Safeguarding Adults' Review

Adult L

Overview Report

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A Local Authority Safeguarding Board Commission

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Chapter 1

Overview Report

Executive Summary

1. Introduction

1.1 This anonymised Safeguarding Adult Review (SAR) was commissioned by a Local Authority Safeguarding Board for Adult L, a male. On the 9 May 2020, Adult L, was stabbed by his partner Adult M, a female who he was in an on and off volatile relationship with. Adult L sustained potential life-threatening injuries but survived following emergency surgery.

1.2 This report has identified features of unconscious and gender bias, coercive and manipulative behaviour which emphasises that Domestic Abuse (DA) incidents must be viewed with an open mind and investigated on a case-by-case basis. The SAR confirms that male gender is not always the sole perpetrator in DA but can equally be a victim, as recognised in this case and subject to the analysis and learning within Chapters 3 and 4 of this report.

1.3 Adult L was known to Adult Social Care (ASC) through working with the local drugs and alcohol substance misuse service. Adult M also experienced her own substance misuse with additional mental health problems. She was also known to Children's Social Care (CSC) as she was approximately seven months pregnant with their unborn baby (UBB) at the time of the assault upon Adult L.

1.4 Both Adult L and M had children with other partners prior to the time they met. CSC had intervened in relation to all the children. During the terms of reference (TOR) period, Adult M's young children were living with their biological father and Adult L's older teenage children were residing with his sister.

1.5 This SAR further encompasses the subsequent child protection action taken by safeguarding professionals who were proactive to ensure the protection of their unborn child. CSC held an Initial Child Protection Conference (ICPC) where appropriate steps were taken to protect the unborn child against the likelihood of potential serious neglect being suffered, due to the background history of child protection concerns of both parents, particularly Adult M.

1.6 Adult M was arrested for the Attempted Murder of Adult L but was subsequently charged with s.18 Grievous Bodily Harm and perverting the course of justice, the latter offence was related to an intention to manipulate Adult L to retract his statement. She was found guilty at court and was given a substantial prison sentence. The full details of the incidents leading up to the trigger event, police criminal investigation, the court result and outcome, is analysed within Chapter 3 of this report.

1.7 Purpose of the Safeguarding Adult Review

1.8 The purpose of the SAR is not to re-investigate the circumstances or to apportion blame, it is:

- To establish whether there are lessons to be learned from the circumstances of the case about the way in which local professionals and agencies work to support adults at risk.
- To review the effectiveness of procedures.
- To inform and improve local inter-agency practice.

1.9 This SAR has looked at how the relevant agencies managed the safeguarding concerns in the scoping period defined by the Terms of Reference (TOR) in Chapter 2, from January 2019 which covers

the period of Adult L and M's relationship until the period when Adult M was charged with Adult L's GBH on the 20 May 2020.

1.10 Purpose of the SAR

1.11 The legislation, guidance and definitions are defined within the TOR in Chapter 2. It outlines the legislative requirements and expectations on individual agencies to safeguard and promote the well-being of adults at risk, in the exercise of their respective functions. It relates to adults with the need for care and support and for their carers, providing a framework for SABs to monitor the effective implementation of policies and procedures in this case. The following adult safeguarding principles (Care Act 2014) and legislation below apply and is subject to further comment within the narrative of the review.

1.12 Adult Safeguarding Principles

1.13 There are six adult safeguarding principles underpinning practices that professionals need to consider when dealing with a safeguarding adult case. These practices were considered when completing this SAR as follows: -

- **Empowerment**. People being supported and encouraged to make their own decisions and informed consent.
- **Prevention.** It is better to act before harm occurs.
- **Proportionality.** The least intrusive response appropriate to the risk presented.
- **Protection.** Support and representation for those in greatest need.
- **Partnership.** Local solutions through services working with their communities. Communities have a part to play in preventing, detecting, and reporting neglect and abuse.
- **Accountability.** Accountability and transparency in safeguarding practice.

Comment: ***There is evidence that the six principles above were being applied by professionals, but learning has however been identified and is detailed within this SAR.***

1.14 Periods of events for consideration

1.15 The review identified three key periods of events concerning Adult L and M's relationship which is further outlined within the Key Events and Professional Practice in Chapter 3. The periods are as follows: -

Period 1 - Background history of Adult L and M.

Period 2 -The analysis of the key events and professional interaction with Adult L and M, during the scoping period of the SAR.

Period 3 - The outcome of the GBH police investigation, criminal proceedings, and child protection of their unborn child. (Date of birth redacted).

1.16 Abstract of Findings

1.17 The SAR has identified the following findings and recommendations which are an abstract of the detailed analysis in Chapter 3 and from the analysis of professional practice within the Key Lines of Enquiry (KLOE), SAR Findings and Recommendations within Chapter 4**: -**

Finding 1 - Developing a Domestic Abuse Pathway and review current thresholds (**SAR Recommendation 1**).

Finding 2 - There is a requirement to display enhanced professional curiosity and conduct thorough research into the background history in domestic abuse cases **(SAR Recommendation 2)**.

Finding 3 - Mental Capacity Assessments and the appropriate use of an IMCA should always be considered in a DA case where there are concerns for the mental health of a person **(SAR Recommendation 3)**.

Finding 4 - Thames Valley Police to ensure DA incidents are investigated and adult protection referrals, safeguarding intelligence and information is appropriately shared in a DA case **(SAR Recommendation 4)**.

Finding 5 - Practitioner access to relevant agency safeguarding record keeping systems **(SAR Recommendation 5)**.

Finding 6 - Displaying professional curiosity (This finding is address in Finding 2 above and within agency Individual Management Reviews (IMR) to the review).

Finding 7 - Awareness of the signs and symptoms of unconscious and gender bias, coercive and manipulative control in Domestic Abuse cases **(SAR Recommendation 6)**.

Finding 8 - Requirement for agencies to conduct thorough risk assessments and ensure the awareness of the Safeguarding Board's Risk Management Tool is known and utilised **(SAR Recommendation 7)**.

Finding 9 - Gender Equality and Culture (This finding is also addressed in Finding 6 above).

Finding 10 - A Board database of relevant and recent learning from published reviews, policies, and guidance **(SAR Recommendation 8)**.

Finding 11 - Learning on the fringes of the SAR process for TVP. A requirement for TVP to review the timeliness of IMR submissions to a review **(SAR Recommendation 9)**.

1.18 Adult L and M, family involvement

1.19 The Board made a request for Adult L and his family, together with an approach made to Adult M's solicitor, to invite them all to participate in the SAR, to obtain their personal views and opinions of their interaction with professionals. The offers have not been accepted, but the details of Adult L and M's voice has been captured within the agency submissions and documentation received for this review and is subject to comment within the narrative of the report. Pertinent questions required to be asked from them to seek clarification has therefore not been possible.

1.20 Diversity and Ethnicity

1.21 Both Adult L and M were White/British. There is no information within the submissions from agencies participating in this review to suggest diversity or ethnicity was an issue in this case. This has been further discussed in the findings within Chapter 4 of this report.

Chapter 2

2 Terms of Reference (Summarised)

2.1 The decision to commission this SAR was made by the Board after a Rapid Review (RR) was held, following the serious assault on Adult L by Adult M. The rapid review, the Board and the Independent Chair determined there were lessons to be learnt in respect of how agencies worked together as outlined within the executive summary, introduction, and background in Chapter 1, that it met the criteria to hold a SAR.

2.2 Overarching aim and principles of the SAR

2.3 The main aim of this SAR is to review and identify learning how Adult L and M were risk managed and interacted with the different agencies involved with them during the scoping period for this review, and whether there are lessons to be learnt. As previously alluded to, this SAR covers the period from January 2019, to cover the period of Adult L and M's relationship until when she was charged with the serious assault on Adult L on the 20 May 2020.

2.4 Methodology and Involving and supporting key staff and volunteers

2.5 The purpose and underpinning principles of this SAR are set out in section 2.9 of the Multi-Agency Safeguarding Adults Policy and Procedures[1]. All SB members and organisations involved in this SAR and all SAR panel members agree to work to these aims and underpinning principles.

2.6 David Byford was appointed as the Lead Reviewer and Author of the SAR report. He has no connection or involvement with any agency, organisation or professional involved in the SAR. This report has adopted a methodology that involved gathering factual information about the case. Agencies were asked and provided an Individual Management Report (IMR) outlining their agency interaction with Adult L and M, which considered the safeguarding action taken in this case.

2.7 The review sought the perspectives of all key staff and volunteers at a Practitioner Event (PE) a facilitated workshop giving them the opportunity to share their views on the case. The event was held, and helpful views and information was obtained for the purposes of completing the review.

2.8. A SAR Panel member from each agency was responsible for ensuring relevant staff and volunteers were provided with a safe environment to discuss their feelings and offered emotional support where needed, including counseling or other therapeutic support if required.

2.9 Governance and accountability

2.10 This SAR was conducted in accordance with the requirements set out in:

- Care Act 2014 and statutory guidance (DH 2014).
- Safeguarding Adults Reviews under the Care Act: implementation support (SCIE 2015).
- Multi-Agency Safeguarding Adults Policy and Procedures; and
- The Safeguarding Board's Safeguarding Adults Review Framework.

2.11 Section 44 of the Care Act 2014 places a statutory requirement on the SB to commission and learn from SARs as laid out in the statutory guidance.

2.12 The Care Act 2014,[2] defines the safeguarding duty as applying to any adult and, as in both Adult L and M's situation: -

[1] https://www.berkshiresafeguardingadults.co.uk/

[2] The Care Act 2014: sets out in one place, local authorities' duties in relation to assessing people's needs and their eligibility for publicly funded care and support.

- Have needs for care and support (whether or not the local authority is meeting any of those needs).
- Is experiencing, or at risk of, abuse or neglect, and,
- as a result of those care and support needs, is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

2.13 The Care Act 2014 is significant legislation for adults. There were changes made to the legislation in April 2015 that includes responsibilities for promoting wellbeing, a focus on prevention, personal budgets, eligibility criteria and support for carers.

2.14 Subjects of the SAR

Name	D of B	Subject
Adult L	Redacted	Subject of SAR and victim of GBH.
Adult M	Redacted	Ex-partner of Adult L and perpetrator of the GBH upon him.
Child	Redacted	Infant child of Adult L and M. The UBB at the time of commissioning this SAR.

2.15 Specific Key Lines of Enquiry (KLOE)

2.16 The Board required agencies participating in the review that their IMR submission to the SAR will consider and reflect on the following KLOE. These specified questions and the agency responses have been reviewed in detail within the analysis in Chapter 4. The KLOE questions and themes are:

- Working Together.
- Communication, information sharing and decision making.
- Decision making.
- Bias.
- Policies and Procedures.
- Risk assessments.
- Diversity & Equality.
- Covid-19.
- Training.
- Learning from previous reviews.

2.17 Membership of the SAR Panel

- DCI Protecting Vulnerable People, Thames Valley Police.
- Asst. Director, Children's Social Care,
- Head of Safeguarding ASC.
- Head of Community Safety Partnership.
- Safeguarding Lead - East Berkshire Clinical Commissioning Group.
- Head of Service for Quality Assurance
- Exploitation Prevention Manager Children's Social Care,
- Support Officer for the Board.
- Joint Manager for the Board.

- SAR Lead Reviewer and Author.

2.18 Agency evidence and submissions to the SAR

2.19 The following participating organisations submitted an Individual Management Report (IMR) to the review: -

- Adult Community Team (ACT).
- Drug Alcohol Action Team. (DAAT), FSM.
- Thames Valley Police.
- GP and East Berkshire Clinical Commissioning Group and Primary Care.
- Conference and Review.
- Children's Social Care.
- Emergency Duty Service (EDS).
- Frimley Health NHS Foundation Trust (FHFT).
- Welfare and Housing Service (W&H).

2.20 SAR report and publication

2.21 The Board will consider how to publish the final report, setting out clear reasons for any recommendations made to promulgate learning and the extent of anonymisation required unless there are exceptional circumstances not to publish the final SAR Overview Report.

Chapter 3

3.1 This chapter outlines the three periods identified to be considered regarding the relationship between the two principles in this SAR and the professional safeguarding action taken to protect their unborn child.

3.2 Period 1 - Background history of Adult L and M prior to their relationship

3.3 **Adult L's Background**. Adult L has been registered at his GP Surgery since 2010. He and Adult M were registered at different GP surgeries. He did not have any ongoing health needs that were being managed by Primary Care at the time of the alleged trigger incident in Period 3 below. Adult L had a history of alcohol and drug misuse and had been previously referred to DAAT to support him for this. He was not on regular medication during the scoping period of the review.

