Executive Summary of the Domestic Homicide Review

In respect of the homicide of Stephanie[1]

In September 2019

Report produced for Oxford City Community Safety Partnership by
Paula Harding
Independent Chair and Author

[1] pseudonym

Preface

In order to protect the anonymity of the victim and her family, the victim will be known by the pseudonym, Stephanie.

Members of the review panel offer their deepest sympathy to all who have been affected by the homicide of Stephanie[2]. They would particularly like to thank Stephanie's parents for their help in enabling them to appreciate Stephanie's life and for her voice to be heard throughout the review.

A personal statement from Stephanie's mother:

> *Stephanie was a bright and vivacious child though her very deep anxieties often led to her outward and attractive qualities strengthening her need to deny her vulnerability. This undoubtedly contributed to the difficulties others, including professionals, at times experienced in seeing how profoundly frightened and anxious she could be. Being in touch with uncertainty was, I think, terrifying for her and she developed an ability to cut off from terror and thus to be hard to reach, or keep hold of, at times of greatest need. She was certainly a survivor of many losses and multiple traumas in her early years and again in the loss of her own children but there never came sufficient time when both aspects of who she was could come together. I hoped this might be more possible with time which in the end we did not have. She was courageous at heart, and in her own way, honest and down to earth; she had a vulnerability and warmth which reached others and made others want to reach her. She was loved and cherished, and life will not ever be the same without her for those who love her dearly.*

A personal statement from Stephanie's father:

> *'Adopting Stephanie was a defining moment in my life. She was a bright, lively nine-year-old who quickly found a place for herself in the large extended family which she had joined. There are many childhood memories of her that give me great pleasure: camping, sea scouts, playing the flute, travelling in India. Being her father became more challenging as she grew into adolescence and then adulthood. She retained her sharp sense of humour and the loyalty of her friends. I learnt that she would follow her own path, but that she needed to know that she was loved and that I would continue to 'be there' for her. She tended to live near the edge but seemed to have been a survivor - until the final tragedy that ended her life. She added a huge dimension to my life, and I find it hard to accept that there will be no more frantic phone calls. I am sure that she would be proud of all seven of her children who are thriving and who will hold her in mind as they grow older.'*

[2] pseudonym

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1. The Review Process

1.1 Background

1.1.1 This summary outlines the process undertaken by Oxford City Community Safety Partnership in reviewing the circumstances leading to the homicide of Stephanie, a 42-year-old woman by her 37-year-old partner, who were resident in their area. Her partner who went on to commit suicide. The coroner arrived at the conclusion that Stephanie had been unlawfully killed and that the perpetrator went on to take his own life on the same day in September 2019.

1.2 Summary of the Review Process

1.2.1 The decision to undertake a domestic homicide review was made by the Chair of Oxford City Community Safety Partnership, after consultation with partner agencies on 08.10.2019. The Home Office was notified of the decision on 29.10.19. An independent chair and review panel were appointed, and the review was managed in accordance with the relevant statutory guidance (Home Office, 2016).

1.2.2 The review panel members are listed in Appendix A accompanied by details of how the need to understand the diversity and vulnerability of the individuals concerned was reflected in the specialisms of the panel.

1.2.3 The independence of the chair and author of the report is featured in Appendix B.

1.2.4 The process began with an initial meeting of the review panel in November 2019. Terms of reference were drawn up and incorporated key lines of enquiry as featured in Appendix C. Agencies participating in this review are featured in Appendix D, as well as those who had no contact. The review panel went on to meet on seven occasions. However, the review was significantly delayed in its conclusion as a result of national arrangements to contain the spread of the Covid-19 pandemic

1.2.5 Stephanie's family were notified about the review in writing by the Independent Chair of the review. They were also provided with Home Office explanatory leaflets as well as leaflets from the support agencies Advocacy After Fatal Domestic Abuse and the Victim Support Homicide Service. As a result, they took the opportunity to meet with the Independent Chair and comment on the draft terms of reference and were updated as the review progressed. The findings of the review were discussed with the family and the draft report shared prior to submission to the Home Office. Their responses have been incorporated into the review.

