG markers.
- Prompt tasking to VEO

2.3.15 East London Foundation Trust (ELFT) – Mental Health

Dorothy was well-known to Mental Health Services and had some involvement with P2R services. Dorothy was diagnosed in November 2020 with Mental and behavioural disorder due to harmful use of alcohol. She had mixed anxiety and depression disorder.

Dorothy's Mental health deteriorated at times requiring hospital admission under a Mental Health Section. Whilst on the ward, Dorothy was normally compliant with the treatment and recommendation from the staff.

Dorothy disclosed incidents of Domestic abuse regularly whilst under the care of mental health services. Mental Health services were asked to lead on two Section 42 Enquiries and multiple recommendations were made for concerns that did not meet the criteria for Safeguarding Adults Enquiries.

2.3.18 Dorothy values herself and doesn't believe him when he says she's fat. Dorothy says if he does anymore, she will leave him. She last left him 22 years ago for 8-9 months and she wanted him to prove himself. Dorothy lost her job as he punched her in the head whilst she was at work and lied to Dorothy's sister about the conditions she was staying with her sister. Her husband eventually moved into her sister's place and they got back together. Dorothy says that everyone has their moments.

Her husband has spent the last four years being verbally abusive, and once in a blue moon would physically assault her. In the last twelve months he has physically assaulted her five times – one time he nearly killed her. Something got taken out of the oven at the wrong time, and he was beating her in a motorhome and he was trying to suffocate her by

covering her nose and her mouth, she didn't end up going into hospital. He has also hit her with numerous objects before, like a clothes horse. Dorothy says that he says it's because of her drinking alcohol.

On this occasion she was banged on the head, by having it hit on the floor. Dr asks whether Dorothy thinks he could kill her, she says that he wouldn't and she isn't scared of him. Dr explains that domestic violence over a long period of time can become brain washed. Dorothy says she says sorry to keep the peace but she knows that she is right.

Dr says that he says sorry but has not changed and has not tried to get any help. Dorothy says that she is also verbally abusive to him. Dorothy says she wants to go back to her husband but if he continues to be like this, she doesn't want to be with him. Dr says that her husband says he has been exonerated by the police and that there will be no alcohol in the house. Dr is concerned this will happen again if she goes back to the house.

When Dorothy stabbed herself in the neck, she wasn't sure whether she wanted to die or whether she wanted to hurt him as well, so he is not powerful. Dorothy drank some alcohol and her husband found the bottle, and said she was an alcoholic and pretended to throw the alcohol away. Her husband then started drinking himself and was hiding the alcohol. Dorothy confronted her husband about the fact he had been drinking alcohol. The next morning her husband ignored her and then a few days later he told Dorothy she had an attitude problem and said she couldn't go to a service for a dead friend. She doesn't go anywhere without him. Her husband made her come back from a friend's house for making a scene about it. Dorothy drank one third of a bottle of vodka and looked up at the CCTV camera in the dining room saying she couldn't forgive him for a number of things and he "kicked off". He started to call her names, and talking about her affair and she couldn't take it so went into the shower and stabbed herself in the next three times. She isn't sure whether she was trying to die or what – she was very angry. Her husband didn't know about this and started smashing things in the kitchen. Dorothy threw a number of seedling trays into the kitchen; her husband saw blood on her neck and "went ballistic". Her husband then went out and called the police whilst Dorothy was calling an ambulance. She was screaming down the phone that he was coming up the stairs – she says she didn't know what he was going to do.

2.3.19 Dr asks whether Dorothy has ever sought support from a domestic violence group and she said "yes, and I ended up in here" – this was the Crisis Team. She has not tried anyone else. She previously tried to kill herself by taking a medication overdose. Prior to admission she was having suicidal thoughts but she wants to live. Dorothy says she is more "elated" now than she has been for the last six months because she does not have to be with him. Dorothy agrees that she has had thoughts about leaving her husband but she does love him. She reports no maltreatment form her family, but she was sexually assaulted in foster care in Leighton Buzzard aged 15. She was walking through a park and four males grabbed her and raped her. She told the police what had happened and she didn't want anyone to touch her, the police said because she wouldn't cooperate it didn't happen. Dorothy says she was stupid to go out in the dark on her own and not to cooperate with the police.

Dorothy became pregnant when she was younger and she was told “it’s him or the child” and so she had a termination – this has happened twice with her husband. With the third pregnancy he didn’t believe she was pregnant and so he ran her down with the car and she miscarried. Now she is 51 he wants to have a baby and says, “you can’t give them to me, you murdered my babies”. Dr states that her husband seems not to take any responsibility and Dorothy says that he says he’s sorry. But now he says it’s her fault as she is mentally ill. Dorothy feels that she does need help.

Safeguarding measures were put in place for her husband not to be allowed on the ward. The ward Occupational Therapist contacted the Central Bedfordshire Safeguarding Team to share concerns around coercion from her husband and were informed of an upcoming MARAC. This information was also shared with the medical team and a domestic abuse worker was allocated.

2018

Two alerts received over safeguarding concerns for Dorothy. No s.42 progressed as Dorothy would not consent.

2019

Safeguarding incident referred by Dorset police. Dorothy declined an assessment and case closed.

2020

August – Dorothy seen by the psychiatry team due to excessive intake of medication but was not detained following an MHA Assessment.

September – An ELFT safeguarding referral was sent to CBC safeguarding team which was raised to a S42 and discharged from hospital. Police sent information that she had slashed four car tyres of Bills. Dorothy was seen at home by the crisis team as she was very angry with her husband as she was struggling to cope with him living at the bottom of the garden in his motorhome with his new girlfriend. Dorothy stated she wanted a divorce and move on with her life. Crisis team requested a Care Act assessment.

Dorothy took an overdose of morphine and was detained under s2 of the Mental Health Act. A s.42 enquiry was opened by Dunstable CMHT. She was later discharged to the care of the Crisis team and a protection plan was made with the use of alcohol noted.

November - A safeguarding conference was held and Dorothy was discharged by the Crisis team to CMHT. During the course of the month, there were 20 separate contacts with Dorothy by the CMHT Social worker and support worker.

Dorothy disclosed that she had been raped by a friend of her husbands after going for a meal on her own in a pub and returning home. She called the police as she struggled to get in her home but did not tell them of the rape. She said that she told Bill who laughed at her when he saw the CCTV of her trying to get in her home. She also described issues with a

friend who had stolen money from her. This was on CCTV but she did not want to take it any further.

2.3.21 A review by the CMHT Psychiatrist diagnosed a mental and behavioural disorder due to harmful use of alcohol and was referred to P2R drug and alcohol service.

December - Dorothy had bruises on her face and legs attributed to a fall that occurred when Bill visited and the cameras were turned off. She was referred to MIND but declined support and called the Police saying she'd had enough. Dorothy called CMHT and asked to be discharged, declining her final appointment. Dorothy called CMHT asking for support from P2R and MIND just before Christmas as her GP results show she has liver damage from excessive alcohol consumption. A referral had been made and safeguarding information shared.

2021

A professionals meeting took place and a plan made to discharge Dorothy from CHMT to P2R. A CMHT triage took place and Dorothy was referred to the Liaison and Diversion service by Luton Police custody following her arrest for common assault. The s.42 outcome was that safeguarding concerns are not upheld due to the cameras being in place to protect Bill from false accusations of abuse from when Dorothy has injuries sustained by falls.

CMHT support Dorothy in temporary accommodation due to her bail conditions not to attend home. Bill informs police that he is concerned about her mental health and following a police referral, CMHT close it.

2023

Phone call made from CBC Safeguarding to CMHT and message left following Bill's arrest. No number left.

2.3.22 Addressing Terms of Reference

The records show multiple examples of information sharing in Dorothy's records. The CMHT shared information with the police, Local Authority and P2R regularly and when risks were identified. A joint meeting took place with P2R to look at the predominant need and agree which team should lead on support for Dorothy.

The Section 42 Enquiries would have benefitted from a multi-agency approach with evidence of information sharing and considerations around vital interest.

The records evidence that the CMHT and P2R were responsive to concerns raised and responded in a timely manner to her mental health and safeguarding concerns. Dorothy was referred to P2R on three different occasions.

The records indicate that referrals were responded to appropriately with enough time and attention by visiting and getting Dorothy's views and wishes. The interventions were hampered by Dorothy's reluctance to engage with support offered. Dorothy often declined assessments and withdrew allegations made against her husband.

As mentioned above, the safeguarding enquiries missed an opportunity to share information within a statutory process and have multi-agency decision making around risk management.

There is no evidence to suggest that Dorothy's mental health needs overshadowed the domestic abuse. The domestic abuse seems to be a constant feature of the majority of assessments and conversations with Dorothy.

Staff are guided by the Mental Capacity Act 2005 to consider if the person has Capacity to decide to decline services. They will be guided by the risk assessment in terms of risk to the person and risk to others. They will consider the reasons for declining support and should consider getting legal advice in cases where vital interest is a concern.

The records indicate that risk information was appropriately shared with other agencies and that staff made efforts to keep agencies such as the police and Local Authority informed of any risks that were identified. One example is that staff telephoned the police to inform them that Dorothy was no longer on a mental health section and would be free to contact her husband.

There also seem to be a timely response to concerns raised with no concerning gaps in responding to risk information. Section 42 processes would provide guidance in the form of ensuring an accurate chronology is kept and evidence is gathered from all agencies involved. Making accurate and evidence-based records of incidents, injuries and ensuring that police reports and findings of police investigations are incorporated in enquiries.

2.3.33 Reflective considerations/Best practice:

Supporting Dorothy to be safe from the abuse she disclosed was difficult as she would often change her mind and refuse consent for enquiries to be completed. She insisted that she loved her husband and wanted the relationship to continue despite the abuse. Dorothy was also reported to be the instigator of abuse at times. The outcome of a Safeguarding Enquiry in October 2021 was that abuse from her husband was not upheld. It deemed the use of cameras in the property to be protecting her husband from false allegations from Dorothy.

Whilst Dorothy engaged well with mental health services overall, there were times that she also refused assessments and did not engage with the mental health team. Dorothy requested to be discharged from the mental health team in December 2020. The CMHT worked jointly with P2R to decide which the most appropriate service for Dorothy was and P2R attempted to engage with her. Dorothy was closed to Mental Health services from January 2022 to January 2023.