3.4 He has numerous convictions and offences from 1999 and 2015. These include offences against the person and against property, public order and several cases relating to police/courts/prisons etc with a caution for one offence in 1999 for an offence against the person. He was known to other Police Services and served time in prison for various offences of assault and dangerous driving offences; he had warning markers for drugs and violence (2014) and DA with Adult M, as analysed below. Adult L was first listed on TVP record management systems (now NICHE) in 2001 with a large amount of intelligence reports for a variety of concerns which are not detailed further.

3.5 Adult L has been open to the Local Authority's Drug and Alcohol Action Team (DAAT) on a few occasions over the years. He was taken on as a client as part of the Family Safeguarding Model (FSM) with a substance misuse Recovery Worker in CSC. The FSM is described on the local authority's public website as a way of keeping families together where it is safe to do so. This is achieved through a collaborative way of working where parents are motivated to identify the changes needed within their own families and is intended to achieve better outcomes for children. Adult L completed the treatment successfully from August until December 2018 when he was reported as alcohol and drug free. During this time Adult L was open to CSC as part of a Child Protection Plan (CPP), due to risks associated with his two older daughters. This was later was stepped down to a Child in Need (CIN) Plan and then the case was closed.

3.6 **Adult M's Background.** Adult M had been registered as a patient at her GP Practice surgery from 2015 and had regular contact with the surgery. She sought out medical care and advice on a number of occasions during the scoping period and had a good relationship with her registered GP. She was able to articulate her needs and wishes and was very open in her communication. Throughout her pregnancy, planned referrals were made proactively to the Perinatal Mental Health Service and Midwife.

3.7 The GP was also aware that Adult M has two other young children who were not in her care due to historical child protection concerns relating to her parenting capacity through her contact with CSC. The GP was further aware of Adult M's mental health needs, as she was diagnosed with having an emotionally unstable personality disorder, depression, anxiety, OCD, and irritable bowel syndrome (as described in records). She was prescribed medication of sertraline and propranolol. Throughout January 2019, the GP was dealing with Adult M's anxiety as she had palpitations and panic attacks. After a telephone consultation with her GP, she was restarted on propranolol at her own request.

3.8 Adult M was first listed on the TVP record management systems in 2005. She is recorded against approximately 130 various reports as the aggrieved (adult protection, outraging public

decency, theft, child protection, assault, domestic incident, rape, harassment), child (domestic incident, assault), and as the suspect (assault, drunk and disorderly, theft, harassment and stalking, criminal damage, public order, offences relating to Sec.136 Mental Health Act and a missing person). She was recorded as the next of kin in the child protection reports relating to her children who had been removed from her previously due her inability to protect and care for them and as they were likely to suffer neglect.

3.9 She was previously subject to a Domestic Violence Protection Order (DVPO) preventing her from contacting a previous partner and it is evident that it was a similar volatile relationship as she had with Adult L. In one incident, TVP report both she and another partner were found to have visible injuries and damage had been caused to the property. House to house enquiries identified that neighbours indicated she was often considered to be the aggressor and they were concerned for her partner as being subject to abuse. This is a situation mirrored in the narrative below and from Adult L's sister who reported concerns to police that suggested Adult L was being abused by Adult M.

3.10 Adult M had three convictions for five offences between 2013-2016, for offences against property and miscellaneous offence and with two reprimands, warnings and cautions for offences, against the person, property and theft. She was also known to other Police Services.

3.11 TVP had warning markers for Adult M for Domestic Abuse with two previous partners both as a victim and perpetrator in 2014, 2016 and 2019 before she met Adult L: Domestic Abuse with Adult L. There were DA warning markers as medium risk to Adult L (Oct 2019), medium risk from Adult L (Dec 2019) prior to the high risk to Adult L (May 2020) which are referred to below; and markers for self-harm and suicidal ideation as the following paragraph outlines.

3.12 **Adult M's significant and worrying self-harm and suicidal ideation behaviour.** In 2013, Adult M tried to swallow clothing buttons whilst in a police cell and expressed a wish to die. In 2015, she drove into a tree whilst pregnant and in 2018, she self-harmed by cutting herself. Police record episodes of depression and anxiety, with a borderline personality disorder. Concerns of suicidal ideation was still evident when she was in custody for stabbing Adult L, concerns which were not shared by TVP and is subject to comment in Period 3 below.

3.13 Period 2 - Analysis of the key events of the relationship between Adult L and M during the TOR scoping period

3.14 **2019**. In January 2019, another Local Authority Children's Social Care held a strategy meeting in respect of Adult M and her children who were living with their father. There was a concern that he was withholding Adult M's supervised contact of the children.

3.15 In May 2019, Adult M was residing in the area in supported accommodation (name redacted). The female parent of another resident (a disabled male) reported that Adult M and another female were trying to get her son addicted to drugs. Adult M had been abusive and threatening towards her when she attended the location. The victim declined to assist police, so no formal action was taken against her. Attending TVP officers should have displayed more professional curiosity and to investigate the possibility of drug misuse and a risk assessment considering the possible vulnerability of a disabled person and child.

3.16 The TVP IMR identified this as learning for the officers concerned and information was recorded on local systems by the Neighbourhood Team which was only accessible to them. A recommendation from a Milton Keynes thematic review, which was adopted from December 2019 has been implemented to address this. Furthermore, in October 2020, TVP Problem Solving

Operational Guidance was updated with respect of where and how information should be recorded, specifically in relation to neighbourhood work.

3.17 In June 2019, a member of the public reported that there was a male (confirmed later as Adult L) in a house shouting and smashing up 'stuff 'and it was believed he was throwing items at a female. Police officers attended the scene and found him intoxicated and shouting at the TV. The incident was closed with no further action (NFA) taken. The TVP IMR noted that the officers did not display professional curiosity and did not enter Adult L's address to check the facts.

3.18 Relationship between Adult L and M.

3.19 In August 2019, TVP first recorded an incident between Adult L and M; the circumstance was a 'fear for personal welfare'. An emergency '999' call was made by Adult L's mother. She described that Adult M had used her sons' phone to contact her saying "*he is going mad, punching walls and taken loads of crack cocaine."* She confirmed that Adult M was Adult L's partner, he was an alcoholic and drug user. This review is unaware of the outcome.

3.20 Mental Health concern for Adult L. A week later on 27 August 2019, at Adult L 's home address there were three 'fear for welfare' reports made by his neighbours regarding concerns for him. He was reported on the first occasion outside in his boxer shorts shouting and screaming. He was then reported wandering around talking to himself and trying to contact '*spirits*' and had a dog who looked dehydrated. He was acting unusually and erratically by approaching young children and finally a reported fight was in progress in nearby woodland (no other details recorded by police). Adult L's dog was left with a neighbour. Police attending the third call stated that Adult L was in bed.

Comment: ***This was a missed opportunity to find out the root cause of his behaviour and to consider a possible mental capacity assessment; a referral to ASC and to contact the RSPCA regarding his dog.***

3.21 A Domestic Incident recorded by police as non-recordable was reported in early September 2019 at Adult M's supported accommodation. Staff reported that Adult L was present and was being aggressive. They identified Adult L as being Adult M's ex-boyfriend, but he had left prior to the police officers arriving.

Comment: ***TVP identified the officers did not complete a DOM5 (domestic abuse referral form) as it should have been and did not record the details of Adult M's children, therefore the incident was not shared with CSC.***

3.22 Allegation of common assault (not confirmed by Adult L on Adult M). On the 3 October 2019 at Adult L's home, an apparent friend of Adult M reported to police that Adult L had stopped her from leaving his address by grabbing her and stated he was banned from Adult M's own accommodation. She denied any assault took place or being in a relationship with Adult L.

Comment: ***Again, the TVP IMR notes there was no DOM5 form completed even without Adult M's co-operation. No Adult Safeguarding referral was made which if the DOM5 form had been completed would have enabled a risk assessment with management oversight. Police could have also spoken to Adult L, to establish what had happened and the status of his relationship with Adult M.***

3.23 Allegation of Actual Bodily Harm (ABH) by Adult M on Adult L. The on and off abusive relationship continued as several weeks later on the 26 October 2019, a member of the public reported seeing Adult L with injuries walking down the street, stating "*She (Adult M) was screaming,*

swearing and made a threat to stab the male. The female then spat at the male on the face." TVP report she had assaulted Adult L and caused a lump to the back of his head, as well as swelling around his eye, nose and cuts to his face. She also bit and cut his left hand and scratched his forearm. This occurred within a taxi journey and continued once they were dropped off. He was not willing to make a formal complaint against Adult M nor was he willing to provide a statement or have his injuries photographed. She was arrested and initially released on bail with conditions not to contact him. Also related to this incident was a reported assault without injury on the independent witness who made the telephone call to police. It was reported that Adult M had spat at him whilst he tried to intervene. He also did not support police proceedings and the investigation was concluded with no further action taken. Police deemed that it was not in the public interest to pursue this without the victim's support.

Comment: ***The TVP IMR surmises that there was no supporting evidence for the investigation into the assault on Adult L to proceed but showed Adult M's propensity of aggression towards males without consideration of any thought for her actions. It also showed her thought process to threaten to stab Adult L. The police officer recorded it as standard risk because "Adult L was significantly bigger than Adult M. She has caused him ABH injuries today because he did not want to fight back, however, I am sure that if he was actually in danger, he would be able to protect himself from her". This is again reported as learning for the officer in the case (OIC) but it does suggest an assumption to diminish any risk.***

3.24 Allegation of Criminal Damage by Adult M against the property of Adult L. Only two days later, police were called to Adult L's home as Adult M was causing criminal damage to his property and his personal effects which, was described as being '*trashed*'. Adult L reported on the telephone to police that Adult M was *'kicking off'* and his dog was missing. She was heard in the background of the call screaming *'rape.'* She left the property in her underwear before officers arrived, she was eventually arrested for the damage, but Adult L, refused to support a prosecution. The rape allegation, TVP state, should have been investigated more thoroughly at the time, but there was no evidence to suggest this occurred. It is expected officers must explore any motives for behaviour or defence under the principles of investigative interviewing as set out by the College of Policing[3]. It would have been expected for an independent officer from the investigation of the assault on Adult L to ascertain if there was any investigation required as to a separate offence or any safeguarding concerns for Adult M.

3.25 Good practice was identified by police that the investigation was timely and this incident along with the assault above were put to the Crown Prosecution Service (CPS). Police attempted to show supporting evidence by securing photographs of the damage at the address and the use of their Body Worn Video (BWV) recording of their attendance. A remand application for Adult M was unsuccessful as the CPS concluded that there was no realistic prospect of conviction (victimless prosecutions is discussed in the findings in Chapter 4).

3.26 Adult M's alleged Hate Crime. On the same day, police received a public order report from Adult M's home where it was alleged that she made a racist comment towards a person delivering pizza on three occasions. This was unrelated to Adult L. As the TVP IMR author states it shows again Adult M's irrational actions without thought for the consequence of her behaviour, which this review concurs with.

3.27 Drunken behaviour by Adult L at Adult M's residence. On the 15 December 2019 a Non-Recordable Domestic Incident was reported at Adult M's supported accommodation. Staff reported

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[3] College of Policing – Investigative Interviewing Principles. Investigative interviewing (college.police.uk)

Adult L was present and very drunk, he had gone into her flat despite being banned from the premises. Officers attending did not see either of them, despite attempts to do so and no accounts were obtained from the informant.

<u>Comment:</u> ***This was the first time that all of Adult M's children's details were recorded on the TVP NICHE system as this had been missed previously. The incident was referred to the Multi-Agency Safeguarding Hub (MASH) and shared with CSC. The attending police officer completed a DOM5 in the absence of the victim supporting any offence which was agreed police practice.***

3.28 <u>Domestic incident report concerning Adult M against Adult L.</u> The following day a further DA was reported against Adult M at his address where a member of the public reported "*Adult M regularly goes up and down the street drunk and screaming. They apparently have an argument most nights, then he suspects may hit her and she leaves shouting abuse at him,*" (there is no evidence to confirm these unsubstantiated comments of abuse).

3.29 Including the incidents reported above, during 2019 there had been five calls to TVP from Adult M's supported accommodation by staff, (May, September, October twice and December 2019). The TVP IMR identified that the attending officers did not always explore nor document information evidentially in the form of witness statements and is a learning point for the officers. The staff had concerns regarding Adult M's drug and alcohol misuse and the violence between her and Adult L. These were missed opportunities to share the information with other professionals or consider calling a professional or strategy meeting/discussion regarding all the mounting concerns which suggests Adult L, may have been verbally abusive.

