Domestic Homicide Review

under section 9 of the Domestic Violence Crime and Victims Act 2004

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

ACRONYMS

AAFDA: Advocacy After Fatal Domestic Abuse
ACES: Adverse Childhood Experiences
A&E: Accident and Emergency
BPAS: British Pregnancy Advisory Service
CCTV: Closed Circuit Television
CRC: Community Rehabilitation Company
DAHA: Domestic Abuse Housing Alliance
DNA: Did Not Attend
GP: General Practitioner
HMP: Her Majesty's Prison
HMPPS: Her Majesty's Prison and Probation Service
IDVA: Independent Domestic Violence Advisor
IKROW: Iranian and Kurdish Women's Rights Organisation
IMR: Individual Management Review
MARAC: Multi-Agency Risk Assessment Conference
MASH: Multi-Agency Safeguarding Hub
MoJ: Ministry of Justice
ODAS: Oxfordshire Domestic Abuse Service
TAP: The Anchor Programme for victims of domestic abuse with multiple and complex needs
TV-CRC: Thames Valley Community Rehabilitation Company
TVP: Thames Valley Police
SARA: Spousal Assault Risk Assessment

GLOSSARY

Building Better Relationships: a programme used within probation services designed to promote change in an offender's behaviours and attitudes to intimate partner violence.
Golden Hour: is the term used for the period immediately after an offence has been committed, when material is readily available in high volumes to the police
Housing First: a housing and support approach which:

- Gives people who have experienced homelessness and chronic health and social care needs a stable home from which to rebuild their lives.
- Provides intensive, person-centred, holistic support that is open-ended.
- Places no conditions on individuals; however, they should desire to have a tenancy.

Multiple disadvantage: a term used to refer to an individual's experienced of the intersection of a number of complex problems particularly homelessness, drug and alcohol misuse, mental health problems, violence and abuse, and chronic poverty
Mental Health Act 1983 (amended 2007) A law mainly about the compulsory care and treatment of people with mental health problems.

- Section 2 - Admission for assessment (or for assessment followed by treatment)
- Section 3 - Admission for treatment

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PREFACE

Members of the review panel offer their deepest sympathy to all who have been affected by the homicide of Stephanie[2].

The panel would 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. They have each provided personal statements for this review.

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.*

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

1. INTRODUCTION

1.1 Background

1.1.1. This review concerns the circumstances leading to the unlawful killing of a 42-year-old woman by her 37-year-old partner who went on to take his own life.

1.2. Aim and purpose of a domestic homicide review

1.2.1. Domestic homicide reviews came into force on the 13th April 2011 having been established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a domestic homicide review should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by (a) a person to whom they were related or with whom they were or had been in an intimate personal relationship or (b) member of the same household as herself; with a view to identifying the lessons to be learnt from the death.

1.2.2. The purpose of a domestic homicide review is to:

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

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

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

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

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

f. highlight good practice" (Multi-Agency Statutory Guidance 2016, para 7)

1.2.3 As well as examining agency responses, statutory guidance requires reviews to be professionally curious and find the "trail of abuse". The narrative of each review

should “articulate the life through the eyes of Stephanie… situating the review in the home, family and community of Stephanie and exploring everything with an open mind” (Multi-Agency Statutory Guidance 2016, paras 8 and 9).

1.3. Timescales

1.3.1. The homicide occurred in September 2019 and the decision to undertake a review was made by the Chair of Oxford Safer Communities Partnership in consultation with affected agencies on 08.10.2019. The Home Office was notified of the decision on 29.10.19.

1.3.2. The review commenced promptly with the first panel meeting being held on 04.11.2019. However, the review was significantly delayed in its conclusion as a result of national arrangements to contain the spread of the Covid-19 pandemic. Nonetheless, the panel met seven times. All panel meetings were minuted and all actions agreed for the panel have been tracked and completed.

1.3.3. The panel considered and agreed the draft Overview Report in April 2021 and family members had the opportunity to provide their comments and further questions for primary care, which were included in the report, before the final Overview Report was endorsed by the Oxford Safer Communities Partnership in April 2022. The report was thereafter submitted to the Home Office for quality assurance in July 2022.

1.4. Confidentiality

1.4.1 This Overview Report has been anonymised in accordance with statutory guidance. In order to protect the identity of the homicide victim, her family and significant others, her parents proposed the name Stephanie as a suitable pseudonym as it had particular significance for her.

1.4.2 Whilst the details of each review remain confidential, available only to participating professionals and their direct line management, the report has sought to extract sufficient detail from the family’s narrative for the lessons and recommendations to be understood, whilst balancing this need for confidentiality.

2. Terms of Reference

2.1. Methodology

2.1.1. The review followed the methodology required by the *Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews* (HM Government, 2016a).

2.1.2. Sixteen local agencies were notified of the homicide and were asked to examine their records to establish if they had provided any services to Stephanie or perpetrator and to secure records if there had been any involvement. Eleven agencies were found to have had relevant contact with Stephanie or the perpetrator. Five local agencies had had no relevant contact.