Dorothy had three periods of care with P2R. Twice in 2020 and once in 2021. Dorothy declined support from P2R every time as she did not feel she had a substance abuse problem and reported she was able to manage her intake of alcohol.

Overall, the records show that Dorothy had a turbulent relationship with her husband but was reluctant to take action to change this and seemed to be emotionally dependent on him. Concerted efforts were made to encourage Dorothy to engage with support for her

substance abuse without success. Dorothy continually denied concerns about her mental health or substance abuse which made interventions difficult.

- There are limited training and support for staff in dealing with perpetrators of domestic abuse when the person chooses to stay in the relationship.
- If a service user declines a Section 42 enquiry, consideration of Mental Capacity, Vital Interest and risk to others should be clearly evidenced.
- Section 42 enquiries should include other agencies involved and ensure information is gathered from involved.
- Safeguarding information and risks should be appropriately shared when referrals are made to other agencies for support.

2.3.34 Doctors' surgery

The Doctors GP notes date back to 1980 just prior to when Bill and Dorothy married. The first entry is in 1980 when Dorothy had a drug overdose recorded having taken Ibuprofen and alcohol following an argument with her boyfriend. There was a further overdose a year later and one in 1985. There were two separate terminations of pregnancy in 1986 and 1991 respectively both recorded as "Husband did not want child". There was a further overdose in 1993 where 'relationship probs' was recorded.

Medically, Dorothy suffered from severe back ache which caused reactive depression from a car accident in 1981 throughout the remainder of her life.

Between 1980 and 2011, the Doctor's notes, which are an accumulation of their own and other organisations notes record 5 separate overdoses by Dorothy who it states worked for her husband. There are also 4 separate disclosures of her relationship with her husband which include being verbally bullied and violent towards her, finding fault all the time and making her feel useless, unsympathetic to her pain making her do 'heavy work' at home and in the garden and doesn't like her phoning her father. Dorothy states that she is unable to perform well sexually due to her back pain.

2016 - A number of entries were made in 2016 in which Dorothy continued to disclose marital problems, presenting as tearful and depressed. During a home visit, Dorothy disclosed struggling in her marriage and cannot leave due to being dependant on her husband financially. She mentioned she cannot attend any appointments as her husband refuses to take her anywhere and she does not have the money. She alleges that her husband records everything on CCTV and in clips where he has been violent. He deletes them from the hard drive. She mentioned that he has pulled her hair and even jumped on her back, dragging her to the floor. On close questioning, she feels very suicidal and feels like slitting her own throat. She was referred to Crisis Team and Social Services.

Towards the latter end of the year, she attended numerous medical appointments with Bill and there did not appear to be any problems. Dorothy had started to walk with the assistance of a stick.

Numerous medical appointments took place over the next few years with no issues recorded in relation to her marriage.

2020

September – Bill phoned surgery reception requesting Dorothy was sectioned. He was informed to ring the Crisis team.

Dorothy contacted the surgery soon after to arrange her prescriptions and the collection of them as she did not want her husband dealing with things. She was advised to put it in writing. A few days later, a double appointment for Dorothy was booked and when they couldn't contact her, they informed her husband.

2021 – February – The GP received a letter two months later from Dorothy requesting her husband did not have access to her medical records.

2022 – Medication review as Dorothy was back with her husband and could help with this. Several appointments with GP throughout the year due to knee pain in which Bill attended with Dorothy for all of them. Dorothy was mobile with a four wheeled walking frame.

January 2023 – The Surgery were notified of Dorothy's death.

2.3.35 Reflective considerations/Best practice:

The recognition, response and recording from the GP in 2011 shows excellent practice of recording conversations and context for future understanding. Appropriate referrals were made to SOVA and IDVA at that time but it does not appear that these were subsequently considered in future years although Dorothy disclosed ongoing and further domestic abuse.

Dorothy requested for her husband not to have access to her medical records in 2020 and although they requested this to be in writing, the surgery went on to contact her husband when they couldn't contact Dorothy although a note of her wishes was on her records. Due to the DA history in their notes, this was not risk assessed or considered.

There is very limited co-working between any GP Surgery and the MARAC. Most referrals into MARAC come from the police with Surgeries feeding into the MARAC when informed of a case. The practice has struggled locally with IDVA engagement and a lack of criteria for referral.

The practice has a robust protocol in place so when a member of staff (clinical or nonclinical) identifies that a patient is caring for another, they are coded in their notes as a carer. This ensures they are recalled each year for a carers health check as well as routine vaccinations, including flu, pneumonia, shingles and COVID-19. These individuals are then booked in for a telephone call with our care coordinator to conduct a carers assessment as well support with booking any appointments with the GP or Surgery pharmacist (or where needed a home visit). Referrals to social prescribers/ local organisations that can provide support are also generated in these appointments.

2.3.36 Adult Social Care

A number of teams and a number of professionals were involved in liaising with Dorothy.

In September 2022 an alert reporting an attempted suicide by Dorothy was received and allocated to ELFT for follow up.

One day early in January 2023, the adult safeguarding team were contacted by the police notifying them of an assault on Dorothy. At this point Police identified that her husband was providing care to Dorothy and as he was now in custody after an incident, they were questioning who would be providing care and what the long-term plan would be.
A decision was made to complete an emergency visit to her home address that evening.

The visiting social workers undertook an in-depth assessment of need and Dorothy declined all support offered, despite several offers being made, including urgent accommodation. In addition to the documented abuse that Dorothy had described previously that she had encountered over many years, she outlined how Bill was watching them through the cameras and would 'kill her'. She described how he would wait until she had taken her `jungle juice' (constipation relieving medication), and when he was aware she needed to use the toilet, he would go into the bathroom and make her wait. There was an Alexa device which controlled many devices around the property including lights, kettle, TV. Dorothy also stated that Bill could turn off the gas and electricity. Dorothy said she has no friends and her husband cut her off from family. She said she used to talk to people on Facebook but her husband got jealous so she doesn't chat on Facebook anymore.

Dorothy advised the workers that her husband would urinate on her and would make her urinate on him. She described an incident where he waited until she needed to defecate, and he removes this from her and inserts the faecal matter into her vagina. She said that she is unable to open her legs due to her mobility problems, so he makes her lie on her front so he can penetrate her from behind.

Safety planning was discussed, such as how to keep the door locked and how to call the police if needed. At this point, Dorothy said that if her husband would not return to her that she would kill herself, but that she would not do so that night. The social workers shared all the relevant information with the First response Team manager who ensure that all the information including the risk of suicide was shared with the police. Police agreed with the Team manager that they would visit Dorothy that night.

The following morning the safeguarding team made a follow up call to Dorothy, at this point a further offer of care support is made which is again declined by Dorothy. The safeguarding team whilst on the call heard a male voice and became concerned for her but Dorothy reiterated that all was well.

2.3.37 Adult social care was at that time making arrangements for a strategy meeting. The next day, a voicemail came through for the support worker in adult safeguarding from Dorothy very distressed asking for help. The support worker made around ten calls back to Dorothy with no response then immediately called 999 and explained the risks of domestic abuse and suicide to the handler, the handler advised that this did not require a 999 response, but that I should call 101 and select op 1- priority response incident.

The support worker contacted the team manager as the case allocated the adults team, to request a worker go out to complete a welfare visit. The support worker was asked to contact 101 for welfare check and handover given the known potential risks of Domestic abuse, Suicide Self-neglect, and as it was not known what Dorothy was asking for help with, but the team manager considered that there was a risk to workers attending. Therefore, the team manager considered it appropriate for police to attend and handover to EDT.

The support worker advised that she had already spoken to 999 and they had also advised 101, however, police tended not to pick up welfare checks during the working day.
The support worker raised that she might be needing care as she had not been supported for a number of days and had been declining all offers of support from the local authority.
The support worker confirmed that she would call 101 and give them all the information and ask for an urgent welfare visit. At 16.31hrs the same day, all information was shared with the police on 101 who agreed that a welfare visit would take place.

On the Monday the team were notified by the PPU that a Police welfare visit was completed on the Friday at 19:33 and a female could be seen through the windows laying on the floor. Entry was forced and despite efforts by police and ambulance Dorothy was pronounced dead at the scene from a suspected suicide.

2.3.38 Best practice/Reflective considerations:
There is a good response from adult safeguarding who agree with adult social care teams that two members of staff would undertake an urgent welfare visit to ensure appropriate assessment offer is made and to ensure care is available to Dorothy. There is also a plan in place to ensure that urgent care is available for Dorothy. It has been identified that good support from the manager of the First response team to staff in assessing risk and liaising with police and other agencies appropriately was provided.

There was a disconnect on the day Dorothy died between the understanding of what EDT would provide after hours and what the police would/could do in relation to a welfare check to the reality of the fact that responsibility remained with the staff that had worked through the day.

2.4 Summary reports

2.4.1 In addition to the IMRs, other members of the panel were asked for summary reports that explained certain processes relevant to this review and respond to the Terms of Reference.

2.4.2 Bedfordshire Hospitals NHS Trust

Bedfordshire NHS Hospital Trusts is an acute hospital providing inpatient medical, surgical and emergency care in addition to maternity and outpatient services.

Bedfordshire Hospitals NHS Trust aims to create a framework of action within the acute Trust to ensure a consistent and effective multi-professional response to the Government's drive in tackling domestic abuse.

Bedfordshire Hospitals consist of two sites currently due to a recent merger between Bedford Hospital and the Luton and Dunstable Hospital. Safeguarding Teams are present on both sites, with each site having a designated lead for safeguarding within Adults, Midwifery and Paediatrics. In addition to this, the Trust has two Victim Support IDVA'S co-located, one on each hospital site.

The Trust recognises that identifying domestic abuse is a regular part of healthcare assessment and promotes routine enquiry which is timely and should occur at key times, such as: initial assessment, out-patient clinics, follow-up appointments or any other appropriate time in the patient journey.

The promotion and development of how the Trust responds to Domestic Abuse has been continuous throughout the past few years and has meant this area has improved substantially resulting in the trust being recognised formally in this area.

