Swindon Community Safety Partnership

Domestic Homicide Review

Into the death of Theresa (pseudonym)

In November 2017

Executive Summary

David Warren QPM, LLB, BA, Dip. NEBSS

Independent Domestic Homicide Review Chair and Report Author

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Section One - The Review Process

1.1. This summary outlines the process undertaken by Swindon Domestic Homicide Review Panel during the review into the death of Theresa (pseudonym), who was a Swindon resident.

1.2. The following pseudonyms have been used for the deceased and her husband to protect their identities and those of their family members: Theresa (the deceased) and Charles (her husband).

1.3. Theresa who was born and brought up in South Africa, was 34 years of age at the time of her death on [redacted] November 2017.Charles who was also born and brought up in South Africa, was 35 years of age. They moved to Swindon in 2007. They were both British citizens.

1.4. **At the date of concluding this review, the Coroner's Inquest has yet to be held.**

1.5. The decision to establish a Review was made on 8 December 2017 and enquiries were made to enquire if a Mental Health Homicide Review would also be opened. It was not until 24 January 2018 that the Swindon Community Safety Partnership was notified that the circumstances of Theresa's death did not meet the criteria for such a Review. Agencies were notified on 25 January 2018 that the first meeting of the review would be held on 20 February 2018.

1.6. Twelve of the twenty-four agencies notified about this review confirmed they had previous contact with Theresa and were subsequently asked to secure their files. Other than non-relevant contacts with his GP, no UK agencies had any contact with Charles.

Section Two - Contributors to the Review

2.1. The agencies contacted are:

- **Advocacy After Fatal Domestic Abuse (AAFDA):** Was contacted to ascertain if the Charity would be able to act as a support/advocacy service for Theresa's family, whilst her widower (Charles) was staying with the family. The Chief Executive of the Charity confirmed that AAFDA would, if requested, give assistance to the family and the DHR Chair provided AAFDA's contact details and leaflet to Theresa's mother.

- **Alcoholics Anonymous:** Theresa's mother has stated that Theresa had told her she had attended an Alcoholic Anonymous meeting, however, this organisation has not been able to confirm this to the review, as they do not require individuals seeking support from them to provide a name.

- **Avon and Wiltshire Mental Health Partnership NHS Trust:** This service provided an IMR in relation to their contacts with Theresa. A senior member of this service who is independent of any contact with Theresa is a DHR Panel member.

- **The Bristol, Gloucestershire, Somerset and Wiltshire Community Rehabilitation Company:** This service had no relevant contacts with Theresa or Charles.

- **Change Grow Live (CGL), Swindon Drug and Alcohol Service:** This service provided an IMR in relation to its contact with Theresa. A senior member of this service who is independent of any contact with Theresa is a DHR Panel member. During this review, CGL's contract was not renewed in Swindon and a senior member of the new service provider, Turning Point, joined the Review Panel.

- **Citizen's Advice Bureau:** This service had no record of any contact from Theresa either locally or nationally.

- **Dorset and Wiltshire Fire and Rescue Service:** This service had one request at 10.30pm on 15 June 2017, to assist the Ambulance Service, to gain entry to Theresa's home but were then not required and therefore had no direct contact with Theresa.

- **Great Western Hospital NHS Foundation Trust:** This Trust provided a chronology of contacts with Theresa and a relevant IMR was completed. A senior member of this Trust, who is independent of any contact with Theresa, is a DHR Panel member.

- **Hometruths:** This small non-statutory service provided an IMR in relation to its contacts with Theresa. [redacted] the IMR author who is also a DHR Panel member) declared her knowledge of and involvement with the deceased at the commencement of the Review.

- **Kiss Gym:** This organisation confirmed to both the Police and to the DHR that Theresa was a member of the Gym. There were no records of her ever being involved in any contact activity. There were no records of her ever reporting any injuries whilst at the Gym.

- **NHS111 (Care UK):** This service provided an IMR in relation to a contact with Theresa. It had no record of any contacts with Charles.

- **National Probation Service:** This service had no relevant contacts with Theresa or Charles. A senior member of this agency is a DHR Panel member.

- **Paladin National Stalking Advocacy Service:** This service had been contacted for advice from Swindon Women's Aid but had no direct contact with either Theresa or Charles.

- **Samaritans:** Whilst Theresa told her GP and NHS111 that she had on occasions contacted the Samaritans as no names are requested or given, the Samaritans were unable to provide any relevant information to the Review.

- [redacted]**:** EMDR Accredited Practitioner and MBACP Senior Accredited Counsellor: The DHR Chair invited [redacted] to take part in the Review, as the deceased's husband had indicated that Theresa had received trauma support services from her. [redacted] responded by letter on 24 May 2018 that she declined the invitation to provide information to the review. (There is currently no statutory requirement for such a private organisation to participate in a DHR). The Wiltshire Coroner has nevertheless directed that the statement she provided to Wilshire Police should be provided to the DHR.

- **Scrappers Boxing Club:** The DHR contacted this club after Charles had informed the review that he thought Theresa may have been a member. The owner of the Club had no record of Theresa having been a member or having attended the club he also checked with all of the Club's coaches and service users. There were no entries referring to Theresa in the club's injury book in which injury that are sustained on the premises are recorded.

- **South Western Ambulance Service NHS Trust:** This service provided an IMR in relation to a contact with Theresa; it had no record of any contact with Charles.

- **Swindon Borough Council Adult Social Care:** This Department provided an IMR in relation to third party referrals regarding Theresa. A senior member of this Department, who is independent of any contact with Theresa, is the IMR author and a DHR Panel member.

- **Swindon Borough Council Housing Options:** This service provided an IMR in relation to a contact with Theresa. A senior member of this service who is independent of any contact with Theresa is a DHR Panel member.

- **Swindon Clinical Commissioning Group (CCG):** A senior member of this organisation who is independent of any contact with Theresa or Charles is a DHR Panel member. The CCG Safeguarding lead has completed an Individual Management Report in relation to Theresa's regular relevant contacts with her GP Practice.

- **Swindon Multi Agency Risk Assessment Conference (MARAC):** The Swindon MARAC Chair responded to a DHR Memorandum of Agreement confirming that Theresa had been referred to three MARAC meetings. He provided a report setting out his review of those referrals.

- **Swindon Women's Aid:** This non-statutory organisation had relevant contacts with Theresa and an IMR was completed. A senior member of this organisation who is independent of any contact with Theresa or Charles is a DHR Panel member.

- **Victim Support**: This service notified the DHR that it had no relevant contacts to report.

- **Wiltshire Police:** This Police Force had relevant contacts with Theresa and Charles and an IMR was completed. A member of this organisation who is independent of any contact with Theresa or Charles is a DHR Panel member.

2.2. The following also contributed to this Review:

- Theresa's family provided information regarding Theresa's early life and provided the review with copies of her diaries and journals.

- Theresa's husband Charles agreed that his statements made to the Police could be provided to the review. He also informed the review of his concerns regarding the service provided to his wife by Avon and Wiltshire Mental Health Partnership NHS Trust. He provided further information to the DHR during a meeting in April 2019

- HM Coroner agreed that the review could have access to papers provided to him for the purpose of the Inquest. The Coroner also asked for a copy of the DHR Overview Report and requested that it should not be published until after the conclusion of the Inquest.

- Theresa's friends and neighbours

- Independent Office of Police Conduct has provided the review with copies of the reports of their investigation.

Section 3 - The Review Panel Members

3.1. The DHR Panel consists of senior officers, from the statutory and non-statutory agencies who are able to identify lessons learnt and to commit their organisations to setting and implementing action plans to address those lessons. With the exception of the Hometruths Panel member, none of the members of the Panel have had any contact with Theresa or Charles.

3.2. The Panel members are:

[redacted]

[redacted] Great Western Hospitals NHS Foundation Trust

[redacted], Hometruths

[redacted], NHS England

[redacted], National Probation Service

[redacted], Swindon Borough Council Adult Social Care

[redacted], Swindon Borough Council

[redacted], Public Health, Swindon Borough Council.

[redacted],, Swindon Borough Council Community Safety Team

[redacted], Swindon Borough Community Safety Team

[redacted], Swindon Borough Council Housing, and Chair of DA Management and QA Group

[redacted], Swindon Clinical Commissioning Group (CCG)

[redacted], Swindon Women's Aid

[redacted]: Change, Grow, Live Drug & Alcohol Service

[redacted], Wiltshire Police

[redacted] Home Office Accredited Independent Chair

Police Initial Investigating Officer: [redacted]: Wiltshire Police

Police Senior Investigating Officer: [redacted] Wiltshire Police

Review Administrator and Minute Taker[redacted]: Swindon Borough Council

3.3. The DHR Panel met formally six times. The schedule of their meetings are:

24 January 2018 (pre-meeting) **Swindon Borough Council Civic Offices**

20 February 2018, **Haydon Wick Parish Council Offices**

24 April 2018, **Swindon Borough Council Civic Offices**

5 June 2018, **Haydon Wick Parish Council Offices**

5 June 2019**, Haydon Wick Parish Council Offices**

3 July 2019**, Haydon Wick Parish Council Offices**

Section 4 - Chair of the Review and Report Author

4.1. The Chair of the DHR Panel is a legally qualified and accredited Independent Domestic Homicide Review Chair. He has passed the Home Office approved Domestic Homicide Review Chairs' courses and possesses the qualifications and experience set out in paragraph 37 of the Home Office Multi-Agency Statutory Guidance (2016).

4.2. He has an extensive knowledge and experience in working in the field of domestic abuse and sexual violence at local, regional and national level. He has provided pro-bono legal work for a Refuge and its residents; been responsible for Government funding and monitoring of the delivery of domestic abuse services across the South West Region of England between 2004 and 2010; was a member of a number of Central Government committees, including those relating to the national funding of local domestic and sexual abuse services, the development of Violence Against Women and Children policies and the national development and implementation of Domestic Homicide Reviews.