1.2.6 The Overview Report was endorsed by Oxford City Community Safety Partnership in April 2022 before being submitted to the Home Office for approval in July 2022.

2. Summary of the Chronology

2.1 Stephanie's early childhood was characterised by trauma and neglect before being adopted at the age of eight. Following significant Adverse Childhood Experiences, she was diagnosed as an adult with Emotionally Unstable Personality Disorder and she went on to problematically use alcohol and drugs for the rest of her adult life. Tragically, she was subjected to domestic abuse in each of her intimate relationships and lost the care of all of her seven children, one of whom was raised by the child's father and the remaining six were removed into care and later adopted themselves. Although she was referred to many agencies over the years, they largely found it hard to engage meaningfully with Stephanie who commonly declined services.

2.2 The perpetrator was born in Iraq and was naturalised in the UK in 2011, having claimed asylum eight years earlier. He was known to experience problematic alcohol use and he was diagnosed with paranoid schizophrenia, experiencing a period of psychosis in, which was thought to be drug induced, in 2016 for which he was detained in a psychiatric hospital. His relationship with Stephanie began when he was discharged from hospital to the local authority's temporary accommodation where she was staying. He was discharged from community mental health services back to the care of his GP the following year after he had disengaged from services and no signs of psychotic relapse were present.

2.3 Whilst in temporary accommodation, complaints were made against Stephanie for noisy, drunken parties throughout the nights with drug dealing indicated. She was convicted of criminal damage and served with a Community Protection Notice to engage with the Complex Needs Service and prohibit her anti-social behaviour. Some months later, she was subjected to a serious assault from her ex-partner and supported by her temporary accommodation officer, who had built a trusting relationship with her, encouraged her to seek medical attention and to report to the police, where she was assessed as high risk and considered at MARAC.

2.4 By the autumn of 2017, both Stephanie and the perpetrator had moved into their respective furnished tenancies with tenancy support attached. This move signalled the end to Stephanie's direct support with the temporary accommodation officer who had been a consistent support for her for nearly three years and future support services were unable to engage with her.

2.5 In February 2019, Stephanie attended the Emergency Department with a fractured ankle and head injury but could not remember how they had happened and self-discharged before treatment was concluded. The hospital and GP went to lengths to locate and engage Stephanie and the police undertook a welfare visit to establish her safety.

2.6 Stephanie only contacted the police about the perpetrator's domestic abuse on one occasion in September 2019 when she fled his flat and sought refuge in a visiting Tesco delivery driver's van. She used the opportunity to disclose to the police the history of abuse, reporting: the perpetrator's escalating and unpredictable abuse; his threats to kill her; use of a stick against her; obsessive jealousy and threats to kill himself if she were to leave him. A bureaucratic mistake meant that she was not referred to MARAC.

2.7 The perpetrator was charged with battery and released on conditional bail, but there was a two-day delay in notifying Stephanie, by which time the perpetrator was already back in contact with her and she began to disengage with the police, eventually withdrawing her allegations. Nonetheless, the perpetrator was later convicted of assault and sentenced to a 24-month community order which was supervised by probation briefly for only the month before the homicide. The pre-sentence report had identified the perpetrator's attitudes to relationships and controlling behaviour but he later went on to minimise his relationship with Stephanie and the responsible officer missed the opportunity to access the pre-sentence report a complete a spousal assault risk assessment when the case was passed to that arm of probation.

2.8 Meanwhile, in July 2019, Stephanie approached her GP as she was 7 weeks pregnant and considering a termination. She was referred to the British Pregnancy Advisory Service (BPAS) and later attended an appointment, to find that she was 12 weeks pregnant. With her partner present she declined to discuss abortion options but contacted them later requesting to go ahead with treatment and over the following weeks she made and cancelled several appointments in London for the termination to be undertaken. In the weekend before she was killed, BPAS notified Children's Services and her GP of the ongoing pregnancy in view of the cancelled appointments and safeguarding risks that were implied.