Comment: ***It does appear from information provided to this review that Adult M was the violent and more physically abusive from the incidents of assault against Adult L during this initial period, which continued into 2020.***

3.30 2020. On the 28 January 2020, Adult M messaged her GP surgery requesting to see a midwife. A maternity first booking appointment was arranged for the 19 February.

3.31 <u>Possible assault Adult M on Adult L.</u> On the 8 February 2020, police were contacted regarding another "fear for welfare" call. A member of the public reported that there was a man (Adult L) with blood on his face shaking her car. On the attendance of police, Adult L was presenting with unexplained facial injuries and his behaviour was erratic and he refused assistance. Police checks confirmed a warning flag on his home address that he was at medium risk of domestic violence from Adult M. During the six minutes the officers were at the scene, they deemed that Adult L had cleaned up his face and was '*capable of looking after himself*.'

Comment: ***More professional curiosity should have been displayed considering the mounting and recently reported incidents, to make further enquiries. It was not known if Adult M was nearby or seen considering the details of the warning flag. This was a further missed opportunity for attending officers to have sought medical attention for Adult L at the scene and to investigate the facts further whether any offences had been committed; whether there was a need for an evaluation of his Mental Health or a requirement to submit an Adult Protection referral.***

3.32 <u>Adult M's Pregnancy</u>. On the 14 February, Adult M was seen by her GP and it was confirmed she was 12 weeks pregnant with Adult L's unborn child. She continued to share a feeling of being anxious and low in mood. A depression and anxiety assessment was completed. The GP discussed a referral to the Perinatal Mental Health Team. She requested a private clinic referral as she was apparently able to access, this supported by her father, who had private medical care, and this was

her choice. She had no suicidal or self-harm thoughts. Medication and 'BUMPS' (best use of medicines in pregnancy) information was shared, and she was referred to a perinatal mental health midwife.

3.33 Allegation (not proven) of common assault at a hotel by Adult L. Adult L and M's on and off toxic relationship continued; on the 16 February 2020 they were staying together at a local hotel when police received a call regarding an assault without injury. Staff at a hotel reported hearing a female shout '*Why did you push me in the bath? Were you trying to drown me?'* TVP officers attended and arrested Adult L, who acted aggressively towards them, for common assault. In police custody, good practice followed. Adult L was dealt with by a Domestic Abuse Investigation Unit (DAIU) Detective Sergeant and Custody Sergeant. An academic tool (the Homicide Risk Triad and Timeline) was used to undertake a risk assessment following the domestic disturbance reported in the hotel. He was later released with no further action taken as it was determined there was no assault.

Comment: ***There was later communication between a Social Worker and Recovery Worker on 20 April 2020, regarding this event where information was shared in relation to the engagement of both clients. There were plans for Adult M to end the relationship with the support of a Domestic Violence charity. There were also discussions encouraging Adult M to apply for a non-molestation order against Adult L due to the above incident, which was possibly unconscious bias, as there was no consideration of the aggression and action taken by Adult M against Adult L that had previously occurred. It was clear at this stage that the practitioners did not have the background history to obtain the full picture of Adult L and M's relationship, and this must have impacted subconsciously on their judgement.***

3.34 GP concern for Adult M's health and that of her unborn child. There was a custody hearing held on the 19 February regarding Adult M's previous children in the care of their father. A day later her GP reported during a telephone consultation that her mood was worsening following the custody hearing. She reported pressures from her partner's family (unknown who this refers to) to terminate the pregnancy. The GP discussed that CSC would need to be involved to support her and the unborn child given the history. The GP again referred her to the perinatal mental health team which she previously did when pregnant in 2015 on the occasion when she was intoxicated and deliberately crashed her car into a tree. On that occasion she was detained under a Section 136 of the MHA. The GP appropriately discussed a missed midwifery appointment with the midwife which was rearranged with Adult M and the midwife told the GP that she will complete a MASH referral, which she did regarding potential child protection concerns.

3.35 Strategy discussion. On the 21 February 2020, there followed a strategy discussion (Section 47) where DAAT shared information that Adult M had reported that Adult L had relapsed and provided her with cocaine. Substance misuse during pregnancy was identified as a risk, however DAAT had received no referral nor any request for a joint visit and substance misuse services were then offered. The TVP IMR states the incident at the hotel was shared with CSC by the MASH, although it was wrongly graded as medium, when it was in fact high. This was corrected by police at the strategy discussion, the risk error did not impact decision making at the meeting. Adult M's GP was notified, and a flag added to her records to alert that she was at risk of violence in the home. The account would appear one dimensional with no evidence of the clarification of facts and reported incidents known by other agencies.

3.36 Adult L's sister reported Domestic Incident/Malicious Communications. On the 26 February 2020, Adult L's sister contacted the local authority to report her safeguarding concerns for her brother and was directed to ACT who signposted her to the police. No further action was taken by ACT as apparently there was no other information to build a larger picture of any safeguarding concerns

(thresholds are addressed within the finding in KLOE 1). Her family were concerned he was being abused by Adult M on a regular basis. It was stated that on a number of occasions, damage had been caused within his house and Adult M had assaulted him, as scratches and bruises were witnessed on his person; his behaviour had changed, he was becoming subdued; he was not visiting his daughters regularly and had become isolated (not allowing people to his property since she had moved in).

3.37 Adult L, when spoken to about these concerns by police, denied there were any issues, saying he was happy with Adult M. Her other children's details were recorded on the NICHE by police and the information was shared by MASH with CSC. The TVP IMR report also said that Adult M sent abusive messages to Adult L's daughters pretending they were from him in order to sabotage his relationship with his children. Furthermore, his sister described Adult L to them as having Autism/Asperger's and being childlike, easily led and described Adult M as manipulative and controlling. She stated *"I'm just very concerned that something is going to happen, and she'll end up stabbing him or something like that. We don't want him to die.'*

Comment: ***Adult L's sister's comments about her brother's safety and worries have not been fully explored from information supplied to this review. There appears no consideration by professionals to consider holding a Sec. 42 Enquiry into the rising concerns in their relationship and to look at alternative safeguarding action to be taken.***

3.38 At a GP appointment on 27 February 2020, Adult M was very engaging and in a cheery mood. She reported that things were going well and that her partner was supportive. Her GP again discussed a referral to perinatal mental health, and she consented. Adult M had booked an appointment and date for a scan and a community midwife had referred her to the perinatal mental health midwifery team.

3.39 On the 6 March 2020, Adult L's GP Practice arranged an appointment with him following written information from TVP regarding his sisters concerns regarding him being assaulted and abused by Adult M. Medical records state that Adult L attended the appointment thinking it was related to another reason which was a previous shoulder injury, but the GP explained about the information received from the police. He was seen alone; there was good interactions and no concerns presented. He denied any abuse by Adult M and apologised for wasting the GPs time, stating *"It was a ridiculous suggestion."*

<u>Comment:</u> ***This review has identified that Adult L's GP was unaware that Adult M was pregnant and was not notified of the Sec 47 investigation and the ICPC. This is addressed in the findings of this report of sharing information and communication.***

3.40 **<u>Initial Child Protection Conference for Adult M and Adult L's unborn baby</u>** was held on the 12 March 2020. This was proactive action taken by CSC and agencies on the reported potential safeguarding concerns for the UBB due to reports received from Police and Health which identified both partners as suspects in cases of DA and safeguarding concern in their respective backgrounds. Both Adult L and M attended the ICPC and discussed was the misuse of drugs and alcohol. They provided a united front and believed there were no concerns which is contrary to the history known of their relationship and their underlying behaviour. Adult L understood and acknowledged the concerns of the professionals because of their past histories. He suggested that "*things were different now: they were living together, they have each other and they were building a family; they both deserve something good out of life,"* and disclosed he had given up alcohol (which was not true).

3.41 Adult L was regarded solely as the perpetrator and Adult M as the victim of domestic abuse. It was clear that all the significant incidents and reports regarding them both was not made available

at the ICPC regarding the fact Adult L was also a victim of DA. This factor was also not written into the ICPC 'Danger Statement' made to assess the action to be taken, whereas Adult M's vulnerability was explicitly stated. It raised concerns that she was suffering domestic abuse and violence from Adult L which put her emotional and physical wellbeing at risk and that of the unborn child. There was a unanimous decision for their unborn child to be placed on a child protection plan under the category of neglect.

3.42 The conference plan included investigation of Adult L's DA history as perpetrator and his substance misuse in the context of his functioning, parenting ability and engagement with services. This was to inform work of the Domestic Abuse Perpetrator Service (DAPS) and Family Safeguarding Model (FSM) recovery facilitation with him, by DAAT for support around his alcohol misuse. The work with Adult M was focused on her mental health, midwifery and victim support. It did not raise the allegation of DA by her upon Adult L. A Review Child Protection Conference (RCPC) was scheduled for 5 June 2020.

Comment: ***It is possible that some unconscious and gender bias was present by treating Adult L solely as the perpetrator and not a victim which he clearly was. This confirms that a research of the full history of a subject's background must always be made in all safeguarding cases to ensure the fullest of information is available for informed decision making.***

3.43 Domestic abuse incident and allegation of assault by Adult M or Adult L. As it transpired following the ICPC, on the 20 March 2020 an anonymous caller reported that a male and female were fighting at Adult L's address. It is believed she caused a cut to Adult L's eye by hitting him over the head with a glass bottle and throwing a chair out of a window causing it to break. Police attended and completed a DOM5, DA referral form even without the victim Adult L's support at the time. The incident was referred by police to CSC and to a DA Charity. She was arrested for the assault but was released under investigation (RUI) as he would not support any police investigation or proceedings.

Comment: ***RUI is a regular procedure which meant that no conditions were imposed on her, so the investigation was not subject to time pressures in the way that it would have been had Adult M been released on bail.***

3.44 The rationale for her release was that she was '*pregnant and had nowhere to stay*.' The TVP have no record or documentation or information that any other options had been considered for her. A review of this decision by a Custody Inspector subsequently for this review has determined that a better option may have been to have released Adult M on bail, (28 days) with conditions not to contact Adult L.

Comment: ***TVP report that as it transpired, Adult M breached her bail conditions in relation to stabbing (trigger event below) Adult L on two occasions within several days, so the imposition of bail conditions may not have had any impact even if they had been put in place.***

3.45. Assessing Adult M's mental health capacity. The progression of the case hinged on establishing Adult M's mental health capacity. She was released under investigation (RUI) with an Evidential Review Officer[4] (ERO) asking for evidence of capacity at the time of the offence with a request for a written statement from the physician treating her (such as her GP or a MH Professional) to ascertain

[4] **An Evidential Review Officer (ERO**) is a police staff employee who reviews evidence presented in relation to a case, to advise on case progression, file quality and to establish whether there is any likelihood of prosecution.

if she had the '*mens rea'* (intention). A L&D[5] practitioner review conducted was to assess whether she knew what she was doing at the time of the offence and whether it was in the public interest element to prosecute her. The outcome of an assessment is not known as a decision was later made (after the trigger incident occurred in Period 3 below) that no further action would be taken against her in relation to this matter.

3.46 A MARAC referral was made by CSC on the 6 April 2020. It was reported that police made a number of unsuccessful attempts to contact Adult M. The police officer then worked with a SW to provide a risk management plan for her which was positive inter-agency working.

3.47 The DAAT FSM Recovery Worker received a telephone call from Adult L at the beginning of April 2020 to request further support around his increased alcohol use. A referral was also received on 9 April 2020 from a Social Worker to also request support which was good communication between agencies. A Group Case Supervision was held between the ABH offence on the 20 March and 9 April 2020 where discussions were primarily focused on Adult L being a perpetrator and the coercive control that Adult L was exhibiting towards Adult M. Events were minimised by professionals, therefore the full extent of the risk according to Adult L was unknown.

3.48 Disclosure by Adult M to police regarding Adult L driving a motor vehicle under the influence of alcohol. On the 10 April 2020, she telephoned and reported Adult M for drink driving. She said, *"My partner has run up the shop in the van and is quite drunk."* She explained that he had previously been imprisoned for drink driving. Officers located him and he failed to provide a sample of breath for analysis and was arrested, charged and convicted at court for the drink driving offence. Whether there was an ulterior motive for reporting him to police is not known, but as a result a drunken driver was taken off the streets and the public were ultimately protected. Incidentally, a few weeks later, Adult L's vehicle was involved in three non-stop road traffic accidents. He denied being the driver of the vehicle at the time of the collisions and no further action was taken.

