Executive Summary

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 their loved one in tragic circumstances, and which has caused this review to take place.

Contents

1. The review process

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.

Dorothy's death was reported to the Coroner by the Police and a file was opened. The report submitted stated that the death was considered to be non-suspicious and was treated as a sudden and unexplained adult death, indicative of a suicide by overdose.

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1.2 - A Post-mortem was subsequently held.

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 10mm abrasion to the central part of the forehead, 10mm 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: 30mm bruise to the anterior aspect of the right arm, irregular area of bruising to the anterior aspect of the right upper thigh, 45mm bruise to the anterior aspect of the right foot and 50mm 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.

1.3 - 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. A white British female.

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

1.4 IMRs were requested from the agencies who had significant communication with Dorothy and Bill or held significant information. Selected agencies were asked to submit a summary report to reflect the Terms of reference and provide context to prevalent areas including unconscious bias, suicide and mental health issues. This was to assist in analysing the depth of knowledge and support already in existence and being required in the Central Bedfordshire area.

2. Contributors to the review

The following agencies have contributed to the review: Each of the agency authors is independent of any involvement in the case including management or supervisory responsibility for the practitioners involved.

- East London Foundation Trust (ELFT)
- Bedfordshire Police
- Bedfordshire Integrated Care Board (ICB)
- Bedfordshire Probation Service
- Carers in Bedfordshire
- P2R
- Housing Department, Central Beds
- Bedfordshire Adult Social Care
- BLMK Public Health department
- GP Practice
- Central Beds Community Safety Partnership
- Bedfordshire Victim Support/IDVA service
- Central Bedfordshire Domestic Abuse Service
- Bedfordshire Hospitals NHS Foundation Trust

3. Review Panel members

The following individuals and agencies/organisations/voluntary bodies have contributed to the Domestic Homicide Review panel:

Name	Area of responsibility	Organisation
Lisa Scott	Safer Communities & Partnership Manager	Central Bedfordshire CSP
DCI Marie Gresswell	DCI – Safeguarding Reviews	Bedfordshire Police
Toni Doherty	Head of Safeguarding	Bedfordshire University Hospitals NHS Foundation Trust

Darryl Springer	General Manager	P2R – Alcohol services/ELFT
Dr Abdullah Khan	GP practice representative. Doctor	Medical Centre of Dorothy
Joy Leighton	Senior Operations Manager	Victim Support/IDVA Bedfordshire
Anthony Orekogbe	Accommodation Services Manager	Housing Operations, Central Bedfordshire Council
Anna Bruce	Deputy Head of Service	Probation Service - Bedfordshire
Rachael Clifford	Public Health Principal	Public Health Department (BLMK)
Susan Childerhouse	Assistant Director Public Protection	Central Bedfordshire Council
Jodie Flynn	Safeguarding Specialist Nurse	Bedfordshire Hospitals NHS Foundation Trust
Leire Agirre	Head of Safeguarding and Quality Improvement	Adult Social Care
Nina Page	Team Manager	Central Bedfordshire Domestic Abuse Service

Each panel member is independent of any involvement in the case including management or supervisory responsibility for the practitioners involved.

A total of three panel meetings have been held during this review, excluding the initial meeting to decide on the commissioning. 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.

4. Author of the overview report

4.1 - 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 undertaken a number of DHRs having completed the Home Office online training, the CPD accredited AAFDA DHR Chair training and is a member of the AAFDA DHR network, regularly attending the monthly forums for CPD and discussion.

4.2 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.

5. Terms of Reference

5.1 Terms of reference were discussed and agreed upon during the first panel meeting on 31st March 2023.

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

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

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.

5.2 - The full Terms of Reference are below:

- 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.

6. Summary Chronology

6.1 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.

6.2 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 states that she is 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 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.

6.3 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.

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, the GP made three lengthy entries in which Dorothy had disclosed her husband controlled every domain of her life and she had suffered extreme domestic violence for over 28 years and her extreme emotional suffering was having an impact on her levels of pain. It also stated that Dorothy disclosed being raped by Bill but feared she would not be believed. 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, 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. Dorothy had just been made redundant.

6.4 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 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. She stated she felt like slitting her throat and was referred to the Crisis team and Social services. A lengthy entry is fully outlined at 2.3.17 of this report of the disclosures made by Dorothy which caused the hospital to apply safeguarding measures whilst 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.

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.

6.5 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.

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 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.

6.6 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.

6.7 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 and married at 18, they've been married 40 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.

6.8 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.

7. Key issues arising from the review

7.1 Communication between organisations to work holistically to enhance support and safeguarding.

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.

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 Bill being a carer identified by them and speaking to Dorothy about a care plan.

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. (Recommendations refer)

7.2 Lack of understanding of the heightened risk of domestic abuse occurring when a family member becomes a carer.

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 this could cause for either the carer or those that are being cared for.

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.

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. (Recommendations refer)

7.3 The difficulty in a victim's voice being heard when they have multi-complex needs

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.

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. Dorothy presented as intoxicated on a number of occasions when the police attended which then leant the officers to listen to Bill's account. (Recommendations refer)

8. Conclusions

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 could 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. 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 protective 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.

9. Lessons to be learned

<u>Understanding of risk between agencies</u>

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)

10. 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 next 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.