3. Conclusions and Lessons to be Learnt

3.1 The impact of trauma, adversity and domestic abuse

3.1.1 Stephanie's experiences of Adverse Childhood Experiences (ACEs) led to significant vulnerability and a compounding range of problems, which would more recently be referred to as 'multiple disadvantage'. Her vulnerability was heightened by virtue of the significant levels of domestic abuse she had experienced from previous partners, which, on many occasions, led or contributed to her children being removed from her care.

3.1.2 The homicide occurred when Stephanie was trying to separate from the perpetrator and when his abuse was escalating, both of which are common precursors to domestic homicide.

3.1.3 It was evident that agencies had worked hard to engage with Stephanie and health agencies, in particular, had been flexible in their contact with her. However, with the exception of the temporary accommodation officer, professionals were not able to build the long term, trusting, person-centred, key worker relationship which she appeared to need. The review therefore considered the challenge of engagement with individuals with multiple needs and recognised that Oxfordshire has made significant strides in this area by commissioning programmes such as Housing First, Oxfordshire Domestic Abuse Services (TAP Programme) and the Lotus Maternity Service for women with multiple needs. In addition, the review has encouraged the application of both trauma informed and gender informed practice within these responses and sought clarity of pathways arising from newly emerging programmes.

Learning Point: Trauma and gender informed practice
Individuals who have experienced trauma may behave in ways which appear risky, erratic or problematic and they may act against advice given by practitioners. Rather than adversely judge the individual, a trauma informed approach will recognise that these behaviours are legitimate response to the trauma that the individual has experienced. Services need to work collaboratively and offer person-centred, holistic trauma-informed and gender-informed support and pathways.

3.1.4 Stephanie attended hospital several times and local improvements to domestic abuse were noted. It was considered that the Emergency and Maternity Departments would have benefited from having co-located Independent Domestic Violence Advisors, available to see domestic abuse survivors in the immediate aftermath of a crisis as well as to support the ongoing professional development of staff in responding to domestic abuse. The introduction of Oxford University Hospitals' Lotus Maternity Services for women with multiple needs was nevertheless seen as good practice.

3.2 Multiple pregnancies as reproductive coercion

3.2.1 The cause of Stephanie's multiple pregnancies was not known. For example, they could have been a consequence of risk taking and impulsivity associated with an Emotionally Unstable Personality Disorder or the accumulating consequence of grief and loss from the removal of her other children. Equally, they could be the consequences of sexual assault and reproductive coercion.

Learning Point: Reproductive Coercion

Reproductive coercion refers to a type of domestic abuse in which an individual's reproductive choices, such as deciding whether they can use contraception, become pregnant, or continue with a pregnancy, are decided by someone else. Practitioners must always consider the possibility of reproductive coercion where a woman has multiple pregnancies or late presentations to maternity services.

3.3 Removal of children and the Pause approach

3.3.1 The review was particularly alert to the complex grief and unresolved loss that will often accompany the repeated removal of children. At the time of her homicide, Stephanie was facing the risk of another pregnancy going to full term and for another child being removed from her care. Stephanie's considerable vulnerability and concerning history of child protection interventions warranted the involvement of Children's Services at the earliest feasible opportunity.

Learning Point: Safeguarding Pre-Birth
Practitioners should be alert to the safeguarding risks attached to an ongoing pregnancy for women who have had significant child protection interventions in the past, particularly where those have resulted in the removal of children into care. Pre-birth assessments in Oxfordshire can be undertaken from 12 weeks but agencies should ensure that advice and early intervention is made available and the pregnancy monitored even before this time where the safeguarding risks may be high.

3.3.2 In the intervening time, Oxfordshire has commissioned the Pause programme to deliver support to women in these circumstances. The approach emphasises working 'with and for' women through a trauma-informed, highly flexible, tenacious, responsive and individually tailored collaborative engagement, which is seen as good practice.

