West Berkshire District Council
Safer Communities Partnership

Domestic Homicide Review relating to the death of Karen in September 2018

Overview Report

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CONTENTS

A message of condolence

The Domestic Homicide Review panel and the independent Chair wish to offer their condolences to Karen's family.

From our contact with them, we know that her loss has been, and continues to be deeply felt by them.

It is our hope that this review provides some answers to their questions and this will help them as they adjust to life without her.

1. Introduction

1. This Domestic Homicide Review (DHR) Overview Report examines agency responses and support given to Karen, a resident of West Berkshire, prior to her murder in September 2018.

2. Karen's death was notified to the West Berkshire (CSP) in September 2018. Following her death there was a criminal investigation. This investigation led to the trial of the perpetrator, Martin, who was found guilty of murder and sentenced to 21 years imprisonment.

3. West Berkshire Community Safety Partnership CSP determined that this case met the criteria for a DHR. The purpose of a DHR is to:

   a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

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

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

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

   e) contribute to a better understanding of the nature of domestic violence and abuse; and

   f) highlight good practice.

4. In addition to agency involvement the DHR has examined the past to identify any relevant background or incidences of domestic abuse or violence before the homicide, whether support was accessed with the community and whether there were any barriers to accessing support. By taking a holistic approach this DHR has sought to identify key issues for learning and to make appropriate recommendations for action.

2. Timescales

5. In May 2019 a process was completed to appoint an independent Chair and author and the formal contract was agreed. The DHR formally commenced at that stage. A first panel meeting was held in May 2019, following a period of scoping and then IMR completion and submission. The process was concluded in April 2020. The DHR panel met three times in person. It also met by teleconference and video as a result of restrictions imposed during the COVID-19 outbreak. The Chair also held discussions by phone with the DHR lead within West Berkshire Council CSP. The commencement of the review was delayed due to ongoing court proceedings.

3. Confidentiality

6. The DHR was conducted in private. All documents and information used to inform the review are confidential. The findings of the review should remain confidential until the CSP accepts the Overview Report, Executive Summary and Action Plan.

7. Pseudonyms have been used in this Overview Report to ensure confidentiality. The victim is represented by pseudonym Karen. Her partner (the perpetrator) is represented by the name Martin. The family were consulted about choosing a pseudonym but preferred that one was chosen at random.

8. The victim was aged 28 at the time her death was notified. Her partner, Martin was aged 30 at the time of Karen's death being notified. Both were white British.

4. Terms of Reference

Terms of Reference were agreed. These were discussed by panel members, the independent chair and with family members. The Terms of Reference were as follows:

1. Examine the events leading up to the incident including the actions of relevant agencies

2. Review the communication between agencies, services, friends and family including the transfer of relevant information to inform safeguarding, risk assessment and management

3. Examine how organisations adhered to their own local policies and procedures and ensure adherence to national good practice

4. Review documentation and recording of key information, communication, case management and service delivery of all the agencies involved. Including, but not limited to, access to Police records, legal proceedings' documents and witness statements

5. Produce a report that summarises the chronology of events, analyses and comments on the actions taken, and makes any required recommendations

In addition, the following areas will be addressed in the Individual Management Reviews and the Overview Report:

- Was the victim known to local domestic abuse services, was the incident a one-off or were there any warning signs. Could more be done to raise awareness of services available to victims of domestic abuse?

- Were there any opportunities for professionals to routinely enquire as to any domestic abuse experienced by the victim that were missed?

- Are there any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of the services available?

- Give appropriate consideration to any equality and diversity issues that appear pertinent to the victim, perpetrator and dependent children.

5. Methodology

9. The decision to undertake the DHR was made by the CSP having received information from the police about the nature of Karen's death and the CSP was satisfied that the case met the criteria for undertaking a DHR.

10. An initial scoping process was undertaken to establish the agencies and organisations that had contact with Karen and Martin. As part of this process a list of agencies and relevant contacts was developed and a timeline was created. This process enabled the gathering of information about types and level of contact and informed the decisions about which agencies and organisations to approach to request Individual Management Reviews.

11. Individual Management Reviews (IMRs) were requested from agencies to establish if there had been contact with Karen and Martin and if so, the nature of that contact and any services or interventions provided to them.

12. The objective of the IMRs which form the basis for the review report was to provide as accurate as possible, an account of what originally transpired in respect of the incident itself and the details of any contact and/or service provision by agencies with both Karen and Martin.

13. The IMRs were to review and evaluate this thoroughly, and if necessary, to identify any improvements for future practice. The IMRs were also to assess the changes that have taken place in service provision during the timescale of the review and considered if changes are required to better meet the needs of individuals at risk of, or subjected to domestic abuse.

14. The IMRs have been signed off by a responsible officer in each organisation and have been quality assured and approved by the review panel.

15. This Overview Report is based on IMRs commissioned from local agencies as well as summary reports and scoping information. The report's conclusions represent the collective view of the review panel, which has the responsibility, through its representatives and their agencies, for fully implementing the recommendations that arise from the review.

6. Involvement of family, friends, work colleagues, neighbours and wider community

16. The panel has sought throughout the review to ensure that the wishes of the surviving family members have informed the DHR Terms of Reference and are reflected in the DHR report.

17. The family were provided with the Home Office leaflets and were provided with information about specialist advocacy. Karen's mother was in receipt of advocacy support from AAFDA[1] throughout the process of the DHR.

18. The Independent Chair met with Karen's mother and sister to both advise and update on the process, but also to seek their insights and views, and to gain a better sense of Karen as a person. This meeting took place at Karen's mother's home and the advocate accompanied the Chair from AAFDA for that meeting.

19. Family members were provided with a draft copy of the DHR Overview Report prior to its finalisation and approval and their comments have been incorporated into the report.

7. Contributors to the review

20. Following an initial scoping exercise, a number of agencies contributed to the review through the submission of IMRs, chronologies or reports. Those agencies were:

- A2Dominion[2]
- Berkshire Healthcare NHS Foundation Trust
- National Probation Service
- Nottinghamshire Police
- Nottinghamshire Healthcare NHS Foundation Trust
- Priory Group
- Royal Berkshire Hospital NHS Foundation Trust
- Sovereign Housing Association
- Swanswell
- Thames Valley Police
- West Berkshire Clinical Commissioning Group (primary care)

[1] AAFDA – Advocacy After Fatal Domestic Abuse, is a national charity providing advocacy and support to families

[2] A2Dominion provides domestic abuse support services in W Berkshire, Oxfordshire and Buckinghamshire. This service is provided as part of a range of other services, including housing, that A2Dominion offer.

- West Berkshire Council Children's Services

21. People who were independent, in that they had no knowledge or connection with the case had produced all the IMRs received.

8. The review panel members

Steve Appleton	Independent Chair and author
Adrian Brunskill	Regional Housing Manager, Sovereign Housing
Beth Sillito	Detective Inspector, Thames Valley Police
Claire Knibbs	Detective Chief Inspector, Thames Valley Police
Tess Snelgar	Detective Constable, Thames Valley Police
Mike Harling	Principal Social Worker, West Berkshire Council Adult Social Care
Elizabeth Porter	Safeguarding Lead, Royal Berkshire Hospital NHS Foundation Trust
Sue Carrington	Domestic Abuse Practitioner, Berkshire Healthcare NHS Foundation Trust
Patricia Pease	Associate Director Safeguarding, Royal Berkshire Hospital
Juliet Penley	Principal Social Worker, West Berkshire Children's Services
Kathy Kelly	Head of Safeguarding Adults, West Berkshire CCG
Melanie Smith	Head of NPS Berkshire, Probation Service
Lorna Skae	Service Manager, A2Dominion Domestic Abuse Service
Nimah Donnelly	Director of Operations, Cranstoun Drug Services/Swanswell[3]
Susan Powell	Building Communities Together Partnership Manager, West Berkshire Council
Jade Wilder	Community Coordinator – Prevention, West Berkshire Council

22. The members of the panel were independent and had no prior contact with the subjects of the DHR or knowledge of the case.

9. Chair of the review panel and author of the Overview Report

23. The independent Chair of the panel and author of the DHR Overview Report is Steve Appleton. Steve trained as a social worker and specialised in mental health, working as an Approved Social Worker. During that time he worked with victims of domestic abuse as part of his social work practice. He has held operational and strategic development posts in local authorities and the NHS. Before working independently, he was a senior manager for NHS

[3] Swanswell is part of the Cranstoun Group

South Central Strategic Health Authority with particular responsibility for mental health, learning disability, substance misuse and offender health.

24. Steve is entirely independent and has had no previous involvement with the subjects of the DHR. He has considerable experience in health and social care and has worked with a wide range of NHS organisations, local authorities and third sector agencies. He is a managing director of his own limited company, a specialist health and social care consultancy.

25. Steve has led reviews into a number of high profile serious untoward incidents particularly in relation to mental health homicide and safeguarding of vulnerable adults. He has also led investigations into professional misconduct by staff and has Chaired a Serious Case Review into an infant homicide. He has Chaired and written over 30 DHRs for local authority community safety partnerships across the country. He has completed the DHR Chair training modules and retains an up to date knowledge of current legislation.

26. Steve as independent and author has never been employed by any of the agencies concerned with this review and has no personal connection to any of the people involved in the case.

10. Parallel reviews

27. There were no parallel reviews undertaken in relation to this case. At the time of writing no inquest has been held.

11. Equality and diversity

28. The panel has been mindful of the need to consider and reflect upon the impact, or not, of the cultural background of Karen and if this played any part in how services responded to her needs.

29. "The Equality Act 2010 brings together the nine protected characteristics of age, disability, gender reassignment (with a wider definition) marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation."[4] There are further considerations relating to income and pay gaps, the gender power gap in public sector leadership positions and

[4] Paragraph taken from Home Office Domestic Homicide Review Training; Information Sheet 14. P47

politics, and the causes and consequences of violence against women and girls, under the Gender Equality Duty.[5]

30. The nine protected characteristics in the Equality Act were considered and sex, in relation to Karen was found to have direct relevance to the review. This decision was taken in the context of the greater prevalence of domestic abuse and violence perpetrated towards women, thus as a woman, Karen was at greater risk. The panel ensured that the review always considered issues relating to the nine characteristics in their thinking about the engagement and involvement of organisations and professionals and where identified, the impact of them on decision making and whether these presented a barrier to accessing support and assistance.

12. Dissemination

31. The Overview Report will be sent to all the organisations that contributed to the DHR. In addition, an appropriately anonymised electronic version of the Overview Report will be placed on the CSP website. A copy will be provided to the Thames Valley Police and Crime Commissioner.

32. Members of the family have been provided with copies of the Overview Report.

13. Background information (The Facts)

33. Karen was a 28 year old woman. She had two children with Martin. The children were adopted as a result of concerns about their welfare and there was no ongoing contact with them. The perpetrator has two other children from a previous relationship with Karen's half-sister. He also has another child with another partner.

34. Karen was not in paid employment at the time of her death.

35. Karen grew up in West Berkshire. Her parents separated and she lived with her mother within a foster family for a period, although there is limited information about this period or the effect it may have had. She had received cautions from the police for offences relating to theft, driving a vehicle without consent and handling stolen goods. She had two convictions; one for criminal damage and another for wilfully insulting a justice.

[5] Gender Equality Duty 2007. www.equalityhumanrights.com/.../1_overview_of_the_gender_duty

36. Martin had been in contact with community mental health services locally as well as with mental health services in Nottinghamshire and Wales. He had spent time in prison in Nottinghamshire and was also known to probation services.

37. Martin was a looked after child from the age of 11. He had a lengthy criminal history and by the time of the murder, he had 39 convictions relating to theft, damage to property, resisting arrest, breach of restraining orders, public order offences, assaults and one sexual offence, that of sexual activity with a child.

38. In September 2018, Martin phoned the police in the early hours of the morning. In that call he reported that he had mental health issues and that he had; 'had an episode and I've killed my girlfriend'. Police attended Karen's home address along with paramedics and although extensive life-saving efforts were made, she was declared deceased. She had received stab wounds to her neck and chest. It is believed that she may have lost consciousness prior to be being stabbed, through sustained strangulation.

39. There was a 11-year history of domestic abuse perpetrated by Martin against Karen. This had been ongoing since the start of their relationship, when Karen was 17 years old.

40. During their relationship, Karen and Martin had periods of separation, sometimes when Martin was in prison, or in hospital and others where the relationship was in abeyance. According to her mother, Karen always restarted the relationship.

41. It is known that Martin had perpetrated domestic abuse with other women, including Karen's half-sister, with whom he had two children. That relationship ended due to Martin's domestic abuse.

42. Karen was known to have a diagnosis of unspecified personality disorder. A person with a personality disorder thinks, feels, behaves or relates to others very differently from the average person. A person with borderline personality disorder (one of the most common types) tends to have disturbed ways of thinking, impulsive behaviour and problems controlling their emotions. They may have intense but unstable relationships and worry about people abandoning them.[6]

[6] Definition of personality disorder: https://www.nhs.uk/conditions/personality-disorder/

43. Karen also lived with epilepsy, for which she took medication and also had partial hearing loss.

44. Martin is believed to have been given a diagnosis of ADHD in childhood, but it is not clear by whom or exactly when.

45. In January 2018, he received a diagnosis of dissocial (sometimes known as antisocial) personality disorder. Antisocial personality disorder is a particularly challenging type of personality disorder characterised by impulsive, irresponsible and often criminal behaviour. Someone with antisocial personality disorder will typically be manipulative, deceitful and reckless and won't care for other people's feelings. Like other types of personality disorder, antisocial personality disorder is on a spectrum, which means it can range in severity from occasional bad behaviour to repeatedly breaking the law and committing serious crimes.

46. A person with antisocial personality disorder may:

- exploit, manipulate or violate the rights of others
- lack concern, regret or remorse about other people's distress
- behave irresponsibly and show disregard for normal social behaviour
- have difficulty sustaining long-term relationships
- be unable to control their anger
- lack guilt, or not learn from their mistakes
- blame others for problems in their lives
- repeatedly break the law.

47. A person with antisocial personality disorder will have a history of conduct disorder during childhood, such as truancy (not going to school), delinquency (for example, committing crimes or substance misuse), and other disruptive and aggressive behaviours.[7]

48. Martin also had issues in relation to substance misuse and had reported occasions when he experienced drug-induced hallucinations. He was reported to have had an addiction to crack cocaine and was using extensively in the period prior to Karen's death, including on the day before her murder.