2.4.3 Chronology

Between 2019 – 2021, Dorothy had a total of five Accident and Emergency attendances and three Outpatient appointments. A review of the records noted that within historical records, there was some information that may be of importance to incorporate into the review.

March 1996 – A GP Surgery letter to Gynaecology stated that Dorothy stated she fell pregnant and her "husband said that she had to choose between him and the baby and she was therefore forced into having a termination of pregnancy, despite herself wanting the baby". She had a further termination in February 1991 for which she was unable to discuss, but on looking through her notes it would seem that this has arisen out of a similar situation where her husband did not wish to have any children".

October 1998 – A Clinical Psychologist letter notes that Dorothy states she has difficulties in her family relationships and disowned them years ago.

August 2012 – A Consultant Clinical Psychologists letter details a discussion with Dorothy in which she stated that primarily, conflict with her husband was the primary problem when discussing her anxiety and mood problems. Dorothy had said that her husband had encouraged her to take an overdose of tablets six weeks previous. She had taken 11 x 25mg Clomipramine tablets. Dorothy was reluctant to accept her GP's offer of a referral to mental health services as it would 'drag up the past'.

August 2018 – A safeguarding referral was completed by hospital staff whereby concerns were raised about Dorothy being assaulted by her husband. This was raised as a s42 enquiry.

September 2020 – A safeguarding concern was raised by hospital staff regarding Dorothy's overdose and that her husband was abusive. This raised a s42 enquiry.

2.4.4 It is clear on review of the clinical records that Dorothy had minimal involvement recently with the Luton and Dunstable University NHS Hospital FT. This was mainly in relation to Accident and Emergency visits and outpatients.
On both occasions whereby Dorothy reported possible DA, staff completed a safeguarding referral which was processed to the local authority and deemed a section 42 enquiry.
Safeguarding procedures were followed and Dorothy was referred to the Trusts internal Safeguarding Team.
It is evidenced that Dorothy made reference to possible abuse historically in records.
In relation to medical interventions, appropriate monitoring, surveillance and discussions appeared to have taken place.
Regular correspondence took place between the hospital and the GP surgery in relation hospital attendances.
During the time period reviewed, the Luton and Dunstable Hospital had a standalone policy for Domestic Violence and Abuse in place from 2017.
Normal safeguarding procedures and protocols were also clearly outlined within the Adult Safeguarding policy available at that time. This would also have included Domestic Violence and Abuse.
Staff at that time would have been knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator.
All Trust staff currently and previously receive training in relation to Adult Safeguarding, whereby Domestic Violence and Abuse is discussed. This training is provided face to face or via online programmes.
Currently the Trust provide standalone domestic abuse training alongside Level 1, 2 and 3 Adult Safeguarding training. The level 3 Adult Safeguarding training is a one-day course and discusses Domestic Violence and abuse in detail including Forced marriage, Female Genital Mutilation and Honour Based Violence. Domestic abuse Training is available in various forms. This can be completed as a standalone training package online, face to face or via generic safeguarding training at all levels.

The Trusts' safeguarding teams have individuals trained who complete risk assessments and protection planning with individuals living with Domestic Abuse. In addition to this, staff are also trained on how to respond to Domestic Abuse with certain areas such as Maternity and the Emergency Department receiving a higher level of training due to increased numbers of Domestic Abuse cases seen in those areas.

2.4.5 Best practice/Reflective considerations:

The Trust has a Domestic Abuse Clinic available each week. This was commenced as a pilot in June 2021 in response to the Trust safeguarding teams not being able to access victims that attended hospital out of hours/ weekends. An appointment is made with the individuals consent by the treating professionals for them to return to hospital. During this appointment and if safe to do so, they would be met with a safeguarding professional, a clinician and IDVA (if consent gained). A full assessment/review can take place with appropriate risk assessments and onwards referrals completed.

Domestic Violence packs are readily available in all clinical areas. These packs are to supports staff with materials/ risk assessments and contact numbers etc. they may require when dealing with a case. These packs also include fact sheets/ supportive advice for staff on how a victim can stay safe within a domestic abuse relationship or of they chose to leave relationship.

In addition to this, the Trust commissions the use of Lip Balms that are stocked in various areas of the hospital such as the safeguarding office, A&E, Maternity and paediatrics. These Lip Balms have the number of the National Domestic Abuse Helpline secretly embedded into the bar code of the product and are given to victims that may return to an area whereby they are suffering from Domestic Abuse.

2.4.6 Path to Recovery (P2R)

P2R is a one-stop service that provides drug and alcohol advice, treatment and support to adults whose lives are affected. Support can include the whole family. P2R provide an integrated service with a range of expertise available in one place.

Dorothy was initially referred to P2R in October 2020 for alcohol use and although she was not initially interested in treatment, after several referrals she engaged in December 2020. Dorothy engaged sporadically for five months in 2021 and she attended several appointments, during which she reduced her drinking and worked on her self-esteem. She raised issues of historic domestic violence from her husband from whom she was estranged. She exhibited poor self-esteem during her treatment which her keyworker attempted to work through with her. She had a pattern of disclosing her feelings and then withdrawing. She abruptly withdrew from treatment in April 2021 having reduced her drinking and couldn’t be persuaded to continue to engage.

2.4.7 Chronology

2020

Following a referral, Dorothy stated that she was not an alcoholic and that she had only started using alcohol when she attempted suicide three times in the last two months. She stated that she only has a pint of lager once or twice a week and declined to be assessed.

During the November, two referrals were received separately from Dunstable CMHT with an assessment booked. During the December, Dorothy did not attend the assessment and P2R were unable to make contact with her by phone or letter. Following a further referral by Dunstable CMHT just before Christmas, a phone call was made on Christmas eve in which Dorothy became quite emotional and explained that she used to drink between a half a litre and a litre of vodka a day. She had spoken with her Doctor and had cut down to 3-6 shots of vodka straight per day. She admitted she was struggling but was also really scared as last time she tried to stop, she got the shakes and sweats from withdrawal. Her husband had intervened last time and when asked about him, she said she would be spending Christmas alone as he had left her the previous March for someone else.

Dorothy said that she had a break down not long after and rang Mind who put her in on the Psychiatric Ward and that messed her up. Dorothy went on to say that she doesn't have any children because her husband made her have two abortions. She said he told her she is like a cuckoo as a cuckoo carries someone else's babies and he told her that the babies weren't his and she had got pregnant with someone else which is why he forced the abortion. It was suggested that if she does not want to speak to Mind, she should ring the Samaritans over Christmas so she has someone to talk to. Dorothy said even though she lives alone, she hides her drink under the stairs. She requested to attend face to face for the assessment.

2.4.8 Level of Use - High-Recently been told by the Dr that her Liver Results are not good and she needs help.

Risk - Medium to High based on the levels she is drinking and her current Mental State.

Safeguarding - She has been assessed by the CMHT Team who feel that no further intervention is needed until she gets her drink under control.

29/12/20 – Dorothy had an assessment completed. She outlined the how much, when and why of her drinking of vodka. She spoke of her husband having an affair and watching her every move on CCTV from his caravan where he was staying. She often falls down and hurts herself from drinking and is concerned about living alone as he was her full-time carer. She did not want to be referred to the Crisis team as she was put I the psychiatric ward after her marriage broke down and feels they 'messed her head up'. Dorothy and assessor spoke about her being referred to the Freedom Programme.

Discussions between workers at the allocation meeting surrounding issues of home visits with cameras in the house and husband coming to the property.

Record checked shows:

- x3 suicide attempts since 2016 noted
- High risk for suicide
- Personality disorder
- x2 section 2 MH admissions
- DV victim from ex-husband
- Concerns re: social capabilities at home, possible care needs
- Concerns re: discharge from CMHT

2021

A visit had been conducted with Dorothy as part of the s42 by CMHT and they had no concerns regarding her being at risk from her ex-husband as he no longer frequently visited. Dorothy was assessed as having capacity and incidents that have occurred appear to correlate with her alcohol abuse. There are no obvious physical disabilities.

Dorothy was tearful and said that she did want support for her alcohol problems but they were due to her abusive husband. Dorothy informed to fill out a drink diary. Following this, she missed several telephone calls over the following week to book an appointment but

then, when she did answer and was asked what she wanted from the treatment, she replied "To be myself again", "To not drink".

2.4.9 Dorothy attended appointments until March where she outlined abuse from her husband had escalated six years previously and she wanted to get back to how she was before that. The Freedom project was again spoken about. Dorothy was adamant she did not want to go back to her husband.

Dorothy discharged herself from the service in March and during a follow up phone call, stated her reasons as finding the keyworker cold and uninterested. A female or different keyworker was offered during the discussion and Dorothy outlined a bad day looked like when she had 'crosswords' with her husband. Dorothy sounded sober during this conversation. Further calls over the following week kept Dorothy engaged and she continued with the service. She engaged well with her new keyworker.

Dorothy continued to engage and disclose differing abuse over the years from her husband and how he was the trigger to her issues. She would compare herself to his present partner. Dorothy spoke of wanting to be more sociable and gain interests such as getting a dog and was looking forward.

Dorothy discharged from the service in April as she felt she was not inclined to drink alcohol and that she now had a better understanding of her own thinking patterns. She was encouraged to continue the support but declined.

2.4.10 Best practice/reflective recommendations

Alternative methods of contact were offered that were suitable to Dorothy's wishes to make her more comfortable of accepting the support. When she called to discharge herself as she was not satisfied with her keyworker, a number of follow-up calls were made to continue engagement and an alternative keyworker was found to suit her needs.

The Freedom Project was discussed with Dorothy showing an acknowledgement of the abuse she had disclosed and attempts for her to understand this as she had stated she couldn't let her husband go.

2.4.11 Central Bedfordshire Council

Two referrals for MARAC were received in relation to Dorothy and Bill, both made by the Police. The first was in 2016 and the second in 2018. The table below shows the records in relation to these two meetings.