3.4 Confidence in the Criminal Justice System

3.4.1 Despite having reported previous domestic abuse, Stephanie only reported the perpetrator on one occasion. As a result of bureaucratic errors in police and probation, there were delays in assessing and managing the risk that the perpetrator posed to Stephanie, although pursuing a criminal conviction in the circumstances was nonetheless proactive. At the same time, the review has demonstrated the importance of adhering to the Victim Code in strengthening the confidence of a victim of domestic abuse in the criminal justice system.

3.5 Housing and temporary accommodation

3.5.1 The couple had met in mixed-sex temporary accommodation when Stephanie was there because of experiencing domestic abuse and the perpetrator's aggression to others was known. The review has highlighted the challenge faced by local authorities in providing temporary accommodation to a wide range of vulnerable people, some of whom may pose a threat to others. Although this accommodation was self-contained, concerns were raised that there was a lack of choice of single sex temporary accommodation and the need for robust risk assessment.

3.5.2 Alongside partner agencies, Oxford City Council is currently implementing the 'Housing First' model which it was hoped would impact upon this issue and other concerns identified including the length of time that Stephanie was in temporary accommodation and the need for sustained engagement and consistent support for multiply excluded homeless people, particularly those who have experienced domestic abuse.

3.5.3 It was noted that greater liaison between mental health and housing services was needed in circumstances where vulnerable people with mental health needs are placed in temporary accommodation. However, in the intervening period, dedicated roles have been put into place to facilitate more support and liaison and access support when an individual's mental health deteriorates.

3.6 Language barriers

3.6.1 There appeared to be some difference of opinion amongst agencies regarding the perpetrator's command of English.

Learning Point: Language Barriers
An individual's command of English as a second language can be affected whilst under pressure and when trying to understand systems and jargon with which they are unfamiliar. Practitioners should take care to ensure that the ability to speak and read English is consistent at these times.

3.7 Concluding Remarks

3.7.1 As well as the Stephanie's experience of trauma, the perpetrator would likely have also experienced trauma in his early life. The degree of influence of this trauma or the potential influence of his cultural upbringing on his expectations of his relationship with Stephanie and agencies was unknown. However, the fact that Stephanie was pregnant and considering a termination of the pregnancy, whilst

facing an escalation of abuse when she tried to separate from him, were each factors that were implicit in the homicide which he went on to commit.

3.7.2 Although the information known by agencies about the relationship was limited, the actions which Oxford has committed to undertake as a result of this review will strengthen the support available to abused women with multiple needs whilst strengthening the response to those that abuse.

4. Recommendations

4.1 Overview & System Recommendations

Recommendation 1: Specialist IDVA support for Emergency and Maternity Departments
Oxfordshire health commissioners to consider the benefits of co-locating Independent Domestic Violence Advisors within the Emergency and Maternity Departments

Recommendation 2: Removal of Multiple Children from Mothers who have Experienced Domestic Abuse
Oxfordshire County Council Commissioners to provide Oxford Safer Communities Partnership and Oxfordshire Domestic Abuse Strategic Board with evaluation of the impact of the Pause programme for women who have experienced domestic abuse

Recommendation 3: Pre-birth assessments
Oxfordshire County Council Children's Services to circulate information for agencies regarding the change in practice (from March 2019) which enables pre-birth assessments to commence as soon as the pregnancy reaches 12 weeks, in order to allow a social worker the time to work with the mother prior to the birth of the baby.

Recommendation 4: The Homeless Pathway and Domestic Abuse

Oxford City Council

(i) to pursue accreditation with the Domestic Abuse Housing Alliance.

(ii) To provide assurance to Oxford Safer Communities Partnership that robust risk assessment is undertaken in the placement of homeless domestic abuse victims which includes full consideration of their proximity to others who may pose a risk to them.