[7] https://www.nhs.uk/conditions/antisocial-personality-disorder/

49. Following his arrest, Martin pleaded not guilty to murder, using the partial defence of diminished responsibility, giving mental health problems as a contributing factor in his actions.

50. At his trial at Reading Crown Court in March 2019, Martin was found guilty of murder by a unanimous decision by the jury. The presiding Judge, His Honour Judge Dugdale described Martin as; "a jealous, controlling and violent man." Martin was sentenced to life imprisonment with a minimum term of 21 years.

14. Chronology

51. A combined chronology has been developed and is provided in a separate document which accompanies this Overview Report. The detail of dates and types of contact are contained in the chronology document and have been drawn from the IMRs and their chronologies.

15. The views of Karen's mother

52. The Chair of the DHR spoke with Karen's mother, in the company of Karen's sister and their advocate from the charity, Advocacy After Fatal Domestic Abuse (AAFDA). This meeting provided an opportunity to gather further insights and ensure that Karen's mother had the chance to input to the review. For the purposes of the DHR and to maintain confidentiality, Karen's mother is represented by the name Tessa and her sister by the name Bella. The meeting took place at Tessa's home.

53. The discussion started with the Chair describing the process of the DHR. Some of this had been set out for her in a letter from the Chair and also in conversations between Tessa and her advocate. However, it was felt important to restate the aims of the DHR and to ensure Tessa had the chance to ask any questions she might have about the process.

54. Tessa described how Karen had met Martin when she was 17 and embarked on a relationship together. During this time, their relationship was on and off, largely due to the periods that Martin spent in prison. Tessa said that Karen moved out of the family home to be with Martin when she was 18. She described how Karen was initially happy with Martin but that it was not long before the relationship became problematic.

55. Tessa described how Karen would always make excuses for Martin's behaviour, whether it was his offending against others or the domestic

abuse he inflicted upon her. She said that Karen and Martin would argue regularly and often in front of her when visiting. She also said that very often, these arguments would be about trivial things and would then escalate in their intensity.

56. Tessa talked about how Martin was regularly using drugs and that this had an impact on Karen. This impact was twofold, in that it affected Martin's behaviour but also led to Karen becoming a casual user of drugs as well. This first started when Bella's father died. Karen had been close to him.

57. Tessa described how the adoption of their children had a traumatic effect on Karen, that she was very upset about it. In contrast she said that Martin appeared to be much less concerned about this. Tessa described her own sadness that the children did not know their real mother. She also said that she felt that Karen's depression was in part caused by the adoption of her children and that she had experienced post-natal depression after one of her children was born.

58. Tessa said that Karen would sometimes talk to her about the relationship with Martin and the domestic abuse she experienced. She also said that Karen would often attempt to hide the abuse, concealing bruises or making excuses for Martin's actions and behaviour towards her.

59. Tessa said that she felt that although the children had been adopted, it seemed to her that Karen felt she should stay with Martin because of a kind of shared bond between them due to the children, even though they no longer had any contact and had been adopted. She also said that Karen had wanted to have another child with Martin.

60. Tessa described how, when Martin had periods in prison or in a mental health hospital that contact between him and Karen was much more sporadic. He wanted her to visit him but she did not always do so.

61. Tessa said that Martin was dependent on Karen and that to maintain his relationship with her he was particularly controlling, but did not describe specific examples of how this manifested itself.

62. Tessa felt that Karen did not recognise how dangerous Martin was and that this was borne out by the excuses she made for his actions and behaviour.

63. Tessa described an incident about two weeks before Karen's death when Martin had turned up at the family home when Karen was there and had made threats and been aggressive towards her, had pinned her down and was aggressive to others present in the household..

64. Tessa described how she and family members had often made calls to the police with concerns about Martin and his behaviour, but that Karen was also reluctant to press any charges against Martin. However, Tessa was also concerned at what she felt was a lack of response from the police who she said had not done enough and that they did not seem to regard Martin as a high risk person.

65. Tessa felt that despite this, it would have been hard to foresee that Martin would kill Karen and that she herself could not have envisaged.

66. Tessa described how she had been attempting to engage in a restorative justice process but that this was proving to be hard both practically and emotionally. She particularly valued the support of her AAFDA advocate.

67. At the end of the meeting, the Chair described the next steps and undertook to ensure that Tessa would be provided with a copy of the draft Overview Report and that he would meet with her again to go through it once it was complete.

16. Views of the perpetrator

68. In accordance with the DHR guidance, the Chair has been in contact with Martin to advise him of the process and to invite him to participate. The staff at the prison where Martin is currently being held have facilitated this contact.

69. The Chair wishes to express thanks to those staff at the prison and in particular to probation services for their assistance.

70. Contact with Martin has not been straightforward. He has experienced ongoing challenges while in prison and did not wish to meet. Indeed the COVID19 outbreak made this impossible. It was agreed that a small number of questions would be sent to him in a letter and that probation and prison staff would support him in responding to these.

71. Martin did make a written response to the questions put to him and what follows are his answers, as he presented them, in his own words.

72. Question 1. Can you please describe your relationship with Karen?

When things we were good, we were good, but when it was bad it was bad. Everyday we disagreed on things, there was a lot of jealousy with both of us. We both loved each other too much to say we could go our own way because we would say things so the other one would stay then it would go downhill.

73. Question 2. When you were in contact with the police, health and care services, how helpful were they? Are there things they could have done differently to help you more?

Nothing the police could say to me or Karen for us to stay away from each other, we would find a way to see each other. If two people love each other the police and that are not going to mean nothing in the end. I told them to get me somewhere as me and Karen were crazy together and I could see it.

74. Was there anybody you felt you could talk to and get help from?

Karen's mum, I talked to her a lot but she kept saying it is Karen, she will be OK later. Karen deffo didn't talk to because it would get into a fight so I would take drugs, sometimes drink but that would go bad if I had a drink because everything I have bottled up would come out at once.

75. How would you describe your relationship with Karen's family?

Karen's mum loved me to bits. I got on with Karen's siblings but that was it. The rest of them didn't like me and to be fair I do not blame them, if my girls had a boyfriend like me I would put a stop to it there and then, trust me.

76. What do you think will be different when you leave prison?

To be fair I do not no (sic) yet, that is a long time away but I have found God in my life.

77. Is there anything else you would like us to know?

If two young people have there (sic) kids taken away from them, because it will not work and if a man on drugs ad drink and got a mad mind it is only going to end bad. If you no (sic) what I no (sic) about relationships, drugs and drink get out of there fast. When you kill someone you love it is not a nice feeling to have for the rest of your life so give people like me and Karen more help with there (sic) problems so they will not end up like me sat in a cell thinking wot (sic) if and it does not upset more families lives.

17. Overview

78. Drawing on information from the IMRs, this section provides an overview of the contact between agencies, Karen and Martin. It summarises the information known to the agencies and professionals about Karen and Martin and any other relevant facts. It is deliberately structured by agency, as the appendicised chronology already provides a lateral timeline.

Berkshire West Clinical Commissioning Group (Primary care)

79. Although the timescale for this DHR is two years prior to Karen's death, some information was provided that went beyond that timescale and where relevant this has been referenced.

80. Electronic records show a first notable contact in August 2002 when Karen was referred to local mental health services and referred for family therapy.

81. The GP records show that in 2011, Karen was living in a foster placement with her first child. She was seen in July that year and presented with low mood. There is no detail about what interventions were offered to address the low mood. There is a record of children's services involvement relating to a child protection conference regarding her first child.

82. In 2013, Karen presented twice according to the GP records. The first presentation in March was related to a sexually transmitted disease and

abdominal pain, no detail of the intervention offered is recorded. In April 2015, Karen presented with abdominal pain but following ultrasound there was no clear cause. It is noted that at the time, Karen was largely resident in Somerset but had returned to West Berkshire to come to the surgery.

83. The next contact appears to have been in July 2016 when Karen required The GP's assistance and support with a housing application. There was no contact with the GP until January and February 2017 when she registered with the GP practice at which she remained a patient until her death.

84. In February 2017, Karen is reported as living with her mother and in May 2017, she had a review of her epilepsy by telephone consultation. A further consultation took place in July 2017 to review contraception medication.

85. In August, the GP spoke with Karen on the telephone about medication ordering as she had left it late to get a repeat prescription. Later that month the GP wrote a letter following an eye examination as Karen had been complaining of headaches for about a month. No concerns were raised and her eye health was good.

86. In late September 2017, the GP records show details of a letter from the neurology department where Karen had attended an appointment. The letter described how Karen had talked about her feelings of anxiety, which centred around visions about drowning or falling in front of a train. Karen had requested an MRI scan at this appointment and had also discussed contraception and had been talking about considering having another baby.

87. In December 2017, the GP records show a Multi Agency Risk Assessment Conference (MARAC) notification but with no action points raised. The notification was appropriately 'read coded' on the files.

88. The next recorded contact of note was in June 2018 following a MARAC notification being received by the surgery from Berkshire Healthcare NHS Foundation Trust (BHFT). The notification advised the GP practice to encourage Karen to engage with domestic abuse services if and when they saw her for consultation at the surgery. This notification was appropriately 'read coded'. Karen was not seen by the GP following the receipt of this notification. The notification did state that there was high risk in relation to MARAC grading of risk. It also stated that Karen was not supporting police action against Martin in relation to instances of domestic abuse. The issue was flagged for discussion at the GPs monthly meeting.

89. The last action recorded before Karen's death was in mid-August 2018 when an administrative medication review took place in relation to repeat prescriptions. Karen was not seen as part of this process as this was not required.

Berkshire Healthcare NHS Foundation Trust (contact with Karen)

90. Karen was known to Berkshire Healthcare NHS Foundation Trust (BHFT) prior to the period covered by the DHR. As noted in the primary care IMR, Karen received cognitive behavioural therapy and other support from local mental health services. This was largely related to Adverse Childhood Experiences (ACEs) and the removal of her children for adoption.

91. Karen was discharged from BHFT services in August 2011 and referred to services in Somerset where she was then living. She was not seen again by BHFT services.

Berkshire Healthcare NHS Foundation Trust (contact with Martin)

92. Martin was known to BHFT through contact with the local community mental health team (CMHT). He had his first informal admission to mental health services in July 2010 following an episode of drug-induced psychosis. This is when the use of drugs such as cannabis, cocaine, ecstasy, ketamine or LSD can bring about psychotic symptoms.

93. In November 2016, BHFT had contact from Nottinghamshire Community Forensic Team. They contacted the Crisis Resolution and Home Treatment Team in West Berkshire to alert them to the fact that Martin was back in their area. They shared an outline of his forensic mental health history and that their assessment was that Martin was a high risk to others. They advised BHFT services to contact Nottinghamshire services if he presented to BHFT services.

94. The next recorded action is a notification of a MARAC in December 2017. It is noted that Martin's records had been accessed for the purposes of the MARAC. The entry in RiO (the electronic records system) is concealed with a note that he is an alleged perpetrator. This was done to prevent accidental disclosure to him and was in line with practice.

95. In January 2018, a referral was made for Martin by his GP to the Common Point of Entry (CPE) for mental health services. The referral was passed to a

psychiatrist who recommended that Martin continue on his existing medication. A letter was sent to Martin's GP to confirm this and advised re-referral if needed. Martin was not assessed in person and Nottinghamshire mental health services were not advised of this intervention.

96. In mid-May 2018, Martin self-referred to the Common Point of Entry (CPE) for mental health services. The practitioner who took his phone call assessed him as low risk and identified Karen (and his relationship with her) as a protective factor. From the records, it does not appear that any previous information about Martin was reviewed as part of this interaction. As previously, Nottinghamshire mental health services were not informed of this contact, despite their request that this happen. A referral to psychiatry for further review of Martin's mental state and his medication was made following his phone call to the CPE.

97. In the first week of June 2018, a psychiatrist reviewed Martin's medication and wrote to his GP. Martin was not seen or spoken to by the psychiatrist as part of this process.

98. In the third week of June 2018, a MARAC discussion took place in relation to Martin and Karen. As mentioned in the GP IMR there was an action for them to encourage Karen to engage with domestic abuse services if they had a consultation with her. There were no actions identified for BHFT in relation to Martin. The MARAC meeting was not recorded in Martin's BHFT notes on RiO, although his records of contact with BHFT were accessed and information shared with the MARAC.

99. This appears to have been the last action prior to Karen's death. Following her death, documents were requested by BHFT from Nottinghamshire forensic mental health services. They were accompanied by reports from the inpatient services Martin had been in previously, as well as from his GP.

100. These documents contain relevant and useful information about Martin and the risks he posed to others. This included that he had suffered emotional, physical and sexual abuse as a child, that he became a looked after child within many different care settings and had been bullied at school. It also highlighted his extensive criminal history and that he had diagnoses of antisocial personality disorder, dissocial personality, sociopathic personality, ADHD, alcoholism and substance misuse.

101. The reports also showed that Martin described his relationship with Karen as 'mutually violent'.

102. None of this information had previously been requested by BHFT staff and therefore, was not available at the time of the assessments.

A2Dominion

103. Karen first had contact with A2Dominion in February 2015. She contacted their domestic abuse helpline seeking refuge. Their records showed that she told A2Dominion that she had previously fled domestic abuse in West Berkshire and travelled to Bath, stayed in a refuge there and then sourced independent accommodation in Somerset. In this contact she advised that she had entered into a new relationship, not with Martin, and that she needed refuge.

104. Two days after this contact, the helpline worker contacted Karen by phone, took further details and completed a Domestic Abuse Stalking and Harassment (DASH) risk assessment. The worker also completed a referral and a safety plan. The worker advised Karen that there was no refuge space available in Oxfordshire but did agree to follow up her application.

105. During the conversation, Karen advised the worker that it was the new relationship (not Martin) that she was seeking refuge from. She did disclose her relationship with Martin and that this too had been abusive, and it was from him that she had previously sought refuge in Somerset. She advised that the current relationship was with a man who was from her local area but who was currently in prison. She also disclosed her use of cocaine and alcohol but stated that she was not currently using either. She also described physical health needs relating to her epilepsy and depression.