MARAC	Key points from discussion	Action	Assigned to	Completed	Action notes
06/04/2016		To arrange for an IDVA to see Sylvia and complete and assessment	IDVA (Victim Support)	No	Updated on the 21/04/16 attempted to contact client not

					been able to speak to her so far
06/04/2016		To follow up reports from Oakley Court involving Dorothy's disclosure	Beds Police	11/04/2016	Email sent to OIC to make them aware of additional info and evidence discussed at MARAC for them to action if appropriate.
05/09/2018	IDVA contacted on 20th of August. IP stated she did not need any support, said she only wanted to be left alone and refused to take IDVA's number if she needed support in the future. Adult Safeguarding noted: Dorothy wants to stay with Bill, closed to s.42	Notify GP of recent Section 42 and ongoing concerns for client's safety	Domestic Abuse Specialist Officer	11/09/2018	Completed

There was no discussion about potential actions for Bedfordshire Police regarding controlling and coercive behaviour in either meeting.

MARAC thresholds for Central Bedfordshire MARAC are:

1. Visible high risk - Dash threshold of 14 ticks or more and/or a DARA graded as high from Bedfordshire Police (Beds Police grade incidents using the DARA as either low, medium or high risk)
2. Professional judgement.
3. Repeat Incident- as defined by Safe Lives, 3 or more incidents over a 12-month period.

4. On escalation- escalation can be assessed by looking at the frequency and/or severity of abuse. Where there is potential for serious harm or homicide when three domestic abuse events have been identified in a 12-month period.

A MARAC is a meeting where information is shared about the victims who are at the highest risk of serious harm or murder due to domestic abuse, between key representatives of statutory and voluntary sectors. The primary focus of the MARAC is to safeguard the adult victim and their children. The MARAC will also make links in relation to child protection and the disruption of perpetrator behaviour.

At the heart of a MARAC is the working assumption that no single agency or individual can see the complete picture of the life of a victim, but all may have insights that are crucial to their safety. No one DA partner owns or dictates a MARAC Forum. The Central Bedfordshire Council MARAC is administrated by MARAC co-ordinator, that is employed by and sits within Domestic Abuse Service in CBC.

Land Registry shows that Bill and Dorothy were owners of their home from 27th January 1995.

Central Bedfordshire have an Adult Carers Strategy 2022-2027 which is a reference to unpaid carers and not those paid to provide care and support. This strategy does not include domestic abuse and the heightened risk of identifying the vulnerability of carers to being either the abuser or subject to domestic abuse due to their role within the relationship.

2.4.12 A counter-allegations toolkit has been developed based on the Male Victim Toolkit developed by Respect. It is designed to provide a balanced risk assessment in a relationship with bi-directional abuse and to ensure men that are contacting the helpline are not perpetrator's themselves as this is a 'tactic' that has been used previously by perpetrators to gain information on their victim's support and provisions.

2.4.13 Carers in Bedfordshire

Carers in Bedfordshire provide information, advice and guidance for unpaid carers that live in Bedford Borough and Central Bedfordshire. They are funded by Bedford Council, Central Beds Council, the ICB and fundraise to continue and enhance our services through local and national grants and trusts.

Carers in Bedfordshire empower carers to know what is available to them, their rights and signpost and refer to other services. This may be in areas such as employment, mental health, emotional health, specifics around their caring role or the person they care for, as well as financial advice. They also administer carers grants on behalf of the NHS ICB.

All information can be found here: Home - Carers In Bedfordshire (carersinbeds.org.uk). Specific information where carer does not need to register is available on our Online Support Hub: Help For Carers - Carers In Bedfordshire (carersinbeds.org.uk)

In addition, they provide free events, workshops, training and groups for all carers from 4 years old. All events can be found here: Whats-On - Carers In Bedfordshire (carersinbeds.org.uk)

To receive one to one support and have access to the above, carers can self-refer online or a professional can refer them here: Register - Carers In Bedfordshire % (carersinbeds.org.uk). Anyone can also call the main line on 0300 111 1919. There is no eligibility criteria. For reference, 'An unpaid carer is a person of any age who provides unpaid help and support to wife, husband, partner, son, daughter, parent, relative, partner, friend or neighbour who cannot manage without the carers help.'

No referrals were received in relation to Dorothy.

2.4.14 Victim Support

Victim Support in Bedfordshire are commissioned to provide the IDVA service. The IDVA service received two referrals for Dorothy. The first was in 2018 following the MARAC process. Police had been called by the hospital as Bill had ripped open her lip in an assault whilst he was drunk. After a few days, they managed to speak with Dorothy on the phone who was adamant there was no abuse and explained Bill was drunk and had no memory of it. She was angry that the Police had become involved and declined support. Due to this, it was not possible to complete a DASH risk assessment.

The second referral was received in January 2023 from a Bedfordshire Police Victim Engagement Officer (VEO) to DASS Health and communities IDVA. Although attempts were made to contact the same day of receipt, Dorothy had already taken her life.

Since 2023, Victim Support uses the 5 critical questions when a person declines the DASH (27 questions) or in some cases/services where we would start off with the 5 critical questions

- Intimate partner homicide is the most predictable form of homicide
- Clusters of risk markers more important than list e.g., DASH
- Motivation more important than actions
- Patterns more important than incidents
- Control predicts homicide and risk more effectively than violence alone

High Risk Clusters – 3 markers

- 1st marker - controlling patterns, coercive control (our first 3 questions on the 5 critical questions)
- 2nd marker – violence – any time (our 4th question on the 5 critical questions)
- 3rd marker – separation – threatened, imagined or real (our 5th question on the 5 critical questions)

Violence would include non- fatal strangulation which includes drowning and smothering. Non-fatal strangulation as a predictor, would raise the marker by 700 to 750% to high risk.

Put these 3 markers together and this increases the risk of homicide by 900%. This cluster is the thread through the homicide timeline.

Source Jane Monkton-Smith

Over the past year, the majority of staff have attended an ASIST course (Applied Suicide Intervention Skills Training) which provides tools to be able to discuss a framework for interventions and increases their confidence in the dealing with suicide.

It is a two-day workshop in which it identifies the key elements of an effective suicide safety plan and the actions required to implement it and recognise the important aspects of suicide prevention including life promotion and self-care.

These two tools aforementioned will be pivotal to Victim Support in the future when dealing with risk and suicide but were sadly trained and implemented too late to support Dorothy.

2.4.15 Housing Operations – Central Bedfordshire Council

Dorothy was referred to the Housing Options team in October 2021 and was placed in temporary accommodation in Luton as following an arrest, she had bail conditions not to return home. The following day, Dorothy called the Police as she was walking lost around Luton and the police returned her to the accommodation.

She remained there until her bail was cancelled in December 2021 when she returned home. There were no issues and no cause for concern whilst she had stayed there.

Central Bedfordshire Housing Service has taken significant steps to address the crucial issue of providing temporary and permanent housing for victims of domestic abuse. The approach outlined demonstrates a comprehensive and collaborative strategy to ensure the safety and well-being of these individuals. Some key considerations are detailed below.

Referral Process: Anyone within the Council can make a referral to the Council's Domestic Abuse Housing Support officers. The team responds within 24 hours and conducts an assessment to determine the level of risk the victim faces (high, medium, or low).

Risk Assessment: High-risk cases are referred to Multi-Agency Risk Assessment Conference (MARAC) or Independent Domestic Violence Advisor (IDVA) services. Medium and low-risk cases are handled internally by the Council's support officers, who work on long-term housing solutions to remove victims from abusive situations.

Communication Improvement: A lack of communication between the Homelessness Intervention Team and the Temporary Accommodation team was identified when SC approached and has now been addressed. The Homelessness Intervention Team now completes the referral form when a person fleeing domestic abuse initially approaches the Council.

Engagement and Support: The Housing service actively engages with both victims and perpetrators to gain a full understanding of the situation. The Council's Domestic Abuse

team also has access to various information sources, including police records, to assess the extent of abuse. This is complemented by a risk assessment process.

Safe Placements: The Council maintains discreet domestic abuse properties across the Borough, ensuring the safety and privacy of victims. The interview process identifies safe areas before placement, adding an extra layer of security.

This comprehensive approach, involving multiple teams within the Council and utilizing various information sources, aims to provide victims of domestic abuse with safe and appropriate housing solutions.

Section 3 - Analysis

3.1 Family and friends' perspective

3.1.1 – Susan

Susan was the only sibling who managed to maintain contact with Dorothy on and off through their lives. There were large gaps in their lives where they didn't have contact but Dorothy was open with her about what happened in her marriage. Susan cannot provide exact chronology but has provided a general recollection.

Susan describes the marriage of Dorothy and Bill as volatile and says that they always fought 'like cat and dog' from the very start. Susan says that they were 'as bad as each other' as Bill would often beat Dorothy causing her bruises and injuries and then text Susan telling her that he hadn't and denying it, but Susan was also aware of times when Dorothy would have hit Bill, like the time she hit him with her walking stick. Susan found it odd that the CCTV was always off when Dorothy accused Bill of anything but was always on if Dorothy did anything. During the latter years, when Dorothy was struggling with her arthritis, Bill took advantage of this to keep control of her. They had been together since Dorothy was about 16 years old and had a strange relationship in that they always did everything with just the two of them, never had any friends and Dorothy never did anything without Bill which left her isolated. They had both always excessively drunk alcohol and had separated a number of times but would then get back together and start arguing again.

3.1.2 Susan thinks that this was why Dorothy was so dependent on him and 'couldn't live without him'. She would ring Susan and say how she wanted him back every time they were separated, either by the choice of Bill or by police conditions.

Susan didn't have any contact with Dorothy for fifteen to twenty years during her marriage but got back in contact about nine years ago and says that nothing had changed in their marriage during that time. Susan feels that Bill would goad Dorothy at times, like when he lived at the bottom of the garden in his camper van with his 'new woman'. Bill was never horrible to Dorothy in front of Susan.

Susan is aware that Dorothy attempted to take her own life on occasions throughout her life but always got found and saved and wonders whether Dorothy thought this would be the case on the last occasion.

Susan would often advise Dorothy not to be with Bill and when they were separated, would encourage her to not reconcile for her own safety but Dorothy would fall out with her. 'She didn't want help' and 'you couldn't help her'. There was no knowledge of incidents in which Susan thought she should call the police herself.

Susan did not feel it appropriate to provide a tribute.

3.2 Terms of reference areas

3.2.1 - Has domestic abuse in any form been the causation or a contributory factor to Dorothy taking her own life?