3.49 A few days later Adult L's Recovery Worker received a telephone call from him, where it was clear that he was intoxicated. He sounded very low in mood and despondent with regards to his relationship with Adult M, the unborn child and police intervention. Adult L shared his concerns in relation to Adult M's declining mental health and about some of the incidents which had taken place over the past few weeks between them. He declined support but the Recovery Worker agreed to contact him within the next couple of days to reassess this.

3.50 A comprehensive assessment was then completed with Adult L in early May 2020, but he disclosed negligible information regarding his relationship with Adult M. He appeared to minimise the severity of the incidents between them. He expressed that his ideal situation would be for her not live in his home, however, as it was 'lockdown' during the COVID 19 pandemic, she had nowhere to go, and he felt unable to tell her to leave.

Comment: ***It is not recorded whether Adult L's concerns for Adult M's mental health was taken seriously and shared considering her pregnancy and previous concerns when she was pregnant. He wanted to support her and prevent her from causing harm to herself and to their unborn baby. There***

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[5] **Liaison and diversion** is a process whereby people with mental health problems, learning disabilities and other vulnerabilities are identified and assessed as early as possible as they pass through the criminal justice systems. This service stems from the Bradley Report published in 2009.

was also an opportunity to also assess whether there was suitable supported accommodation (which she had in early 2019) or any family members available, to rehouse her. There were 27 incidents in total recorded on police systems involving Adult L and M, either individually or as a couple with 17 of the incidents relating to them as a couple.

3.51 At a MARAC meeting held to discuss Adult M on the 7 May 2020, an action was made for police to liaise with CSC to put together a plan, to make contact and check on her welfare. Adult M was graded to be managed at medium risk. She was arrested for the Grievous Bodily Harm (Period 3) three days later, however, the police officer continued to work with CSC to complete a risk management plan with her.

3.52 Period 3 - Details of the GBH police investigation, criminal proceedings and child protection outcome

3.53 **Trigger incident**. On the 10 May 2020, at 1.51am, South Central Ambulance Service (SCAS) were called to a stabbing incident at Adult L's home address. He had sustained three stab wounds (one in his back) approximately one hour before the ambulance had been called. He also sustained defence wounds to a hand. Adult L was taken to hospital where he was detained, underwent surgery and was later discharged a few days later.

3.54 Adult M, who was about seven months pregnant with his child at this time, was arrested by police on suspicion of causing the injuries to him. She was initially released on bail with conditions not to contact him, but she breached these conditions on two occasions resulting in her again being arrested. She was subsequently charged with the offence Section 18 GBH against Adult L and remanded in custody after the second breach of bail.

3.55 The account given by the officer in the case who also assisted the review by attending the practitioners event, outlines the circumstances of the serious assault by Adult M on Adult L. The witness statement of Adult L was provided together with the transcript of Adult M's police interview and a summary of the Trial Judge's sentencing remarks obtained, to assist the SAR to further understand the sequence of events and the accounts by both parties to the knife incident. Both accounts below are detailed in order to capture their voices for the purposes of this review.

3.56 **Adult L's account in person and as part of his police witness statement**. At the initial police attendance, he said that he had been stabbed by an unknown person near to his home while taking his dog out for a walk. His friend who he went to for help disclosed to police that Adult L had told him that Adult M had stabbed him. When police visited him at the hospital the following day on the 11 May 2020, he confirmed to the investigating officer that Adult M had stabbed him. He was not very well at this point, and it was agreed for the officer to revisit him when he was sufficiently recovered and out of hospital in order to obtain a witness statement. The statement was obtained on the 14 May 2020 after his discharge from hospital.

3.57 In his statement he confirmed that she had been living with him at his home on and off since summer 2019. On the day in question, he had been drinking with a friend and admitted he was intoxicated and readily admitted he could be a "*pain*" when he had been drinking. That evening he returned home and saw Adult M, who he did not want to reside at his home. They argued as to why she was there, as he did not know she was coming to his house that day. He went to bed and a few hours later he woke up and went to Adult M's bedroom. She was on the bed dressed in lingerie and he could hear her talking to a male on her laptop. He admitted he got angry and grabbed her laptop and she covered herself with a towel. He was shouting and swearing at her as he was very upset by her behaviour and because she had been drinking from cans of cider she had in her bedroom. Adult L

felt she should not have been drinking whilst she was pregnant. He admitted he acted in an aggressive fashion and threw things around the room, but he was not physically violent towards her.

3.58 At some point he was outside her room, and she shut the door. He removed her bedroom door as it was not properly fixed and moved a wardrobe aside which she had placed in the way. She then produced a purple handled knife (which she had taken from the knife block in the kitchen earlier) and stabbed him three times including to the frontal chest area and when he turned away from her to go to his own room, she stabbed him again in his back. When he was first stabbed, he had put up his hands to protect himself and sustained cuts to his left hand. He was surprised at what happened. After she stabbed him, Adult M told him to lie down, and he wrapped a towel around his waist as he was bleeding profusely. She did not assist him to telephone for the emergency services, so he went to a neighbour who called for an ambulance.

3.59 His statement included his Victim Personal Statement (VPS) where he admitted it had a huge impact on him and his family including his two teenage children who were worried for him. He was feeling stressed about the incident. He admitted they should have ended the relationship "*ages ago.*" He had hoped it would work and they could have made a go of being a family with their child. He stated having met with their Social Worker a few months earlier (this would have been the time of the ICPC) he was "*buzzing*" to make a go of it, but it went downhill from then. He took responsibility for his part in the breakdown of the relationship and knew he was not always the best boyfriend but felt that Adult M stabbing him was not right either.

3.60 Adult L subsequently gave evidence at a Crown Court (details of the venue and date are redacted). In his evidence during the trial, he was consistent with the statement he had provided to police. He admitted he was quite drunk on the night so he could not remember everything that happened but was quite candid in his answers.

3.61 **<u>Summary of Adult M's evidence and transcript of her police interview</u>**. Adult M gave a full account in the first police interview held on the 10 May 2020 having been arrested for GBH. She told the OIC that she had broken up with Adult L a few days previously, but he did not want her to leave which is contrary to his account. She said they had been in a relationship for about a year and a half. She admitted to stabbing him but claimed it was done in self-defence. She went back to his home having been at a male friend's house, at around 8pm. Adult L came home and was intoxicated, argumentative and threw things around. She outlined a history of abuse and controlling behaviour mostly verbal but also physical. She had been reluctant to report anything because of her unborn child and was very fearful of her child being taken away from her. She describes that Adult L went to his room and fell asleep. He woke up a few hours later and became aggressive again, as she was on her laptop talking to a male friend. She went downstairs as he was throwing things around in his room.

3.62 As she went back upstairs, apparently to pack her things, she took a kitchen knife with her. Adult L removed the bedroom door and the wardrobe which she had placed in his way to stop entry. She said he threatened her, and she felt he was going to kill her. As she went to leave her room, he tried to grab her shoulder and at this point she had the knife in her hand and swung it at him in order for him to let go. She said she did not know if she had made contact with him. Adult M went back into her room from the bathroom, and she said he burst in and went to grab her. She said she was scared of being seriously harmed so picked up the knife again and did not know what to do. At this point she said she stabbed him in self-defence but did not mean to hurt him, she was jabbing at him. After this occurred, Adult L's demeanour apparently changed, and he calmed down. They were both trying to find their own phones and she confirms he left to go to a neighbour and returned shortly afterwards. He then walked off again, and the ambulance arrived soon afterwards.

3.63 On viewing Adult M's transcribed police interview, the OIC highlighted inconsistencies in her evidence. She soon found her phone and called her sister instead of calling for emergency help for Adult L. She made attempts to clean the bedroom up and admitted placing the knife she used to stab Adult L with a top, into the washing machine and turning it on. Once the OIC was aware of the seriousness of Adult L's injuries, she further arrested Adult M for Attempted Murder however, this was amended to Sec 18 GBH later. Once the recordings and text messages found on Adult M's mobile phone were viewed by police, it became clear that whilst a lot of her account was broadly consistent with some of the events on the night, there were very significant parts that were inconsistent and cast doubt on her claims of self-defence. In the practitioner's event, the OIC stated she was the coercive and manipulative person in their relationship.

3.64 <u>TVP's failure to share information regarding significant concerns that Adult M will harm herself and consuming alcohol whilst pregnant.</u> Adult M was released on bail and on two occasions. On the 14 May 2020, she was arrested for harassment and breach of bail towards Adult L. She had a significant amount of cash (£1700) in her possession. There appears no professional curiosity documented as to the origin of this money, when secondary checks would have shown a documented issue the previous day between them both with him owing her a similar amount, found on her person. There were no extensive enquiries and no DOM5 was completed, therefore, the information was not shared with other agencies. There was no statement taken from Adult L, nor any indication that a relative who had reported the contact was spoken to by investigating officers.

3.65. The second occasion on the 20 May 2020, a third party reported that she was trying to climb over Adult L's fence to get into his property, with sounds of breaking glass being heard. Adult M was again arrested for harassment and breach of bail at his address. She was further interviewed for both breaches of bail and answered "*no comment* "on both occasions. She was remanded on the latter occasion into custody charged with the serious assault on Adult L.

3.66. The TVP IMR identified concerns regarding her custody detention following these arrests. On the first occasion Adult M was under the influence of alcohol whilst pregnant and disclosed a deteriorating state of mind to the Liaison and Diversion (L&D) professional who was available for support in the custody suite. Furthermore, on the second occasion, she disclosed to the L&D professional that she had thoughts of *"ending it*" and had fresh self-harm marks. Risk was mitigated for all parties due to her being remanded in custody after a thorough application by the OIC. Regardless, these two occurrences whilst detained by police should have resulted in a referral being made and was again a missed opportunity as support should have been put in place in case the remand application was not approved, and she was released on bail at the Magistrate's Court.

3.67 <u>Adult M's Breach of Bail and Perverting the Course of justice.</u> Adult M was later charged with perverting the course of justice, a charge relating to her sending a letter intended for Adult L in July 2020. The letter was addressed to her sister, but the contents were clearly meant for Adult L and were intended to get him to withdraw his allegation. The prison authorities managed to intercept the letter before it could reach him. She was interviewed about this on 23 September 2020 and provided a short, prepared statement denying that the letter was intended to get him to withdraw his allegation. Adult M however, later entered a plea of guilty to this charge before her trial. She also offered a plea to a Section 20, wounding assault, a lesser charge than GBH the week before the trail, but this was not accepted by the prosecution.

Comment: ***Looking at the contents of the letter by its tone, confirms the OIC view at the Practitioners Event that Adult M was in her opinion the manipulative and controlling partner in their relationship. It was noted at court that it was quite an effort by her to exercise control over Adult L with an***

attempt to use an emotional hold over him as she was carrying his child, to persuade him not to go forward with the case.

3.68 At her trial, she pleaded not guilty on the grounds of self-defence, which the jury disagreed with, and she was found guilty of the offence of Sec 18 GBH, together with the perverting the course of justice charge. She received a total of five and a half years imprisonment.

3.69 **Outcome for Adult and M's unborn child.** The unborn child was effectively protected and subject to a CPP prior to the above incident between the parents. The child was subsequently born and removed from Adult M (gender and date of birth is not disclosed for anonymity purposes). The child is a Looked after Child (LAC) and is safe and well protected. A positive outcome for the child.

Chapter 4

4 Analysis of Professional Practice of the KLOE's, Practitioners Event and SAR Findings and Recommendations.

4.1 This chapter analyses professional practice. It assesses responses from Agency IMR's and professionals' views from the Practitioners Event, and from an IMR Author and SAR Review Team meetings that were held, in order to evaluate professional practice in their interaction with Adult L and Adult M. All opinions and views were taken into consideration and where relevant are encompassed within the narrative of this overview report. There are eleven findings and nine SAR Overview Report Recommendations for the SAR, including one additional learning on the fringes of the review recommendation for TVP and incorporates the new Domestic Abuse Act 2021 (29 April 2021). The analysis of the KLOE's, findings and suggested SAR Recommendations are as follows: -

Key Lines of Enquiry

4.2 KLOE 1 - Working Together. ***The extent to which local services worked effectively together to safeguard Adult L, his partner Adult M and their unborn child. This is as an opportunity to reflect on safeguarding systems as a whole and explore how different aspects of the responses to services relate to each other and whether there are any gaps in the services provided.***

4.3 There was information provided to this review that there was some effective working together regarding the concerns in the relationship between Adult L and M, but generally agencies were working individually with no one with an overall perspective of the relevant data known. Adult M's GP was aware of her mental health and social history so alerted the midwife as to the known risk factors and agreed an appropriate and proportionate plan of support in the antenatal period, including a referral to the Maternity Safeguarding Team (MST) and MASH which was good practice. There was then an ICPC arranged by CSC to consider the safeguarding of their unborn child where there was collaboration between agencies at the conferences using the Family Safeguarding Model (approach) and Signs of Safety mapping tools which were effective. MASH has identified that TVP were failing to meet the statutory obligation to attend all child protection conferences, through its 2020 policy and process review. Attendance varies across the force, between 30-80% for ICPC's, and as low as 5% for RCPC's. The TVP and MASH are trying to increase attendances by moving to attending remotely to reduce travelling time, as well as increasingly requesting the presence of specialist staff at the meetings if they are the OIC and this is being addressed. TVP did not attend the ICPC but sent a report.