106. The following day, the A2Dominion worker began background checks with police and social care services in West Berkshire and Somerset to ascertain any risks of Karen seeking refuge in Oxfordshire. A referral was then made to the Oxford Refuge Project run by A2Dominion. The Refuge Support Worker and the helpline worker made arrangements for Karen to travel to Oxford to sign tenancy papers at the refuge, this was due to take place six days after the initial call. However, Karen was unable to travel to Oxford and given concerns about the risk to her, it was agreed that Karen would stay with her mother. Three days later, in the last week of February 2015, Karen moved to the Oxford Refuge.

107. While resident at the Oxford Refuge, Karen engaged in the Freedom Programme and a range of other activities. There was a verbal altercation

with another resident during April 2015 and staff and the other resident resolved this with her.

108. Karen appears to have engaged well while at the Oxford Refuge and by June 2015, a referral was made to the Elmore Team who work with people with complex needs (including mental health) who do not easily fit into existing service provision or who need support to access service provision in their local community. Karen also agreed to refer herself to the NHS Complex Needs Service.

109. During July 2015, Karen began to stay away from the refuge for extended periods without following the service protocols. This continued to be the case in August 2015 and by September, she was advised that she was in breach of her license agreement. It appears that Karen was staying with her mother during these periods of absence from the refuge. She built up arrears of her accommodation fees. She did have some phone contact with the refuge during this period but wanted to pursue the option of private rented housing either in the Vale of White Horse council area or back in West Berkshire.

110. At the end of September 2015, the refuge contacted Karen to advise that it was their intention to terminate her license agreement. This prompted Karen to return. When she did so, she was engaged in conversations with the workers at the refuge about what had gone wrong, the consequences of being in breach and how she could better manage her concerns and her accommodation.

111. Throughout 2016, Karen was resident at the refuge and received a range of advice and support services. This included housing applications, one of which to the Vale of White Horse was declined by the council. Karen still had a tenancy in Somerset but this was due to expire in March 2016 and she did not wish to return. Her application to West Berkshire for housing was made and she was encouraged to actively bid for properties.

112. Through the course of 2016, Karen remained reasonably well engaged with the support provided by the refuge. There was one incident of verbal altercation with another resident in August 2016, which appears to be related to use of communal facilities.

113. Karen shared details of a letter from her children's adoptive parents and she discussed this with a worker at the refuge. She asked for counselling or

therapy about this issue. The content of the letter is not known, so it is not clear what led her to ask for counselling.

114. Karen spent some time at her mother's home in late August and early September 2016 and again in October 2016. She was away from the refuge for approximately ten days during October 2016.

115. On her return she disclosed that the man she had fled from (not Martin) had been in contact with her mother from prison and that his brother had sent abusive text messages to Karen's mother. Karen was advised that the police should be contacted about this but she was reluctant for this to happen.

116. There was also an incident where a child of another resident entered a room and Karen was verbally abusive to that child. It was agreed by senior staff that Karen should be transferred to a satellite refuge project in Oxford where only single females are present. Karen moved to this project in mid-October 2016.

117. Karen reported that she was unhappy about this transfer and wanted to leave. She requested leave from the project and submitted leave forms to a worker. The forms had little detail and did not give the address where she would be staying, only that it was with Martin. It was established that she would be in Nottinghamshire. Karen was away from the project for three days.

118. On her return at the start of November 2016, Karen stated that she was considering moving in with Martin and that the local authority had agreed to add her to his tenancy at his request. Karen stated that Martin was not aggressive when she was with him and that he had matured a lot.

119. The worker acknowledged that the new project move had unsettled Karen, but also advised of the risks Martin posed to her and that he had been subject to mental health detention for five years. Karen insisted that Martin had changed and that she loved him. She was continuing to bid for properties in West Berkshire at this time.

120. In mid-November 2016, Karen went to stay with her mother again, and did not advise the project where she was. She was away for over two weeks and did not return on the date that had been specified by her. At the start of December 2016, the worker at the project made further attempts to clarify Karen's intended return but got no response.

121. It then transpired that Karen did return to the project and collected her belongings and left her keys with another resident. Five days later, she contacted the worker and said she would not be returning. Karen did not provide any address details to the worker.

122. A year later, in December 2017 an Independent Domestic Violence Adviser (IDVA) at A2Dominion received a referral for Karen via the West Berkshire MARAC co-ordinator. The perpetrator in the referral was named as being Martin.

123. The IDVA attempted to contact Karen but received no response or reply. No message was left as it was not safe to do so. At the end of December, just before Christmas, Karen's case was discussed at MARAC and this was recorded by the IDVA in the files. A2Dominion were not allocated any actions from the MARAC discussion.

124. Further attempts at contact with Karen were made but following a lack of response her case was closed in January 2018.

Sovereign Housing Association

125. Karen had contact with Sovereign as part of her application for a tenancy. The first contact was at the end of November 2017, during the pre-tenancy assessment (PTA) process. The PTA was held at Sovereign's office. The assessment contained sections relating to behaviour and conduct as well as support being received and support and advice that may be required in the future.

126. During the PTA with Karen, it was noted that there had been issues relating to noise disturbance in previous tenancies and issues regarding drug misuse by Karen and Martin. A previous eviction by a private landlord, due to anti-social behaviour was also noted. In terms of current support needs, Karen's epilepsy was recorded and it was noted that the neurology department of the Oxford Radcliffe Hospital in Oxford had seen her. No new or future support needs were identified in the PTA other than a need for furniture for the property. A comprehensive budgeting section was completed as part of the PTA. This did not raise any immediate concerns for Sovereign and Karen was in receipt of full Housing Benefit and Employment Support Allowance.

127. Karen signed her tenancy just before Christmas 2017 and moved into the property in West Berkshire where she lived until her death. No specific queries were raised during the handover of keys and tenancy signing meeting. Due to her previous issues with rent arrears, she was referred to Sovereign's tenancy Support Advisor to open a support case.

128. Once Karen moved in, she raised a number of repair issues, and there were two reports of broken windows, which she asked to be fixed swiftly as she did not feel safe.

129. A settling in visit was conducted a month after Karen moved in, in January 2018. A Housing Officer from Sovereign conducted the visit. No specific concerns or issues were identified or raised. Support was offered to Karen in relation to outreach input for her, but it is not clear from the records what form this might have taken. A referral was also made to Sovereign's Employment and Training Advisor, as Karen was feeling isolated and wanted to 'pick up her life'. Again, it is not clear from the records, what actions if any resulted from this.

West Berkshire Council Adult Social Care (contact with Martin)

130. Adult Social Care (ASC) first had contact with Martin in September 2008, when a GP referred him to the local community mental health team (CMHT). The CMHT was a multi-disciplinary and integrated team at that time.

131. Martin had presented with symptoms of low mood, was alcohol dependent and reported experiencing persecutory hallucinations. It was not felt that he had any suicidal ideation at that time.

132. The CMHT advised the GP, to encourage Martin to attend a drug and alcohol service. There is no record of whether Martin attended any subsequent appointments, following this referral.

133. The second period of involvement with Martin took place in July 2010. The police took Martin to the local mental health hospital. He had been detained under Section 136 of the Mental Health Act. Section 136 states that; *if a person appears to a [police] constable to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons—*

(a) remove the person to a place of safety, or (b) if the person is already at a place of safety within the meaning of that section, keep the person at that place or remove the person to another place of safety.) The power of a constable under subsection (1) may be exercised where the mentally disordered person is at any place, other than (a) any house, flat or room where that person, or any other person, is living, or (b) any yard, garden, garage or outhouse that is used in connection with the house, flat or room, other than one that is also used in connection with one or more other houses, flats or rooms.

134. The police had detained Martin, using these powers as a result of behaviour he was displaying in a place to which the public had access and as such, they were able to use the powers under Section 136.

135. The records state that Martin was in hospital for four days, but there is no record of what actions or assessment were undertaken. However, there is a record that he was given a diagnosis of mild learning disability and of mental and behavioural disorder due to the use of amphetamines. As with the incident in 2008, Martin was offered follow up support through drug and alcohol services but does not appear to have engaged with that support at the time. Martin did not define himself as a dependent drinker or drug user and was reportedly aware of the effect of amphetamines on his mental health.

136. A discharge planning meeting was held before Martin left hospital. It was agreed that there was no requirement for CMHT input other than the standard seven day follow up, post discharge. It was agreed that the Crisis Resolution and Home Treatment Team would see him within three days of his discharge but it is not clear from the notes, if this happened or what the nature of any input might have been.

West Berkshire Council Children and Families Service (WBC C&F)

137. WBC C&F had no contact with Karen during the time period covered by this DHR, as she had no children in her care. At the time of Karen's death, WBC C&F had no contact with Martin and had not done so for some time. There had been significant involvement in the past but this ended in 2012.

138. That involvement related to the two children that Karen and Martin had, who were subject to court proceedings and eventual adoption as a result of child protection concerns.

139. Although WBC C&F did not have direct contact with Martin, they were engaged in liaison and communication with agencies in relation to his two children with his former partner (Karen's half-sister). This began in January 2017, when the Contact Advice and Assessment Service (CAAS) was contacted by the police as Martin's former-partner had contacted them to report that Martin had been seen in the area. No further action was taken by WBC C&F as part of this notification.

140. In February 2017, there was a further automatic notification to CAAS from the police, as Martin had been attempting to make contact with one of his children. His ex-partner raised concerns, including some relating to historical abuse. The school the children attended, had been informed. The matter was screened and assessed by CAAS and no further action was taken.

141. In October 2017, a referral was made by the Emotional Health Academy (EHA). One of Martin's children was presenting with challenging behaviour and Martin was shortly to be released from prison. The referral was screened and assessed and passed to the Targeted Intervention Service (TIS) for support.

142. In November 2017, there was a general request for information as Martin was due for release from prison in December and there was a need for updated risk assessment. WBC C&F passed information to TIS.

143. In January 2018 there were further concerns that Martin had been seen in the area where his ex-partner lived. Risk assessment work was undertaken and later that month probation provided further risk information that graded Martin as high risk of serious harm to Karen and to the public (in respect of arson) and to staff.

144. A family and professionals meeting was held in January 2018 including probation to discuss the existing issues and risks. A plan was developed and subsequently reviewed in February 2018.

145. TIS ceased their involvement and closed the case in late February 2018. An Emergency Duty referral was received in mid-May 2018 from the police. Martin's ex-partner again advised them that Martin was trying to make contact with the children, and had approached one of them outside school. A CAAS social worker called Martin's ex-partner to discuss the situation and the incident but no further action was necessary.

Swanswell Drug and Alcohol Service (contact with Karen)

146. Swanswell had only two contacts with Karen. The first was in late June 2018 when she contacted the service to cancel an appointment on Martin's behalf as his car had broken down. The second was in July 2018 asking if Swanswell were aware of Martin's whereabouts. She was worried about him and did not know where he was. There is no record of what action, if any was taken following this second contact.

Swanswell Drug and Alcohol Service (contact with Martin)

147. Martin was in contact with Swanswell from May 2018, he had no previous contact with the organisation or its services.

148. At the end of May 2018 Martin referred himself to Swanswell following advice from probation. He disclosed that he was using 8mg of Subutex[8] and that he had previously used 1 ½ bags of crack cocaine or heroin. No safeguarding risks were identified during triage and no risks were shared by probation.

149. Martin also completed a Blood Borne Virus (BBV) screen and a sexual health screen.

150. Five days after the referral and triage, in early June 2018, Martin completed a Drug Rehabilitation Requirement (DDR) assessment[9] by telephone. The DDR was granted following that assessment, due to his motivation during the first triage appointment. He was advised he would be required to attend the DDR group every Thursday.

151. At a further assessment discussion three days later Martin stated that he had not used for a week. Nothing about his relationship was discussed. A risk assessment was conducted which focused on his mental health, his offending and substance misuse, but did not cover any issues regarding his relationship.

152. Martin attended the next two DDR groups, but did not attend the third. Karen called the service to cancel his attendance as his car had broken down. Martin did not attend the fourth DDR group session and probation were advised of this by email.

[8] Subutex is an opiod used to treat opiod addiction.
[9] A DDR is a community sentence that requires offenders to attend a drug treatment programme, with regular testing for between three and six months as an alternative to prison.

153. In mid-July the service received a call from Karen enquiring about Martin's whereabouts. The service advised they could not discuss as they did not have consent and suggested that if Karen remained concerned she should contact the police.

154. Martin did not attend the fifth DDR group and again probation were informed by email. Attempts were made to contact Martin.

155. Martin did attend the sixth DDR group, in mid July and reportedly engaged well. There was no exploration about his previous non-attendance. He failed to attend the seventh DDR group a week later.

156. A one to one meeting did take place at the start of August 2018 and Martin raised no issues. He refused training in relation to the use of Naloxone.[10]

157. Martin did attend the eighth DDR group and eight days later had a phone call with the service in which he stated he was working. He wanted to attend another group but was told this group did not form part of the DDR.

158. Nonetheless Martin did attend this additional Self-Management and Recovery Training (SMART) group, but then failed to attend the ninth, 10th and 11th DDR groups in late August and at the start of September 2018. Probation was advised and there was no further contact with Martin.

The Priory Group (contact with Martin)

159. The Priory Group is an independent sector mental health care provider and operates a number of hospitals across the country. Martin was an inpatient at their hospital in Wales from August 2014 where he was admitted under Section 37 of the Mental Health Act.[11] He had been transferred there from another secure hospital in Yorkshire. He had been admitted to hospital in Yorkshire in August 2013 from HMP Nottingham on Section 35 of the Mental Health Act[12].

[10] Naloxone is a medication used to block the effects of opioids.

[11] The criminal courts can use Section 37 of The Mental Health Act if they think a person should be in hospital instead of prison. This is also called a 'hospital order'. A person must have a mental disorder and need treatment in hospital and have been convicted of a crime that is punishable with imprisonment. It is a sentence and does not have a fixed end date.

[12] Under Section 35 a court can decide that a person needs to be remanded in hospital for the preparation of a report on your mental condition. The purpose of Section 35 is to establish a diagnosis and a persons fitness to plead at court when they return. A court and a doctor who is Section 12 approved and has specialist experience in the treatment and diagnosis of mental illness doctor put you on the section. A person can be kept in hospital for up to 28 days at first and is renewable for further periods of 28 days, up to a maximum of 12 weeks.

160. Martin was moved to a Section 37 in October 2013 following conviction for affray and possession of an offensive weapon.

161. During his time at the secure hospital in Yorkshire, Martin was diagnosed with paranoid schizophrenia and personality disorder. However, when he moved to hospital in Wales his diagnosis was reviewed and changed to a non-specific psychotic disorder with significant personality difficulties involving anti-social behaviour, and that his use of drugs and other stressors could precipitate further psychosis.