4.3. The Chair has no connection with the Swindon Community Safety Partnership and is independent of the agencies involved in the Review. He has previously served as a senior police officer in Avon and Somerset Constabulary and the then Regional Crime Squad until 1999. More recently, he has been the Home Office Criminal Justice System Manager for the South West Region of England. In a voluntarily capacity, he has been the Chair of a substance abuse charity. Since 2011, he has chaired numerous statutory reviews including Serious Case Reviews, Mental Health Reviews, Drug Related Death Reviews and Domestic Homicide Reviews in different areas across the country. 4.4. He has had no previous dealings with Theresa or Charles.

Section 5 - Terms of Reference

5.1. Agencies that have had contact with the deceased, Theresa (pseudonym) and/or Charles (pseudonym) should identify any lessons to be learnt. They should also set out provisional actions to address them as early as possible, for the safety of future victims of domestic abuse, particularly those who are vulnerable through mental health issues and/or substance misuse.

5.2. This DHR which is committed within the spirit of the Equality Act 2010, to an ethos of fairness, equality, openness, and transparency, will be conducted in a thorough, accurate and meticulous manner.

5.3. The Domestic Homicide Review will consider:

5.3.1. Each agency's involvement with the following, from 1 January 2015 to the [redacted] November 2017, the date of Theresa's death, as well as all contact prior to that period which could be relevant to domestic abuse, violence, stalking, controlling behaviour, self-harm or other mental health issues.

a. Theresa was 34 years of age at date of her death.

b. Charles was 35 years of age at the time of Theresa's death.

5.3.2. Whether there was any previous history of abusive behaviour towards the deceased and whether this was known to any agencies?

5.3.3. Whether there was any previous history of mental health problems and if so, whether that was known to any agency or multi-agency forum?

5.3.4. Whether family or friends want to participate in the Review. If so, ascertain whether they were aware of any abusive behaviour to Theresa prior to her death?

5.3.5. Whether, in relation to the family members, were there any barriers experienced in reporting abuse?

5.3.6. Could improvement in any of the following have led to a different outcome for consideration:

a) Communication and information sharing between services?

b) Information sharing between services with regard to the safeguarding of adults?

c) Communication within services?

d) Communication and publicity to the general public and non-specialist services about the nature and prevalence of domestic abuse, and available local specialist services?

5.3.7. Whether the work undertaken by services in this case are consistent with each organisations':

a) Professional standards?

b) Domestic Abuse policy, procedures and protocols?

5.3.8. The response of the relevant agencies to any referrals relating to Theresa or Charles concerning domestic abuse, controlling behaviour, stalking, harassment, other significant harm, mental health, or any Safeguarding issue. It will seek to understand what decisions were taken and what actions were carried out or not and establish the reasons. In particular, the following areas will be explored:

a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards with Theresa.

b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective?

c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made?

d) The quality of any risk assessments undertaken by each agency in respect of Theresa.

5.3.9. Whether organisations' thresholds for levels of intervention were set appropriately and/or applied correctly, in this case?

5.3.10. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective individuals and whether any specialist needs on the part of the subjects were explored, shared appropriately and recorded?

5.3.11. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and completed in a timely manner?

5.3.12. Whether, any training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse processes and/or services?

5.3.13. If any other statutory Inquiry or Review is established to examine the circumstances surrounding the death of Theresa, the DHR will liaise with the organisations involved to avoid duplication and to take due notice of any findings or recommendations made by such an Inquiry or Review subject to the final shape of the review meeting the requirements as set out in the statutory guidance.

5.3.14. The Review will consider any other information that is found to be relevant.

Section 6 - Summary Chronology

6.1. Both Theresa and Charles were both brought up in South Africa.

6.2. Theresa's family have said, that In 2006 after witnessing a murder, Theresa became withdrawn and fearful about going out. She started to drink heavily and subsequently took an overdose of prescription medication, which resulted in her having her stomach pumped.

6.3. Due to her continual fears about the South African crime rate, Theresa made the decision, with Charles, to emigrate to the UK. In March 2006, they moved to Swindon and later married in 2009. They had no children. After Theresa and Charles took up permanent residence in Swindon, her parents and brother also moved to the UK. Her parents purchased a house close to Theresa and Charles in Swindon. Her brother lives in London.

6.4. The first recorded concerns about domestic abuse was on 15 August 2016. Theresa's GP spoke to her about domestic abuse, as she had noted that Theresa, who was regularly being treated for anxieties and low mood, had presented six times over a short period with injuries she claimed were caused by falls either during or after exercise. Theresa denied that she was being subjected to domestic abuse, although she stated her husband was unsupportive. Later, on 31 August 2016, after Theresa had attended an appointment with a LIFT Psychology nurse, with head injuries which she stated were the result of a fall. She was advised to see her GP. Theresa then admitted to the LIFT Nurse that her husband was controlling towards her. Her GP subsequently gave her the contact details for Swindon Women's Aid, although Theresa still denied that Charles was hurting her.

6.5. On 12 September 2016, Theresa presented at her GP Practice with bruising around her neck and complaining of swallowing difficulties. She told her GP the injuries had occurred during sex with her husband. The GP advised her to report the matter to the police as she was concerned about the risks of further harm to Theresa, but Theresa refused. The GP sought advice from a colleague, but as Theresa was noted to have capacity and had not given her permission for the GP to break confidentiality, the GP did not report it to the police.

6.6. However, in September 2016 did Theresa seek help from Swindon Women's Aid (SWA). Up to the time of her death she had 177 contacts with SWA and three referrals to the Swindon MARAC. She also had contacts with the charity Hometruths and with Wiltshire Police in connection with her reports of domestic abuse. It is on the basis of these contacts that the Wiltshire Police considered Theresa's death met the criteria for a Domestic Homicide Review (DHR).

6.7. On 19 September 2017, Theresa telephoned the Swindon Women's Aid IDVA (Independent Domestic Violence Advisor) and indicated that she was contemplating taking her own life. The police were called and officers were immediately deployed to Theresa's home, where they found her in the garage, standing on a stepladder with a rope around her neck. She later told the Swindon (Mental Health) Intensive Team that the suicide attempt was planned and that she fully intended to end her life.

6.8. On [redacted] November 2017 Police were called to a Motorway bridge after Theresa had been seen leaning over the bridge. They found her visibly upset and was dressed only in a jumper and trousers despite the cold temperatures. She told the officers she was "*out for a walk*". She smelt of intoxicants and confirmed to the officers that she had been drinking. Due to the officers' concerns about Theresa, a request was made for a member of the Mental Health Triage team to speak to her on the phone. During this call, a plan was made by Mental Health Triage and Theresa that she would make contact with her doctor's surgery the next morning. Mental Health Triage also stated that they were happy for Theresa to return home that evening. She did not disclose to the Triage or officers that she had any intention to harm herself, despite being asked this a number of times, as officers were concerned about her distressed state.

6.9. At 7.45 am on [redacted] November 2017, Theresa telephoned NHS111 because she was having suicidal thoughts. The Clinical Advisor contacted the Mental Health Service Crisis team, but Theresa was advised to go to her GP. Theresa stated she was tired of going to and fro with them. NHS111 notified Theresa's GP Practice about this call. At 12.58pm, the same day Theresa telephoned the police informing them that she did not want her family to find her, that she had written them a letter and had a rope in her garage, which was the way she intended to take her own life. The Call Handler offered to get the in-house mental health Street Triage Team to speak to her; Theresa agreed but then hung up. The Call Handler called her back immediately and said the Street Triage Team would phone her within one minute. When they did, the call went straight to answerphone. Other efforts were made to contact her on the telephone but it was not until 1.14pm that police officers were sent to her home.

6.10. The first officers arrived at Theresa's home at 1.23pm. They found Theresa hanging from a rope suspended from a beam in the garage. An Ambulance crew attended and at 1.24pm, it was confirmed that Theresa was deceased.

6.11. CID officers attended and found a note addressed to her family. (A second note to her brother was later found by the family in a drawer in the house). The officers were satisfied that Theresa had taken her own life and although they were aware that there was a Standard Operating Procedure (SOP) warning "marker" on the premises relating to domestic abuse, no attempt was made to search the premises and a forensic post mortem was not requested.

6.12. Charles who was working out of the Country on the day Theresa died has consistently denied ever having used violence towards Theresa, although he recalled that they occasionally engaged in consensual "rough and tumbles".

6.13. The Toxicology Report highlighted that Theresa had a history of depression, alcoholism and that she was withdrawing from Sertaline, but that there was no direct toxicological cause of death.

6.14. The Pathologist concluded that the post-mortem examination had identified the direct cause of death as compression of the neck structures by a ligature. He noted that Theresa

had been treated for depression and was known to be a "problem drinker and with visits to alcoholics anonymous[1]". The toxicology report showed that Theresa had consumed alcohol prior to death but the level would likely have only caused "mild" drunkenness. The endometrial appearances suggested secretory and possible premenstrual phase, which may have increased suicide risk. The Pathologist also detailed a number of external bruises on her head, body and arms, one of which appeared to be an old bruise as it was "yellowing".

6.15. In May 2018, after the Chronologies and IMRs from Swindon Women's Aid and from the Swindon CCG in relation to Theresa's GP Practice were received and considered by the DHR Panel, at the request of the Coroner, Wiltshire Police opened an investigation into Theresa's recorded domestic abuse and injuries. The Police notified the DHR on 28 March 2019 that they had concluded their investigation and the Senior Investigating Officer had made the decision that there is insufficient evidence to demonstrate that a crime had been committed.

Section 7 - Key Issues and Conclusions

7.1. The Domestic Homicide Review is not an inquiry into how Theresa died or into who is culpable; that is a matter for the Coroner. The review has focused on identifying lessons learnt from agencies' past actions or inactions and setting service responses to address them. To put the actions and inactions of the participating agencies into context, the review has considered issues, which were key to Theresa's decision making. These include Theresa's mental health, self-harming, alcohol use, physical injuries, reported controlling behaviour, why Theresa was reluctant to leave home and why she refused to report matters to the police.