Dorothy was separated from her family at a young age which would have left her feeling isolated, lonely and vulnerable. She already had issue with drug and alcohol abuse which may have been accentuated as a coping mechanism. She married at a young age having already disclosed troubles in her relationship when she took an overdose, with her sister confirming that Bill and Dorothy argued from the very beginning.

The marriage may have provided Dorothy with company but the relationship did not do anything to diminish her vulnerability. Whilst struggling with her emotions, these were compounded by a physical injury that would cause depression and pain throughout the rest of her life, leaving her physically dependent on her husband who became her carer in years to come.

Emotional abuse came in many forms from Bill, with Dorothy disclosing to professionals the derogatory language and name-calling he would use to her. This could be seen as a way of taking her self-esteem along with knowing how much it hurt her that he had left her for a new partner, he then flaunted this by moving to the bottom of their garden in his camper van to flaunt this.

In 2016, Dorothy made disclosures of a number of forms of domestic abuse that she had suffered over the years by Bill to the psychiatric Liaison Team at the hospital.

Bill made Dorothy choose between him and having a baby on two occasions, pressuring her to put his needs and wishes over her own. This event affected her for the rest of her life as she frequently mentioned this to professionals when she was outlining the abuse in her marriage.

Bill showed controlling and coercive behaviour in a number of forms. In the installation of CCTV cameras in every room of the house apart from the bathroom, accessing it remotely and utilising it to manipulate his narrative to the police by deleting evidence against him but keeping any negative behaviour from Dorothy and he would embellish this in interview on the occasions he was arrested, always outlining Dorothy's alcohol abuse, explaining any behaviour by himself as stress for caring for her and making counter allegations that her behaviour would have initiated any argument. His behaviour was manipulative of professionals in this way. The Police did not consider or record controlling and coercive behaviour for any incidents that they attended.

Dorothy told of how Bill controlled her by utilising the Alexa to determine the heating and electricity supply. The Culture, Media and Sports Committee have released a report[6] stating that the Government must make tackling smart technology a priority amid a warning that the use of smart technology and connected devices in facilitating domestic abuse is becoming a growing problem.

Dorothy's independence was further diminished by her disclosures that she did not have access to any money as Bill did not allow her to have a bank account in her own name or a bank card. Although this review has not been able to ascertain any financial situation they may have had, a Police officer took cash out of Bill's wallet on his arrest to ensure Dorothy had some money available. Economic abuse is a means of controlling and coercive behaviour, limiting Dorothy's ability to make choices in her life and increasing her dependence on Bill and could cause a barrier if she were to consider leaving the relationship.

Sexual violence was disclosed by Dorothy on more than one occasion and her report of a historical rape was the reason for Bill's arrest shortly before her death. She told of how she didn't tell anyone as she feared not being believed. When she disclosed to a psychiatric nurse that she had to get drunk and then Bill would have sex with her and video it, but stated it was consensual when told it was a criminal offence because she wanted to make him happy. This is a sign of Dorothy acquiescing to not only this sexual behaviour but to other forms of abuse and it should be considered that her drive to make him happy could be due to fear and consequences as well as love. Bill would humiliate her by urinating on her and would make her urinate on him. He would also insert her faecal matter into her vagina.

Physical violence occurred frequently within the relationship with both Dorothy and Bill being arrested on occasions and both receiving injuries at times. However, due to Dorothy's lack of mobility, this would make her more vulnerable with the inability to protect herself. Dorothy disclosed an incident where Bill had tried to suffocate her by covering her nose and mouth. It had not been reported at the time and was reported in 2016 with other disclosures of abuse that although there wasn't a timeline, had occurred over the course of

[6] Culture, Media and Sport Committee Connected tech: smart or sinister? August 2023

her marriage. The increase of risk with this behaviour has now been recognised in legislation with it becoming a standalone offence with non-fatal strangulation under the domestic abuse Act 2021 with the seriousness of the offence carrying a sentence of up to five years imprisonment in a Crown Court. However, no direct response was made to this by professionals when Dorothy disclosed this.

Although there were times over the years that Dorothy would tell Professionals that if Bill continued to treat her badly, she would leave him, this never transgressed and more often than not, as in her last meeting with social services, Dorothy expressed her need to have Bill back living at home with her. She expressed her love for him and her final letter outlined the hurt it caused when he told her he didn't love her.

3.2.2 Are processes and communication between agencies sufficiently effective in order to respond to those with multi complex needs in a timely manner?

Dorothy suffered from alcohol abuse throughout her life and although Bill always stated he wasn't an alcoholic, Susan stated that her observations were that he was and on a number of occasions when Police were called to domestic incidents, alcohol was present in one or both of them.

Bedfordshire Police process in regard to referrals for alcohol support are that front-line officers have the initial responsibility and then the Officer in the case who is usually a different officer should secondarily review the investigation and make referrals if appropriate and have not been made at that stage. There is a third review process by the MASH for all medium DA. However, no referrals in regard to alcohol were made over the years by the police and at times, reports appeared to blame the alcohol as the cause of the domestic incident, albeit more so in the earlier years than the latter. (Recommendation refers)

P2R worked with Dorothy sporadically for a period of five months in 2021 which was the longest Dorothy had engaged with any agency and tellingly, was when she was separated from Bill due to him having a relationship with another woman. They discussed the Freedom project with her and tried to encourage her to take this as it would help her understand the behaviour she had been subjected to and provide her choices if the situation arose where the relationship could be rekindled. This was good practice even though Dorothy did not want to attend. However, referrals to support provisions for DA for Dorothy in particular were scarce, even though she disclosed this to a number of agencies.

The Police noted the problems that Dorothy faced in 2020 following an incident with Bill but didn't make any referrals. No incidents were graded as high and there were no MARAC referrals due to professional judgement or accumulation since 2018. This would have provided an opportunity for sharing of information and for a holistic plan across agencies to be made to suit and focus on all of Dorothy's needs. (Recommendation refers)

The GP surgery had records dating back years recording disclosures of DA by Dorothy yet when she took the decision in 2020 in a phone call to request he did not have access to her medical records which would have been a big step in her trying to claim her independence from him, she was informed to put it in writing. Shortly after this, before they received confirmation in writing, they contacted Bill as they could not reach Dorothy by phone. This was not only against her wishes, would have been detrimental to the steps forward she had made in taking some control of her life and her mental health, but was also a risk as they were aware of the DA history and a request of such a nature would suggest all was not well in the relationship. Processes have now changed to ensure this would not occur in the future.

The vast and complex disclosures made by Dorothy in 2016 to the Psychiatric Liaison Team were responded to by contacting the Central Bedfordshire Safeguarding Team and when informed there was an upcoming MARAC, it would appear that this was considered sufficient although the Psychiatric Team did not attend. Records show only two actions coming from the MARAC, one of which was for the IDVA to contact, who when unable, closed their file. This would have been an opportunity for all relevant agencies to work together to find safeguarding measures and solutions to assist Dorothy who by then, had returned home for Bill to be her carer.

3.2.3 How effective are services and agencies provisions and responses within Bedfordshire for when identifying the correlation between Carers and domestic abuse?

From a young age, due to her car accident, Dorothy was in physical pain which had an adverse effect on her mental health and provided unexpected vulnerabilities. As the years passed by, her physical ability lessened and made her have to rely on Bill for issues such as toileting.

It was already recorded on a number of Health records and Police records of the domestic abuse within the relationship and the alcohol consumption by both parties, yet there were few referrals or interventions in order for a holistic approach to identify the fact that the abuser on a number of occasions was the full-time carer of Dorothy. An assessment was never completed and therefore the risk remained unknown. The lack of referrals into ASC/SOVA prevented them identifying Bill as a carer and speaking to Dorothy about a care plan.

On occasions when Dorothy spent time in Mental Health Trust, there does not appear to be any consideration on discharge that she would be going back home for her abuser to have sole responsibility for caring for her. No risk assessment was made into her safety in returning back to him. In 2016, whilst in hospital, Dorothy had a safeguarding note recorded following her disclosures of domestic abuse whilst in there that her husband was not allowed on the ward. Although the information and concerns were shared to appropriate partners, Dorothy was still discharged home where Bill was to care for her without a care plan with safeguarding implemented. In 2020, the crisis team did request a Care Act assessment but it is not recorded that this was carried out.

Following her arrest in November 2021, Dorothy had bail conditions not to attend her home address and was therefore placed in temporary accommodation in a nearby town to her house. There is no record of any care assessment needs, referrals to Social services or sharing of information between services. She was treated solely as a perpetrator of domestic abuse with no holistic approach or consideration of her vulnerability, disabilities or past experiences.

Central Bedfordshire have a Carers strategy but this does not mention domestic abuse and does not provide any consideration of the correlation between the two when there is a carer in the family and the heightened risk of domestic abuse this could cause for either the carer or those that are being cared for. Also, agencies may not realise this correlation as the police were aware of Bill as a victim, perpetrator and the someone who installed cameras in his home but did not connect these to consider whether he may have been suitable as a carer. The panel did consider that this must be balanced with Dorothy's wish for him to remain and not allow anyone else to care for her. (Recommendation refers)

3.2.4 How effective are processes when the victim has also been a perpetrator and either neither party or the victim wish to engage with agencies.

The requirement for consent can sometimes be a barrier to authorities being able to support those who decline their services. This can be for a myriad of reasons that agencies must understand, such as mistrust due to previous experiences, trying to gain some control and independence from a situation that makes them feel helpless or embarrassment of requiring support. It is important that to decline support is not seen as refusal and non-compliance and for the agency to withdraw on this premise.

Social Services faced this issue two days prior to Dorothy's death, when with Bill in Police custody they responded to a call from the Police and visited Dorothy in her home. They identified a number of needs whilst with her and carried out some immediate practical needs there and then such as moving the commode to a place that was easily accessible but when they offered carers who could be arranged urgently to support with meals and washing her, Dorothy declined as she did not want people in her house and didn't want to be touched. The workers were in the unenviable position of having to leave the location knowing that Dorothy needed that support and was at a certain risk without it but were unable to provide this with no consent.