162. During his time at the hospital in Wales, Martin engaged in occupational therapy and psychological formulation work, including attendance at a drug and alcohol misuse group and had support to help him recognise and maintain healthy relationships.

163. In July 2015 Martin was referred to a locked rehabilitation unit in Nottinghamshire. This was felt to be necessary before any discharge back into the community, which would also require periods of leave.

164. The assessment process for this transfer to the rehabilitation unit was commenced in October 2015 and his placement was agreed in October 2015 but was delayed due to issues with completion of necessary paperwork by the commissioner of the service.

165. Martin was discharged from the hospital in Wales at the end of October 2015 with a clear risk assessment plan and recommendations that he continued with his psychological support work. There was no documentary information in the records to substantiate this. There were also concerns that his discharge had not led to the allocation of a care co-ordinator and this was escalated by the social worker at The Priory Group to the NHS commissioner.

Thames Valley Police (TVP)

166. The first record of Karen and Martin coming to police attention as a couple was in September 2008 when Martin assaulted Karen when she was pregnant. He was arrested and pleaded guilty to battery.

167. Between 2009-10 there were several reports of domestic abuse of Karen by Martin including periods when they were separated. In each of these cases Martin was graded as medium risk.

168. Between 2012 both Karen and Martin lived outside the Thames Valley Police area, they lived together in Somerset for a time during 2012. In May 2012 Martin was arrested for assaulting Karen, but no charge was brought. Then in July 2012 while Karen was living in a refuge, Martin reportedly used violence to enter the building and assault Karen. He was convicted of battery and sentenced to 22 weeks imprisonment.

169. In March 2013 Martin was detained in a secure hospital following an incident in Nottinghamshire where he chased his mother and a police officer with a cleaver, threatening them and then threatening to take his own life. He was released from secure care in July 2016 but his release address was not known to TVP.

170. In September 2016 a woman who had been a friend of Martin's for 17 years reported that he had stolen and crashed her car. A DOM5[13] was created as she reported that she had had a sexual relationship with Martin three weeks before. When a DOM5 was completed the woman stated that she thought Martin had spiked her drink and suspected that he had raped her. This was recorded and investigated. The boyfriend of the woman and Martin had been involved in recent harassment. The police investigated the matters fully but there was insufficient evidence to bring any charges.

171. In November 2016 Karen reported that Martin was missing. She reported that he was resident in Nottinghamshire but had been staying with her in West Berkshire. Martin returned to Karen's address the following evening.

172. In late November police attended a local public house on an unrelated incident and found Martin being ejected. They were advised that he had assaulted a woman, Karen. He was arrested. Karen gave a statement to the police and supported an investigation but said she would not go to court. Martin admitted arguing with Karen but not to assaulting her. He made counter allegations against Karen. There were no independent witnesses and Martin was released without charge.

173. In mid-December 2016 Martins psychiatric nurse in Nottinghamshire spoke with TVP officers as she had heard about the two recent incidents. She expressed concern about Martin's level of risk and the officer recorded that Martin had been in prison for five years for threatening a police officer.

[13] The DOM5 is an initial risk assessment tool

174. At the start of January 2017 Karen called the police from her mothers home She had locked herself in the bathroom as Martin had become verbally aggressive towards her. Police attended but there had been no offences. A DOM5 risk assessment was completed. Martin was removed to a local hostel. Karen described controlling and jealous behaviour by Martin and that they had separated as a result of this incident.

175. In February 2017 Karen's mother approached the police at a petrol station and stated that she feared for Martin's welfare. He had been out the night before and got drunk and sent several messages to Karen about feeling suicidal. He was recorded as a medium risk missing person. The following day Karen's mother contacted the police to say that Martin had returned to her address. On that same day the police were contacted by Martin's ex-partner to say that she had had contact from Martin on social media asking to meet and discuss seeing their children. This was in response to her solicitor making arrangements to change the children's names. This was recorded as a domestic incident.

176. In April 2017 Karen contacted TVP to report that Martin had stolen her puppy and sold it to the landlord at the local pub to get money to buy drugs. She said she had been living with him in Nottinghamshire and had called the police and asked him to leave. She was now back at her mothers address.

177. It is understood that in the days that followed, Martin set fire to his flat in Nottinghamshire after taking drugs and alcohol. He was arrested and subsequently imprisoned for seven months for damage to property. A DOM5 risk assessment was conducted and it reported that both Karen and Martin had personality disorders. The DASH process showed that Karen stated she was not frightened of Martin and a standard risk grading was applied.

178. Martin was released from prison on licence in August 2017 and managed by Nottinghamshire Probation Service. He was recalled to prison less than four weeks later in mid-September 2017 for breach of licence including theft of his mother's car. It is reported that prior to his arrest, Karen's mother hid him at her home at Karen's request. He served the remainder of his sentence and was released from prison at the start of December 2017 on to a post-sentence supervision programme that was due to expire at the end of September 2018.

179. TVP were advised of Martin's release on the day he left prison. He was intending to return to West Berkshire and to reside at Karen's mother's

address. The assessment of probation was that Karen was at high risk of serious harm from Martin. Nottinghamshire Probation had requested a MARAC referral. A Risk Management Occurrence (RMO) was completed to document safety planning. The Domestic Abuse Officer made a call to Karen who confirmed that she did intend to remain in a relationship with Martin and that he would be staying with her at her mothers address. She did state that she was hoping to move and did not want Martin to come with her as this would jeopardise her keeping the property. She had no safety concerns and said she would end the relationship if Martin started drinking again.

180. A MARAC was held just before Christmas 2017. The decision made after the meeting was that the risk was medium, as there was no information forthcoming that suggested Karen was at imminent risk of serious harm. An action was set for the Domestic Abuse Investigation Unit (DAIU) to visit Karen at her new address, three attempts had been made and there had been no reply. A neighbour confirmed that a couple were living at the property and that they had been heard arguing on a couple of occasions. The action was thus marked as complete.

181. In mid-January 2018 the DAIU recorded that they had been contacted about Martin attempting to make contact with his children (who lived with his ex-partner). This was prohibited by a Court Order. There were concerns that Martin might be staying with Karen who lived close to his ex-partner. There was discussion about whether Martin should be a MAPPA[14] case. It was determined that although Martin's offence had been a Schedule 15 offence[15] it did not attract a 12 month sentence and so he did not qualify for MAPPA. It was agreed that if there were concerns that Martin presented imminent risk of harm to others then probation could refer him as a category three person of concern to MAPPA.[16]

182. The probation officer documented that a decision had been made not to refer using category three because there was no identified specific benefit from multi-agency management.

[14] Multi-Agency Public Protection Arrangements

15 A "specified offence" is a violent, sexual or terrorism offence listed in Schedule 15 Criminal Justice Act 2003. This includes a wide range of indictable offences which fall within these three categories.

[16] There are three categories of MAPPA offenders: **Category One –** All registered sexual offenders. Registered sexual offenders are required to notify the police of their name, address and personal details under the terms of the Sexual Offences Act 2003. **Category Two –** Violent or other sex offenders not subject to notification requirements, including violent offenders who have been sentenced to 12 months or more, or to detention in hospital, and who are now living in the community subject to Probation supervision. **Category Three** – Other dangerous offenders who have committed an offence in the past and who are considered to pose a risk of serious harm to the public.

183. In mid- March 2018 Karen reported Martin as missing. He had not returned after calling her from a payphone. This was graded as a low risk missing person enquiry but increased to medium by the reviewing Inspector. Karen contacted TVP in the early hours of the following morning to report that Martin had been in Brighton and been taken to hospital with chest pains. Sussex Police visited him but there was no further action.

184. In May 2018 Martin was arrested on suspicion of burglary at a barbers shop. He was charged and bailed and in June 2018 was ordered to pay costs and compensation. While in custody during the initial investigation of this offence Martin was reported by his ex-partner to have approached one of their children outside school while drunk and said he wanted to meet the child without the child's mother's knowledge. This was recorded as a child protection incident and WBC C&F were involved.

185. Later in May 2018 Karen's half-brother contacted the police to report an incident involving Martin at Karen's mother's address. The location was flagged for high-risk domestic abuse of Karen by Martin. A lone officer arrived within five minutes. Karen accused Martin of head-butting her. Martin became aggressive and captor spray was deployed and Martin was arrested. Neither Karen nor her mother were willing to provide a statement however accounts were recorded on Body Worn Video (BWV). Karen knew she had been assaulted but did not want to take any action. She refused to do the DOM5 with officers. Karen's mother stated she did not want Martin to return to her home.

186. While in custody Martin refused to see a health care professional despite saying he would need medication, and in the morning following the incident stated that he was fine. He denied assaulting Karen and causing damage to the property. Given the lack of witness statements no charges could be brought. A warning marker was made that Martin was violent on arrest. The case was referred back to MARAC.

187. In late June 2018 the case was considered again at MARAC. The risk level remained at medium, as there was no information that suggested Karen was at imminent risk of serious harm.

188. At the end of June 2018 TVP received a call from a neighbour reporting that Karen and Martin were shouting in the garden of Karen's home, that Martin was very drunk and that Karen was shouting at him to leave. A flag had been placed for the address and police attended. Karen and Martin confirmed

they had been arguing but neither disclosed any offences. Karen was listed as a perpetrator and Martin as the victim, and he refused to undertake a DASH. The risk grading for this incident was standard, and it was not acknowledged that the couple had recently been the subject of a MARAC. The incident was recorded as a domestic incident and then filed.

189. In mid-July Martin was arrested in North Oxfordshire on suspicion of personal possession and use of cocaine. He disclosed he was a heroin addict and had personality disorder. He stated he was of no fixed abode and that Karen was his nominated person to contact. An ambulance was called whilst he was in custody as he could not be roused and it was feared he may have had a cardiac event. He was taken to hospital and released under investigation. Karen was informed. This investigation was ongoing at the time Martin killed Karen.

190. This was the last contact with Karen and Martin before her death in September 2018.

Royal Berkshire NHS Foundation Trust (RBFT)

191. The RBFT had limited contact with Karen apart from her maternity care. Referrals had been made for dental treatment, a referral to neurology and dermatology by her GP in 2008.

192. Karen attended the Emergency Department once during her second pregnancy in 2010 following a witnessed seizure with a neurology outpatient follow up appointment made. The hospital record shows that Karen did not attend any of these outpatient appointments, but she did attend all her maternity related appointments.

193. RBFT maternity staff involved in Karen's care were involved and aware of child protection concerns and fully participated in the child protection process around Karen and her children. The notes indicate that the child protection concerns were regarding domestic abuse, (from Martin) and Karen's ability to care for her child/ren.

194. Martin has had a small number of attendances for investigation and repair of a hernia in 2007. Martin also attended to the Emergency department on three occasions, firstly in 2009 accompanied by the police, once from mental health hospital in 2010 and lastly via the ambulance service having been found intoxicated and bleeding from his head in April 2018.

National Probation Service

195. Martin was subject to a Post Sentence Supervision (PSS) licence. This came into effect following a seven-month prison sentence for arson with intent to endanger life, imposed by Nottingham Crown Court in July 2017. The offence occurred in the context of Karen saying she was ending her relationship with Martin and was treated as an attempt on his own life.

196. Martin had 37 previous convictions for 62 offences and four previous cautions when sentenced in Nottingham. His first conviction was in 2005 when he was 17 years old. He committed a sexual assault offence in 2006 against a female minor. Most of his offences were related to violence, damage or public disorder. His most recent conviction before 2017 was in 2013 when a hospital order was imposed following offences of affray and possession of an offensive weapon.

197. At the end of July 2017 Nottingham Crown Court sentenced Martin to seven-month imprisonment for arson. No pre-sentence reports were completed. A psychiatric report was produced but did not address matters of risk of harm. An automatic allocation to NPS was made.

198. When Martin was released from prison in August 2017 the Nottingham Local Delivery Unit (LDU) of the East Midlands Division of the National Probation Service (NPS) managed him. Mental health support was reportedly offered to him by local forensic mental health services but he did not attend appointments.

199. A referral was made for him to live in approved premises but this was rejected, many approved premises do not accept people with a history of arson.

200. Martin stated that he was going to live with his mother and this was accepted due to the lack of alternatives. The NPS officer spoke with Martin's mother and was reassured by her ability to manage.

201. Martin was reported as presenting with mental illness symptoms but when questioned deflected those questions. He also appeared pre-occupied by sexual matters but said he was not in a relationship at that time and did not identify any previous partners. The officer commented that Martin only attended appointments to get something, such as help with welfare

benefits. A domestic abuse assessment was completed and he was graded as high risk to partners.

202. By late August the NPS officer had conducted a home visit to Martin at his mother's home, though she was at work at the time. Although he stated he had been feeling unwell he had not been to see his GP. He also failed to attend a mental health service appointment.

203. At the end of August 2017 Martin had failed to attend three appointments with the NPS officer and a recall process was initiated.

204. In early September following careful review, Martin's mother contacted the NPS officer by phone. Martin had taken her car and she thought that he had gone to visit Karen. He had also reportedly been posting intimate pictures of himself on Facebook and sending them to a child. There was no evidence to support this. Standard recall was initiated, endorsed and submitted.

205. At magistrates court in mid-September 2017 Martin was given 28 days imprisonment for taking his mother's vehicle without consent. In the last week of September 2017 Martin returned to prison. While in prison he told the NPS officer that he wanted to return to West Berkshire on release. The officer felt a referral to MARAC would be appropriate if he did return to West Berkshire. The NPS officer made connections with NPS colleagues in West Berkshire and made an approved premises referral but did not expect it to be accepted.

206. Throughout October and November 2017 there were various calls, meetings and visits in relation to Martin and his case. In one visit by the NPS officer in mid-November Martin disclosed first time that he had been in a relationship with Karen previously and that she had lived with him in Nottinghamshire for nine months before the offence for which he had been jailed.

207. None of the NPS officers' application for approved premises for Martin were successful. She spoke to Karen and her mother. She believed she had secured agreement that Martin should spend four weeks at approved premises and only see Karen during the day. Karen's mother was apparently insistent that Martin had never been a problem to her.

208. TVP were in contact with the NPS officer during this period in relation to what work had been done to safeguard Karen, she said she would be making

a MASH referral. There was a clear view that Martin was likely to return to Karen's address.