7.2**. Mental Health**:

7.2.1. Theresa's mother believes the shooting Theresa witnessed in South Africa in 2006 was a turning point for her. In her witness statement to the police, she stated*, "This traumatic event certainly changed (Theresa). In the short to medium term, she was too scared to go out in public places at night. This was exacerbated by other crimes reported in the news and the growing crime rate in South Africa. (Theresa) initially had terrible dreams and feared that the criminals had seen her car license plate and would be able to find her. When she started going out again, she would drink a lot as a means of coping with her thoughts and fears. This period ended with (Theresa) taking an overdose of prescription medication where she had to be taken to the hospital to have her stomach pumped."*

7.2.2. Theresa's mother has told the review that after Theresa arrived in the UK she appeared happy and healthy and it was not until after September 2015 that she started to seek medical help for her anxieties and stress. Her GP treated her with medication and referred her to mental health services

7.2.3. Avon and Wiltshire Mental Health Partnership (AWP) which provides mental health services in Swindon, found evidence of symptoms of PTSD related to Theresa's experiences in South Africa. However after Theresa disclosed that she had been subjected to domestic abuse and had considered self harming, it was decided that the psychological interventions indicated for PTSD would not be suitable as they are contraindicated with

[1] There is no available record that Theresa visited Alcohols Anonymous but it is known she received limited support from Swindon Drug and Alcohol Services.

high risk to self-harm or suicidal behaviour. She was prescribed antidepressants but the AWP Psychiatrist was of the opinion that where a person is living in an abusive relationship it is very understandable for them to be exhibiting signs of depression and anxieties. Such symptoms cannot be “medicalised” as it is the situation that needs to change.

7.2.4. The Review Chair drew the Panel’s attention to independent research that indicates that intimate partner violence is a common health care issue.[2]

7.2.5. None of the mental health problems Theresa experienced indicated to the mental health professionals that an admission to hospital would have been an appropriate pathway for her. Firstly, the psychological work for PTSD would not normally be delivered within an inpatient setting and again would have been contraindicated with Theresa's self-harming behaviour. Additionally as Theresa was at that time, accepting mental health interventions and engaged with the Intensive Team, detention under the Mental Health Act would not have been appropriate. On two separate occasions, when Theresa had tried to take her own life, Police Officers considered detaining her under the Mental Health Act, but concluded they did not have the power to do so as she had mental capacity within the meaning of the Act and on one of those occasions; she was at her home address.

7.2.6. The Review Panel acknowledged that Theresa was deemed to have mental capacity at the time, but questioned if her increasing suicidal ideation could have been considered to be temporarily adversely affecting her mental capacity. Following professional advice, the Panel accepted that this was a professional judgement and in any case may not have been sufficient to detain her in hospital for any significant time against her will.

7.2.7. The involvement of mental health services in Theresa's case was primarily that of providing support to her when she reached out to services asking for help. This involved providing a space for her to discuss her experiences and consider her options, as well as working with her to manage her risks to herself. However, her trust in the mental health services dented after information was disclosed to the police without her consent Theresa lost confidence in the mental health service and became reluctant to engage with them.

7.2.8. Significant lessons have been learnt regarding the mental health care Theresa received and these lessons, together with Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) action plan to address them, have been agreed by the DHR Panel.

7.3. **Self-Harming**

7.3.1. Theresa first presented to her GP with anxieties and panic attacks in September 2015 when Charles was working abroad and her mother-in-law was staying with her. Over the following five months, she presented twenty-five times with anxieties and fainting episodes. Initially these were attributed to her mother-in-law’s visit and to PTSD relating to the South African shooting incident she had witnessed.

7.3.2. Over the following three months, Theresa regularly saw her GP and when asked, denied having any thoughts to self-harm. The first time she acknowledged having low moods and thoughts of self-harm was on 6 June 2016 when she told the GP, she felt that life was not worth living. She said she had thought about taking an overdose of medication, but said she had no specific plans to do so. She admitted that in the past in South Africa, she had taken an overdose of her mother’s Thyroxine, Paracetamol and Cocodamol tablets. Although she was tearful, on examination, she had good eye contact and rapport.

[2] These are summarised in the Overview Report.

After this initial admission of suicidal thoughts, there were several similar admissions to her GP over the following weeks and she was referred to Mental Health Services.

7.3.3. On 7 September 2016, Theresa told the LIFT Psychology nurse that she was not happy in her relationship with her husband. She denied that he had any involvement in her repeated injuries and also denied that she had been harming herself.

7.3.4. Theresa continued to admit to her GP and the SWA IDVA that she was occasionally having thoughts of self-harming. On 4 November 2016, Theresa told the SWA IDVA that she did not have much left in her to cope and the risk of self-harm was discussed. On a scale of 1-10 Theresa has reached 9 the previous week (she had got close to the rail track at a train station and Charles had pulled her back). She said she currently scored herself as 6/7 and said she did not have any plans to harm herself. (See Overview Report para 16.71.) She later told the IDVA that she had accessed support from the Samaritans, which stopped her taking tablets that she had lined up. She added that she even called her father. He came to visit her with her mother and Theresa told them that she was struggling with feeling low; she did not however disclose any domestic violence but did say that her relationship with Charles was not as great as it appeared to be. Her father acknowledged that Theresa spent a lot of time on her own and invited her to stay with them when Charles was working away.

7.3.5. Increasingly during 2017, Theresa told her GP and IDVA that she had thoughts of self-harming and she made several attempts to do so: by taking an overdose of tablets; by walking towards an oncoming train; being found in a dishevelled state on a motorway bridge and attempting to hang herself (before later succeeding in doing so). She told those professionals she confided in, that the reasons for her unhappiness with life was because she felt trapped in her marriage and could see no way out, other that by either her husband killing her or her taking her own life. (See Overview Report paras 16.153, 16.158, 16.169) In February 2017, while worried about what action the police might take after they had received the report about her injuries, she made a plea for help, in a text message to the SWA IDVA stating: “Please I need to know where to go from here as I feel without the right help when it comes to my mental health this is going to end badly.” (See Overview Report para.16.93) Yet, in a very moving note addressed to her brother, Theresa stated she was in a “dark place” and blamed no one.

7.3.6. Theresa’s closest friend told the review that Theresa had confided in her over a period of about three years that she had been having suicidal thoughts.

7.3.7. The Swindon Clinical Commissioning Group IMR Author, made the following summary of Theresa’s situation in her report:

“Theresa presented to her GP with multiple medical problems. There were ninety-one entries where Theresa’s mental health had been a feature. There were twenty-six disclosures of domestic violence, most of which were of significant harm, including strangulation to the point where Theresa lost consciousness. Theresa commented on several occasions that she felt trapped due to financial reasons. She became increasingly suicidal, attempting suicide, being found on a bridge, saying she had bought a rope, attempting hanging but was found, before eventually committing suicide by the method of hanging.”

7.3.8. There are several references in Theresa’s journals about taking her own life. On 10 March 2017, she wrote; Thoughts about what I am going to do. Wondering how we are going to do about my suicidal thoughts. Mind wondered about it a bit today but not as bad as other days. I wonder how long I can resist the urge to end it all.”

7.4. **Alcohol:**

7.4.1**.** In 2017, Theresa told the SWA IDVA that when the family saw her with bruises, they believed these were due to her binge drinking episodes. She explained that this was because Charles had told her parents that she was addicted to drugs and alcohol. She was upset and shocked at him for using this tactic and felt that he was painting a picture of her that was not true. Theresa feared this would prevent her parents from believing her if she told them about the domestic violence she had described to the IDVA. (See Overview Report para 16.51)

Theresa's mother has stressed to the review that she had never witnessed Theresa drinking heavily, but in 2017 Theresa told her, she had a drinking problem and that she would be seeking her for it.

7.4.2. Theresa's mother understand that Theresa attended Alcoholics Anonymous meetings, but as the name implies, no records of the names of persons attending meetings are available for this to be confirmed. However, it is known that in September 2017 Theresa did engage with Change Grow Live at Swindon Drugs and Alcohol Services. After an initial assessment on 3 October 2017, she attended only one meeting before disengaging. At the Assessment, she stated she was binge drinking six days out of twenty-eight and her drinks of choice were Champagne and Whiskey. (See Overview Report Appendix I).

7.4.3. The first recorded reference to Theresa's use of alcohol in the UK was on 15 August 2016 when it was noted in her medical records that although she was feeling unsupported by her family and was having occasional thoughts of self-harm, she had reduced her alcohol intake and had no excess medication in the house. (See Overview Report para 16.14) Later, in October 2016 Theresa admitted to the Swindon Women's Aid IDVA, that she used alcohol to numb pain and to help her sleep. (See Overview Report para 16.40)

7.4.4. There were no other significant agency references to Theresa's drinking until 30 August 2017 when it was noted in her medical records that Theresa was concerned about the police considering taking action against Charles and she had asked her GP to document that she had alcohol problems and mental health issues and had lied about the abuse. The GP contacted the Police Safeguarding Officer with Theresa's consent and was advised that the Safeguarding Officer was unable to stop the police investigation (See Overview Report para 16.151)

7.4.5. Theresa made a number of references in her journal about her use of alcohol as a prop. On 27 March 2017, she wrote, "Turning to alcohol, I feel once I start I struggle to stop." On 16 May 2017, she wrote "Had a rough day, drank almost an entire bottle of whiskey. Called the Crisis Team. Slept at Mum and Dad. I was in a dark space."

7.4.6. After Theresa's death, the Pathologist noted that Theresa "had been treated for depression and was known to be a problem drinker and with visits to Alcoholics Anonymous". However, the toxicology report shows that whilst Theresa had consumed alcohol prior to death, "the level would likely have only caused "mild" drunkenness, (See Overview Report paras's 17.16.3-4)

7.4.7. Change Grow Live (CGL) who provided Swindon Drug and Alcohol Services conducted an Unexpected Death Review into Theresa's death and their report is set out in Appendix I.