Recommendation 5: Meeting the needs of individuals with mental health issues in temporary accommodation

Oxford Safer Communities Partnership shares the learning from this review with the Homeless Pathway Strategic Partnership Board and requests clarification of how housing and mental health teams will be integrating to provide effective support

Recommendation 6: Intensive, co-ordinating, trauma and gender informed support

Oxfordshire Domestic Abuse Strategic Group

- reviews the domestic abuse pathways in order to be able to integrate the new intensive support models; and to set standards for this type of work where domestic abuse is a key feature
- promotes trauma and gender informed practice amongst its partner agencies

Recommendation 7: Strategic Responses to Mental Health and Domestic Abuse

Senior representation from Oxford Health NHS Foundation Trust to be secured on the Oxfordshire Domestic Abuse Strategic Board

4.1 Individual Agency Recommendations

British Pregnancy Advisory Service

- To review all safeguarding policies and the safeguarding training package.
- To implement a DNA Guideline within BPAS and to consider earlier intervention when a woman has multiple needs
- Recording who is accompanying clients to consultation/treatment

Oxford City Council

- To require a more in-depth handover of vulnerable tenants from Temporary Accommodation to Tenancy Management to ensure that support is maintained and reduced where appropriate in a structured manner.
- Departmental teams to have easier access to background and current information with the introduction of the new 'QL' Housing database, to be introduced in

September 2020. A flag will be used to indicate that a tenant is vulnerable and so will notify an officer that further investigation may be required.

Oxford Clinical Commissioning Group

- All professionals in a GP practice should be reminded that safeguarding is everybody's business and that any concerns should be raised by the person with the concern. There can be a risk of the message being diluted or miscommunicated if a third party makes the referral.

Oxford Health NHS Foundation Trust

- To strengthen the domestic abuse pathway with knowledge and clarity of specialist domestic abuse and other relevant services and include particular reference to Oxfordshire Domestic Abuse Service (ODAS) TAP Programme and the MEG Programme.
- Where there are significant social and complex housing needs, information about significant changes to care such as discharge should be shared with the housing support service, with the patient's agreement

Oxford University Hospitals NHS Foundation Trust

- Supervision must be recorded in the electronic patients' records to reflect the complexity of support to the person and their family and to enable the multi-disciplinary team to include the supervision notes in the MDT discussions and action planning.
- Individual and MDT psychological support and supervision when supporting people who have complex needs to address staff own stress and enable them to consider paths of action and support not focussed on because of staff lack of confidence/ stress in supporting the person concerned.
- The High Intensity User team and the Lotus Maternity Team has been implemented
- Routine enquiry about risks from domestic abuse needs to be undertaken irrespective of someone's current relationship status. This has been added into the Trust's policy and procedures.
- Internal methods needed to be exhausted, or where there was a real and immediate risk to life, before welfare checks should be requested of the Police. This has been added into the Trust's draft policy and procedures.

Thames Valley Community Rehabilitation Company (Probation Service)

- To ensure that initial appointment case notes and documentation are carried out in line with TV- CRC Policy.

- To issue guidance on the timeframe and clarify who is responsible for adding the equality information into case records.
- To ensure that SARA assessments are completed for domestic abuse perpetrators by all staff
- To deliver webinars, briefings and other short training briefings on the identification of the toxic trio and management of these cases to all staff.
- In view of the forthcoming unification of the National Probation Service and Community Rehabilitation Companies, the review has recommended that learning from this review, together with outstanding recommendations and actions for probation services, be adopted by the new organisational model in the region.