209. At the start of December 2017 the licence expired and the PSS licence commenced. The NPS officer spoke with Karen on the phone and Karen told her that she was getting a flat. But won't allow Martin to stay. She said he drank when things were difficult and that she didn't want to talk to professionals in case it put her housing at risk. The NPS officer did not believe that Karen was fearful of Martin, rather that she saw herself in a caring role. The NPS officer made a MARAC referral at the start of December 2017 and this was due to be discussed at a meeting just before Christmas.

210. Management of Martin's case was transferred to West Berkshire Local Delivery Unit (LDU) in January 2018 and was allocated an offender manager. Throughout his period of management he was assessed as posing high risk to Karen on his re-release in December 2017.

211. Throughout January and February 2018 he was compliant with his PSS. Probation reported that Martin did not display signs of mental illness. He reported weekly to his offender manager, who had some contact with Karen but did not visit the home address. During this period the issue relating to Martin attempting to contact his children was reported by his ex-partner, as described earlier in this report.

212. By March 2018 Martin was reporting that he and Karen kept falling out with each other and that he wanted to get his own accommodation but did not want to register with the council.

213. By May 2018 there had been instances of domestic abuse by Martin against Karen (detailed in the TVP summary).

214. In June 2018 Martin was given an 18-month community order for a burglary and was inadvertently bailed to Karen's home address while awaiting sentence. He committed the offence to get money to buy drugs. The order required him to engage with the DRR with Swanswell that has been described earlier in this report.

215. Martin was arrested for possession of drugs in July 2018, he could have been 'breached' but his NPS officer decided to offer him one further chance. There were a number of contacts between the NPS officer and Martin through July and August. By this time Martin had secured employment,

though it is not clear from the report what sort of job he had. It appears that his work had some impact on his attendance at DDR sessions.

216. His last contact with NPS was the day before the murder in September 2018 when he spoke to an Employment, Training and Education Officer on the telephone and stated that all was well.

Other sources of information

217. As part of the DHR the panel sought chronologies and information from other organisations that had had contact with Martin in order to form as full a picture of his history as possible. These including Nottinghamshire Police, HMP Nottingham, Sherwood Hospitals NHS Foundation Trust and The Canterbury Psychological Clinic. These organisations had contact with Martin in the period prior to the scope of this DHR and have not been detailed within this Overview Report. However, their contacts are contained in the combined chronology.

18. Analysis of the Individual Management Reviews

West Berkshire Clinical Commissioning Group (primary care)

218. Karen had a number of contacts with her GP surgery within the timescale covered by this DHR. Many of them were not face-to-face contacts and related to issues regarding medication review and repeat prescriptions.

219. Issues about domestic abuse were well communicated within the GP surgery and where instances were known about they were appropriately recorded and 'read coded' on the electronic records system within the practice. In particular the MARAC notification was recorded and was available for practice staff to view. Specifically, the GP had noted the action for primary care arising from one of the MARAC meetings. Unfortunately there was no contact with Karen between that notification of action and her death.

220. The MARAC action did not specify any particular urgency to the request. Had it done so it may have prompted the GP practice to be pro-active about contacting Karen or inviting her to attend the surgery, where she could have been encouraged to actively seek out domestic abuse support. However, there can be no certainty that such encouragement would have yielded a positive response from Karen.

221. It is evident that the multi-disciplinary team (MDT) within the GP practice did discuss Karen's case and that the concerns they had as practitioners were discussed and shared within the team at the surgery. This MDT approach was good practice. There is also evidence that the GP practice adhered to local safeguarding policies and procedures, including the appropriate 'read coding' process.

222. The GP practice had undertaken local approved domestic abuse training and issues relating to domestic abuse were well understood by practitioners working within the surgery.

223. Individual GPs within the surgery were well aware of Karen's circumstances. There is evidence that they attempted to support her in areas such as housing applications. What is less clear is whether there were direct conversations with Karen about her relationship with Martin, or about issues of domestic abuse more specifically.

224. The IMR comments that there is no evidence to indicate that these discussions took place. Given that Karen's circumstances were well known, and that those working in the practice had received training, it seems that the gap between that training and day to day practice remained larger than would be hoped for, in particular in demonstrating within the records a greater degree of professional curiosity.

225. The levels of risk Karen faced do not appear to have been fully understood by the GP practice. In saying that, it is important to note that the practice was not in possession of information from other agencies such as the police and accident and emergency updates that would have provided a clearer line of sight into those levels of risk in relation to domestic abuse. It is important to note that the level of detail in the MARAC was limited.

226. Karen appears to have had a positive relationship with the GP practice and there are examples of her proactively contacting them on a range of matters. Although much of the contact was undertaken by telephone, she did attend appointments and sought to re-book when she could not attend.

227. The GPs written record appeared to focus solely on the clinical presentation, but the interview with the GP highlights that there was an awareness within the surgery of the wider social and relational circumstances affecting Karen. However, there is no recorded evidence of any external discussion or routine enquiry in relation to domestic abuse by the GPs involved in Karen's care

with other professionals. The clinical presentations, types of calls and contact to the surgery did not indicate any missed opportunity or potential to have a conversation with Karen. It is recognised that professional curiosity within cases of domestic abuse is good practice with both patients and other professionals and this is something that could have been better demonstrated.

228. The primary care IMR made no recommendations.

Berkshire Healthcare NHS Foundation Trust

229. BHFT were made aware of Martin's return to West Berkshire in November 2016. This notification was made by services in Nottinghamshire, who requested that BHFT advise them if Martin came into contact with BHFT services. This request was not followed, even though Martin had contact with BHFT services. This was a missed opportunity to share relevant information about contact and presentation.

230. Although the Nottinghamshire request could be viewed as informal, it would have been good practice for BHFT to contact them when Martin presented to their services. It would have enabled swift and up to date information exchange and may have provided useful history to inform local decision-making.

231. When Martin was referred to the CPE in January 2018 he was not seen by the service, nor was he spoken to on the phone. Due to the nature of the CPE service, it was not unusual for a face-to-face assessment not to take place. However, given Martin's previous history and levels of risk, including his time detained in forensic medium secure services, the referral should have led to a much fuller assessment of his mental health.

232. Such an assessment should ideally have been conducted by a psychiatrist, who would have been better placed to conduct a fuller medically informed assessment of Martin's mental state and level of risk. It may also have provided an opportunity to explore issues relating to Martin's misuse of drugs and also to gather a more holistic view of his relationship circumstances and the risks he presented to Karen in particular.

233. When Martin was re-referred to CPE in May 2018 his referral was appropriately triaged, however, once again the assessment was not sufficient, indeed it is described in the IMR as lacking detail. There is no

evidence to indicate that previous records were accessed to gather historical information that might have informed the assessment. Information provided by Martin was not appropriately challenged or explored in more detail; rather it was taken "at face value". There does not appear to have been any consideration of his previous detention in forensic medium secure care and the implications in relation to risk that this might have entailed.

234. A much fuller assessment appointment should have been made with Martin. The fact that it was not should be seen as a missed opportunity to engage with him and to have taken greater account not only of the presenting mental health issues, but to take a thorough history, that included issues relating to his relationship with Karen, his history of domestic abuse, his substance misuse and his offending behaviour.

235. There was very little information about Martin's relationship with Karen on the BHFT records. However, that which does exist suggests that practitioners viewed Karen as a protective factor in Martin's life. Although the MARAC notification that BHFT received was effectively 'concealed' in the electronic records, to avoid inadvertently revealing this to him, there was a means by which practitioners could have accessed this information. It appears they were unaware of how to do this.

236. The MARAC entries put on RiO when the records are accessed for both victims and perpetrators did not list the victim or perpetrator on each other's records. A recommendation in the IMR is that the alleged perpetrator and alleged victim be named on both records.

237. Karen's own contact with BHFT was particularly limited, though psychological intervention was offered. This occurred outside the timescale covered by this DHR.

238. There was a lack of routine enquiry about his relationship by practitioners engaged with Martin on both occasions that he was in contact with BHFT.

239. The BHFT IMR makes five recommendations.

A2Dominion (Domestic Abuse Service)

240. Karen's contact with A2Dominion went back to 2015 when she was first in receipt of their services. It was known that she had previously fled domestic

abuse perpetrated by Martin, and had spent time at a refuge in Somerset and had later sought independent accommodation there.

241. A2Dominion did classify Karen as vulnerable, though as other DHRs have noted, the term vulnerable can be open to a wide interpretation. However, A2Dominion correctly identified Karen as being at risk of domestic abuse and that she sometimes posed a risk to herself. Although not clear this seems to have been in relation to her own use of drugs from time to time as well as her not always acknowledging the domestic abuse that had been perpetrated against her, usually by not wishing to take forward police investigations into such incidents.

242. A2Dominion appropriately identified a complex needs service as being one that Karen would benefit from. However, her own challenges in relation to service engagement meant that a self-referral service that relies on engagement to be successful was probably always likely to be difficult for her to fully benefit from.

243. A2Dominion had a thorough and up to date knowledge of Karen's difficulties and acknowledged her needs in relation to emotional regulation, mood changes and unstable relationships. The staff within the service worked hard, and were successful in, building a positive relationship with Karen. She appears to have trusted them and was able to disclose difficult and sensitive issues. However, this level of trust and disclosure was not consistent and she would often draw back from the support being offered. A2Dominion staff worked hard to maintain their positive relationship with Karen, even when that was challenging.

244. There are a number of examples where the refuge sought to support Karen and these are outlined in some detail in the A2Dominion IMR. Although this period falls outside the timeframe of this DHR, the panel has considered them. There is clear evidence of the development of an Independent Living plan early in Karen's time at the refuge. In the first three months of her time there it is evident that she engaged well in a range of support activities, including frequent key-worker sessions that sought to address issues relating to safety, physical and mental health as well as more practical matters such as financial planning.

245. Refuge staff routinely accompanied Karen to appointments with other agencies and liaised effectively with General Practice services in particular, as well as housing, where they supported her application to West Berkshire.

They also appropriately provided support and liaison around family and support networks, and emotional support relating to the loss of her children.

246. The refuge provided these supports despite issues relating to Karen's behaviour, which is recorded as having challenged the boundaries set by the project. Karen did not wish to continue to attend sessions relating to mental health with local NHS and third sector providers, and did not wish to continue being supported. Refuge staff worked well to keep her engaged in support, despite her not paying her rent and were able to another support programme, designed to help people with complex needs.

247. There is little information that confirms the content of discussions about abuse, but it is clear that staff attempted to engage Karen in these conversations.

248. Although the A2Dominion staff had worked pro-actively to support and manage Karen, she continued to display aggression towards them, and no longer wanted to engage in the support offered. It was at this point that a team decision was taken to transfer Karen to a satellite refuge project.

249. It cannot be said with any certainty that the transfer to the satellite service was a directly influential factor in Karen's later experiences. However, she was clearly unsettled by the move and it does appear that it contributed to her disengagement from the services provided by A2Dominion. Nonetheless, staff acted appropriately in the best interests of both Karen and other residents on the basis of the facts and situation at the time. The lack of a more pro-active follow-up to resettlement may have been beneficial and may have enabled the development of a safety plan for Karen. Whether it would have had the effect of Karen not re-establishing her contact with Martin is impossible to say.

250. The A2Dominion staff were partially successful in enabling Karen to engage with wider services, and sought to help her maintain her place as a resident in the refuge. They worked hard to mitigate the challenges, in particular her relationships with other residents, and were cognisant of safeguarding issues in relation to other residents and their children. The transfer to a satellite service was a last resort, but one that was necessary given the challenges in the main refuge setting.

251. The A2Dominion IMR makes seven recommendations, some of which are already being acted upon.

Sovereign Housing Assocation

252. The contact between Karen and Sovereign was focused entirely on her application for housing. It centred on three key contacts, the pre-tenancy assessment and the settling in visit.

253. Both these contacts were conducted in accordance with Sovereign policy and procedure and were of the necessary standard.

254. The only query that the analysis of the IMR highlights is whether there was sufficient discussion or questioning about Karen's support needs, given that Sovereign were aware of the background of domestic abuse. Although a referral was made to a Tenancy Support Advisor at the start of the tenancy, this appears to have been primarily about Karen's history of rent arrears rather than for specific support or advice on other matters.

255. During the settling-in visit a referral was discussed and then made for outreach work. This appears to have focused on Karen's desire to seek employment and to mitigate her feelings of loneliness and isolation.

256. Given the known history it would have been helpful to explore the domestic abuse issues in more detail, or if that happened, for it to have been documented more clearly.

257. The third contact related to repairs at the property. Karen stated she did not feel safe whilst the repairs were not done. This is assumed to relate to her not feeling safe because the property was insecure. However, the fact this is not clear, and may have related to her feeling unsafe due to domestic abuse, is something that could have been explored. The role of repair staff in engaging with tenants is an important one, and their awareness of that welfare role can be critical in establishing engagement and gathering information.

258. The Sovereign IMR does not make any recommendations.

West Berkshire Council Adult Social Care (WBC ASC)

259. Both WBC ASC's contacts with Martin in 2008 and 2010, took place outside the timescale for this DHR. Nonetheless their contact with him assisted the

DHR panel in building up a clearer picture of his history in relation to contact with local services.

260. It is clear that interventions took place in the context of CMHT involvement following referral from the GP in 2008 and then via use of the Mental Health Act (Section 136) in 2010.

261. On both occasions Martin was displaying signs of poor mental health but these appear to have been related to his misuse of drugs.

262. These engagements were limited in terms of scope and length of contact. It is clear that since those engagements the way in which adult mental health services are organised and delivered in West Berkshire has changed significantly. ASC is no longer part of a partnership arrangement with the NHS and as such, would be unlikely to have contact through such a referral route today. His levels of need would likely not reach the threshold for the provision of ASC services and his drug related problems would most likely be addressed through referral via the NHS to a specialist service, such as the one he did access.

263. From the information available it appears that the response of ASC to Martin and his presenting needs at the time was appropriate and met the standard required. Although falling well outside the timescale for this DHR, the record of these contacts has been helpful in plotting the longevity of Martin's mental health and substance misuse difficulties, and the context in which some of his behaviour manifested itself, particularly in relation to his domestic abuse perpetration history.

264. The WBC ASC IMR makes no recommendations.

West Berkshire Council Children and Families Service (WSC C&F)

265. WSC C&F had no direct contact with Karen during the timescale covered by the DHR as she had no responsibility of care for children during that period. There had been previous contact in relation to child protection proceedings, which resulted in her children being removed and subsequently adopted.