7.5. **Physical Injuries.**

7.5.1. Across the period focused on in the DHR Terms of Reference, the reports received from several agencies revealed evidence that Theresa suffered repeated physical injuries to various parts of her body. Swindon Women's Aid has provided the review with copies of three self-taken photographs of one set of bruises to Theresa's body and Wiltshire Police provided twelve further photographs of injuries to Theresa's face, neck, arms and body[3]. (See Overview Report paragraph 16.77.)

7.5.2. On several occasions, the Swindon Women's Aid IDVA and her Supervisor saw marks around Theresa's neck and bruises and wounds on her body (See Overview Report para. 16.54.) Theresa described to them, how her husband was responsible for the injuries, stating that on different occasions, he punched, kicked, beat her with a metal pole, hit her in the face with the TV remote control, strangled her with a rope and his belt and held her head under water. (Overview Report paras 16.81, 16.82, 16.82).

7.5.3. Hospital staff who saw and x-rayed injuries to Theresa's head and arms were so concerned that they reported the injuries to the police, as they feared that she might suffer serious injury. (See Overview Report para 16.107). On one occasion, hospital records noted that Theresa "while withdrawn and reluctant to give information during the consultation; confirmed she had been assaulted by her partner the previous day, but did not want the police notified as Swindon Women's Aid was formulating a safety plan for her. She was discharged after her injuries were x-rayed". (See Overview Report para 16.61).

7.5.4. Likewise, Mental Health Services, on information from their Nurse, who had seen the bruising on Theresa's neck, reported her injuries to the police. (See Overview Report para 16.25)

7.5.5. Theresa's GP examined and recorded her injuries on twenty-six occasions. The injuries included, strangulation marks on her neck, deep bruises to her legs, arms, abdomen, ribs, eyes and head. (See Overview Report paras 16.53, 16.69, 16.78. 16.121, 16.124. 16.175, 16.177).

7.5.6. In January 2016, when Theresa first began presenting to her GP with physical injuries, she claimed they were caused during fainting or falling episodes, during intercourse or during or immediately after exercise. Her GP took blood samples, treated her with medication and made a neurology referral, but nothing unusual was found and no diagnosis was made. Over the following months Theresa's GP questioned her about self-harming but Theresa initially denied she was having any such thoughts. When asked about domestic abuse Theresa at first also denied that her husband was violent but admitted that he was controlling[4]. It was several months later (September 2016) that Theresa disclosed that her husband was physically violent towards her. Following her confiding in the Mental Health Service that her husband strangled her during non-consensual rough sexual intercourse and their subsequent reporting it to the police[5]; she had become distrusting of new agencies and would refuse to explain how her injuries were caused. (See Overview Report

[3] The Wilshire Police investigation has noted that Theresa sent these photos her cousin as well as to Swindon Women's Aid. She told her cousin the injuries were caused by a fall and told Swindon Women's Aid they were inflicted by her husband.

[4] The Police investigation did not identify any evidence of controlling behaviour by Charles on either Theresa's mobile phone or on Charles phone.

[5] It was noted in the police investigation that Theresa had told Friend B that the mark around her neck in a selfie she sent her was caused by Charles putting a collar on her during sex. Theresa said that she had instigated it and introduced it into their sex life.

para 16.25). She told the SWA IDVA, whom she trusted, that she had played down what her husband had done by telling the police, that she had consented to the rough sex. (See Overview Report para 16.28)

7.5.7. Whilst Theresa had become cautious about explaining how her injuries had been inflicted, she continued to speak openly to her GP and the SWA IDVA. There were times when Theresa turned up at the GP surgery in a distressed state and with visible injuries, which she asserted were a result of assaults by Charles. On one of those occasions, the GP Practice receptionists saw clear marks around her neck. Theresa told her GP, SWA staff and once to hospital staff, that her husband had used a metal pole to beat her. She stated he would kick her, stand on her and hold her head under the bath water. Her GP records note, that on examinations, she had an imprint of a shoe on her body, finger marks on her arms and rope marks on her neck. On 13 December 2016, the SWA IDVA noticed that Theresa had a large bruise on the left side of her face which she said was caused by Charles hitting her round the face with a TV remote control. (See Overview Report para 16.74)

7.5.8. Theresa never told her parents that Charles used violence on her:

- On 11 October 2016, Theresa told the IDVA, that her parents had visited her at the weekend, they had asked how she hurt herself and she had replied that she had fallen. (See Overview Report para 16.36)

- On 3 November 2016, Theresa told her GP that she had tried to leave her husband, but he had attacked her and physically prevented her from leaving. She stated he had hit her with a metal pole across the left side of her abdomen. She said her husband had telephoned her parents and told them she had a drug and alcohol problem. She said she felt unable to confide in them and did not want the police involved. On examination, she was seen to have extensive bruising on the right side of her upper chest, right lower abdomen, left lower ribs, right arm, left lower arm and left upper outer thigh. (See Overview Report para 16.53)

7.5.9. Dr. [redacted] a forensic physician was used as an expert witness by Wiltshire Police. After examining photographs of Theresa's injuries and reading medical records, she concluded that whilst some of the injuries may be explained by falls onto a hard surface in her opinion these injuries are typical of repeated blunt trauma, such as punches with a fist, or another hard object, and/or repeated kicks. She stated it was highly unlikely that these repeated blunt trauma injuries resulting in bruising and swelling would have been self-inflicted. It was also highly unlikely that the injuries to the abdomen would have been caused by accidental trauma.

7.5.10. At the post mortem examination, several bruises were visible on Theresa's body and were detailed by the Pathologist in his report. (See Overview Report para17.16.2)

7.5.11. After Theresa's death, Charles made a witness statement to the police, in which he denied ever having been violent towards Theresa[6]. He included that once, during sexual intercourse, she had asked him to put a leather collar around her neck and the buckle left a mark on her neck. He added that Theresa often had bruises, as a result of sparring at Friday evening boxing classes. (See Overview Report Appendix D).Charles later provided

[6] Charles provided the Police with a further statement on 19 January 2019 when he reiterated that he had never assaulted Theresa.

the DHR with the name of the Boxing Club he thought Theresa attended. That club "Scrappers" was contacted by the DHR and had no record of Theresa having ever been a member. Other Gyms she attended had no record of her taking part in sparring activities or suffering any injury on their premise[7]

7.5.12. Whilst professionals from several agencies (including the GP Practice, Mental Health Services, Swindon Women's Aid, Hometruths and [redacted] Hospital) saw Theresa's injuries and had early reports from her on how those injuries had been sustained, their different policies, regulatory guidance and understanding of information sharing without consent, resulted in the police not being provided with all of the facts that were available at the time. The Home Office is leading on a recommendation from this Review, for unambiguous national guidance in respect of information sharing without consent when there is a risk of serious harm or death to an adult.

7.5.13. Theresa's mother, after reading this report, has asked that the following is added:

"About 2 weeks prior to my daughter's death we were visiting my daughter and the following conversation took place in front of (Charles), myself and my husband just as we were leaving.

(Theresa) – "Mom did I tell what (Charles) said to me".

Me - "No what did he say".

(Theresa) - "(Charles) said that he could snap my neck in a heartbeat, cut up my body and dissolve it in acid and no one would ever find me".

Me - I said to (Charles) "Are you sick? If I don't get hold of my child I will come looking for her".

(Theresa) - "I told you my mother would say that".

(Charles) - "Yes it is easy" and went on to explain how he would do this.

(Theresa) said this in a joking way as she was obviously petrified of him but wanted to let me know.

On leaving, I said to her that we must get together and sort out the Christmas meal and presents. She said that she had already ordered the meats from M&S and that there would be no presents this year (2017). I found this rather strange as (Theresa) loved Christmas and enjoyed spoiling people with gifts.

This was the last time I saw my daughter alive and I now ask myself, was (Theresa) trying to warn me of something. I mentioned this to the police and the review but yet there is no mention of this."
(Note: Proper names changed to pseudonyms by report author).

[7] Wiltshire Police also made enquiries in relation to gyms where boxing classes took place – Theresa was not a member at any of these – the gyms that were spoken to stated physical contact whilst sparring was rare and that any injuries caused would be recorded. There were no such records. Theresa made diary entries relating to her exercise - running and going to the gym, but there is only one reference to going to boxing. This was on 13 November 2017 10am to 11.30am.

Note: Charles has responded: "I do not accept (Theresa's mother's) verbatim account of a discussion that happened over 20 months ago. Her recollection of the conversation is somewhat different to what I recall. The conversation was related to a crime drama that we had watched on TV and I don't recall us discussing it in length or in depth as she describes. As she states the conversation was in a "joking way".

7.6. **Reported controlling behaviour**

7.6.1. Charles was described by Theresa's parents as "doting on her and being besotted with her from an early age." Theresa told the SWA IDVA that she had met Charles at school. He was her friend; however, she described him as displaying possessive behaviour towards her from a young age. During school, he would refuse to go to lessons and sat outside her classroom until the teachers became involved. Theresa's education was affected, as she could not concentrate in class. Looking back, she felt she never had a choice about being with Charles, as she has no experience of adult life without him. (See Overview Report para 16.33)

7.6.2. Theresa told the IDVA that during an argument, when they were dating, Charles had driven his car towards oncoming traffic, saying if he could not have her, no one would[8]. Her parents stopped her seeing him for a while but they were eventually reconciled and he did not do anything like that again. (See Overview Report para 16.27).

7.6.3. On 10 May 2017, Theresa, while explaining to police officers why she was afraid to report the assaults, said she was concerned that Charles had changed people's opinion to be against her and therefore she would never be believed. She described Charles as a psychopath, charming one moment and aggressive/abusive the next. Theresa stated that Charles was very intelligent and she felt he was able to track her movements and affect the settings on her phone even when she turned off options such as location settings. The Officers did see two webcams at Theresa's home. They also noted that Theresa had a large bruise on the inside of one of her arms, but when asked about it, she would not say how it had occurred. (See Overview Report para 16.122).