Thames Valley Police

- Thames Valley Police to review the effectiveness of LPA compliance with the newly created prompts for taskings within NICHE (for CP/AP/DA) and correct use of the safety net.
- Thames Valley Police to review the handling of medium risk domestic incidents in terms of who is best placed to investigate and risk manage such cases.
- The NICHE Create course is currently under review and it is recommended that the practice of checking for existing occurrences is added to the lesson plan. This should prevent duplication of occurrences such as this which had a detrimental effect on the tasking process.
- TVP will be supplying specific written feedback to relevant staff around individual learning points
- Thames Valley Police to provide evidence to Oxford Safer Communities Partnership of how their recent programmes of change, such as the Endeavour Programme, Domestic Abuse Matters course delivery and introduction of the Contact Management Platform have brought effective outcomes for domestic abuse victims seeking protection from the police, particularly in areas of
    - Domestic abuse investigations
    - Understanding domestic abuse and coercive control
    - Undertaking background checks in domestic abuse related cases, including anti-social behaviour and distressed abandoned calls

Appendix A: Review Panel Members

Name	Role/Organisation
Paula Harding	Independent Chair
Adrian Thomas	Detective Inspector, Thames Valley Police
Andy Symons	Turning Point
Ann Phillips	Tenancy Management Manager, Oxford City Council
Anne Lankester	Named Nurse Safeguarding Adults and Children, Oxfordshire Clinical Commissioning Group
Britta Klink	Oxford Health NHS Foundation Trust
Caroline Heason	Head of Safeguarding, Oxford University Hospitals NHS Foundation Trust
Caroline Jackson	Oxford University Hospitals NHS Foundation Trust
Fran Jubb	Oxford Health NHS Foundation Trust
Heather Walls	Oxfordshire Domestic Abuse Services run by A2 Dominion Housing Association
Hugh Ellis	Operational Manager, Oxfordshire County Council Adult Social Care
Ian Wright	Head of Regulatory Service & Community Safety, Oxford City Council
Kayleigh Hills	British Pregnancy Advisory Service
Kharman Adhim	Senior Independent Domestic Violence Advisor Iranian and Kurdish Women's Rights Organisation (IKROW)
Liz Jones	Anti-Social Behaviour Investigation Team Manager & Domestic Abuse Lead , Oxford City Council
Lou Everatt	Thames Valley Community Rehabilitation Company
Maria Godfrey	Area Service Manager, Oxfordshire County Council Children's Social Care

A2 Dominion provided the local domestic abuse service and therefore brought particular expertise on domestic abuse and the 'victim's perspective' to the panel. Turning Point provided expertise on drugs and alcohol and Oxford Health provided expertise on mental health, each of which were issues particularly pertinent to this review. The Iranian and Kurdish Women's Rights Organisation (IKROW) joined the panel in the later stages to provide expertise on potential cultural influences on the perpetrator and the cultural competency of agency responses where known.

Appendix B: Independence of the Chair

The Independent Chair and Author is Paula Harding, an Associate Chair with the charity, Standing Together Against Domestic Abuse. She has over twenty-five years' experience of working in domestic abuse with both senior local authority management and specialist domestic abuse sector experience. For more than ten of those years, she was a local authority strategic and commissioning lead for domestic abuse and violence against women and has been an independent chair and author of domestic homicide and safeguarding adult reviews since 2016. She completed an M.A. (Birmingham) in Equalities and Social Policy in 1997, focusing on domestic abuse and social welfare, and is a regular contributor to conferences, national consultations, and academic research. She completed the OCR certificated training funded by the Home Office for *Independent Chairs of Domestic Homicide Reviews* in 2013. She has also completed the on-line training provided by the Home Office,[3] as well as undertaking training on the Significant Incident Learning Process and Learning Disability Mortality Reviews.

The Chair has no connection with Oxford Community Safety Partnership or any of the agencies involved in this case aside from one previous domestic homicide review undertaken in the area.

[3] Available at https://www.gov.uk/guidance/conducting-a-domestic-homicide-review-online-learning

Appendix C: Terms of Reference

The panel agreed that the review should focus on the contact that agencies had with Stephanie and perpetrator during the period from early 2016, when their relationship was thought to have begun, until Stephanie's homicide in September 2019. Information about earlier times will be included for contextual information only. The key lines of enquiry determined that the review should address the 'generic issues' set out in the Statutory Guidance (Home Office, 2016) as well as the following specific issues identified in this particular case.