4.4 TVP Police stations within Berkshire utilise specialist services including the MASH, with staff from CSC, health and education co-located in the same office; Healthcare Professionals (HCP) working in police custody suites, who conducted assessments on both Adult L and M when they were arrested; mental health professionals were present who work with front line Incident and Crime Response Officers as part of the Mental Health Street Triage scheme[6] together with medium risk safety planners sitting in the domestic abuse office, who are employed by a DA charity called HESTIA. The Welfare and Housing caseworker worked closely with Adult M's Social Worker when she was 17 weeks pregnant at the point of making the offer of temporary accommodation which, she did not take up. Also, Adult L had been a client and service user, open to the DAAT as part of the FSM substance misuse Recovery Worker in CSC during 2018 when he was open to CSC as part of a CPP, due to risks associated with his two older daughters. ACT provide front desk triage service across all adult services. Neither Adult L

[6] **Mental Health Street Triage** - the use of a M/H professional to ensure the most appropriate pathway for a person in crisis who presents to the Police

nor Adult M met the criteria for ACT. The process is not clear or straightforward for adults with drug and/or alcohol problems. If people do not meet the care act definition, they are dealt with through other processes. There needs to be a full understanding of roles and responsibilities. The following three findings and recommendations are therefore made to address this KLOE: -

4.5 Finding 1 - Developing a Domestic Abuse Pathway and review current thresholds. A DA pathway should be developed within the Local Authority area for all safeguarding partners and other voluntary organisations involved in DA. There should be a strategy to tackle domestic abuse as there are multiple agencies involved who can have their own different strands or priorities such as ACS, CSC, Police and Health. A 'Champion" for DA or a Single Point of Contact (SPOC) either an individual or team, should be implemented, which will be a gateway for professionals, third-party referrers and members of the public. This will ensure such serious cases are linked when there are both adult and children, focuses on identifying those cases are referred, recorded, information is shared and supervised, in order that the correct pathway is being followed by professionals to support and conduct positive and effective prioritised actions for safeguarding adults. A SPOC will need to be able to coordinate this process through agreed channels to the right person or team to deal with the subject or victim of DA using the person-centred approach of Making Safeguarding Personal (Care Act 2014). There should be clarification of roles and responsibilities; a need for thresholds to be reviewed to guarantee they are comprehensive and still up to date for all aspects of DA. This finding and recommendation is another level of safeguarding protection where practitioners will be aware of who to contact regarding domestic abuse cases including when there are additional complexities such drug and alcohol abuse and mental health issues to deal with. It will support practitioners and agencies in their safeguarding roles to protect and support adults at risk. By having an established DA pathway and SPOC, it will ensure that the findings and recommendations listed below are supervised and any remedial action required is appropriately taken. Members of the public with concerns for DA should be made aware of contact numbers and who they can report cases to. The following recommendation is made: -

Recommendation 1

Safeguarding Board and Partner agencies:

- ***Review the local Domestic Abuse pathway to ensure all cases of domestic abuse are responded to effectively.***
- ***Consider the need for a 'Champion' or a Single Point of Contact who is able to advise and facilitate staff/volunteers to fulfil their safeguarding responsibilities.***
- ***Ensure current thresholds in domestic abuse cases reflect LGA and National guidance.***
- ***Promote the local DA pathway, ensuring staff and members of the public are aware of the contact details and help numbers of services.***

4.6 Finding 2 - There is a requirement to display enhanced professional curiosity and to conduct thorough research into the background history in domestic abuse cases. There were gaps in service, as not all practitioners were fully unaware of the previous safeguarding concerns of Adult L and M's background history, to assist their assessments and decision making. The DAAT Recovery Worker did not know of early TVP reports that Adult M was also a perpetrator to Adult L; his GP was unaware of the unborn child, even though Adult M's GP was apparently aware she was in a relationship. The CCG

IMR confirms in both subjects that the records did not demonstrate further professional curiosity regarding other children within the households, their partner details, social circumstances and networks that may have given further information to support decision making. More effective communication and the fact that some agencies did not make safeguarding adult referrals, even though the information was known within agencies own record keeping systems, was because access to other agency systems was not always available to some practitioners. Vital information was therefore, not generally known. Access to record keeping systems is addressed below in the following KLOE 2 but there is a requirement for practitioners to display professional curiosity (also identified in Agency recommendations) and conduct thorough background checks on adults at risk in DA cases: -

Recommendation 2

Safeguarding Board and Partner agencies:

- ***Ensure all relevant staff are enabled to use their professional curiosity***
  - ***This can include (where appropriate) conducting thorough background checks.***
  - ***Referrals should ensure all relevant information is shared to inform assessments, decision making and evidence gathering between agencies working with adults and/or children.***

4.7 Finding 3 - Mental Capacity Assessments and the appropriate use of an IMCA should always be considered in a Domestic Abuse case where there are concerns for the mental health of a person. There were mental health concerns known regarding Adult M by her GP and shared with midwifery when she was pregnant. There were also worrying episodes of behaviour displayed by both Adult L and M, as reported to TVP, outlined in the narrative in Chapter 3 above. There was no concerted attempt to consider a thorough mental capacity assessment (MCA) or to obtain the advice or assistance from an Independent Mental Capacity Advocate (IMCA) whose advice would have assisted practitioners in order to try to understand the persons behaviour and to identify the right course of action needed to be taken. There were missed opportunities to assess both their mental capacity earlier in order to fully understand their chaotic lifestyle, potential health concerns and abusive issues in their relationship. The following recommendation is made: -

Recommendation 3

Safeguarding Board and Partner agencies:

- ***Ensure concerns regarding the mental health or mental capacity of a person are fully explored and consideration given as to the necessity for a formal assessment. Where relevant, advice from an advocate (such as an IMHA or IMCA) should be considered.***

4.8 KLOE 2 - Communication, information sharing and decision making (record keeping). ***Was there effective communication and key safeguarding information shared between key partner organisations and if not, why not? Were there any missed opportunities?***

4.9 There was some good communication, information sharing and decision making in this review. CCG consider for the most part there was effective communication and key safeguarding information shared between partner agencies and within Primary Care to support decision making. FHFT report no concerns as to the unborn child, who was referred to CSC following an appointment with the

midwifery team who were also made aware of verbal domestic abuse from Adult L to Adult M. FHFT's internal safeguarding processes were followed, and information sharing took place with health visitors and information was provided for the ICPC and the subsequent RCPC held.

4.10 The CSC IMR states after referral into the duty and assessment team, there is evidence of agencies (police, midwifery, CMHT) being contacted for input and the replies received are recorded. Notably, the social worker contacted Adult M's last housing provider and the manager provided some key insight about Adult M's alcohol and substance misuse and DA. The language used "*fights between Adult L and B,*" framed the abuse as bi-directional. There was also shared communication and shared reflection between the DAAT FSM Recovery Worker who works alongside social workers embedded within the FSM model. Communication was made by CSC following the birth of the baby to inform the hospital that an Interim Care Order (ICO) had been granted and the CPP ended which was good practice. The findings and recommendation for this KLOE is as follows: -

4.11 **Finding 4 - TVP to ensure domestic abuse incidents are investigated and adult protection referrals, safeguarding intelligence and information is appropriately shared in a DA case.** There were five missed opportunities by TVP officers to create adult protection referrals for both Adult L and M following calls, which were not recorded or shared. Furthermore, two Intelligence reports should also have been completed in 2019 when Adult M was trying to get a vulnerable male, who lived in supported accommodation, addicted to drugs and when Adult L was believed to have caused damage to three parked cars in a non-stop RTC in May 2020, as he was on bail for a drink driving offence at the time. Of the seventeen relevant recorded incidents between Adult L and M, by TVP, six of these were not shared with CSC considering they had respective children who had been taken from their care. This was contrary to TVP Domestic Abuse Operational Guidance; the children of Adult L and M, should have been recorded on all the occurrences of domestic incidents.

4.12 When Adult M was arrested in March 2020, a risk assessment was conducted by Welfare and Housing, for an appropriate placement, but the police check was never received back. Furthermore, when she was 17 weeks pregnant during the initial assessment, the Welfare and Housing caseworker sought information and advice from her social worker and herself in relation to the DA that she stated that she had experienced. There was no suggestion from any party that Adult L was a possible victim of DA as he was alleged to have been the perpetrator of the abuse.

4.13 DAAT also report there were several referrals sent into CSC and ASC from external agencies such as TVP and Adult L's sister about her concerns and during the initial SAR meeting. Information of a further incident was shared by TVP which the DAAT Recovery Worker had not previously been made aware of that Adult L was a victim of DV (see the narrative in Chapter 3). It is recognised that these omissions have impacted on some agencies' assessment of risk where the full details of the incidents between Adult L and M, were not always fully shared. The TVP IMR has identified learning for a number of police officers. There is, however, due to the number of omissions, a requirement for TVP to remind all their staff of the domestic abuse policies and guidance and action required so that professional curiosity is displayed to ensure communication, sharing information and decision making is effectively carried out during such incidents.

4.14 The TVP IMR also states that when officers or staff were approached by the IMR Author, they were able to offer more information than is recorded on police systems about actions they have taken. This was not documented on the TVP Niche record keeping system and was only accessible to the team. It was revealed during a recent Service Improvement Review (SIR) and previous statutory case reviews (an Oxfordshire Partnership Review following a homicide) that many Neighbourhood Teams were storing their patrol plans or work on local drives or 'Livelink' system and had not been recorded on the correct systems. This is being addressed by a recommendation from another IMR completed

in December 2019 (Milton Keynes Thematic for Hoarding and Self-Neglect) to ensure that information is stored in an appropriate and accessible place. It has also been established together with Force Intelligence and Specialist Operations (FISO) that there is no clear current guidance in relation to the subject of intelligence submissions. Following a recent internal review in relation to a Buckingham CSPR, a relevant recommendation was adopted in August 2020 which addresses further analysis and submission of intelligence reports. These latter issues are subject to TVP recommendations being implemented; however, the following SAR Recommendation is required for TVP to reassure the Board that the lessons from this SAR are being learnt: -

Recommendation (4)

Thames Valley Police:

Assure the Safeguarding Board that they have instructed all staff and supervisors:

- ***of the requirement for enhanced professional curiosity***
- ***to investigate fully (to include the decision-making at a domestic abuse scene) and record details of their enquiries, intelligence and decision making on the correct database.***
- ***That, in compliance with Local and National Domestic Abuse Policies and Guidance, relevant information is shared expediently with relevant safeguarding agencies***

4.15 Finding 5 - Practitioner access to relevant agency safeguarding record-keeping systems. There were reported concerns that some professionals did not have reasonable access to other agencies record keeping systems. This suggests a gap in safeguarding information and processes as to relevant information required to be known in DA incidents where, background information within Mukti-Agency meetings was not comprehensive. CSC state the FSM Substance Misuse Recovery Worker had access to both Children's and Adult's Social Care systems and were able to highlight the Adult Safeguarding contact relating to risk to Adult L and M. This information did not appear to filter down to the long-term workers via the ICPC. An issue was the DAAT FSM Recovery Worker had to search for information which was dispersed in at least three different locations or databases, and they do not appear to link up and information can be missed. The information of DA incidents was located between Adult L's older children on CSC's Smart Open record, the unborn child on Smart Open record and Mosaic (computerised system). Other systems are: 1) LAS (adults recording system) ASC and DAAT can access. 2) Mosaic (used to be called Framework I), Early Help and CSC and other workers have access depending on their role. 3) RIO primarily a health recording system, where CSC staff have no access but will gain some form of access through the MASH as will other practitioners. It was also reported that DAAT (at their New Hope Services office) had information about Adult L and M, which could have informed decision making that was not generally known. Information, therefore, was not always readily available for professionals, to all relevant safeguarding records. TVP also identified that some information was placed on systems that were not readily accessible to other police staff. These concerns have been addressed in Individual Agency Recommendations and within SAR Recommendation 1 - Developing a DA Pathway and SPOC above, which will be able to evaluate and oversee this finding and supports SAR Recommendations 5 below: -

Recommendation 5

Safeguarding Board and Partner agencies:

- ***Are assured that the LA has effective mechanisms to enable key practitioners to access relevant safeguarding information that may be located within databases operating in different departments.***
- ***And relevant information is shared appropriately.***

4.16 KLOE 3 - Decision making. ***What impact did communication and information sharing have on decision making? Was there sufficiency or a lack of professional curiosity in some decision's practitioners made in this SAR?***

4.17 Decision making is also touched on in KLOE 2 above, where communication and sharing information of reported DA incidents and the outcomes are discussed. In TVP there were examples of good work and considered decision making throughout the incidents involving Adult L and M. However, there were also occasions when some lines of enquiry were not followed during reported incidents. TVP believe that lines of enquiry may have been carried out but not documented. This is being addressed by TVP by way of a recommendation to the SAR.