7.6.4. There were many reported examples of Charles monitoring Theresa's movements including allegedly turning up unexpectedly when she was planning to leave him, questioning her why she had parked the car in a different place, asking why she had been so long at the GP surgery, phoning the hospital when she was there for an x-ray to one of her injuries and later telephoning her twenty-seven times whilst she was at the GP Practice. (See Overview Report para 16.63).

7.6.5. On one occasion, Theresa could not understand how Charles had found money she had hidden in the house, only to later discover a camera hidden in her home office. "Theresa showed the SWA IDVA pictures of a camera that she had found hidden on the bookshelf behind her desk. She also claimed she had found a tracker device on the car. She said she was very scared and relived all the telephone conversations that she had had in the house and wondered how many of them (Charles) had overheard". (See Overview Report para 16.59). "She thought he was tracking her, as he seemed to know when she had been to the gym including one night at 3am." (See Overview Report para 16.133)

7.6.6. Theresa told the IDVA, that on another occasion she had built up the courage to leave home and had stayed overnight in a hotel. The next morning she went for a run and

[8] Theresa's brother confirmed this incident to the DHR as he was in the car with them .

soon after Charles arrived at the hotel to take her home. (See Overview Report para16.68).

7.6.7. Theresa claimed Charles had put an app on her mobile phone, which could tell him where she was at any particular time. She said there was a Tracker on the car and surveillance cameras at their home. She told the IDVA that Charles controlled all the money and he expected swift replies to his emails when he was away on business. He would read her text messages and emails; e.g., "He was suspicious that she was going to leave him, as he had read a text message on her phone from her Grandmother asking if she was OK." [9] (See Overview Report para 16.52)

7.6.7. On 2 May 2017, Theresa's situation was discussed at the Swindon Multi Agency Risk Assessment Conference (MARAC), following a referral from Swindon Mental Health Liaison after Theresa had made a suicide attempt by taking an overdose whilst drinking alcohol on 16 April 2017. The referral reiterated that Theresa was reporting being subjected to emotional and physical abuse and that her husband was stalking her. The MARAC considered information from her GP and from Hometruths that Theresa's resistance to change was based in fear and a belief that her husband would always be able to find her and harm/kill her, as he had been aware of previous occasions when she considered home. (See Overview Report para 16.120)

7.6.8. It is emphasised that Charles has never been charged with any criminal offence. He has consistently denied having been violent to Theresa. He has also explained that he had cameras installed at their home because Theresa was worried after two attempted burglaries and that he had apps on both their mobile phones so that they would know where each other were at any given time. As he worked away from home so often, he frequently contacted her by text and telephone. (See Overview Report Appendix D)

7.7. **Theresa's reluctance to leave home and her refusal to report her injuries to the police.**

7.7.1. The Review Panel acknowledges that Theresa's reluctance to leave Charles and her refusal to report alleged abuse to the Police whilst perhaps being frustrating for agencies keen to help her, are identifiably common behaviours for a victim of domestic abuse. Indicative research into the reasons women do not leave their abusers is highlighted in the Overview Report of this DHR.

7.7.2. The under-reporting of crime to the police is known to be particularly acute for domestic abuse offences, with many more offences committed than are reported to and recorded by the police. "Estimates based on those interviewed in the Crime Survey for England and Wales during the year ending March 2015 showed that around **four** in **five** victims of partner abuse (**79%**) did not report the abuse to the police".[10]

7.7.5. In Theresa's case there were several reasons, she put forward as explanations on why she did not want to leave Charles or to see him prosecuted. They included:

- Feeling isolated / Charles was her only contact. (Overview Report paras 16.74. 16.105)

[9] Charles has pointed out that Theresa was aware of the apps and she could have dispensed with it at any time. It is also known that Theresa's brother also shared such an app with her.

[10] Domestic Abuse: findings from the Crime Survey for England and Wales: year ending March 2017

- She had no experience of adult life without Charles. (Overview Report para 16.33)
- She was too scared to leave; she could not see a future for herself on her own. (Overview Report para 16.56)
- Theresa felt she would not be believed. She believed that Charles was very clever and people would always believe him. (Overview Report para 16.36. 16.51. 16.143)
- She would be without work/finances. (Overview Report para 16.32)
- She believed he would never leave her alone, he would always find her. (Overview Report para 16.62. 16.105)
- Threats of further violence towards her. She described Charles as a psychopath. (Overview report para 16.87)
- Fears for her family financially: Through working in Charles business, she was funding some family members still in South Africa. (Overview Report paras 16.24. 16.35)
- Charles threatened violence to family members. (Overview Report paras 16.86., 16.95. 16.102. 16.126)
- Threats from Charles that if she left him, he would reveal confidential information, relating to someone she cared about, that could destroy that person's life. (Overview Report para 16.56.)
- Theresa felt Charles had done so much for her family that she could not report him to the police for the assaults on her. (Overview Report paras 16.46. 16.105)
- If he was prosecuted, Charles would lose his job, which required him to have security clearance and a clean criminal record. Her family would then suffer. (Overview report para 16.35).
- She had a lack of confidence in the Police. (Overview Report para 15.9)
- The explanation from police officers of what action would take place, if she reported the abuse was not reassuring as they stated he would get bail without explaining how she would be supported or about DVPOs. (Overview Report para 16.106)
- Refuge places were frequently not available when she decided she might leave him. (Overview report para 16.151. 16.164. 16.170)

7.8. The PTSD, depression, the violence and abuse, concerns regarding police action, worries about her family and her feelings of resignation that no one could resolve her problems, led Theresa to feel a "mental torture" she could not escape. In her text message to the Swindon Women's Aid IDVA in February 2017, Theresa wrote:

"Please I need to know where to go from here as I feel without the right help when it comes to my mental health this is going to end badly." (See Overview Report para 16.93)

Also in the note she left for her brother when she took her own life, she stated, "the pain of living is too much and no matter what anybody does or says it's all on me. Just know that there is nothing you or anybody could have done to stop this."

7.9. The Wiltshire Police Investigating Officer stated that he suspected that Theresa denied the assaults to police because she knew Charles did not commit them and did not want him to get into trouble for something he did not commit.

7.10. Whilst it is for the Coroner's Inquest to deliberate on the cause of Theresa's death; the DHR Panel having considered the above factors, is of the opinion that the following contributed to Theresa's suffering

- T**he cross agency confusion regarding information sharing;**
- **The police failure to take timely positive action;**
- **The lack of available local refuge space at critical times for Theresa;**
- **The failure of agencies to recognise the warning signals of the increasing number of attempts by Theresa to self-harm.**
- **The failure of the MHCRT to positively respond to the telephone contact from NHS111 on the morning Theresa took her own life.**
- **The length of time it took the Police to send units to response to her telephone call that she was intending to take her own life.**

7.10. Events that occur after a death are normally outside the remit of a DHR, but in this case, the Panel considers that the lack of any investigation by the police officers who attended the scene of Theresa's death was a missed opportunity to search for and secure anything which may have clarified the reasons for Theresa's death or that could have supported or negated the information she had provided to agencies relating to domestic abuse. It was also a missed opportunity that a forensic post mortem was not requested. If such actions had been conducted Theresa's family would not have undergone the prolonged stress of the subsequent police investigation, and the Coroner and Domestic Homicide Review would have had more information to assist them.

Section 8 – Lessons To Be Learnt

8.1. The following summarises what lessons agencies have drawn from this Review. The recommendations made to address these lessons are set out in the Action Plan template in Section 20 of this Report.

8.2. Avon and Wiltshire Mental Health Partnership NHS Trust

8.2.1. Initially, there was not a sufficiently robust plan in place requiring the Mental Health Liaison to seek the advice of the Safeguarding Team. Staff were not clear regarding DASH and MARAC processes.

8.2.2. The lack of outcomes regarding the robust recommendations made (by senior members of the team) meant that significant information was not known by the rest of the team.

8.2.3. Information recorded in the progress notes was not always consistent when recording police reports relating to Theresa's suicide attempt in September 2017. Care needed to be taken to ensure the documentation was consistent and there was no disparity between teams. Disparity in the documentation can lead to confusion and the possibility of incorrect information being handed over.

8.2.4. Where Theresa reported domestic abuse to both PCLS and LIFT Psychology (March 2017) this should have been reported to the police and a MARAC referral made. Following discussion with team members, it was evident that the SIS team were not aware of the MARAC referral process and the need to make a new referral for every disclosed serious domestic violence incident. This lack of understanding (regarding the MARAC process) meant that the domestic abuse that Theresa had revealed was not reported accurately.

8.2.5. Some progress notes were not completed and validated in real time, as required under the AWP Health and Social Care Records Policy and associated guidance.

8.2.6. Staff were not all aware of rapid accesses processes in the SIS team.
(Not requiring referral from GP) Pressure of time was cited as the primary reason for progress notes not being completed or validated in real time.

8.2.7. The manner in which AWP Mental Health Services responded to NHS111's contact in relation to Theresa revealed a clear lack of clarity in the pathways between the services.

8.3. Care UK.

8.3.1. The Clinical Advisor could have considered an adult safeguarding referral for the caller. The caller (Theresa) had indicated that she was not receiving the care needed and was vulnerable.

8.3.2. There are few options available for clinicians to refer to for patients with mental health problems. Options are often limited to Hospital Emergency Departments or General Practitioners. The availability of mental Health services and the presence of care options on the Directory of Services (DoS) requires system review. (Note Care UK are no longer the 111service provider in Swindon however, the CCG has undertaken to ensure that the new provider signs up to a new care pathway to address this issue.)

8.4. [redacted] **Hospital**

8.4.1. The Hospital documentation demonstrates staff accessed/contacted the relevant services/team/people to protect Theresa. However, attempts to carry out additional risk assessments may have provided further information in respect of current risk.