- **Individual Practice: how effective were agencies in identifying and responding to both need and risk for Stephanie and the perpetrator?**

Agencies were asked to consider the following reflective questions:

- A pen picture of how the individuals were known to you?
- What knowledge your agency had about their relationship?
- What needs did your agency identify for either individual and how did your agency respond?
- How were decisions made and actions taken by agencies to reduce risk and prevent harm, considering, for example: indicators of risk; how risk was assessed and managed; attention to previous history; how were the individual's attitudes to risk perceived and understood, and how did this affect decisions made or actions taken; safety planning; escalation; managing risk on closure of cases?
- If domestic abuse was not known, how might your agency have identified the existence of domestic abuse from other issues presented to you? For example, were there policies and procedures for direct or routine questioning and how well were they implemented in this case?
- What opportunities were there to engage and refer over substance misuse issues?
- What barriers to engagement did agencies face and how did they seek to overcome these barriers?
- How did agencies recognise and respond to issues of equality and diversity for either individual, including in respect of protected characteristics of race, religion or belief, disability, pregnancy and sex? Was there any evidence of unconscious bias in the assessments, decisions or services delivered?
- How effective was record keeping?
- How effective was management oversight?
- Did resource issues impact upon services offered?

- **Multi-Agency Practice: how effective were agencies in working together to prevent harm and to meet individual's needs?**

Agencies were asked to consider the following reflective questions:

- How were roles and responsibilities understood and multi-agency protocols adhered to?

- Was there a shared ownership and approach?
- How effective was the co-ordination of services?
- How effective was communication, information sharing and sharing records?
- How effective was escalation between agencies?
- **What good practice could be identified?**
- **Improving services:**
- What lessons can be learnt to prevent harm in the future?
- What recommendations are you making for your organisation and how will the changes be achieved?
- What system-wide, multi-agency recommendations do you consider need to be made?

In addition, the following agencies were asked to respond specifically in their IMR to the following additional points.

- Oxfordshire Health to consider how the perpetrator's mental health was understood and how this understanding changed over time?
- Oxford University Hospitals: how seriously Stephanie's concerns about having a fit were taken when she attended the Emergency Department?

Equality and Diversity

The review will give due consideration to each of the nine protected characteristics under Section 149 of the Equality Act 2010[4], as well as wider vulnerabilities for both Stephanie and the perpetrator. The review will consider how sex, pregnancy and maternity, race, adverse childhood experiences, mental health and substance misuse may have been relevant. In addition, matters of ethnicity will be considered with particular regard to examining prevailing cultural attitudes to mental health, relationships, interracial relationships, pregnancy and violence against women within Iraqi Kurdish communities, where known. Matters of race were also considered in respect of the responses of agencies to the perpetrator, as well as potential barriers to services arising from language, illiteracy and knowledge of the English legal system, culture and services.

The review will apply an intersectional framework to review the couple's life experiences. This means to think of each characteristic of an individual as inextricably linked with all of the other characteristics in order to fully understand one's journey and one's experience with local services and within their community.

[4] The nine protected characteristics under the Equality Act 2010 are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation

Appendix D: Agency Involvement

Individual agency reports and chronologies were provided by the following organisations:

- A2 Dominion
- British Pregnancy Advisory Services
- Crown Prosecution Service
- Oxford City Council Housing Services
- Oxford Health NHS Foundation Trust
- Oxford University Hospitals NHS Foundation Trust
- Primary Care supported by Oxfordshire Clinical Commissioning Group
- Oxfordshire County Council Adult's Social Care
- Oxfordshire County Council Children's Social Care
- Thames Valley Community Rehabilitation Company
- Thames Valley Police

Agencies without contact

The following agencies were contacted but confirmed that Stephanie or perpetrator were either not known to them, or that their involvement was not relevant to this review:

- Connection Support
- Eve
- Mind
- South Central Ambulance Service NHS Foundation Trust
- Turning Point
- Reducing the Risk IDVA Service