4.18 Some decision making, and assessments were compromised by not having the full background history of both Adult L and M and the lack of some TVP adult referrals and information not being recorded. CCG in both their cases, reflect that the records did not demonstrate professional curiosity regarding other children within the households, their partner details, social circumstances and networks that may have supported decision making. The police reports provided a very different picture of the couple's relationship and this information could have prompted wider conversations with both Adult L and M, in relation to domestic abuse, (a CCG Recommendation has been made).

4.19 The focus of the ICPC was on the safeguarding of the unborn child. The danger statement at the ICPC acknowledged that if both parties continue denying the level of abuse within their relationship, it will be difficult to assess the situation accurately to enable agencies to offer appropriate intervention. Therefore, as part of the Child Protection Plan, the conference asked for a chronology to be compiled by the social worker in relation to the couple's individual histories around domestic abuse in previous relationships, substance misuse, services offered in the past and level of compliance with services. This was a good decision as Adult L at the ICPC was treated solely as a perpetrator and Adult M the victim, which was not the true and full facts. The information sharing prior to the ICPC presents a mixed picture about their relationship dynamic as the roles of victim and perpetrator did not seem clear cut. A Single Assessment looked at the possibility of Situational Couple Violence (bi-lateral abuse) alongside the possibility of Adult L being the principal perpetrator hence the disconnect between the Single Assessment and this balanced approach was not reflected in the subsequent CP Plan. A DA worker believed it was violence resistance by Adult M, but this SAR knows that not all the full facts as to her previous history and reported abuse was fully known. Once information about Adult M as a perpetrator became known was when appropriate action was taken, including work with the family to signpost and provide support for Adult L from adult services.

4.20 A lack of background history impacted on all practitioners' decision-making processes to truly evaluate the risk that Adult L was exposed to. As previous information or incidents were not fully researched, known or shared, the decision making in assessments could not be as comprehensive as would be expected. This KLOE element is addressed in SAR Recommendations 4 and 5 above.

4.21 **Finding 6. Displaying professional curiosity,** has been highlighted in a number of Agency IMRs and recommendations made in some instances and in the narrative above. The Recovery Worker felt there was very little communication from CSC regarding Adult M and no reports were shared relating to her substance misuse but did seek out Adult M's previous Recovery Worker to gain more understanding of risks which did show professional curiosity.

4.22 Adult L's sister included in her concerns that he had Autism/Asperger's, was childlike and easily led. She described Adult M as manipulative and controlling and was concerned Adult M would stab him and was frightened, he would die. There was some positive decision making by TVP during this investigation such as sharing the information with CSC and approaching his sister to ascertain if

she or his daughters would provide a witness statement for the information disclosed and for offences of malicious communications towards them. Had they done so, TVP may have been able to build an evidence led prosecution for the offence of Coercive Control towards Adult L, as well as listening to the voice of the child through his daughters. These allegations were followed up by Adult L's GP who spoke to him; he denied his sister's concerns.

4.23 Other opportunities to show inquisitiveness was when a member of the public reported seeing Adult L with injuries consistent with ABH, walking down the street with Adult M screaming, swearing, and making threats to stab him and when Adult L told practitioners that he did not want her to live in his house. Once she was pregnant, he felt compelled to allow her stay, through the Covid-19 lockdown, as she had nowhere to go. He also stated to professionals that he believed she had mental health concerns and was worried that she may harm herself and the baby. It is not clear whether practitioners actively listened to him and took his comments seriously.

4.24 Professional curiosity should be displayed whether or not there was support from Adult L or his family, to ensure the concerns and comments were appropriately followed up. There is no SAR recommendation for this KLOE as the elements are covered within the findings and SAR Recommendation 4 above and in KLOE 4 below. Individual Agency IMR Recommendations have been set covering professional curiosity, which will form part of an Action Plan that follows the completion of this review.

4.25 KLOE 4 - Bias. ***Did bias in respect of the role of gender (for both Adult L and M), or a recognition of coercive control including unconscious bias of practitioners, influence professional judgement of services provided and decision making?***

4.26 Finding 7 - Awareness of the signs and symptoms of unconscious and gender bias, coercive and manipulative control in Domestic Abuse. There was an initial assumption in this case that Adult L was predominately the aggressor in the relationship. The elements of possible manipulative and coercive control and unconscious gender bias on reflection due to the facts of this review is that either gender could be a potential victim and/or perpetrator of domestic abuse and circumstances must be assessed on a case-by-case basis. TVP, in conversation with the reporting officer on the 26 October 2019 where Adult M reportedly assaulted Adult L, stated that the officer was of the impression that he could defend himself because he was physically bigger than her. In the incident two days later when she was arrested for criminal damage in Adult L's home, a police officer made assumptions that Adult L has some responsibility for the incident. The reasoning for this assessment is unclear as the officer had limited memory of attending the incident, but TVP would not expect a victim to have to justify their actions in any case.

4.27 Potential gender bias was evident when police were called to Adult M's supported accommodation in December 2019. Without any clear information to the contrary as to who was the victim or suspect in the incident, Adult L was recorded as the suspect. This was further exacerbated by a supervisor's comments that they agree with the risk grading of medium for Adult M due to the offender (Adult L) history without checking the facts. This together with other incidents of potential coercive control and unconscious gender bias has been readily identified by TVP as learning to be addressed from a small number of incidents.

4.28 At a MARAC meeting held in May 2020, it was suggested Adult L had coercive control over Adult M. At the ICPC, the concerns relating to gender equality and to Adult L's vulnerabilities were not raised as he was still regarded as the sole perpetrator of DA. By the time of the June 2020 RCPC for their unborn child, the full circumstances of Adult M's abuse of Adult L became apparent when the

details of the serious assault by Adult M on Adult L, became known. It is possible that there was an element of unconscious bias on the part of agencies prior to the ICPC and that this affected information sharing and decision making. It was acknowledged that both parties minimised the abuse in their relationship, and emphasis was placed on Adult L's history of violence but not Adult M's. Clearly during this period, they were abusive and aggressive towards each other but the extent of any coercive control, unconscious and gender bias was not that solely of Adult L as first believed. Research would have shown Adult M's abusive behaviour she directed at Adult L was mirrored in her previous relationships when she was served with a Domestic Violence Protection Order. The reason for this view is that when arrested for the stabbing of Adult L, the OIC who conducted an effective and thorough investigation, stated at the practitioner's event that on researching her telephone, it confirmed she was manipulating Adult L and attempting to use coercive control. This was further evidenced when she wrote a letter from prison, which was intercepted, directing him, not to pursue the case.

4.29 Events during this scoping period agrees that most women are the victims at the hands of men of intimate partner violence (IPV) or even intimate terrorism which is coercive controlling violence (CCV) when one partner, often a man, uses coercive control and power over the other partner using threats, intimidation, and isolation. The analysis of the preceding narrative, the coercive and possible intimate terrorism would suggest that Adult M is the manipulator in this unhealthy relationship, and confirmed if we listen to Adult L's sister's concerns that it was, he who was being isolated by Adult M. What must be remembered, it is not always the male gender who are the perpetrators of domestic abuse as the violent episodes and events in this report show.

4.30 CCG made a recommendation for Primary Care Domestic Abuse Training to be updated to consider the impact of unconscious bias when having contacts with male victims of domestic abuse. TVP will be reminding staff to be aware of unconscious gender bias, to consider and recognise that males are also victims of domestic abuse and coercive control which became a criminal offence under Section 76 of the Serious Crime Act, 2015. Conference and Review also have also made an agency recommendation that Conference Chairs must continue to be alert to men also being victims of domestic abuse. There are numerous academic papers and research material available which discusses and has opinions on this subject. Nevertheless, there is a need to ensure all safeguarding practitioners dealing with domestic abuse incidents are aware of the signs and symptoms, to identify cases earlier for positive action to be taken, as the following recommendation requires:

Recommendation 6

Safeguarding Board and Partner agencies:

- ***Are assured that all relevant staff are aware of and are able to recognise all forms and symptoms of coercive and manipulative control***
- ***And are aware of unconscious and gender bias in cases of Domestic Abuse and the support plans required to protect the individual.***

4.31 KLOE 5 - Policies and Procedures. ***Was there compliance with established policies and procedures? If not, what was the reason for non-compliance, and did it affect the agency's safeguarding responses and outcome?***

4.32 Generally, unless where raised in the narrative of this report, policies and procedures were followed and it is acknowledged there is a crossover with other KLOEs in relation to this aspect. The concerns identified by TVP in their IMR, have also been addressed in SAR Recommendation 4. CCG

report there were no links between Adult L and M's records and so information regarding the pregnancy was not available to the GP when seeing Adult L in March 2020. There was good practice identified in both their notes and through discussion with the GP to support compliance to established policies and procedures. Adult L's records did not have an alert in relations to the domestic abuse report where he was identified as perpetrator of domestic abuse. CCG made recommendations for Primary Care to ensure that appropriate information related to domestic abuse incidents are recorded in the medical notes of patients that are the alleged perpetrators.

4.33 TVP have clear and established policies within their Domestic Abuse Operational Guidance. All policies and operational guidance are available to officers and staff through the Force intranet pages but were not always followed. At the incident on the 20 March 2020, two officers recorded Body Worn Video evidence whilst in attendance at an incident that resulted in Adult M's arrest for a domestic assault on Adult L. The BWV Joint Operational Guidance was not followed as only one set of BWV footage was correctly marked as evidential, the other was incorrectly deleted whilst the investigation was ongoing and may have provided an insight into Adult M's demeanour and capacity.

4.34 There was evidence from CSC that policies and procedures were being followed, albeit adaptively due to the outbreak of Covid-19 and subsequent restrictions on face-to-face visitation which is understandable. Child Protection visits, either face-to-face or by video call were completed within timescales and FSM Group Case Supervisions, where the reflective discussion around cases takes place, was completed. Social Workers also receive one-to-one supervision to discuss the general well-being of cases.

4.35 A DASH form was completed for Adult M which resulted in a prompt referral to the MARAC (although there are no timescales written in policy around this). The five-day review for the Section 47 investigation was completed within timescales and reflected a balanced view. The assessment with evidence of two-way abuse was being considered and the threshold met for ICPC where Adult L as stated previously was adjudged the perpetrator in their relationship. CSC supervision was also compliant with timescales. Individual Agencies recommendations together with SAR Recommendation 4 above, cover the above comments and findings, therefore no individual SAR Recommendation for this KLOE is required.

4.36 KLOE 6 - Risk assessments. ***Were appropriate risk assessments carried out by agencies in their involvement with Adult L and M? Was there professional knowledge and awareness of the Safeguarding Board's Risk Management tool? Is the tool being effectively used and if not, why not***

4.37 There is evidence of some good practice identified from Agency IMRs with discussion with the GPs for both Adult L and M, around risk assessment. However, as previously stated there could have been more professional curiosity displayed as noted in most agency IMRs. Based on the available information, a single agency risk assessment was undertaken by the GP for Adult L and there was no indication that the Risk Management Tool was required at that time. (The CCG have made an Agency Recommendation for risk assessments).

4.38 Conference and Review conclude that risk assessments were carried out at both the ICPC and RCPC effectively, using the Signs of Safety mapping tool to extract key information as well as the Family Safeguarding Model and approach through Motivational Interviewing and Appreciative Enquiry techniques. The Welfare and Housing Caseworker completed a number of assessments to establish the situation with Adult M, including a domestic abuse risk assessment. Prior to being offered emergency accommodation in March, a number of other assessments were completed, and a police check was also requested (no record of response). However, the risk management tool is not used by the safeguarding team in the same form in the Welfare and Housing Service.