8.5. Swindon Borough Council Adult Social Care

8.5.1. Members of the safeguarding team did screen the concerns raised regarding Theresa but following communication with the GP and SWA, considered she did not have care and support needs. As a result of each of the alerts, the team confirmed support was being made available from domestic abuse services, which appeared to be appropriate in the circumstances. However, more could have been done to obtain Theresa's views directly or to consider different approaches should this appear to be unsafe or difficult. Currently, there is a review of the function of the safeguarding team with a view to improve the responses from the screening/triage function.

8.5.2. With domestic abuse an "abuse type" referred to, in Care Act Guidance, there is a training need on Coercive Control. This is being arranged for all staff in adult services by 18 June 2018. There was also guidance from the Association of Directors of Adult Social Services and the Local Government Association, Adult Safeguarding and Domestic Abuse - A guide to support practitioners and managers. All staff in the safeguarding team have had this document circulated and to consider it as essential reading. Supervision sessions will check this awareness of the content of the document and further training on this subject will be delivered.

8. 6. Swindon Borough Council Housing Department

8.6.1. **Theresa** should have been contacted the day after the original telephone call (if she had agreed) and she should have been referred to the Domestic Abuse Housing Options Officer.

8.7. Swindon Clinical Commissioning Group & GP Practice

8.7.1. There is conflicting guidance from GMC to GPs on information sharing without consent where there is a perceived risk of serious harm or death to a patient.

8.7.2. GPs do not necessarily have an in-depth knowledge about the implications of the Care Act 2014. (The Swindon CCG is currently in the process of ensuring that all GP's have this training).

8.7 3. GP Practices in Swindon need to understand what action to take on receipt of a MARAC report in respect of one of their patients.

8.7.4. There is an apparent need for GP Practices to sign up to a Swindon-wide Safeguarding Protocol that would be kept up to date (by CCG) with new legislation.

8.8. Swindon Community Safety Partnership

8.8.1. Swindon Community Safety Partnership identified the need to ensure that domestic abuse practitioners working in the Swindon area fully understood legislation relating to stalking and coercive control coordinated training for Swindon Women's Aid and Homeththruths IDVAs and other Domestic Abuse operational personnel relating to technological abuse including the use of security and covert cameras, listening devices, vehicle tracking

equipment and mobile phone apps. Recommendations to embed this training into local and national Domestic Abuse Strategies are included within this report.

8.8.2. This review has identified that, due to differing professional guidance and interpretations of Data Protection Act, Information Sharing Codes of Practice and Care Act Safeguarding, in circumstances when consent to share has been withheld; practitioners are faced with critical dilemmas in situations when they have clear grounds to believe that an individual is at serious risk of harm or death if information is not shared. In this case, some organisations shared information with the police without Theresa's agreement, whereas others did not.

8.9. Swindon Drug and Alcohol Service (CGL)

8.9.1. Risk of domestic abuse was not acted upon when information relating to Theresa was received from her GP.

8.9 2. The disengagement protocol was not followed correctly in respect of Theresa.

8.9.3. Theresa should have been booked an Alcohol Nurse Assessment immediately after trigger points on AUDIT/SADQ were met.

8.9.4. Theresa's closure was not discussed at a Clinical Team Meeting.

8.10. Swindon Women's Aid

8.10.1. When a victim of domestic abuse contacts a refuge and there are no places available the person taking the telephone call should offer to check availability at other refuges and where safe to do so, telephone the victim back rather that expect the victim to make several calls herself. This did not always happen in Theresa's case, although it is noted that she was not always able to receive calls safely.

8.10.2. When Theresa self referred to Hometruths, Swindon Women's Aid did not have in place a structured referral pathway to ensure that Theresa received seamless support.

8.11. Wiltshire Police

8.11.1. Wiltshire Police policies for dealing with domestic abuse are up to date and in line with ACPO guidelines.

8.11.2. The Wiltshire Police policy and procedure on tackling domestic abuse gives guidelines to officers on taking positive action:

- Positive action includes arresting the suspected perpetrator for any offence disclosed. It is the decision of the attending officer whether or not to arrest a suspect and therefore victims should not be asked whether they require an arrest to be made.

- The requirement for 'positive action' means that in all domestic abuse cases, officers should consider the incident as a whole, not just the oral or written evidence of the victim.

- Officers must focus efforts from the outset on gathering alternative evidence in order to charge and build a prosecution case that does not rely entirely on the victim's statement. This is particularly important where at any stage the victim appears not to support a prosecution.

- The victim's views are always to be considered but the decision to arrest remains with the officer even if the victim does not wish to pursue a complaint. All actions will be taken in the interests of the victim in order to take the pressure and responsibility away from the victim.

- It is acknowledged that on occasion, the victim may not agree with the actions taken, however the overriding concern is to keep the victim safe. Only by protecting the victim can we be truly focused on the survivors of domestic abuse.

- Previous withdrawals of support for a prosecution should not adversely influence the decision making in whether to arrest for an offence.

- The Domestic violence definition does not require 'violence' to have been used and 'abuse' is much wider than any criminal allegations.

8.11.3. This was not an easy case for the Police to resolve, having to balance the need to take positive action with Theresa's wishes. The reports of domestic abuse on Theresa came to the police thorough other agencies. (Although Theresa did attend a Police Station the day prior to her death but had to leave to keep a GP appointment before being seen). When Theresa was spoken to by Police Officers and DAIT Safeguarding Officers, she stated that nothing had happened and she was not suffering any domestic abuse. She did however say that her husband was stalking her by monitoring her movements with cameras and a tracker. Had evidence been forthcoming, officers could have considered either the specific offence of stalking or the offence of controlling or coercive behaviour in an intimate or family relationship.

a. Stalking: The Protection of Freedoms Act 2012 amended the 1997 Act and created two new offences of stalking:

• Stalking (section 2A) which is pursuing a course of conduct which amounts to harassment and which also amounts to stalking

• Stalking (section 4A) involving fear of violence or serious alarm or distress

The offences came into force on 25 November 2012.

b. **Controlling or coercive behaviour :** The offence came into force on 29 December 2015.

An offence is committed by A if:

- A repeatedly or continuously engages in behaviour towards another person, B, that is controlling or coercive; and

- At time of the behaviour, A and B are personally connected; and

- The behaviour has a serious effect on B; and

- A knows or ought to know that the behaviour will have a serious effect on B.

There are two ways in which it can be proved that A's behaviour has a 'serious effect' on B:

- If it causes B to fear, on at least two occasions, that violence will be used against them - s.76 (4)(a); or
- If it causes B serious alarm or distress which has a substantial adverse effect on their day-to-day activities - s.76 (4) (b).

8.11.4. The report by the Community Psychiatric Nurse on 2 June 2017 did trigger a sequence of events that should have led to the arrest of Charles when he presented at [redacted] Police station and this was a missed opportunity. The delay in ultimately filing the police investigation was unacceptable and caused Theresa significant distress.

8.11.5. Theresa's death should have triggered a course of events aimed at gathering evidence; this should have included a forensic post mortem. The IMR Author concluded after having read the various chronologies, particularly from the GP that there were grounds to believe that Theresa had been subjected to repeated violence.

8.11.6. On the day that Theresa took her own life, there was a delay of sixteen minutes from the police control room receiving the call from Theresa to police officers being sent to her house. The call from Theresa had been treated as a call from a person with critical mental health problems rather that one where there was an immediate risk to life.

8.12. Actions re lessons identified prior to the adjournment of the Review in June 2018

8.12.1. National

8.12.1. There are broad principles relating to information sharing without consent set out in the Data Protection Act with an expectation that organisations should treat each case on its merits, in accordance with existing legislation and common law. However, the GMC guidance (which is highlighted in section 17.12 and Appendix G) may inhibit GPs from using their discretion to disclose to the police when a non-consenting patient is at risk of serious harm or death, for fear that they could be criticised or sued for failing to follow GMC Guidance.

8.12.1.2. The Home Office confirmed, on 8 May 2018, that discussions between the Home Office, the Department of Health and Information Commissioner on this issue are continuing and they anticipated to be in a position to provide a plan of action later this year. (2019)

8.12.2. Local

8.12.2.1. On 5 June 2018, the Review Panel notified agencies that although the review would be adjourned to await the outcome of the Wiltshire Police criminal investigation, the

recommendations to address lessons learnt should be implemented expeditiously for the safety of future victims of domestic abuse and individuals with mental health issues.

8.13. The DHR Panel's recommendations and up to date action plan at the time of concluding the review on 3 July 2019 is detailed in the template in Section Twenty of this report.