The Police have the opportunity to safeguard those who potentially are not able to safeguard themselves by authorising a DVPN and applying to the Court for a DVPO which would then provide a distance between the parties for a given time to enable the victim some 'breathing space' from the situation and potentially re-assess their relationship. It also provides initial safeguarding at the immediate time the victim is potentially most vulnerable, following any arrest or police attendance at the home.

DVPOs are a civil order that fills a "gap" in providing protection to victims by enabling the police and magistrates' courts to put in place protective measures in the immediate aftermath of a domestic violence incident where there is insufficient evidence to charge a

perpetrator and provide protection to a victim (or victims) via bail conditions. Although the current process and policy has recently been reviewed by Bedfordshire Police and they are satisfied with its sufficiency, it has not been implemented in any of the incidents between Bill and Dorothy and could have been a useful tool to exercise when Dorothy chose not to support police action. (Recommendation refers)

It is noted that Dorothy said on more than one occasion that she did not wish to go into the past which is why she declined certain support. She had been detained under S2 MHA in 2016 which then deterred her from ringing the Crisis team on future occasions as she felt it had been detrimental to her. She also stated that she did not wish to go on the Freedom project as she did not want to go deep in the past which is a highlight of her past experiences affecting and influencing her present decision making. Dorothy was deemed to have capacity which then reduces the options and powers that the health authority can invoke on a person who clearly requires support but declines it.

Section 42 of the Care Act is a formal adult safeguarding enquiry into the range of actions undertaken or instigated by the Local Authority in response to an abuse or neglect concern in relation to an adult with care and support needs who is unable to protect themselves from the abuse or neglect or the risk of it.

A s42 was opened on more than one occasion in respect of Dorothy but closed shortly afterwards as she declined an assessment. The sharing of information by ELFT with other agencies was minimal and the rationale and risk assessment to close the enquiry only outlined Dorothy's unwillingness. Due to not working holistically, this may have prevented gaining information from other agencies that may have assisted. (Recommendation refers)

3.3 Other areas for analysis

3.3.1 Communication between Police and ASC on the day of Dorothy's death.

This area has been a focus following the receipt of the IMRs and the second panel meeting where their appeared to be an anomaly between the information Adult Social services felt they had provided to the police as immediate concern and the Police response.

This has been reviewed for a second time by a senior officer in the police who was not involved in the incident and had no supervision of any department involved. Both phone calls have been listened to and the incident logs read.

Adult safeguarding contacts the Police, summarising the recent history of Dorothy and refer to a callback message they have received on their system from her. They outline the husband is currently on bail not to be at the location and is her main carer and initially refer to when Dorothy stated that she would kill herself if he doesn't return.

The caller states that Dorothy had called that day and asked for help. She did not say what help she needed. It is clarified that the call had been left anytime between 1405 and 1500 hours that day. It is stated that the team picked up the voicemail message about 1545 hours

and had spoken to her about 15 minutes prior to a call to the police. It is regrettable that the call for help was not picked up sooner as Dorothy may have been more inclined to accept help at the time that she was making the initial call.

Caller confirmed that Dorothy had sounded distressed when she had left the message, but when they eventually spoke to her, she sounded calm and quiet but wouldn't engage. There was a concern that a male could be heard in the background and a supposition that it was Bill, but Dorothy had said it was a neighbour.

The call handler asks if anyone from adult services had been out that day, but it was stated he was from a safeguarding team and that they are a triage team who take in information and redirect it. During the panel meeting, the representative from ASC also stated that a risk assessment would have been conducted at the time and if they felt that Bill may have been at the address then they would not have attended. It does not appear that consideration was given to a joint visit with the police if this was the case.

There was then a reiteration of previous suicide attempts and the fact she has mental health problems. The caller confirmed there was no mention that day of self-harm or suicide, but it was reiterated that she had said previously that if her husband did not return, she would kill herself.

The call handler confirms that 'the threshold for concern' for an officer to be sent out was met and that officers would be sent out. The call handler asks if anything changes can they call him back and the response is no, calls would then need to go to EDT who 'might be able to arrange emergency care or something'. This shows a disconnect and misunderstanding of processes and responsibility as it would have been the initial day staff that would see this through as the call came when they were on duty and does not come under the jurisdiction of EDT.

The Control Room try to call Dorothy direct and leave a message on her phone at 1700 hours. The command-and-control log is commented that 'all units are committed'. At 1800 hours it is further commented that all units are still committed.

There was no suggestion that Dorothy was in immediate risk and that the police ought to have attended immediately after either contact from adult services. The risk level was graded appropriately, and officers attended as soon as was reasonably practicable on the day.

At 19.33hrs, the same day, Officers force entry to the home and find Dorothy deceased. This happened late on a Friday, which is historically the time of the week that professionals experience as the most difficult to respond to when they receive information just prior to the end of the working week. (Recommendations refer)

Section 4 – Conclusions and Recommendations

4.1 Conclusions

4.1.1 Dorothy was isolated from her family at a young age and turned to drugs and alcohol as a coping mechanism. On meeting Bill at 16 years old, Dorothy found company to stop feeling alone and although her sister states that Dorothy and Bill argued from the moment they met, Dorothy married him in 1980 when she was 18 years old. This was in the same year that Dorothy had taken her first recorded overdose citing an argument with her boyfriend as the course. This is an early insight into her fragility and there were three further recorded overdoses between then and 1993 during which time Dorothy suffered a lifelong back injury from a car accident and was forced by Bill to have two terminations that she didn't want. These early experiences would shape Dorothy's vulnerability within the marriage, Bill's treatment of her and Dorothy's dependence on him.

Alcohol was present in either one or both of them during incidents where the police had to be called and it was known to professionals over the years that this was an issue. The Police did not make appropriate referrals for support in relation to this and at times, recorded this as the cause of the domestic incident. Bill utilised Dorothy's intoxication to help his narrative to manipulate the police into thinking that Dorothy was the cause of the arguments and violence. Professionals referred Dorothy to P2R for support and P2R showed good practice in their communication with her when she stated that she did not want to engage. They were also the only organisation who recorded the recognition that the alcohol use may be caused by the domestic abuse and tried to get her to enrol on the Freedom Project to provide her with more understanding of the behaviour she had suffered and how to make a change.

When dealing with health professionals, although disclosures of her abuse were made, concentration was focussed on Dorothy's mental Health or alcohol abuse and overshadowed the domestic abuse that she was suffering. Although it is accepted that Dorothy had alcohol and mental health issues from a young age, consideration was not given to whether the cause of these issues later in her life were the domestic abuse suffered over a marriage of forty years or whether they were the main reason for her vulnerability to be susceptible to the abuse. Appropriate referrals were not made and there were very few referrals to MARAC, either on professional judgement and accumulation or due to the fact the DASH assessments were not graded as high.

It is accepted that Dorothy would, at times, assault Bill, but due to her protectiveness of him and the fact that he could manipulate the CCTV to record the moments that he wished to disclose, it is not known what caused Dorothy's behaviour in the lead up to this and whether this was. Bill used humiliating and degrading behaviour towards Dorothy over a number of years in both a sexual manner, derogatory name-calling and living with his new partner at the end of the garden in his campervan.

His controlling and coercive behaviour isolated Dorothy from the family she had managed to stay in touch with and Dorothy had no friends, doing everything with Bill or not at all. She

lived in her house with poor mobility, knowing or assuming she was being watched by him through the CCTV he had installed which was not questioned by the police or considered as this as he had explained it was to protect himself from Dorothy making false allegations. This was also a cause of concern for professionals who recorded discussions within meetings prior to home visits of their concerns. It is not known whether this was a barrier to discussions or prevented open discussion at times. Dorothy requested seeing P2R out of the home which is an indication of not wanting to speak with the cameras on and the control Bill had over her, even when he was not living there at that time.

ELFT were aware that Dorothy's husband was also supporting her with her physical and mental health. The records do not indicate any conversations with Dorothy's husband about his caring role or support available for him.

Bill was listed as the alleged perpetrator in the safeguarding concerns but there is no indication that he was offered any support help with managing his own behaviours or referrals to a perpetrator program.

There appears to be a gap in services supporting couples that choose to remain together despite allegations of domestic abuse. Services lean towards supporting the victim of domestic abuse and there is very little training or support for staff on how to deal with perpetrators of domestic abuse and supporting the couples involved. Although at times, appropriate information was shared, Dorothy was still discharged home into the care of Bill with no surrounding care plan or safeguarding in place.

Dorothy clearly loved Bill and would express this whilst disclosing his abuse. She was protective of him, not wanting to support police action. She would not accept support of agencies, preferring him to be her carer even though this subjected her to abuse and vulnerability. She knew deep down that Bill didn't love her and hadn't for some years, as expressed in the note that she left and she knew how lonely life can be on your own from her early experiences so it could be assumed that the reason for not engaging with 'outside' support was to keep her dependency on Bill and keep him close as that is all she knew, even though this was not the life someone would expect to lead.

Although Dorothy did not specifically mention her abuse in the note that she left, she did refer to his alcohol use, explaining that as the reason for his behaviour and that he didn't mean to do it which was an excuse she had made for him previously. The domestic abuse that Dorothy was subjected to in many forms for over forty years was undoubtedly a major contributory factor in her sadly taking her own life.

4.2 Lessons to be learned

Understanding of risk between agencies

On the day that Dorothy took her own life, she had contacted Adult safeguarding and left a voicemail sounding very distressed and asking for help. This was listened to late in the day

and several attempts to contact her back received no response. Earlier that day, she had been phoned by a support worker who thought that she heard a male voice I the background that Dorothy said was a neighbour.

Adult Safeguarding contacted the Police as they felt that there may be immediate danger due to Dorothy's suicidal comments the previous day and the fact that they thought Bill may have been there breaching his bail conditions. They did not attend following a risk assessment on their staff.

A social worker initially made a 999 call to the police but due to what they were told, they advised them to call back on the 101 system. When they called back on this, they provided history regarding Dorothy and the current circumstances in which they felt there was immediate danger. Due to the answers provided to questions in relation to the delay in receiving the voicemail, Dorothy's response to the male at the location and no suicidal comments that day, the police assessed that although this met the criteria for them to attend, this did not require an immediate response and a second review of this decision by a senior officer concluded this was graded appropriately.