4.39 TVP have Medium Risk Safety Planners who are employed by a domestic abuse charity called HESTIA. Risk Management Occurrences[7] were created for both Adult L and M, after they were graded as medium risk during domestic incidents. TVP have recorded that the HESTIA safety planner made contact three times with Adult L and twice with Adult M until both declined any further support. There were four occasions when domestic risk assessments were not completed (DOM5 forms). DOM5 police forms were missed which would assist risk assessments and is addressed in the TVP IMR.

4.40. Independent risk assessors were based in the MASH until 2018 when they were removed. Since this time, all DA incidents graded as high risk are reviewed by a Police Sergeant in the Domestic Violence Abuse Unit (DAIU). TVP are unsure whether there has been an agreed expectation that the risk framework multi-agency tool is routinely used by TVP as DAIU staff are aware but do not necessarily use it. Ten officers were contacted but only one was aware of the risk framework tool. TVP replicate many of the aims of the risk framework tool in the course of their work, particularly the Problem Solving and Neighbourhood Teams who carry out more long-term safeguarding work in their roles. Risk assessment and grading is being addressed through a recent DA Service Improvement Review and the introduction of a risk consistency grading pilot which commenced in June 2020 and is being assessed for one year and if deemed successful, it will be written into operational policy.

4.41 This SAR is aware that ASC have delivered some training on the BFRM tool. There is also good knowledge of the risk framework tool within CSC. The DAAT Recovery Worker's risk assessment and management plan say the assessment of risk would have been higher had the previous incidents had been known. There was, however, a timely referral to the MARAC after Adult met (and exceeded) the threshold score as High Risk.

4.42 Finding 8 - Requirement for agencies to conduct thorough risk assessments and ensure the awareness of the Safeguarding Board's Risk Management Tool is known and utilised. Cases such as this can be challenging, often dependent to a degree on the willingness of the adults at risk to take part in the process. Problems of sharing information and the variance known within different agencies and at the MARAC and ICPC has been identified and is a risk. They were unaware of the concerns for Adult L and had they been, this may have highlighted the need to use the BFRM Tool and risk framework process. If ASC had all the information regarding police call outs to their DA incidents, they may have acted differently to the safeguarding concern raised by his sister. Also, the Recovery Worker may have been alerted to the concerns earlier and ASC may have made contact with Adult L sooner, which could have linked to a previous referral. Risks may have been known earlier if information was shared effectively as a matter of course. The police reports that were sent to CSC were linked to the unborn child, but the assaults and DA took place between two adults who were deemed at risk and should also have been made aware to the ASC Agencies should remind staff of the Risk Framework tool or reassure the Board that other accepted risk assessments are being conducted, and the rationale recorded to ensure effective safeguarding practice.

4.43 Further to this finding, the Care Act 2014 (Section 42) requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom. This did not occur for either Adult L or M, again, a missed opportunity. Due to the escalating risks of the domestic incidents, a professional meeting could have been called to assess thoroughly the risks and escalating DA incidents. Domestic Violence Protection Orders (DVPO) and DVP Notices (DVPN) were developed in March 2014 for all police services in England and

[7] **Risk Management Occurrence** – A non-crime related report that can be created on NICHE to document risk management measures taken around vulnerable individuals, ie. Missing Persons, Domestic Abuse victims etc.

Wales. It provides another level of protection for victims by enabling police and magistrate courts if a risk assessment finds it is necessary, to put in place protective measures where there is insufficient evidence to charge a perpetrator. A DVPO was placed upon Adult M in a previous relationship which was probably effective, as we know she eventually moved on to form a relationship with Adult L. When a victim of DA does not wish to pursue a prosecution, advice can be sought by police from the Crown Prosecution Service as to whether they would consider conducting a victimless prosecution.[8]

4.44 The new Domestic Abuse Act 2021 (enacted 29 April 2021) gives Police new powers including a Domestic Abuse Protection Notice (DAPN) that provides immediate protection following a domestic abuse incident and a new civil Domestic Abuse Protection Order (DAPO). These replace the DVPO and DVPN's in existence during the period of this SAR and consolidates existing protection orders (see Conclusions in Chapter 5). A breach of a DAPO is now a criminal offence. This finding is addressed in the following SAR Recommendation 7 and would be monitored for effectiveness if SAR Recommendation 1 above is enacted: -

Recommendation 7

Safeguarding Board is assured that relevant partner agencies ensure:

- ***Relevant staff/volunteers are familiar with the Safeguarding Board's Risk Management Tool. Where the tool is not used, agencies should ensure an effective risk assessment is conducted and the rationale recorded.***
- ***That relevant staff/volunteers are aware of duties under Section 42 Care Act 2014, and that safeguarding enquiries are conducted when an adult is experiencing or is at risk of abuse or neglect.***
- ***Relevant police officers and safeguarding professionals are aware of and utilise (where appropriate) Domestic Abuse Protection Notices and Orders (DAPN and DAPO) that consolidates existing protection orders and non-molestation orders under the Domestic Abuse Act 2021.***
- ***Investigating officers, in consultation with the CPS, consider a prosecution without the support of the victim in cases of Domestic Abuse.***

4.45 KLOE 7 - Diversity & Equality. ***Were there elements of diversity and equality identified within agency interaction with Adult L and M in the SAR and did it affect practice?***

4.46 Finding 9 - Gender Equality and Culture. There is no evidence that either Adult L and M experienced any discrimination in their interaction with professionals and did not appear to face barriers to accessing primary care services as defined by the Equality Act 2010. Adult M was identified with increasing risk due to her pregnancy and her mental health issues, with appropriate and proportionate action taken by her GP and by midwifery. TVP state there was one significant occasion where considerations of equality may have had an impact on practice where it appears that Adult M's pregnancy was a major factor in her being released from custody to Adult L's home address after assaulting him and causing damage to his property.

4.47 There is no evidence of any reflective discussion on gender equality, which is known through research as being inextricably linked with domestic abuse. If there had been a consideration of the full facts of her violent abuse against Adult L, it may have prompted more reflection on gender bias. It may not have changed some practitioner's conclusions as to the nature of Adult L and M's relationship, but may have suggested more open-mindedness, having knowledge of Adult L's abuse, where

[8] https://www.cps.gov.uk/north-east/news/cps-committed-prosecution-domestic-abuse-cases-without-support-victim

opinions and reasoning may have changed. As such, it is the view of this SAR that Adult L was subject to gender equality bias, as views and opinions were biased towards Adult M, which may not have been the case if her abuse against Adult L was more widely shared as the recommendations above have addressed. There may have been a significant difference in content and information provided to both, due to them being deemed a 'victim' and a 'perpetrator'. For this reason, risk management plans and predicted outcomes may have been overshadowed by prejudices even though that they were equally responsible for their own behaviour and actions, however the evidence suggests that there were more services in favour of Adult M.

4.48 DAAT say Adult M was well spoken, presented as physically smaller than Adult L and this impression may have played a part in bias and perception of risk (as TVP also suggest in the narrative above). Equality may have been overlooked by agencies, as practices were focused on and put in place for Adult M's protection, whilst minimal support or safety plans of actions were not put in place for Adult L until the serious incident when he was stabbed. The DAAT Recovery Worker for Adult L, at most times felt that he was being overlooked due to the fact that he was labelled the 'male perpetrator' in this case. There is no SAR Recommendation for this finding as it is addressed above in identifying the signs and symptoms in SAR Recommendation 6.

4.49 KLOE 8 - Covid-19. ***Did Covid-19 impact on the provision of local services and the ability to safeguard vulnerable individuals during the pandemic? Will there be an impact on services to be provided for the future?***

4.50 A particular difficulty linked to COVID-19 was the often-lengthy delay in telephones being answered by Police and Hospitals, but it is suggested this will not impact services to be provided for the future. Primary Care has adapted to how services and patient consultations are being delivered; with more remote consultations being offered. CCG Agency Recommendations were made for Primary Care for the safe use of online consultation and how to consider the risks of hidden harms when carrying out consultations that are not face-to-face with the patient; with safeguarding guidance for remote consultations, developed prior to this SAR, and shared in November 2020 by the Lead GP for Safeguarding in all surgeries and circulated across Primary Care within East Berkshire CCG.

4.51 The Covid-19 pandemic did not impact on the Conference and Review team's ability to continue its work. The ICPC was held at a venue before Covid, and the RCPC was held virtually. Both meetings were attended by parents and all relevant agencies or reports sent. Since their child was born, the LAC reviews were held virtually and in line with standards and expectations with no anticipated negative impact on services. W&H considered Covid-19 impacted in supporting Adult M when she presented as homeless in March 2020. At the point of referral, they had to contact seven domestic abuse refuges, but none were willing to take Adult M. A number of reasons were stated including because of Covid-19. Even outside the pandemic, established refuge spaces for those with complex needs including substance misuse, are limited which is outside the scope of this review.

4.52 DAAT confirm that no home visits were being completed due to the pandemic by the Recovery Worker, and had Covid-19 not prevented this, there may have been a better opportunity to assess Adult L's level of alcohol consumption as well as the dynamics of his relationship in his home environment, for a more accurate assessment of risk. All interactions with Adult L were over the telephone, which he had expressed that he did not like using previously. During this period, it was said Adult M fled the home on a number of occasions to a neighbouring authority, returned to the local authority and then fled to family members. She allegedly returned home to Adult L, due to needing the toilet on one occasion during lockdown. Why she did not return to her family or whether her account could be verified, is not known.

4.53 Covid-19 did not impede CSC in the safeguarding of Adult M with communication by phone and video call. The DASH form was completed, emergency accommodation was sourced, case discussion and safety planning took place via the MARAC without any delays. The response to Adult M suggests that any similar response to Adult L would not have been affected by Covid-19 had he been perceived as a victim. There is a commitment by agencies to attending conferences remotely which will reduce travelling time and is likely to become a more usual way of working post the pandemic. There is no SAR Recommendation made for this KLOE.

4.54 KLOE 9 - Training. ***Have agencies provided the necessary training and support for each of their staff or is there training that should be considered to be provided?***

4.55 There has been extensive training that has and is being conducted from agency submissions to the review. Individual agencies have identified additional training through agency recommendations (See the Board's Action Plan) that follows the completion of this SAR. A CCG Recommendation for Primary Care's annual training update will use this review as a case study to raise awareness of the impact of domestic abuse on male victims. The Conference and Review Team has been trained in child protection procedures and there is on-going training on topics such as unconscious bias and domestic abuse with regular updates for staff. TVP highlight that one DAIU police officer felt there was inadequate training for risk assessing even though there is a five-day course for DAIU staff which includes risk assessment. When officers join TVP, they complete Foundation Training including the topic of Domestic Violence and Mental Health.

4.56 ACT have implemented training during the SAR process as there was a need for ongoing safeguarding training and development (refresher and updates) for practitioners carrying out safeguarding roles. Relevant changes to the process have since occurred and this has ensured that greater support and monitoring is provided to staff carrying out these discussions, by experienced safeguarding practitioners. Practitioners will also be able to access relevant information more easily using their intranet, an area undergoing significant change within the local authority.

4.57 CSC confirm that the FSM Recovery Worker, who is a trained Independent Domestic Violence Advocate (IDVA), complemented her specialist knowledge in the area and the Social Worker had attended several DA training sessions. Regular facilitated training sessions and workshops are held for staff and an introduction to DA and MARAC training is also made available to frontline workers. Following the stabbing of Adult L, CSC are undertaking a reflective review of complex DA work with the expectation of in-house training for all social, family, adult workers to be developed and rolled out. CSC offer a note of caution on training as the role of gender in DA is hotly debated with competing views. This has been addressed in Agencies IMR Recommendations and SAR Recommendation 6 above; there is no requirement for a further recommendation for this finding.

4.58 KLOE. 10 - Learning from previous reviews. ***Have agencies taken into account learning from other published reviews? If not, why not and what will the agency do to ensure lessons are learnt in the future?***

4.59 Agencies have given evidence to this review that learning from previous reviews is regular and ongoing. However, W&H are not aware of any published reports but learning within the service is used to inform service delivery moving forward. ACT's awareness of learning from published reviews is limited due to the breadth of reviews published. They ask if it would be helpful to understand how teams might be able to access or be aware of the themes from various reviews for future reference and for learning. Both W&H and ACT would normally be expected to conduct their own routine research of recent learning from published reports which are widely known and accessible. CSC learning is predominately from published Child Safeguarding Practice Reviews (CSPR) formerly Serious

Case Reviews. TVP have recently implemented, during the SAR process, learning from previous regional and national case studies from published reviews including intelligence, information storage, risk management, case conference attendance, recording of children's details and adult protection referrals. The following two findings and recommendations relate to learning from published reviews and supporting statutory reviews.