Section Nine - Recommendations from the Review

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion

In this DHR professionals from different organisations made conflicting decisions on whether to share with the police information relating to Theresa, without her consent when they believed she was a risk of serious harm or death. Some (including Mental Health Sevices, and Hospital) ,following the ICO Codes of Practice and Care Act decided to share; others (including Swindon Women's Aid and Hometruths) considered that Theresa had mental capacity to make her own decisions. An other (GP) followed the General Medical Council's Good Practice Guidance on handling Patient information(25/4/2017 onwards) paras 57-59; This divergence of opinion, adversely affected the support Theresa received. The DHR Panel therefore recommends that the Home Office draws to the attention of Dept of Health, NHS England and ICO what happened in Theresa's case and works with those Departments to provide to practitioners clear guidance which is in line with the ICO Code or Practice.	National	The Home Office agreed to raise the differing professional guidance and practice interpretation of the ICO Codes of Practice on information sharing without consent when there is a risk of serious harm or death, with other Government Agencies including ICO, Dept of Health and NHS England., Proposal sent to HO on 2 May 2018 as the DHR Panel felt that differing practice could put future victims at added risk. **The Home Office provided an update on 4 March 2019 that they are still in discussions with the Department of Health and Information Commissioner on this with a view to strengthening the statutory guidance which they will shortly commence updating with the intention to publish a revised iteration later this year**.	Home Office, ICO, Dept Health, NHS England	Home Office agreed to work with Dept of Health and The. InformationCommissioner to review this issue 9 May 2018		Ongoing at date of completion of the this review

That Community Safety Partnerships embed within their Domestic Abuse Strategies that IDVAs and DV practitioners receive training on legislation and practice relating to stalking and coercive control .This training should encompass technical abuse including the use of security and covert cameras, listening devices, vehicle tracking equipment and mobile phone apps.	National	1.Swindon Community Safety Partnership has already completed local training on this issue as a result of this DHR and are in the process of including it within their Domestic Abuse Strategy. 2. Home Office to cascade this nationally to other CSPs	Swindon Community Safety Partnership and Home Office	1 Training provided to Swindon Women's Aid and Hometruths in June 2019		1 Completed in Swindon.
For agencies to be aware of all available civil and criminal justice options to tackle perpetrators of domestic abuse.	National	Swindon CSP to prepare a practitioners guide to using civil powers under the ASB, Crime and Policing Act 2014, as a supplement to police and CPS powers, to tackle domestic abuse.	Swindon Community Safety Partnership Team	1st Draft produced. To be finalised	01/09/18	2 Ongoing
Commissioned Swindon Domestic Abuse Services should have clearly defined processes for supporting victims who may want to stay in relationship and DASS referrals to other support services	Local	1. Swindon CSP and SBC to draft contract variation for approval by Law and Democratic services. 2. Varied contract finalised by Commissioner	Swindon Community Safety Partnership Team		31/12/18	ongoing

For all members of the Swindon Intensive Team to be aware of patients who have a rapid access plan into services and to be aware of its purpose.	Local-AWP	1. Develop locality Safety Alert to highlight this RCA, the process for implementing a rapid access plan and ensuring its dissemination in teams. 2. Disseminate locality Safety Alert and ensure all teams respond to state that the Safety Alert has been shared and understood 3. Deliver brief training sessions on Rapid Access Planning to all staff in SIS team. 4. Develop and implement process to log all Service Users who have a Rapid Access Plan centrally and process to ensure staff check log when Service Users contact the team.	Avon and Wiltshire Mental Health Partnership NHS Trust	**1.** Alert to be sent out as directed. **2.** This will follow from point 1. **3.** The Intensive Team management will arrange deliver brief training at the next Governance meeting. This will be recorded in the meeting minutes. **4.** Completed. Assurance gained that staff continue to log all SU's Rapid Access Plan info on the SIS Discharge Planner.	31 July 2018	1. Due to be sent out 20.03.2019 2. From 1. 3. Senior practitioner to deliver in team Governance meeting 4. **COMPLETED**

To ensure that the Swindon Intensive Team update RiO with any outcomes of multi-agency processes.	Local-AWP	1. Discuss the need to follow up multi-agency advice requests and processes for outcomes in SIS Team Meeting and 1:1 Line Management Supervision 2. Review outcomes of referrals and advice requests in SIS planning meetings and handovers to ensure these are followed up.	Avon and Wiltshire Mental Health Partnership NHS Trust		30 May 2018	**Actions COMPLETED.** Discussion with the team in team meetings has been had in addition to Line Management Supervision. Planning meetings now ensure that referrals and advice requests are now followed up.

Ensure that the Swindon Intensive Team validate progress notes in real time.	Local AWP	1. Discuss need to validate progress notes in SIS Team Meeting. 2. Review progress notes validation as part of IQ Records Management audit.	Avon and Wiltshire Mental Health Partnership NHS Trust	**1.** Complete. Previously discussed in the Intensive Service's Governance Meetings on the 31st August, 21st September and 25th October 2018 - Evidence in meeting minutes. Intensive Team management will reiterate the need for real time validation of progress notes in shift handovers and again in the next Governance meeting. **2**. Progress Notes validation will be/is managed through IQ Records Management Audit by Intensive Team management alongside monthly audit using the five random samples that are generated in line with IQ, Management Team will also check validation of progress notes ad hoc or if indicated.	30July 2018	**COMPLETED.**

Named Professional for Safeguarding Children and Domestic Abuse to work alongside Swindon teams to ensure the use of the DASH risk assessment tool (following disclosure of domestic abuse) and understanding of the MARAC processes.	Local AWP	1. Named Professional to attend Locality Quality and Standards Meeting to deliver awareness raising session on MARAC processes.2. Team Managers to use the Trust Safeguarding Checklist in Line Management Supervision to ensure appropriate Safeguarding processes have been followed where there is reported domestic abuse. 3. Named professional to attend Team Meetings for LIFT, MHCRT, SIS and PCLS to deliver awareness raising sessions on MARAC processes. 4. Carry out audit of records of cases where there is known domestic abuse to ensure appropriate safeguarding processes have been followed.	Avon and Wiltshire Mental Health Partnership NHS Trust	**1.** Completed: Named Professional attended the Swindon Q&S meeting in June 2018. **2.** Intensive Team management will add the Trust Safeguarding Checklist to the staff supervision form as a prompt to discuss any SUs that provide evidence indicating that safeguarding needs to be raised and ensuring this is done in a timely and accurate manner. **3.** Completed: See point 1. **4.** Swindon Quality & Improvement Lead has requested, and the Intensive Team Management team have confirmed, they will audit records of SU's cases where there is known domestic abuse to ensure appropriate safeguarding processes have been followed. Further audits to take place by Swindon Quality & Improvement Lead.	30 November 2018	1. **COMPLETED.** 2. Senior practitioner will complete 3. **COMPLETED.** 4. Ongoing
For teams to ensure that there is no disparity when documenting information regarding the same incident.	Local AWP	Develop locality Safety Alert highlighting this incident and the expected standards of record keeping in progress notes. Disseminate locality Safety Alert and ensure all teams respond to state that the Safety Alert has been shared and understood Monitor quality of progress notes on monthly basis in team though IQ Records Management audit.	Avon and Wiltshire Mental Health Partnership NHS Trust		30 May 2018	Actions **COMPLETED..** Local Safety Alert has been disseminated and progress notes continue to be monitored monthly.

1. Develop locality Safety Alert highlighting this incident and the expected standards of record keeping in progress notes. 2. Disseminate locality Safety Alert and ensure all teams respond to state that the Safety Alert has been shared and understood 3. Monitor quality of progress notes on monthly basis in team though IQ Records Management audit.	Local	3. Named professional to attend Team Meetings for LIFT, MHCRT, SIS and PCLS to deliver awareness raising sessions on MARAC processes.	Avon and Wiltshire Mental Health Partnership NHS Trust		30 May 2018	**COMPLETED.**
Mental Health Services to develop clear pathways to support 111 advisors and clinicians to gain advice and support regarding possible referrals to Mental Health Services and enable appropriate direct referrals without service users in crisis having to go back to the their GP.	Local	The actions associated with this recommendation will be taken forward as part of the project AWP are currently undertaking as commissioned by B&NES CCG to work with Medvivo to develop these pathways. This work is currently in the scoping phase and therefore more detailed actions will arise from the outcome of this.	Avon and Wiltshire Mental Health Partnership NHS Trust	Care UK is no longer the Swindon 111 service provider, however Swindon CCG has undertaken to ensure that the new provider is aware of this pathway and also has a mechanism in place to ensure it is monitored initially.	31 December 2018	Ongoing
1-2-1 supervisor feedback should be provided for clinician involved	Local to the South West call centre	Book feedback session with the CA, listen to the case and get the CA to reflect on their actions.	CARE UK	Room has been booked and interview set up to enable feedback/reflection	1 October 2018	**COMPLETED.** 1 November 2018
Reflective statement addressing current and future practice, with particular attention to adequate safety-netting.	Local to the South West call centre	This will be formulated as a result of the above meeting.	CARE UK	Room has been booked and interview set up to enable feedback/reflection	1 October 2018	**COMPLETED.** 1 November 2018

Clinician involved to ensure up to date with adult safeguarding training.	Local to the South West call centre	Check with training manager on training status and arrange time for CA to complete	CARE UK	CA is currently up to date with training however will be undertaking own CPD on mental health	1 November 2018	**COMPLETED.** 1 November 2018
Clinical lead to raise mental health safeguarding with safeguarding lead to try and identify patterns in referrals. If there is a lack of appropriate referrals or a training need is identified, it will be raised with the national safeguarding lead	Local/National	Meet with safeguarding lead and review past 6 months of mental health safeguarding referral and review cases that have the potential to be safeguarded	CARE UK	Meeting with the safeguarding lead.	1 October 2018	Target **COMPLETED** on1st January 2019
Ensure all staff are up to date with mandatory training - level 2 (health advisors) and level 3 (clinical advisors)	National	This is already reviewed across Care UK monthly and will continue to be monitored	CARE UK	Monthly review	1 October 2018	Ongoing yearly
111 Care UK leads to continue to contribute to discussions at a CCG level regarding the availability of mental health services	Regional	Clinical lead to continue to push the subject of mental health	CARE UK	NA	1 October 2018	**COMPLETED.** 1 November 2018

Consideration of the use of the DASH risk assessment: Where there is a known risk domestic abuse clinical 'alerts' must signpost staff to consider DASH risk assessments	Local	**COMPLETED**	[redacted] Hospital	There was no Trust wide Domestic Abuse policy in place at time of intervention. However, a policy has now been established and ratified and is being rolled out Trust wide from April 2018. When a disclosure of domestic abuse is made this document will clearly guide staff working in the Emergency Department, Minor Injury Units, Urgent Care, and Walk in Centre & Maternity to complete the Safe Lives DASH Risk Checklist which will enable an assessment of the level of risk that the victim is subjected too.	31.05.2018	**COMPLETED. April 2018** Domestic Abuse Policy fully ratified and implemented **03.05.2018 COMPLETE** Domestic Abuse Policy formal launch 03.05.18 all clinical areas, including SWICC were visited that day by Safeguarding Lead (acute) and IDVA (Swindon WA)

Agree 'alert' terminology on the electronic patient record to ensure when relevant, staff consider the use of DASH risk assessment	Local	**COMPLETED**	[redacted] Hospital	A current alert system is in place for all domestic abuse cases referred and discussed at MARAC. However, following investigation it is acknowledged this does not guide staff to consider frequency of attendance and to consider DASH.	31.05.2018	**03.05.2018COMPLETED.** Request discussed with GWH MARAC representative statutory wording agreed. This will guide staff to consider DASH within the MEDWAY alert. This will be applied to <u>all</u> future cases where GWH attend MARAC.