266. Similarly there was no direct contact with Martin, although there was contact in relation to his children with his ex-partner. The first of these interactions in January 2017 followed concerns that Martin was attempting to contact the children. The matter was appropriately recorded and given

there were no safeguarding concerns identified no further action was felt to be necessary. This was a reasonable decision given the facts available. The only area where action might have been helpful would have been the provision of information about local domestic abuse services being made available to Martin's ex-partner.

267. In February 2017 when similar concerns were raised by Martin's ex-partner, WBC C&F were again notified. The service did consider contacting Martin directly, but decided against this on the advice of the police. It was appropriate for them to take that advice and showed good communication and liaison with another agency. WBC C&F knew that Martin's ex-partner was taking the necessary steps to prevent contact between Martin and the children and there were no other immediate risks. On that basis the decision to take no further action and close was appropriate. It would have been beneficial if the decision had been more accurately recorded, as this would have set out the rationale more clearly.

268. At the time the presenting information or concerns did not meet the threshold of 'significant harm' (evidence that a child was at risk of or suffering significant harm) and therefore the decisions taken were appropriate. Since this time the process and procedure has changed, and any second referral would be passed to the MASH.

269. The third contact arose eight months later in October 2017. There were concerns that one of the children was exhibiting challenging behaviour and that Martin's ex-partner was finding it harder to cope with this. WBC C&F suggested some specialist parenting support and a referral was made to the Targeted Intervention Service (TIS).

270. No previous support had been offered. The family had always sought appropriate advice from C&F and were asking for particular help at this time. It was appropriate to pursue this specialist option, and the process followed the necessary guidance and procedure.

271. The meeting held in January 2018 to discuss the case was reportedly well attended by key professionals and demonstrated good engagement and participation by those involved. There was an appropriate discussion about the merits of a MAPPA referral and MARAC. At the same time it was agreed that a worker would visit the children to explain that contact with Martin was not allowed. This was a sensible course of action. It was also agreed that a photograph of Martin would be supplied to the children's school to help

them identify him if he continued to attempt contact, and to increase monitoring of the children, though it is not clear what form this monitoring took.

272. A further review took place in February 2018 and it was agreed that TIS would support Martin's ex-partner in seeking legal routes to prevent him contacting the children. TIS went beyond their remit in supporting Martin's ex-partner in a number of ways and demonstrated effective partnership working with other agencies and professionals including probation. It was appropriate to close the case at this point and Martin's ex-partner had been appreciative of the work done. Although a referral to MARAC had still been under consideration, it was not pursued. It may have been beneficial to do this before closing the case. The decisions made by TIS were sound and based on the facts at the time. The team was impacted by the lack of a Team Manager, but this does not appear to have had any direct bearing on the conduct of the case.

273. The final contact was in May 2018 following a referral to the Emergency Duty Team (EDT). The police made this contact following an incident of Martin directly contacting one of the children on their way home from school. The police were requesting confirmation of previous involvement and relevant history. The referral was correctly passed to the CAAS team for follow up, which took place with Martin's ex-partner. Following this discussion, it was agreed that there would be no further action by WBC C&F and the case was closed. The service was satisfied that Martin's ex-partner was in liaison with the school and that WBC C&F had passed all relevant information to the police. This was an appropriate action and the decision to close the case was sound.

274. Overall, the analysis indicates that the contacts undertaken were of a low level and were largely about information exchange and onward referral. Recording appears to have been largely accurate, though Martin's children were not listed on the MARAC referral for Karen (usually all children are listed) therefore there was no linking between the concerns for Karen of risk from Martin and the concerns of risk from Martin to his ex-partner. If this had happened it may have led to an increase in the level of concern about his behaviour.

275. The WBC C&F IMR makes three recommendations

Swanswell Drug and Alcohol Service

276. Swanswell were engaged with Martin for a limited period, around four months, during 2018. Their principle role was the delivery of DDR sessions in relation to Martin's substance misuse and his licence conditions. It appears that Swanswell had very limited information about Martin, indeed they did not know much about him at all.

277. There is no evidence from the IMR that the issue of domestic abuse was ever raised with Martin, or indeed with Karen in her very limited contact with the service, which was largely to cancel Martin's appointments or enquire of his whereabouts.

278. It is not clear whether the Swanswell worker was aware of Martin's history of perpetrating domestic abuse. Certainly they did record this and during interview for the IMR they stated that if they had known or enquired about this they would have recorded it. This is a significant gap in their knowledge about Martin and his history, as well as in their risk assessment.

279. It does not appear that Swanswell actively sought information from other agencies. They were in contact with probation and it would have been reasonable to assume that this information would have been passed to them, or that they would have enquired about it as a standard enquiry on any referral. The worker did not request a copy of the probation risk assessment, this is a significant gap in practice, equally, probation could simply have offered that information, why they did not is unclear.

280. Policy was not adhered to with the organisation. This was in relation to follow-up of non-engagement by Martin. Contact should have been attempted after every appointment with Martin, by phone, to check on welfare and re-book the appointment. This did not happen and was a significant gap in practice.

281. There was a lack of appropriate supervision in this case. Indeed it appears that the worker never raised the case in supervision certainly such a discussion was not recorded.

282. As a result there was a lack of managerial oversight of the case, which given the seriousness of Martin's difficulties and risks, represents a significant deficit in practice and management.

283. Martin only had one 1:1 appointment after assessment. This appears to have been especially low as the expectation highlighted in the IMR is that clients should have such a meeting on a monthly basis. There is no explanation as to why this was the case. The lack of such meetings meant there were even fewer opportunities to ask Martin about his relationships, assess risk or tailor different strategies for engagement.

284. The Swanswell IMR makes four recommendations.

The Priory Group

285. The Priory Group was asked to provide an IMR in order to establish a fuller history of Martin's mental health support. Their input was outside the timescale for the DHR but was helpful in providing the context for his diagnosis and the nature of the care and treatment he received.

286. It is evident that The Priory had a full history in relation to Martin and were well aware of his background and the range of difficulties that he had presented and lived with.

287. The majority of engagement with Martin, other than with medical staff, appears to have been through a student social worker. Although that student social worker was able to establish a rapport with Martin and attempted to engage him in conversations about his mental health, relationships and domestic abuse, these were not especially fruitful. The appropriateness of allocating a student to work directly with Martin, whose needs were complex and who presented a high risk seems particularly questionable. A more experienced worker would have been more appropriate, or at least a more experienced worker providing close supervision would have been expected.

288. Martin had another ex-partner in Wales, with whom he had a child. It was agreed that she could visit him at the hospital. The history of domestic abuse perpetrated by Martin was later taken into account and such visits were not allowed. It is surprising that this was even considered given his history and the risk he posed and suggests initial poor judgment.

289. Martin's ex-partner does not appear to have been provided with information about domestic abuse services, certainly there is no record of this happening.

290. Martin's time at The Priory featured a number of discussions and debates about responsibility for his care and treatment between local authorities in

relation to Section 117 aftercare.[17] There were apparently disagreements about this, it is unclear why, given that the legislation is clear about where Section 117 responsibilities lie in relation to local authorities and out of area placements. It also appears that Martin did not have a care co-ordinator after his release from prison, nor that he had one on discharge from The Priory. This is a breach of national policy guidance contained in the Care Programme Approach and represents a significant deficit in practice.

291. The degree to which information was exchanged with other agencies appears to have been limited. The lack of a care co-ordinator would have had an impact on such liaison and communication.

292. Martin's diagnosis was changed while he was at The Priory; the reasons for this are unclear. As a result of this change of diagnosis, Martin thought he would be discharged if he stated he no longer had mental health problems. There is no evidence to indicate this was discussed with the Ministry of Justice. The IMR states he had been hospitalised 'under false pretences'. This seems to represent a fundamental misunderstanding of the provisions of the legislation at the time, indeed, how they apply currently.

293. There is no evidence to indicate that Martin's levels of risk were ever communicated to or shared with other agencies, nor were they discussed with his family or previous and current partners.

294. There are gaps in practice throughout the time Martin was a patient at The Priory. Although none of these appear to have had a direct bearing on the outcome, they were significant in terms of the quality of the service.

295. The Priory IMR makes three recommendations.

Thames Valley Police

296. The TVP IMR details a range of contacts and interventions with Martin and Karen, many of which took place outside the timescale for this DHR. The analysis concentrates on those contacts that took place after September 2016, though those that have been reviewed prior to that provide a helpful picture of Martin's history of domestic abuse against Karen as well as his ex-partners.

[17] Some people who have been kept in hospital under the Mental Health Act can get free help and support after they leave hospital. The law that gives this right is section 117 of the Mental Health Act, and it is often referred to as 'section 117 aftercare.

297. In November 2016, in response to an incident in a local bar, the police attended and recorded this incident as domestic abuse. This was the first domestic abuse incident TVP had dealt with between the couple since 2010.

298. The incident was risk graded as standard. Karen described how she had been strangled by Martin, though the police report describes her as being grabbed by the throat. The language used is relevant as this appears to have had an impact on the risk-grading outcome. The IMR notes that non-fatal strangulation is a powerful predictor of future homicide. There seems to have been insufficient evidence to ascertain the exact nature of the assault and this led in part to the risk grading. It appears that officers did not give particular weight to the possible use of strangulation in the assault.

299. Although the risk assessment history was comprehensive in relation to Karen and Martin's non-domestic abuse history there was no detail of previous out of force area domestic abuse incidents. This meant there was not a full picture of past history available to them. There were no warning markers present on Martin's record on the Police National Computer (PNC), other than his alcohol misuse and self-harm history. Therefore there were gaps in the information available that could have assisted in the risk assessment process and grading. It is worth noting that domestic abuse markers are now a feature of the PNC system.

300. TVP did have contact with Nottinghamshire mental health services in December 2016 and received information about Martin's level of risk. The officer concerned appropriately created an Adult Protection report. Although the MASH were aware of this report there was no contact made with Nottinghamshire mental health services by them at that time.

301. The incident at Karen's mother's home in May 2018 was correctly recorded as an assault with injury and criminal damage. No action was taken against Martin following this incident. Given that successful prosecution was unlikely, it appears that this decision was sound. This was in part because Karen's account of the incident was inconsistent and there were concerns about the admissibility of the evidence from the Body Worn Camera. Had the incident been graded high risk, it could have been referred to the Domestic Abuse Investigation Unit DAIU, but this did not take place.

302. There is no evidence that a Domestic Violence Prevention Notice was considered. It is not certain that such a notice or order would have been

granted in this case but it should have been considered and a rationale for not seeking it set out in the records.

303. There is no evidence that any safety planning was done with Karen, other than the provision of general advice. It appears that her assurances and reluctance to engage were readily accepted.

304. Throughout the TVP IMR there are examples of issues relating to risk grading and the basis upon which those grading were made. In many instances there appears to have been a lack of information available, and in some cases the grading was incorrectly made on the basis of 'imminent risk'. It is reasonable that risk assessments should to some extent be incident led, but it should also take into account past history and predictive factors as well. Throughout the TVP IMR there are examples where insufficient weight was given to historic concerns and behaviour.

305. Imminence in particular was cited as a rationale for risk grading and response. The issue of imminence is not part of the grading system and the IMR makes this explicitly clear.

306. Too much emphasis appears to have been placed on the actual level of violence in each incident of domestic abuse against Karen, rather than an assessment of Martin's likely actions and capability for violence, along with other risk factors such as his mental health and his substance misuse.

307. The TVP IMR raises concerns about the effectiveness of the MARAC process in West Berkshire at the time, notably in 2017/18. The notes of those MARAC discussions appear not to have been comprehensive enough and little or no information was shared in relation to Martin's mental health history. Although it is known that practice has improved these issues served to compound a lack of a holistic view of Martin, as well as his relationship with Karen, the risks to her and how the police and other agencies could best respond.

308. The IMR contains details of concerns about the operation of the MARAC at the time covered by the DHR. In particular it appears that there were issues in relation to differing perceptions and approaches to risk assessment among the relevant agencies. This could have had the effect of influencing the discussions and decisions taken at the MARAC. There is one example of the risk being downgraded by TVP following a MARAC discussion. It moved

from high to medium. Although only a small number of cases were ever regarded as being high risk, and managed by the DAIU.

309. TVP did respond appropriately to all calls in relation to Karen and Martin. In doing so they clearly sought to engage and apply the law. They utilised the correct processes including the DOM5. In so doing they complied with expected practice.

310. In relation to the matters regarding Martin's children with his ex-partner (Karen's sister) there was limited information available to TVP about any safeguarding measures that had been in place for the ex-partner and her children. Again this meant that TVP did not have clear oversight of all the issues. However, they did appropriately engage and communicate with other agencies in respect of the concerns about Martin's attempts to contact the children.

311. The deficits in risk assessment overall are clear and these are well drawn out in the IMR. These may also have been influenced in some degree by the way in which Karen sometimes downplayed incidents or did not wish to take forward any formal complaint against Martin.

312. The TVP IMR makes four recommendations.

Royal Berkshire Hospitals NHS Foundation Trust (RBFT)

313. RBFT had limited contact with Karen, and such that it did have was largely focused around her maternity care, which fell outside the timescale covered by this DHR.

314. Beyond that there was a contact following a seizure during Karen's second pregnancy, which resulted in attendance at the Emergency Department. It appears that appropriate medical care was provided but there is no mention of any direct enquiries in respect of Karen's relationship or any enquiry about domestic abuse. There is reference to summaries in Karen's notes about child protection concerns at the time and these do mention that Karen had experienced domestic abuse. However, it is not clear whether that information led to any other form of enquiry or offering of advice and support.

315. RBFT did participate in child protection meetings in relation to Karen but their role in those discussions is not made clear.

316. RBFT had four contacts with Martin. One of these was for surgery and then follow-up during his period in prison in 2007. They were aware that he was in a relationship with Karen at that time. They were also aware of his issues in relation to substance misuse.

317. His other attendances related to incidents of violence, the first after he kicked a door and dislocated his knee. He was accompanied to hospital by the police. There is no reference to any enquiry about why he had engaged in this act, and no exploration of any relationship issues, mental health problems or substance misuse issues other than to have noted that these were present in Martin's history.

318. When Martin presented again in April 2018 having been found intoxicated and injured, he was physically aggressive to the treating staff at RBFT.