4.60 Finding 10 - the Board's database of relevant and recent learning from published reviews, policies and guidance. To assist safeguarding partners and voluntary organisations to be aware of necessary and relevant learning the following SAR Recommendation is made: -

Recommendation 8

Safeguarding Board:

- ***Further develop its portal to enhance and promote easy access for staff/volunteers to established libraries and resources (e.g. SCIE, NSPCC, the National panel) and other sources of learning from published Safeguarding Adult Reviews, Child Safeguarding Practice Reviews, Domestic Homicide Reviews.***

4.61 Finding 11 - Learning on the fringes of the SAR process for Thames Valley Police. There has been a significant delay by TVP in providing an IMR for this SAR. A final report was due in October and was not received until the 5 March 2021, a significant delay. The IMR was apparently held up within TVP's SIR Quality Assurance (QA) department. This has required SAR Review Team meetings to be rescheduled on two separate occasions. An Agency IMR Authors meeting was held in early January 2021 for the authors to present their agency findings to the SAR Review Team. There was no TVP IMR or author present at the meeting, however, the TVP SAR Review Team representative was present and helpfully managed, after the meeting, to obtain a draft but unfinished report. This allowed some work to begin on the SAR Overview Report. Additionally, assistance from two TVP police officers attending the subsequent PE, gave valuable insight into TVP's interaction with Adult L and M.

4.62 There was still a substantial delay, therefore the Board escalated this to senior management within TVP. There is a need for TVP to review their QA system for the completion and submission of IMRs for all reviews. This is in order to support and assist the Local Authority to meet their statutory obligations of timescales to be met as there was also an apparent delay in a previous LSCPR that needed to be escalated. It must be stated, this is not systematic within TVP, as the SAR Lead Reviewer has personally completed five SARs and SPRs recently where the TVP IMRs were presented on time, but the delays within the Local Authority area needs to be reviewed: -

Recommendation 9

Safeguarding Board are assured*:*

- ***That Thames Valley Police review their quality assurance process with regard to the submission of Individual Management Reports contributing to Safeguarding Adult Reviews in order that they comply with statutory obligations.***

4.63 Agency IMR Recommendations have been made which will form part of a Board SAR Action Plan that follows the conclusion of this review. They are not reproduced at this juncture but where relevant have been referred to in the narrative of this report.

Chapter 5

5 Conclusions

5.1 Predictability and Preventability. It must be appreciated that dealing with adults at risk of DA, is a very difficult process for practitioners to contend with. This is particularly so when there may be added possible mental health, substance and alcohol misuse concerns that can impact on their health, welfare and interaction with professionals. This review suggests in order to co-ordinate an effective strategy, there needs to be developed a clear domestic abuse pathway as this report recommends. A DA Pathway will ensure that practitioners and concerned members of the public can be confident of whom to contact, the process and support available, with the assurance that the right action is being taken, by the right agency, with the outcome, rationale of risk assessments and decision making, recorded, to protect and support any person subject to DA. It is imperative in the first place that all DA incidents are reported and referred appropriately to ensure safeguarding processes can be followed.

5.2 Initial assessments were never able to be as rigorous as was required, because not all of the safeguarding concerns were reported or shared. The significant background history of both Adult L and M was not fully known or researched effectively. On the information supplied to this review, their relationship and their previous and ongoing concerns remained high-risk throughout. These concerns were never fully investigated, understood or resolved until the final trigger event when Adult L was stabbed with a knife by Adult M.

5.3 It is the view of this SAR, with the known information and complexities, the outcome of serious domestic abuse between Adult L and M was predictable. If all the information referred to was known, it is anticipated that different action could have been taken to safeguard and protect both of them and the serious mounting concerns may have been avoided and therefore preventable. This can only be an assumption, as we know that Adult M, even when she was on police bail and directed not to approach Adult L, she continued to do so. In their relationship, the confirmed evidence of actual physical abuse and manipulation was upon Adult L by Adult M, as the perpetrator.

5.4 The effectiveness of agencies to identify the safeguarding concerns for their unborn child was expedient and efficient and the child was appropriately protected by the safeguarding child protection processes carried out. Safeguarding concerns for their child was therefore predicted and prevented.

5.5 Voice of Adult L, Adult M and Adult L's Family. Information provided to the review suggests that Adult M was listened to by professionals, and she was accepted as a competent communicator. Adult L, however, was described as not articulate according to his DAAT Recovery Worker. TVP followed up the reported concerns of his sister and shared the information with his GP who also spoke with him, but he denied his sister's concerns. There is highlighted in the findings in the preceding chapter that there required more professional curiosity displayed to explore the possibility that he may have had Autism/Asperger's and whether there was alternative evidence to support court proceedings even without his or his family's agreed involvement. There were also the incidents when he was seen with facial injuries in the street with Adult M, apparently screaming and making a threat to stab him; his statement to practitioners that he did not want her to live in his house but once she was pregnant, he felt compelled to allow her to stay and furthermore, his repeated concerns for her mental health. It is unclear whether practitioners listened to him and took his comments seriously, as no mental capacity assessment was conducted considering some of the worrying behaviour, they had both displayed. The opportunity for Adult L and M to participate in the SAR where these and other

pertinent questions could have been posed to them has not been possible, as the Board did not receive an acceptance to participate from either party.

5.6 Previous SARs. Relevant learning from previous published SARs to this review are as follows:

5.7 Milton Keynes. - SAR Adult B 2019. There was similar learning, as in this SAR, for the implementation of a one stop shop, pathway and champion for homelessness, an additional level of safeguarding; the appropriate use of IMCA's and conducting MCA assessments; record keeping and sharing information; training issues; professional knowledge and compliance with guidance and legislation.

5.8 Bracknell Forest - SAR GH 2019. There was also similar learning identified which is relevant to this review including risk assessments, record keeping and improved communication.

5.9 Bracknell Forest - SAR AB 2018. As a result of this report the Risk Management Tool was developed, and its use is pertinent to this SAR. It includes a recommendation to ensure there are policies and procedures in place (and that practitioners are aware of how to access such a pathway) for a multi-agency forum to review high risk or complex needs cases; a recommendation of training for the Mental Capacity Act to ensure practitioners are clear that the assumption of capacity principle does not prohibit formal capacity assessments being undertaken. (See SAR Recommendations 1 and 3 in Chapter 4 above further defines the learning required).

5.10 Leicester SAR - Bert 2018. The review highlighted the importance of understanding different professional roles and responsibilities and the legal parameters in which professionals work. This enables clear communication of risk assessments and agreement over each partner's contribution to the risk management plan and DA Pathway will ensure this is captured and validated.

5.11 West Berkshire SAR - Mrs. H 2016. There was a mismatch of information and incomplete understanding of the levels of risk in decision-making. *(This mirrors this review and SAR GH above. The risk framework tool as stated above, has now been implemented but this review requires further awareness and training for safeguarding agencies practitioners in its existence and use).*

5.12 Good Practice. Agency IMRs reported good practice, and this has been permeated throughout the narrative of this report. Suffice to say that all agencies were attempting to offer clear advice and support which was never really accepted by both Adult L and M. There is good practice acknowledged even though learning has been identified for the improvement of domestic abuse outcomes.

5.13 Current initiatives being developed. CSC have started work on a new multi-pathway DA Service that will flexible and adaptive, to reflect the complexity of the cases that come into the service. At a SAR meeting to consider this report, it was agreed that the work should also incorporate both CSC and ASC, with the additional involvement of the Community Safety Partnership (CSP) whose Strategic Priorities for 2020 to 2023 includes, 'Reduce harm caused by domestic abuse.' By incorporating both disciplines of CSC and ASC, will go towards completing the implementation of SAR Recommendation 6 above, with a more comprehensive approach. The work, which is in development, will look at motivational interviewing to address four elements, **1)** Situational couple violence graded standard risk and Parental Conflict, **2)** Males in medium/high risk situational couple violence relationships or violent partners in coercive controlling relationships, **3)** Women in medium/high risk situational couple violence relationships or non-violent partner in coercive control relationships and **4)** Abuse in adolescent relationships.

5.14 The DA Executive (a multi-agency sub-group of the Community Safety Partnership) is aware of a reduced level of take-up of 'Introduction to Domestic Abuse' training as well as the

MARAC/DASH training. In line with the recommendations of the KK SAR and to ensure that partners ensure that existing staff and new staff within their service areas are able to offer the best service possible to victims and children where there is DA, representatives of the group will be tasked with monitoring attendance (including refresher training). This initiative will be overseen by the DA Executive as part of its quarterly meetings.

5.15 Domestic Abuse Act 2021. The new act became law on the 29 April 2021.[9] It will provide additional protection for people who experience domestic abuse and strengthen measures to tackle perpetrators. It has a wide-ranging legal definition of domestic abuse which incorporates physical violence, including emotional, coercive or controlling behaviour, and economic abuse. The measures include important new protection and support for victims ensuring that abusers will no longer be allowed to directly cross-examine their victims in the family and civil courts and giving victims better access to special measures in the courtroom to help prevent intimidation. As stated previously, the new DAPNs and DAPOs will replace the current DVPN and DVPOs. A DAPO will introduce an alternative application route so that victims and specified third parties including a social worker, can apply for a DAPO directly to the family court. This will enable criminal, family, and civil courts to make a DAPO of their own volition during existing court proceedings, which do not have to be domestic abuse related cases.

5.16 DAPNs will provide victims with immediate protection from abusers, while courts will be able to hand out new DAPOs to help prevent offending by forcing perpetrators to take steps to change their behaviour, including seeking mental health support or drug and alcohol rehabilitation. Other measures include: extending the controlling or coercive behaviour offence; established in law the office of Domestic Abuse Commissioner; places a duty on local authorities in England to provide support to victims of domestic abuse and their children in refuges and other safe accommodation; provides that all eligible homeless victims of domestic abuse automatically have ‘priority need’ for homelessness assistance; places the guidance supporting the Domestic Violence Disclosure Scheme (“Clare’s law”) on a statutory footing and the expectation that the law will fundamentally transform professional response to tackling domestic abuse by providing much greater protections from all forms of abuse.

5.17 In Conclusion. It is evident that learning lessons from both Local and National SARs has identified similar concerns that are still repeating themselves. If the recommendation to develop a Domestic Abuse Pathway and SPOC is accepted, this will go towards ensuring no DA case is overlooked and this will give an “*Extra Level of Domestic Abuse Safeguarding.”* An implemented matrix or flowchart of actions and agency’s expertise and support services available will ensure the right agency and professionals are engaged, who have the necessary knowledge and experienced required in DA cases including with other complexities, that are supervised, assessed and monitored to enhance the safeguarding of adults.

5.18 Submission of Overview Report. This SAR Overview Report for Adult L is submitted to the Safeguarding Board to consider the findings and recommendations and to promulgate the necessary learning through the SAR Action Plan that will accompany this report.

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[9] Home Office, Ministry of Justice, Gov UK

Appendix 1

Bibliography

The following legislation, documentation and guidance was consulted for the process of completing this SAR (see also inserted footnotes for additional review and research material considered): -

Safeguarding Adults Board Annual Report 2017-18

Multi-Agency Safeguarding Adult Policy and Procedures

Multi-Agency Risk Framework February 2019

Local Government Association 'making safeguarding personal resources' in Understanding what constitutes a safeguarding concern and how to support effective outcomes (local.gov.uk)

Care Quality Commission (2010) Guidance about compliance: Essential standards of quality and safety. What providers should do to comply with the section 20 regulations of the Health and Social Care Act 2008, London: CQC

Care Act 2004, 2014

Equalities Act 2010

European Convention on Human Rights (ECHR)

Human Rights Act 1998

Inter-Agency Partnership Agreement for East Berkshire (December 2017).

Mental Capacity Act 2005.

Appendix 2

Glossary of terms

Adult Community Team	ACT
Adult Social Care	ASC
Approved Mental Health Professional	AMHP
Community Safety Team	CST
Drug, Addiction and Alcohol Team	DAAT
Emergency Duty Team	EDT
Family Safeguarding Model	FSM
General Practitioner	GP
Independent Mental Capacity Advocate	IMCA
Lead Reviewer	LR
Liaison and Diversion	L&D
Local Authority	LA
Mental Health	MH
Mental Health Act	MHA
Officer in Case	OIC
Police Officer	PO
Safeguarding Adult Review	SAR
Safeguarding Practice Review	SPR
Social Worker	SW
South Central Ambulance Service	SCAS
Terms of Reference	TOR
Thames Valley Police	TVP
Welfare & Housing	W&H