Specialist Safeguarding Supervision for all enquiry managers will include identifying if there has been appropriate involvement of service users in their safeguarding cases, focus on alleged DA and multi agency arrangements.	Local	Engage supervision to provide specific supervision All adult safeguarding staff to "sign up" for these (mandatory) sessions UPDATE: Since reorganisation of safeguarding arrangements with adult services, this supervision has been extended to key staff acting as Enquiry Managers within the care team	SBC Adult Social Care	>Identify suitably experienced person to carry out sessions >Arrangement of sessions >scope of session to include areas highlighted in review >All staff allocated session and time to attend. [redacted] started this work (with another session planned 3rd May). [redacted] is Regional Association of Director or Social Services (ADASS) project manager, but is working on this role outside of ADASS role.4 sessions set op 23rd April. Another 3 sessions and a group supervision set up for 3rd May. Following feedback from the 2 days, arrangements with future sessions will be made.	23 April 2018	**COMPLETED**. 23rd April 2018 -
Making Safeguarding Personal (MSP): (initiative to ensure service users views throughout the safeguarding process) to be revisited to ensure direct involvement (rather than 3rd party) is a feature of all safeguarding cases – wherever possible	Local and Regional	Regional conference being established to focus on MSP - operational staff to attend.	Association of Directors of Social Services	Conference and workshops within it will have sessions on MSP and how coercive controlling behaviour may influence views held by individuals subject to safeguarding procedures >Report back to Local Safeguarding Board 5 Swindon representatives attended the conference, reported back to LSAB in August 2018	22 June 2018	**COMPLETED**.

Making Safeguarding Personal (MSP): (initiative to ensure service users views throughout the safeguarding process) to be revisited to ensure direct involvement (rather than 3rd party) is a feature of all safeguarding cases – wherever possible	Local	An overview of Coercive and Controlling behaviours along with any other new and emerging themes will be included in the annual Safeguarding Adults Refresher training all staff attend.	SBC Adult Social Care	>Consider suitable trainer >If existing trainer - brief her on current issues >Arrange training event(s) (also, to be included in specialist safeguarding supervision) Training to include other adult care teams as possibility of them managing safeguarding cases New Team manager started 2nd Jan 2019 who is committed to promoting MSP.	30 September 2018	**COMPLETED**.
A full action plan has been drawn up through the Local Safeguarding Adults Board (LSAB) following a Safeguarding Adults Review SCIE Review where Coercive Control was considered to be a factor	Local (but with some Regional learning)	The Head of Social Work has arranged formal training in relation to "Coercive Control & Domestic Abuse" over three dates in May and June 2018, LSAB to include links to related policy/guidance within Safeguarding Adults Procedures, including ADASS 2015 'Adult safeguarding and domestic abuse: A guide to support practitioners and managers'.	SBC Adult Social Care	>all relevant staff to attend training >Policy and Procedures includes ADASS document >safeguarding staff to reread document - for discussion in supervision >LSAB webpage to include this document	30 June 2018 30 April 2018	**COMPLETED.**
Provide training to the Housing Options Team to ensure all cases involving domestic abuse are referred to the appropriate officer and that we should always seek agreement from domestic abuse victims to contact them at a time and via a way that is chosen by them.	Local		SBC Housing	Training provided and completed		**COMPLETED.**

GP's need to be trained in more detail about the implications of the Care Act 2014. The Swindon CCG is currently in the process of ensuring that all GP's have this training.	Local	To include adult safeguarding training in teaching sessions to GP practices. In the interim all GP safeguarding practice Leads will have this training and they will be required to ensure that all their staff are aware of these implications.	Swindon CCG	All GPs receive training about Care Act 2014	May 2018 for direct teaching to practices. Adult safeguarding training will take place on September 25th 2018 and all leads will be asked to cascade information to their staff following this training. (All practices are covered over a year period.)	ongoing

A review should take place on whether the law / GMC guidance should be changed enabling a GP to contact the police if they believe that a patient is at high risk of serious harm or death if they go home to a domestic abuse situation even if no one else would be at risk other than the patient.	National	This is part of the first recommendation of this DHR (see above) but should be supported by a letter to GMC from Swindon CCG. Outcome to be disseminated to all GP practices.	Home Office/ Swindon CCG			ongoing (linked with ongoing Home Office Action above)
Swindon CCG to continue to put together a Safeguarding Protocol that all surgeries are required to sign up to that will be kept up to date (by CCG) with new legislation. This would include domestic abuse information and what actions a GP practice should take on receipt of a MARAC report for one of their patients.	Local	Action already taken: All current safeguarding policies have been requested from GP practices in Swindon. Action to still take: to review and collate to form a unified Safeguarding Protocol following receipt of the pratice protocols. To include in the NHSE funded safeguarding development monies on DVA and primary Care	Swindon CCG	Safeguarding protocol for all GP practices launched.		**COMPLETED.**

All personnel should be reminded of the policy that: 1. The "Missed Appointment Matrix" is to be followed for all clients – especially prior to closing. 2.Workers. to double check hard copy file for client's preferred method of contact and follow this course of action first. 3.If paperwork received from external partners – the allocated worker to be notified and given the paperwork before admin scan it to the document library to help ensure that potentially vital information is received. 4. A contact note should be put on record indicating a new document has been scanned.	Local		Swindon Drug and Alcohol Service (CGL)	All staff to be notified of this requirement		**COMPLETED.**1 May 2018
When a victim of domestic abuse contacts the Refuge and there are no places available, the person taking the telephone call should offer to check availability at other refuges and if safe to do so, phone the victim back rather that expect the victim to make several calls herself.	Local	Policy agreed and all refuge staff be notified	Swindon Women's Aid	Memo detailed policy sent to all staff on 2 May 2018. discussed at staff meeting on 4 May 2018		**COMPLETED.** 4 May 2018

Swindon Women's Aid require a structured Referral Pathway Protocol for those occasions when a survivor of domestic abuse moves to another service provider.	Local	Draft, approve and disseminate a Referral Pathway protocol	Swindon Women's Aid	Referral Pathway written and disseminated to all staff		**Completed 19 July 2019**
Close DA offence investigations to only on the written authority of an inspector if the suspect has not been interviewed or arrested.	Local	Where criminal offences have been disclosed in domestic violence cases and the suspect has not been arrested or interviewed, investigations will only be closed on the written authority of an Inspector. The Inspector must satisfy him/herself that positive action has been taken.	Wiltshire Police	This is now written into force DA policy and was communicated to all officers and staff on the 06/03/2019.	1 July 2018	**COMPLETED.**14/03/2019

Evidence led prosecutions audit to take place	Local	Wiltshire Police should review victimless prosecutions to ensure 3rd party material is utilised effectively in the absence of victim testimony.	Wiltshire Police	A number of audits have taken place, mainly around domestic abuse to benchmark our current investigative standard and to identify areas for improvement. Audits have recently led to a force wide campaign to raise awareness of why victims may not engage with a prosecution and how we can build evidence led prosecutions, another audit finding has led to the change in Policy that all DA offences where no interview is to take place must be authorised by an Inspector. All ERO's have had additional training delivered by a former CPS crown prosecutor in relation to evidence led prosecutions, this includes the importance of first response such as utilising BW camera footage, 999 calls, previous history etc, capturing the evidence in terms of witnesses, House to House, CCTV, Digital media etc. understanding Res Gestae, the significance of section 78 of PACE and how documentation a victims fear can help avoid hearsay evidence from being excluded.	31 December 2018	**COMPLETED.** 14032019
Criminal Investigation into alleged perpetrator to be considered	Local	Wiltshire Police should consider the viability of conducting a criminal investigation into offences committed against Theresa by her husband.	Wiltshire Police	Investigation ongoing commenced and being managed by MCIT.	Ongoing	**COMPLETED** 14/03/2019

Consideration to be given to a stalking and harassment clinic.	Local	PPD DA DI to drive forward the potential of a stalking and harassment clinic in both Wiltshire and Swindon at the relevant safeguarding board subgroups.	Wiltshire Police	Stalking and Harassment clinics in Wiltshire and Swindon are being scoped by [redacted] who is now the force tactical lead for Stalking and Harassment.	31 December 2018	**COMPLETED** 14/03/2019
All high risk cases should be referred back to MARAC when another incident occurs regardless of whether an offence has been committed or not.	Local	All high risk cases should be referred back to MARAC when another incident occurs regardless of whether an offence has been committed or not.	Wiltshire Police & MARAC	The process of MARAC referrals has been changed so that a professional decision is made by the DACC coordinator if a further DA incident is appropriate to be referred back into the MARAC process.	1 September 2018	**COMPLETED** 14/03/2019
When the police receives a call from a person with critical mental health issues which may indicate a risk of serious harm or death, in addition to referring the caller to the in-house mental health Street Triage Team the call should be treated as a Grade 1 call requiring an immediate response.	Local (Wiltshire Police area wide)	1. Update crisis and negotiator training given to CCC staff to ensure that any suicide concern is dealt with as a priority. 2. Messaging to all CCC staff reminding them of the importance of tasking a unit to suicidal callers before attempting to seek mental health support.	Wiltshire Police	Crisis and Negotiator training is provided to all new crime and communication centre recruits by the Force lead Negotiator. This training already includes support for dealing with suicidal callers in crisis.	1 July 2019	