319. They noted that Karen was his partner, but there does not appear to have been any exploration of issues in their relationship or of domestic abuse.

320. RBFT were aware of Martin's history and the notes indicate that his attendances largely related to the results of violent behaviour. There is nothing to suggest that his care and treatment was anything other than of the appropriate standard and quality. However there are gaps in relation to exploration of the wider issues he experienced with his mental health and substance misuse, both of which appear to have been factors in his behaviour. This may be characterised as a lack of professional curiosity.

321. The RBFT IMR makes four recommendations.

National Probation Service

322. NPS had significant involvement with Martin during the period covered by this DHR, starting in July 2017 until the time of Karen's death in September 2018.

323. When he was allocated to NPS it was on the basis of his high risk of re-offending and his high risk of serious harm, particularly to known adults and the public. An historic assessment process was used, but this does not appear to have impacted the outcome in terms of his assessment of risk.

324. The assessment was to some extent compromised by the short time between sentence and release and a lack of available information. His risk of domestic abuse was assessed even though the offence he was convicted of was not related to this. He was assessed as being of high risk to partners. This was good practice. His risk to children through domestic abuse was assessed as medium.

325. The initial assessment of risk did identify a number of key issues but did not contain a detailed analysis of these. It did not include the children he had had with Karen, nor the impact of their subsequent adoption on Martin or his relationship with Karen. Other areas of risk, such as arson were not explored in depth, had they been so the assessment would have been more robust.

326. The decision to recall Martin to prison in September 2017 was sound and followed policy, legislation and guidance. The recording and process was of a good standard.

327. The consultation about whether Martin should be considered for MAPPA was an appropriate one. Although advised that he did not meet the criteria for level three MAPPA appears to have been appropriate in terms of the application of the relevant guidance, given his risks and history, it may have been an appropriate action that of itself would have resulted in greater oversight and co-ordination at a senior level across a number of agencies.

328. A start-license assessment was conducted in December 2017, 12 days after Martin's release from prison. Although detailed, it relied on a good deal of historical information and Martin's own self-assessment on the day of release. It lacked detail about the situation at the time of his release, including the exact nature of his relationship with Karen and the risks he posed to her. It also failed to assess the impact of Karen's mothers relationship with Martin, whether she was a protective factor or not, which the assessing NPS staff member believed her to be. That particular judgment could be called in question.

329. When Martin returned to West Berkshire the start-licence assessment was not updated as the worker felt it remained accurate. It appears that at least in part, workload pressures influenced this decision, with the worker having an excessively high caseload.

330. Following Martin's offence of burglary it was appropriate to refer him for a DDR programme. However, the process for this involved a report, which was only given orally and based on notes made by the pre-sentence report author. These do not appear to have been sufficiently detailed and did not meet the required standards that the NPS requires. The IMR finds that the PSR author should in fact have produced a Fast Delivery Report during the adjournment period in the criminal case. This would have allowed for a more fully formed judgment about risk, relationship issues and accommodation. These matters did not relate the actual offence so may not have influenced the sentence, but would have allowed for a fuller and more detailed overview.

331. There were significant challenges in the securing accommodation for Martin within approved premises (AP). A number of factors contributed to this but the fact that AP was not secured is of concern.

332. It resulted in Martin residing at Karen's mother's address, which neither he nor Karen ever acknowledged directly. This may have exposed Karen to greater risk. Given that Martin's licence agreement required him to live in AP enforcement action could have been taken, but the lack of alternative accommodation would likely have hampered such action.

333. Although offender managers could not prevent Martin moving to West Berkshire, he claimed he was living with friends. If workers had conducted a home visit to Karen's mother they would likely have been able to establish that Martin was in fact residing there.

334. No mental health assessment was conducted and no referral from Nottinghamshire services to West Berkshire was requested by NPS. There was no liaison with the Nottingham mental health service, had there been such liaison it may have facilitated referral, or at least provided helpful information.

335. When Karen moved to her new address permission for Martin to reside there was not given. This was an appropriate decision. However the worker was aware that Martin visited Karen there.

336. It is known that Karen would often check on Martin's attendance at appointments and that the NPS worker had contact with her by phone but this was not routinely recorded in the files. It is clear that Karen had stated she had full understanding of Martin's history of domestic abuse but that she did not want any support.

337. Both NPS workers had made clear to Martin his need to register for accommodation with local councils. When he returned to West Berkshire he did not do this and did not volunteer information about where he was staying. He did request permission to move to Bristol but this was refused. This appears to have been an appropriate decision, based on concerns that he might have become homeless or lost contact with probation services.

338. The NPS worker was supportive of Martins attempts to secure independent accommodation and felt this was a factor in protecting Karen, though his motivation to do this appears to have been less when his relationship with Karen was positive.

339. The NPS worker appropriately sought to support Martin in seeking employment, which he secured on building sites. This was a positive development, albeit one which had its challenges.

340. The bailing of Martin to Karen's mother's address following the burglary incident legitimised his presence there. The NPS worker did not record her monitoring of where Martin was living or her conversations with him when challenging him about staying with Karen. This was a gap in the accuracy of recording.

341. There were gaps in the implementation of elements of Martin's licence, specifically a Rehabilitation Activity Requirement. There was no alternative plan documented and this represented a deficit in practice.

342. After Martin was given a community order there were a number of incidents including one where people associated with the victim of a previous sexual offence attacked him and he briefly left West Berkshire. He had a series of short-term jobs, which interrupted his contact with the NPS worker and his attendance at DDR meetings, which was highlighted in the Swanswell IMR.

343. During his last meeting with the NPS worker, Martin described his relationship with Karen as being good and raised no concerns the following week with a worker who was providing cover. There do not appear to have been any signs of deterioration or difficulties developed in the immediate lead up to Karen's death.

344. Martin did comply with his PSS licence and reported weekly. This was an improvement on his previous actions. The NPS worker appears to have been

diligent in reminding Martin of his conditions and warning him about behaviour that would constitute a breach, including consulting with senior colleagues before warning him. Those challenges appear to have been robust and appropriate and were well evidenced.

345. The IMR shows that the lack of pre-sentence assessment and the short sentence for the index offence put constraints on the ability of the NPS to manage him, especially as he was a high risk offender when released.

346. The key deficit identified in the NPS IMR was the lack of rigour in the assessments undertaken, that they lacked quality and robustness, there also appear to have been deficits in planning and review. Domestic violence issues do appear to have been taken account of, and the risks Martin posed known about and documented. Less clear is the detail about the mitigations that were in place to reduce risk and how effective they were.

347. The NPS IMR makes eight recommendations.

19. Conclusions and lesson learnt

348. Having reviewed and analysed the information contained within the Individual Management Reviews (IMRs) and having considered the chronology of events and the information provided the panel has drawn the following conclusions relating to organisational involvement and come to more general conclusions about this case.

349. Karen and Martin had been in a relationship for over ten years. Their relationship was punctuated by domestic abuse perpetrated by Martin throughout their time together.

350. There was a pattern whereby Karen wished to end her relationship with Martin, but did not do so, indeed her mother referred to her daughter restarting the relationship. There may have been a number of reasons for this, and it would not be sensible to speculate. However, research has shown that a common pattern of domestic abuse, especially this between intimate partners, is that the perpetrator alternates between violent, abusive and apologetic behavior (sic) with apparently heartfelt promises to change and that the abuser could very pleasant most of the time.[18]

[18] Domestic Violence and Abuse in Intimate Relationship from Public Health Perspective, Zlatka Rakovec-Felser, NIH, Health Psychology Research October 2014

351. Evidence set out by the World Health Organisation suggests that most abused women are not passive victims – they often adopt strategies to maximize their safety and that of their children. Heise and colleagues argue that what might be interpreted as a woman's inaction may in fact be the result of a calculated assessment about how to protect herself and her children. [19]They go on to cite evidence of various reasons why women may stay in violent relationships, including:

    Fear of retaliation
    Lack of alternative means of economic support;
    Concern for their children;
    Lack of support from family and friends;
    Stigma or fear of losing custody of children associated with divorce; and
    love and the hope that the partner will change.

352. Martin has been a serial domestic abuser, who has a lengthy history of convictions and has been a repeat offender. His offences when not directly related to domestic abuse revolved around violence to others, damage to property, burglary, sexual offences, and the misuse of drugs. He has spent a number of periods in prison over the past 13 years or so.

353. Martin has experienced mental health problems for much of his adult life. He has spent time as a detained patient in a medium secure forensic mental health hospital. He has been diagnosed with a personality disorder, but there have been changes to his diagnosis, in particular during his time in the secure hospital.

354. Karen also lived with the effects of mental health problems, having a diagnosis of personality disorder. She was an occasional user of drugs and had some physical health issues, including epilepsy and hearing loss.

Organisational conclusions

355. In respect of primary care involvement, there was very little information available in relation to Martin's engagement with primary care and none that provided any specific insights into his behaviour.

356. Karen's engagement with primary care was sporadic and largely not face-to-face, being conducted most often through telephone contact. Much of this

[19] Heise L, Ellsberg M, Gottemoeller M. E*nding violence against women*. Baltimore, MD, Johns Hopkins University School of Public Health, Center for Communications Programs, 1999

related to repeat prescription requests. The clinical care provided by the GP practice was of a good standard. Although the GP practice was aware of the issues of domestic abuse there were only limited opportunities for them to explore these with Karen.

357. Although the GP practice was aware of the circumstances between Karen and Martin, there was no recorded routine enquiry about domestic abuse issues. It is not clear that there was a specific opportunity for this to happen, but as was highlighted in the analysis, this may be more a matter of general professional curiosity not being used. The practice staff had received training but do not seem to have translated this into their day-to-day practice in this case. More broadly, the use of routine enquiry has been shown to be an issue in other DHRs, including in West Berkshire. This may point to a broader issue in relation to closing the gap between training and practice delivery, not just locally, but elsewhere too.

358. The GPs focused on clinical presentation rather than a more holistic view of the situation. However, there were examples of good practice, notably their proactive attempts to engage Karen.

359. The engagement of mental health services in West Berkshire with Martin through the BHFT was patchy. It is concerning that the requests from Nottinghamshire services to inform them of contact with BHFT were not responded to or followed up. It is our conclusion that this meant that opportunities for information exchange were missed and that this affected the way in which Martin was assessed and responded to.

360. The assessments of Martin by BHFT were insufficient in both detail and quality. Accepting that it may have been appropriate that he was not seen in person, it is difficult to understand how an effective and robust assessment could have been made without talking to him. Our conclusion is that this was a missed opportunity to engage with Martin and to gather a fuller picture of his history, presenting problems or to seek his views about his situation, in particular about his relationship with Karen.

361. From the limited information available it seems that BHFT regarded Karen as a protective factor for Martin. This was, in our judgement, a flawed assumption that perpetuated her own understanding of her role in the relationship. This meant that the risks he posed were not well understood or considered. Again there was no routine enquiry about domestic abuse, and this was a gap in local practice.

362. BHFT's recording system effectively concealed the MARAC flag within his notes. Although staff could access it, the process for doing this does not seem to have been clear.

363. Although it is understandable and probably appropriate to use this process to avoid the individual discovering the flag inadvertently, the efficacy of such concealment should be an area for consideration in the improvement of day-to-day practice of record keeping within BHFT.

364. The engagement of A2Dominion was a positive step and Karen made good use of their services. It is clear that the staff working in those services were able to build a positive relationship with her and provided a range of support to her.

365. There is good evidence of robust risk assessment and management planning within the A2Dominion services.

366. There were challenges for A2Dominion in managing their working relationship with Karen, and there were occasions where her behaviour towards other residents was inappropriate. In part this contributed to her eventual move to a satellite service. It is our conclusion that Karen was unsettled by that move and that it may have been handled more sensitively, but it cannot be said with certainty that it contributed to her later circumstances or behaviour. However, there should have been a safety plan in place to mitigate some of the risks when she did leave those services.

367. Karen's contact with Sovereign Housing Association was focused only on her application for housing and repairs to the property. The organisational policies were followed in relation to the pre-tenancy assessment and settling-in visit.

368. Sovereign were aware of Karen's history and it is our conclusion that it would have been helpful if a more thorough exploration of this had taken place during the pre-tenancy assessment. Her support needs were only seen as relating to previous problems with rent arrears. Domestic abuse was not discussed and that was a gap in the process that meant a fuller view of her support needs was not considered. Although this does not appear to have had a bearing on the outcome, it is an area where the pre-tenancy assessment could be improved, again through some form of routine enquiry.

369. WBC ASC had limited contact with Martin. It is our conclusion that as a result of organisational changes locally it is unlikely that WBC ASC would have any

role if Martin presented in the same way now. However, the response of WBC ASC was appropriate in the context of the way services were structured at the time.

370. WBC C&F had previous contact with Karen in relation to the child protection issues with her two children, who were subsequently adopted. That process took place outside the timescale for this DHR, but from the information provided that work was undertaken in accordance with legislation and policy.

371. WBC C&F did have engagement with other agencies in relation to Martin's children with his former-partner (Karen's half-sister) though these did not lead to direct contact with Martin. WBC C&F demonstrated effective liaison and communication with other services, in particular the police, probation and other social care agencies.

372. WBC C&F were largely fulfilling and information exchange role and were able to contribute to decision making that assisted in preventing Martin from contacting the children. There is demonstrable good practice. Although one of the teams with WBC C&F did not have a Team Manager in post at the time, it is our conclusion that this did not adversely affect decision-making.

373. Martin was engaged with Swanswell as part of the DDR programme. It is striking that Swanswell appear to have had very little information about Martin and his history at the point at which they took on his case. Given his lengthy history of criminality, coupled with his substance misuse, we can only conclude that this must have compromised the way in which Swanswell were able to assess him and initially work with him. Although that information should have been provided as a matter of course, it is surprising that Swanswell did not seek to more proactively seek information about Martin's history, either directly from him, or through enquiry with other agencies, including probation, given they had facilitated his referral.

374. Domestic abuse was not raised or explored with Martin during his time engaged with Swanswell. Given that his substance misuse was known to be a contributory factor to his offending behaviour, this is a significant gap in practice and meant that their assessment of his risk and risk management was flawed.

375. Swanswell's policy and procedures were not adhered to in relation to follow-up on non-engagement. It is our conclusion that this further exacerbated

that non-engagement. Although in part it can be attributed to Martin being in employment at times during the DRR programme, that lack of follow-up was a gap in practice.