Due to demand, the police did not attend for a further two hours where they then found Dorothy deceased in her home. Adult safeguarding had stated to ring EDT if the police needed to call back as it was after time they would work until which is incorrect process as they should maintain responsibility of the situation and they did not consider a joint visit.

Clearer communication of assessments of risk needs to be conveyed when communicating to another agency due to differences in terminology and thresholds. (Recommendations refer)

Overshadowing

When dealing with health professionals, although disclosures of her abuse were made, concentration was focussed on Dorothy's mental Health or alcohol abuse and overshadowed the domestic abuse that she was suffering. Although it is accepted that Dorothy had alcohol and mental health issues from a young age, consideration was not given to whether the cause of these issues later in her life were the domestic abuse suffered over a marriage of forty years or whether they were the main reason for her vulnerability to be susceptible to the abuse. Appropriate referrals were not made and there were very few referrals to MARAC, either on professional judgement and accumulation or due to the fact the DASH assessments were not graded as high.

Training is required amongst professionals to understand the correlation between domestic abuse and Mental Health and also, how to address multi complex needs to ensure they are all responded to which will prevent overshadowing. (Recommendation refers)

Agency engagement in the DHR process

The completion of this DHR faced significant delays due to more than one agency/organisation not completing their IMR or required submission of information until well beyond the specified deadline date. This led to delaying panel meetings and affected

the ability for informed discussion during panel meetings of the information that had still not been supplied. There were also issues with representative attendance for some agencies for panel meetings which again impeded progressive dialogue on specific subjects relating to the absent agency. (Recommendations refer)

4.3 Recommendations

National

There were no National recommendations identified during this review.

Local

1. **When commissioning services, Central Bedfordshire Council are to ensure that a requisite is that the agency willingly engages with the DHR process and complies with the requisites of supplying information within the agreed timelines and attending panels.**

   This will ensure that from the outset, those services applying for commissioning will understand the expectations and requirements of their agency in relation to DHRs.

2. **Central Bedfordshire Council to implement a local process for the escalation of non-compliance of attendance, action completion and report completion within the timelines set within a DHR when required to ensure it is immediately addressed.**

   This will ensure that a process is in place to address those services who do not comply with attendance at panel meetings and requisites of a DHR and will negate unnecessary delays in the DHR completion.

3. **ASC to communicate to all staff and provide reference the process that EDT do not support with day cases that are allocated and the process for how to arrange joint welfare visits with the Police.**

   This will provide guidance on responsibilities and processes to ensure timely and correct responses to those seeking or in need of immediate care.

4. **All ASC staff to undertake training in managing risk of suicide and responding to suicide.**

   This will provide an understanding of risk assessing a person with suicidal ideations, how to convey that risk to other agencies/organisations and how to respond within their own organisation.

5. **Central Bedfordshire Council to include domestic abuse as part of the carer's strategy.**
   Domestic abuse is not included in the carer's strategy at this time and as carer's do not generally meet the adult safeguarding threshold, this leaves them with little means of support or recognition of the heightened risk within the household. Inclusion will provide a framework to address the specific correlation between carers and domestic abuse.

6. **Central Bedfordshire Domestic Abuse Service to send communication to all relevant agencies and organisations within their area of the Safelives guidance in respect of MARAC referrals.**
   This will serve as a reminder to all of when a referral can be made and act as a guideline for decision making on referrals with the emphasis on making the referral if in doubt as it can then be assessed.

7. **Bedfordshire Police to review the process for making referrals to appropriate alcohol services, including the seeking of consent to make the referral where necessary, and to subsequently audit to confirm the process is effective.**
   This will ascertain whether or not referrals are being appropriately recognised and made in relation to alcohol abuse within DA incidents with the current process or whether this requires review to make it more effective.

8. **Bedfordshire Police to communicate the reinforcement of DVPN/DVPO policies, particularly in standards across the workforce to ensure consistency of practice, auditing and early intervention for vulnerable victims and perpetrators of domestic abuse.**
   This will ensure the current processes are being effectively practiced in order to utilise/consider the use of DPVN/DVPO in each case as a means of safeguarding the victim whether or not they support police action.

9. **ELFT to communicate to staff undertaking s.42 enquiries the need to ensure that all agencies involved are invited to meetings and that information is gathered from all involved to ensure risks are appropriately considered.**
   This will provide a holistic and informed approach to allow all information to be incorporated within the risk assessment.

10. **ELFT to ensure that all staff are aware of how to engage with alleged perpetrators as part of ongoing s42 enquiries.**
    This will reduce risk to the victim and provide additional information to the assessment of risk and enhance staff's overall knowledge of domestic abuse and the most appropriate communicative response.

11. **ELFT to ensure that their procedure and protocol for discharge includes a discharge plan that incorporates safeguarding and that consultation with the patient takes place to identify any issues, concerns or needs the discharge into the present carer may cause.**
    This will negate a victim of domestic abuse being discharged from hospital/care back to the perpetrator if this is deemed appropriate without a care plan that incorporates safeguarding measures and information sharing.

12. **ELFT and Bedfordshire University hospitals staff are to identify when a carer needs support when they are discharging a patient and refer them to the appropriate team to recommend the carer has a carers assessment and provide pathways to local carers organisations.**
    The carers assessment is the point where the carer would have the option to state that they didn't want to care anymore and provide this opportunity. It also provides an opportunity to identify risk.

13. **GP surgery to work closer with domestic abuse provisions and ensure domestic abuse is at the forefront of safeguarding considerations.**
    This will provide specialist guidance, advice and improved professional curiosity in domestic abuse from the GP Surgery.

14. **Bedfordshire Police to complete a dip-sample review of recorded domestic abuse incidents over the six months to satisfy the partnership that controlling and coercive behaviour is being considered for all situations where there are repeat incidents reported to the police.**
    This should confirm that officers and staff are considering appropriate offences and identifying Controlling and Coercive behaviour, whilst adhering to Home Office Crime recording standards and making appropriate submissions to the CPS for charging advice.

Appendices

Appendix A

Terms of reference

- The date parameters under consideration for documentation are from 2016 to January 2023. However, if relevant information is held prior to this, a summary is to be provided to provide context.
- This is to be reviewed as a suicide based on the investigation by appropriate authorities. The purpose is to establish if DA was a deciding or contributory factor in the death of Dorothy.
- Ensure the review seeks to involve any identified family and friends in the process.
- When multi-complex needs are identified in victims of domestic abuse, is the following effective amongst agencies:
  a) Communication and information sharing between services.
  b) Adequate provisions and processes to enable an effective and timely response to their needs
- Are alcohol misuse provisions appropriate for multi-complex domestic abuse cases? Were appropriate referrals made when it was established this was a factor with Dorothy and Bill?
- Is the correlation between domestic abuse and carers recognised amongst agencies within Central Bedfordshire for
  a) Identifying the vulnerability and impact of carers to being either the abuser or subject to domestic abuse due to their role within the relationship and are adequate safeguarding measures and recording processes implemented in these situations.
  b) Information sharing between services with regard to the safeguarding of adults and their carers.
  c) Are referral mechanisms adequate and were they sufficiently made to support Bill and safeguard Dorothy
- Establish the response to Dorothy's Mental Health and establish:
  a) Was sufficient time apportioned following each referral to respond to Dorothy's needs?
  b) What safeguarding measures for DA were considered by the professionals when disclosed by Dorothy.
  c) What sharing information processes and referrals took place and did Dorothy's mental health needs overshadow the domestic abuse.
  d) Was the response effective in relation to suicidal ideations and self-harm.
- Identify the processes and risk assessing that Housing associations have available in relation to domestic abuse victims and perpetrators and whether they are effective. How effective is safety planning for those placed in temporary accommodation?

- What processes exist to ensure that if support is offered by any agency and declined, that contact is maintained to ensure a continuation of assessment.
- Were procedures sensitive to the vulnerability, disability and age of the deceased? Were any of the other protected characteristics relevant in this case?
- Identify and highlight good practice for wider sharing
- Establish what processes are in place to record appropriately, decision make and provide support when it may be unclear who the victim and the perpetrator are within the relationship.

Appendix B

Glossary

AAFDA: Advocacy After Fatal Domestic Abuse

CMHT: Community Mental Health Team

CSP: Community Safety Partnership

DA: Domestic Abuse

DARA: Domestic Abuse Risk Assessment

DASH: Domestic Abuse Stalking and Harassment

DVPN – Domestic Violence Protection Notice

DVPO: Domestic Violence Protection Order

DHR: Domestic Homicide Review

EDT: Emergency Duty Team (Adult Social Services)

ELFT: East England NHS Foundation Trust

GP: General Practitioner

IDVA: Independent Domestic Violence Advisor

IMR: Individual Management Review

MARAC: Multi Agency Risk Assessment Conference

MCU: Major Crime Unit

MHA: Mental Health Act

SOVA: Safeguarding of Vulnerable Adults

VEO: Victim Engagement Officer

Appendix C

Transcript of the note/letter recovered from the scene of the sudden death of Dorothy. (This note has been included to provide context to Dorothy's last thoughts)

Page 1

To the Police,

May there be lesson learned, as to, when someone has been married for 40-year, disable and total rely on the husband, when they show reaction like mine, heed their words.

Nobody Listened.

PC H, I believe is her name, deliberately heard me saying 'it's only for a few days'.

They knew our 40th wedding anniversary is on 29.01.23 but won't let him home a minute sooner than *** or somewhere near that date.

Page 2

They (she) knew I was real and desperate, but still gave me all those lies.

You all bruised and manhandled my Bill so badly.

Sorry my writing is becoming eradicul if that's the right words. It's the effect of the meds I have taken.

In the end no one police officer other than my PC C Luton Police Station. He was the nicest and gentlest officer I've ever had a good luck to meet. He really deserves a medal. NaH… give him promotion and a good pay rise too. I mean it. I'm a hard

Page 3

Nut to chew, but he's something else. He really care.

Please merit him. If nothing more can come of my pathetic, unloved, uncared life, please merit him. He's the only one that got through to me.

Right, enough of myself. My Bill needs ** + is up no persecuting him. He can't help what he does when he's drunk. He's a totally different guy. The love of my life, only he could never see it. There is no shame on being alcohol dependant. Many Police officer do and have suffered with this.