376. The supervision of Martin's case by Swanswell was insufficient. The fact that the case was never raised in supervision is particularly concerning given the levels of risk Martin posed. It may in part be explained by the lack of information the organisation possessed about Martin. However, it points to a failure in process that resulted in a lack of senior management oversight of the case.

377. The Priory contact with Martin took place outside the timescale covered by this DHR, however, the information provided gave helpful background and context to his mental health difficulties.

378. There were a number of issues in relation to his period at The Priory and his eventual discharge, which point to deficits in internal processes and the management of his care. In particular the lack of an allocated care co-ordinator represents a failure to comply with Care Programme Approach guidance, which has been in place for almost two decades.

379. Martin's discharge was also characterised by disagreements over Section 117 (Mental Health Act) funding responsibility. It appears that these disagreements may have contributed to the lack of a care co-ordinator. The legislation is clear: it is the duty of the CCG in England or the Local Health Board in Wales, and local social services authority (usually the one in the area the individual lived in before they were detained). It is their responsibility to provide the individual with aftercare services, or to arrange for them to be provided. That these disagreements occurred would seem to demonstrate a lack of understanding of the law and how it should be applied.

380. There is no evidence that The Priory effectively communicated the risks Martin posed with other agencies. They did not communicate these risks to Karen, or other family members. This was a significant lapse in process and meant that other agencies, Karen and other family members were not aware of the range of risks that had been identified, nor could these be effectively mitigated as a result.

381. Thames Valley Police (TVP) had a number of contacts with Karen and Martin in the period covered by this DHR. These contacts are characterised by swift

responses to calls for their attendance and in most instances, the appropriate application of the law, policy and procedure. However, it is our conclusion that there were some gaps in practice.

382. In particular, there were inconsistencies in the application of risk grading in relation to Martin and his behaviour. These centre on the application of the test of imminence of danger. Imminence of itself is not a sufficient test and it was not appropriate to use this measure in grading Martin's risk to Karen or others. There was a concentration on the actual violence used, rather than seeking to understand the levels of risk of future violence or offending, or indeed, historical behaviour which is generally accepted as a reasonable indicator of future behaviour. Historical and predictive factors should have informed those decisions about risk and risk grading more fully, that they did not have an influence on risk grading that appears, on occasions, to have minimised the perception of the risks Martin posed.

383. TVP did not have access to historical information about Martin's 'out of force area' risks or offending behaviour. Again this compromised their ability to make a well informed and holistic judgment about risk, risk management and potential future offending.

384. TVP often had to balance the presenting situation with Karen's reluctance to press ahead with giving a statement or supporting further investigation. This meant that on occasions their ability to intervene further was hampered. However, where steps such as the use of a Domestic Violence Protection Notice (DVPN) could have been used, this was not actively pursued. We conclude that this could have been a helpful tool, even if its granted could not have been guaranteed. In addition, it does appear that Karen's assurances were sometimes readily accepted without deeper exploration or consideration. Whether this was simply about time and capacity is not clear.

385. TVP did attempt to offer Karen general advice but did not engage in any thinking about safety planning.

386. There is evidence that TVP did engage with other agencies, and were central to discussions relating to MARAC. Their engagement in that process is clear, but it has also highlighted issues with the MARAC at the time.

387. RBFTs contact with Karen was minimal and was outside the timescale covered by this DHR. It focused on her maternity care. RBFT were aware of

child protection concerns and appropriately engaged in meetings related to this. Beyond this there was nothing of particular to note.

388. RBFTs contact with Martin again largely took place outside the timescale covered by this DHR. The only contact in scope was in 2018. There was note taken of his relationship with Karen at that time, but no routine enquiry in respect of domestic abuse.

389. Although he was known to experience mental health issues, there was little in the way of exploration of these during the 2018 attendance, which came about as a result of Martin being intoxicated and injured in a public place. His clinical care was of a good standard but the lack of professional curiosity displayed about his wider problems and circumstances meant that an opportunity to gather that information and potentially engage him with other services was missed.

390. The NPS had significant contact with Martin in the period covered by this DHR, both in West Berkshire and Nottinghamshire, from where his case was transferred.

391. The assessments undertaken by NPS were comprised, at times insufficient. We conclude that they lacked detail, were not robust and failed to take into account a number of important factors. One of these was the relationship between Martin and Karen's mother, which was seen to be protective, when in fact, it could be characterised to have been to some extent potentially collusive.

392. The inability to secure approved premises was a particular factor in Martin residing with Karen's mother. We conclude that while there must be an appreciation of the difficulties in securing AP for Martin, and the reasons for this have been made clear, it provided opportunities for him to live where he should not have, and that this enabled him to engage in acts of domestic violence against Karen, as well as other criminal behaviour.

393. The lack of home visits meant that the NPS worker was unable to gather a direct view of the circumstances in which Martin was living, his relationship with Karen, her mother, and thus the understanding of the wider situation was incomplete.
394. We conclude that there were gaps in recording of contacts, decisions and actions. These represent a deficit in practice. In particular the lack of monitoring and recording of where he was living is of concern.

395. Decisions made about Martin's recall to prison were appropriate, based on evidence of his non-compliance and taken in a timely way. It is also evident that the NPS worker did attempt to build a positive rapport with Martin and was able to create the conditions for compliance with his PSS licence. This was good practice.

General conclusions

396. Karen had experienced domestic abuse over a number of years. She had fled from it, notably to Somerset and then to Oxford. However, her relationship with Martin was one of interdependence and she found it hard to end their relationship. She had attempted to do this on a number of occasions, often when he was in prison or in hospital.

397. The wider and longer lasting impact of the removal of her children on Karen does not seem to have been more broadly considered or addressed with her. Whatever the situation at the time, it is known from talking to her mother, that their removal and subsequent adoption was a significant event in her life and one that she found distressing.

398. Throughout the DHR the issue of risk assessment, risk grading and risk management have emerged as key themes. The differing approaches of organisations to risk, its assessment and management demonstrate a lack of consistency and common understanding. It was too reliant on individual practitioners and professionals, on nuances of language and did not take sufficient account of historical factors, concentrating more on the immediate situation in isolation.

399. Information sharing between agencies was inconsistent. There are examples of information not being sought, requests for information not being followed up, and a lack of proactivity in both sharing and seeking information about both Karen and Martin. This resulted in agencies not having a full, accurate and up to date knowledge of the history or current circumstances.

400. The involvement of organisations with Karen during the period covered by this Domestic Homicide Review was characterised by a lack of collaboration and joint working, with each organisation working in isolation from the others. This contributed to a number of key deficits including:

- The lack of a holistic view of Karen and Martin's relationship, their interdependence on one another, the risks posed by Martin to Karen, the impact of his wider offending and drug misuse and his mental health problems.

- A lack of effective communication and information sharing between agencies

- In some cases a lack of senior oversight of key decisions and actions, and knowledge of these by other agencies

- Whilst all professional have a role in relation to risk, differing professionals within any multi-agency context will have more contact, time and opportunity to monitor, engage and assess risk.

401. The way in which the MARAC was used and operated at the time has been identified within the IMRs as an area for improvement, and some of this work has already been undertaken. However, it can be concluded that those discussion that did take place were not comprehensive enough and were influenced by the variability of view about risk already highlighted.

402. Throughout her interactions with agencies, notably the police, Karen downplayed the seriousness of the domestic abuse perpetrated against her. She contextualised and rationalised it. This contrasts with the occasions when she did recognise it for what it was and took active steps to remove herself, both to refuges in Somerset and Oxford.

403. It could be concluded that Karen did not always see herself as a victim of domestic abuse, indeed, she may have reached a point in her relationship with Martin where she was almost desensitised to it, it was her normal experience. The agencies that were in contact with her were unable to help her to see differently.

404. Those same agencies were unable to work with Martin to address his behaviour effectively.

405. This case is one characterised by two individuals with complex needs and interdependencies. The history of domestic abuse against Karen was lengthy and ultimately it ended her life prematurely. The effect of her loss has been profound for her family and those that knew her.

20. Recommendations

406. This section of the Overview Report sets out the recommendations of the DHR panel and also the recommendations from the IMRs. The DHR panel recommendations are intended to address system wide issues and to support and build upon those recommendations already made and being acted upon in the IMRs.

DHR panel recommendations

1. The use of routine enquiry across all statutory bodies in West Berkshire should be monitored. Training should be provided where needed, but ultimately the test of effectiveness is the change in day-to-day practice and this should be subject to regular review.

2. Provision should be made to enable perpetrators of domestic abuse to access support and intervention to recognise and address their abusive behaviour.

3. The changes to MARAC process in West Berkshire should be reviewed to ensure they have been effective and have addressed the deficits highlighted in this and other DHRs.

4. The statutory agencies engaged in this DHR should work together to ensure that current protocols for information sharing between themselves and with commissioned agencies (independent and third sector) are workable, robust and being used routinely.

5. Work should be undertaken to ensure practitioners in the agencies involved in this DHR better understand the nature of protective factors in relationships and are thus well placed to make accurate and sound judgments about those factors.

Agency IMR recommendations

Berkshire Healthcare NHS Foundation Trust

1. If there is a forensic history then attempts should be made to request previous records if available when making assessment in the Common Point of Entry (CPE).
2. A clear pathway to the Forensic Mental Health team should be developed and support accessed to help with assessment. *Since the IMR recommendations were agreed the Head of Safeguarding West of Berkshire CCG, CPE operations manager, clinical director and specialist practitioner domestic abuse met and felt this was not needed as there is a pathway to forensic services*
3. Further Domestic Abuse training provided to CPE in particular to focus on perpetrator risk and mental health and risks to partners when they are being identified as a protective factor. *This action has been completed*
4. Contact made with the Agency who provided the CPE practitioner to feedback performance. *The CPE practitioner has moved to a substantive post in another area.*
5. Entries showing records have been accessed for MARAC should not be concealed and the alleged victim should be recorded on the alleged perpetrator's records and visa versa. *This action has been completed.*

A2Dominion

1. A more systematic and robust approach to follow-up/resettlement contact when residents leave in an unplanned way.
2. Ensuring notifications are sent to the relevant local authority and police force advising of a resident's new location, if known, or recording that this was not possible if not known.
3. Both of the above points could be achieved by conducting a brief case closure review in cases where a resident's move-on is not planned in advance with staff.
4. A2Dominion Domestic Abuse Services will review the "End of Support From" and amend to ensure these practices are incorporated – by 30.09.19.

Case management could be more robustly demonstrated by:

- Ensuring that responses and outcomes from management decisions are clearly entered in contact logs.
- Ensuring that reasons for decisions accompany such notes.
- A2Dominion Group are developing a holistic case management system which will support a comprehensive case management approach to front line

support work; phase two (covering helpline work) is due to go live on 28.10.19, and phase three (covering the remaining ADAS services) will go live at a yet to be confirmed date in 2020.

- In the meantime, the ADAS Service Manager will issue written guidance to the team, and a face-to-face, in-depth exploration of these findings with Team Leaders – by 30.09.19.

West Berkshire Council Children and Families

1. Following a 2nd domestic abuse notification, a referral to be subject to MASH processes. (Agreed procedure 2019).
2. In cases where domestic abuse is a key feature then managers should consider within supervision if there is a need to complete the relevant risk assessment form (DASH) and refer to MARAC
3. EDT to be reminded to check accurately the boundary of Local Authorities and not rely on address names

Swanswell

1. Domestic Abuse information to be made a mandatory field on the assessment form to ensure the question is being asked and the response recorded.
2. All workers to request risk information from Probation when a new order is given.
3. All service users on a Probation order to be offered a 1:1 session once a month as a minimum to complement group work activity.
4. To monitor the implementation of the Engagement Policy, the Team Leader to select a random sample of cases to be discussed at each supervision as well as the cases the worker brings. This will ensure management oversight of cases where attendance is erratic.

The Priory

1. The service in Wales to ensure that a care co-ordinator is allocated to all patients to ensure a robust discharge plan is in place and to co-ordinate between agencies and share information
2. As part of pre-admission risk assessment, the Hospital Social Worker to gather background information on patients social circumstances and share with Multi-Disciplinary Team (MDT) for example forensic history and any active injunctions

3. To ascertain if the patient and former partners are aware of legislation such as the Violence Against Women, Domestic Abuse and Sexual Violence Act 2015 (Wales)

Thames Valley Police

1. TVP to review the process for dealing with intelligence about risk and consider how this is used when determining a domestic abuse level
2. TVP to review its processes for assessing risk in domestic abuse including the role of secondary risk assessing
3. TVP to deliver refresher training about domestic abuse behaviours to all relevant officers and staff
4. TVP to review all aspects of their current MARAC processes, procedures and partnership arrangements. The review will include training, roles and responsibilities, repeat cases referred back to MARAC, and how activities should be recorded in the various systems

Royal Berkshire Hospital NHS Foundation Trust

1. MARAC flags to continue to be placed on the Electronic Patient Record (EPR) for victims of domestic abuse.
2. It is recognised that front line staff are not always confident to discuss domestic abuse with victims and the completion of DASH forms work is on-going to improve this. Updated Trust Domestic abuse policy supports this on-going work.
3. Professional curiosity - continues to be discussed in safeguarding training.
4. Any additional system learning to be integrated

National Probation Service (NPS)

1. To provide information to a forthcoming national review of the work of Central Referral Unit's regarding the difficulties encountered by the worker in making Approved Premises referrals with a view to identifying and implementing process improvements
2. To ensure that the transfer process as set out in PI 07/2014 is fully implemented within Berkshire Local Delivery Unit (LDU)
3. To develop the workers skills in relation to assessment, review and planning
4. To clarify, or formalize, the process for making referrals and reviewing suitability assessments for offenders for accredited programmes provided by the Community Rehabilitation Company (CRC)
5. To clarify the suitability screening & recording process for the Offender Personality Disorder (OPD) pathway project

6. To ensure that the worker is undertaking home visits, recording her monitoring of offender's accommodation and her approval of addresses as required for offender's subject to Post-sentence Supervision (PSS) licence, particularly when this is related to risk of serious harm.
7. For the worker to consider how contact with individuals at risk could contribute to managing risk

8. Pre-sentence Report author to clarify with his line manager the NPS's responsibilities to make courts aware of risk issues when requesting adjournments and deciding on the most appropriate report type. Also, to identify when it is appropriate to consult his line manager in making professional judgements