Page 4

I will say now, Bill has not contacted me in any ways (unfortunately). I long to see him now.

Bill have not influenced me nor through his good friends D **and A** to take own life.

I can't and won't be forced to live without Bill (enforced by Police even though I begged them).

I DO NOT DO NOT want or wish to be revived. If so, I'll have to do it again. You can't keep lifelong companion apart. I want my Bill back immediately.

Page 5

Sorry, but my vision is now affected. Again, DO NOT resuscitate me. I'm becoming at peace now. I so wish Bill was here. I love him.

You (Police) don't listen to old people. You lie so you can make the scene more relaxed. That is not the way to handle it.

NOT ALWAYS.

I so hope someone listens and *** words.
Thank you for your help. Appreciated to no end or the end.
Sorry to babble on so long, 43 years is not nearly enough time to be with my Bill (broken Heart Drawing).

Page 6
I so hope it could have been so many years more. He told me 3 years ago that he’s not loved me in decades. This has cut my heart in two. He’s the most wonderous, generous, kind caring but now loving.
No blame is laid on my Bill. Please ease of now. Please dismiss all charges against him. It wasn’t fare. He didn’t know what. He was innocent. The drink Bill took hold. That’s not my Bill. He’s enough to deal with now. Kind Regards, Sound of mind Dorothy (plus signature).

Appendix D

Home Office

Interpersonal Abuse
Unit 2 Marsham
Street London
SW1P 4DF

Tel: 020 7035 4848
www.homeoffice.gov.uk

Lisa Scott

Safer Communities & Partnership Manager

Central Bedfordshire Council

Priory House, Monks Walk

Chicksands, Shefford

Bedfordshire,

SG17 5TQ

25th September 2024

Dear Lisa,

Thank you for resubmitting the Domestic Homicide Review (DHR) report (Dorothy) for Central Bedfordshire Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 14th August 2024. I apologise for the delay in responding to you.

The QA Panel noted that there has been a good response to the previous feedback provided. It was felt that the choice to highlight all changes made in red was a helpful inclusion. The confidentiality section is now present, and the dissemination section has been amended to include the Police and Crime Commissioner.

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published.

Areas for final development:

- The QA Panel noted that the report is still lacking a combined chronology. This is a critical element of any review, and its absence needs to be addressed.

- Self-harm, suicidal thoughts or suicidality ought to be included as a specific key line of enquiry within the terms of reference.

- It has been clarified that the Chair retired from Bedfordshire Police in January 2021 and they were commissioned to lead the review in February 2
there are mentions of sections 3.3.3 and 3.3.2, neither of which seem to exist.

023. The QA Panel advise that two years is not enough of a gap to ensure independence and request the CSP notes this for future reviews.

- There are a number of references to sections which are absent. For example,

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Panel

Appendix E

	Recommendation	Scope of recommendation	Action to take	Lead Agency	Key Milestones achieved in enacting recommendation	Target Date	Completion date and outcome
1	When commissioning services, Central Bedfordshire Council are to ensure that a requisite is that the agency willingly engages with the DHR process and complies with the requisites of supplying information within the agreed timelines and attending panels.	Local	Proposal submission to Central Bedfordshire Council for a DHR oversight Board. Inclusion into commissioning process. Implement oversight Board	Central Bedfordshire Council – Head of Community Safety	August 2023 – DHR Scrutiny Board agreed and commissioned.	January 2024	
2	Central Bedfordshire Council to implement a local process for the escalation of non-compliance of attendance, action completion and report completion within the timelines set within a DHR when required to ensure it is immediately addressed.	Local	Proposal submission to Central Bedfordshire Council for a DHR oversight Board. Agreement from all heads of department for commitment. Implement	Central Bedfordshire Council – Head of Community Safety	August 2023 – DHR Scrutiny Board agreed and commissioned.	November 2023	

			oversight Board				
3	ASC to communicate to all staff and provide reference the process that EDT do not support with day cases that are allocated and the process for how to arrange joint welfare visits with the Police.	Local	Communication strategy agreed Integration into training Review current process to ensure it includes required process Oversight allocation Dissemination of information	Bedfordshire Adult Social Care – Head of safeguarding adults and Quality Improvement	August 2023 – Communication strategy agreed. Process reviewed and relevant. Email sent to all operational team managers to inform them of oversight	September 2023	
4	All ASC staff to undertake training in managing risk of suicide and responding to suicide.	Local	Identify external agency to deliver training. Provide both face to face training and then an online continuous follow-up. Prioritise front-line staff to receive training in first instance.	Bedfordshire Adult Social Care	August 2023 – ongoing training already commenced by Samaritans	December 2023	
5	Central Bedfordshire Council to include domestic abuse as part of the carer's strategy.	Local	Identify specialist to write paper on heightened risk of DA with a family member as Carer. Proposal to Carers Board. Inclusion in strategy.	Bedfordshire Adult Social Care – Head of commissioning			

			Communication strategy.				
6	Central Bedfordshire Domestic Abuse Service to send communication to all relevant agencies and organisations within their area of the Safelives guidance in respect of MARAC referrals.	Local	Safelives training to be delivered to Chairs and relevant staff at CBC. Review referral process and guidance for professionals to utilise when referring. Dissemination process to be identified Training and implementation plan to be identified	Central Bedfordshire domestic abuse service – Service Manager	MARAC coordinator and Chairs have attended SafeLives MARAC Chair training. Completed 21/07/23 MARAC referral pathway, form and SafeLives toolkit for professional referring into MARAC. Shared with all MARAC representatives and asked to disseminate across their agencies on 15/08/23. Round Table event for professional organised for 16 Days of Action to highlight MARAC referral processes arranged for 02/12/23	July 2024	

					MARAC and DASH risk assessment training refreshed and information about SafeLives guidance on making referrals included, dates for delivery agreed for the 23/24		
7	Bedfordshire Police to review the process for making referrals to appropriate alcohol services, including the seeking of consent to make the referral where necessary, and to subsequently audit to confirm the process is effective.	Local	Identify relevant partners for collaborative working. Work with partner agencies to agree an effective and practical process. Implementation plan once identified.	Bedfordshire Police – DCI PPU hub	The agreeing of a process and audits 3 months after implementation.	31/12/23	
8	Bedfordshire Police to communicate the reinforcement of DVPN/DVPO policies, particularly in standards across the workforce to ensure consistency of practice, auditing and early intervention for vulnerable victims and perpetrators of domestic abuse.	Local	Upskilling of officers involved in the investigation of DA offences, plus those senior officers who have to authorise DVPN applications	Bedfordshire Police – Domestic Abuse Lead	Training has been delivered to all Beds DA Champions across the organisation. DVPN/O has been included in a new Induction package for all staff coming	Further update by 31/12/23	

					into the PPU. We have carried out CPD on this across Crime/Patrol/PPU Further training is being carried out for new Superintendents Dip sampling jobs to review missed opportunities and the use of DVPNS/DVPO's is a measure in monthly performance data. There has been a slight increase in the issuing of DVPNs in the last 3-4 months. August 2023 - Advertising for recruitment for a Detective Sergeant and team of officers as 'proactive enquiry team' that will		

					assist in applications/management of DVPNs'DVPOs and other orders.		
9	ELFT to communicate to staff undertaking s.42 enquiries the need to ensure that all agencies involved are invited to meetings and that information is gathered from all involved to ensure risks are appropriately considered.	Local	Scope for gaps in knowledge from staff and DHRs. Develop a training package to include these areas. Roll out of Face-to-Face S42 training with all teams focussing on key learning from this DHR around multi-agency working and information sharing	ELFT – Assistant Director.	July 2023 – Training package development started. This is to be ongoing training.	Training to begin by Jan 24	
10	ELFT to ensure that all staff are aware of how to engage with alleged perpetrators as part of ongoing s42 enquiries.	Local	Collaboration with Central Beds Domestic Abuse Service for advice and expertise within this area. Training to be integrated within the s42 package outlined at rec.9	ELFT – Assistant Director.	July 2023 – Training package development started. This is to be ongoing training.	Training to begin by Jan 24	
11	ELFT to ensure that their procedure and protocol for	Local	Review of current Procedures and	ELFT – Assistant Director.	July 2023 - ELFT reviewed the	December 2023	

	discharge includes a discharge plan that incorporates safeguarding and that consultation with the patient takes place to identify any issues, concerns or needs the discharge into the present carer may cause.		protocols to ensure they are up to date and if they include suggested procedures. To include recommendation requisites if necessary. Ensure clear guidelines for good communication about safeguarding concerns with all involved including the patient. Discuss in safeguarding supervision with wards.		Safeguarding Adults policy and were satisfied that there are clear guidelines for good communication about safeguarding concerns with all involved including the patient.		
12	ELFT and Bedfordshire University hospitals staff are to identify when a carer needs support when they are discharging a patient and refer them to the appropriate team to recommend the carer has a carers assessment and provide pathways to local carers organisations.	Local	To be a topic of discussion at each quarterly supervision meeting. Communication to staff for awareness and consideration. Utilisation of onsite carers lounge, integrated discharge team consisting of social	ELFT – Assistant Director /Bedfordshire University Hospitals – Safeguarding Lead		February 2024	

			workers from various areas, community nursing and hospital staff that specialise in discharge.				
13	GP surgery to work closer with domestic abuse provisions and ensure domestic abuse is at the forefront of safeguarding considerations.	Local	Collaborative working with BLMK Public Heath and Central Bedfordshire Domestic abuse services. Attend bespoke workshops provided. Cascade guidance and best practice amongst staff within the surgery. Foster relations with specialist services to understand the support they can provide.	GP Surgery – DA Champion		March 2023	
14	Bedfordshire Police to complete a dip-sample review of recorded domestic abuse incidents over the six months to satisfy the partnership that controlling and coercive behaviour is	Local	Establish parameters for sampling. Identify appropriate review team. Conduct review. Establish findings.	Bedfordshire Police – Chair of Change	Analysis of review Response plan to findings.	Oct 2024 Nov 2024	

	being considered for all situations where there are repeat incidents reported to the police.		Implement appropriate plan from findings.				