2.1.3. Arrangements were made to appoint an Independent Domestic Homicide Review Chair and Author and agree the make-up of the multi-agency review panel.

2.1.4. Thames Valley Police provided the findings from the criminal investigation and provided details of the family who were to be invited to engage with the review.

2.1.5. The terms of reference for the review were drawn up by the Independent Chair together with the panel and incorporated both key lines of enquiry and specific questions for individual agencies where necessary. It was identified that seven agencies were to provide Individual Management Reviews (IMRs) and chronologies analysing their involvement and a further four agencies were to provide information reports due to the brevity of their involvement. Briefings were made available for IMR authors by the Independent Chair in order to support report authors in their task and maintain the focus on the key lines of enquiry.

2.1.6. All reports were written by authors who were independent of the delivery of services provided. Wherever possible, report authors presented their findings to the review panel in person and, where necessary, were asked to respond to further questions. The individual agency reports concluded with recommendations for improving their own agency policy and practice responses in the future and informed the multi-agency and thematic recommendations which followed.

2.1.7. The Independent Chair authored the Overview Report after consultation with Stephanie's family and each draft was discussed and endorsed by the review panel before submission to the Community Safety Partnership.

2.2. Involvement of family and friends

2.2.1. 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.

2.2.2. The review was unable to identify any members of the perpetrator's family.

2.3. Independent chair and author

2.3.1 The Independent Chair and Author is Paula Harding. 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 the local authority strategic and commissioning lead for domestic abuse and violence against women for a large metropolitan area 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, *Conducting a Homicide Review,*[3] as well as undertaken training on the Significant Incident Learning Process and Learning Disability Mortality Reviews.

2.3.2 Beyond this review, the Chair has no connection with Oxfordshire Community Safety Partnerships or their agencies.

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

2.4 Members of the review panel

2.4.1 Multi-agency membership of this review panel consisted of senior managers and designated professionals from the key statutory agencies and all were independent of the case.

2.4.2 Wider matters of diversity and vulnerability were considered when agreeing panel membership. 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.

2.4.3 The review panel members were:

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

2.5. Time period and key lines of enquiry

2.5.1. 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 was included for contextual information only.

2.5.2. The key lines of enquiry determined that the review should address the 'generic issues' set out in the Statutory Guidance 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?*

2.5.3. 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?

2.5.4. The review was open to adopt further lines of enquiry as further information became available.

2.6. Individual agency reports

2.6.1 Individual agency reports and chronologies were requested from 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

2.7. Agencies without contact

2.7.1 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

2.8 Definitions

2.8.1 During the course of this review, the Domestic Abuse Act 2021 was enacted and introduced a legal definition of domestic abusive behaviour as consisting of a single incident or course of conduct between two people who are personally connected, each aged 16 or over, and involving any of the following:

(a) physical or sexual abuse
(b) violent or threatening behaviour
(c) controlling or coercive behaviour
(d) economic abuse
(e) psychological, emotional or other abuse (s1: Domestic Abuse Act 2021)[4]

2.8 Parallel reviews

2.9.1 The deaths of Stephanie and the perpetrator were subject to an inquest which was observed by the Independent Chair and a panel member.

2.8.2 As the perpetrator had been under the supervision of probation services at the time of the killing, a Serious Further Offence Review was undertaken by Thames

[4] https://www.legislation.gov.uk/ukpga/2021/17/part/1/enacted

Valley Community Rehabilitation Company and submitted to HM Prison and Probation Services and the analysis and findings were shared with the domestic homicide review panel. No other parallel reviews were undertaken

2.10. Equality and diversity

2.10.1 The review gave due consideration to each of the nine protected characteristics under Section 149 of the Equality Act 2010[5], as well as to wider matters of vulnerability for both Stephanie and the perpetrator.

2.10.2 Stephanie was a 42-year-old, white woman of mixed heritage. Her mother was French, and her father was white-British. She experienced a very troubled early childhood where she was exposed to significant parental mental illness and substance misuse and neglect and went on to experience significant periods of mental ill-health herself. As an adult, she was diagnosed with Emotionally Unstable Personality Disorder. This disorder is "…characterised by significant instability of interpersonal relationships, self-image, mood, and impulsive behaviour … [with] … a rapid fluctuation between periods of confidence to despair, with fear of abandonment and rejection, and a strong tendency towards suicidal thinking and self-harm" (NICE, 2009). She also experienced problematic substance misuse, in terms of both alcohol and drugs, throughout her adult life.

2.10.3 Significantly, Stephanie had experienced domestic abuse from multiple ex-partners before this most recent relationship and medical records had featured injuries as a result of domestic violence since 1995. Domestic abuse and domestic homicide are considered to be, most often, gendered crimes (Stark, 2007). In the three years before Stephanie was killed, the majority (seventy-seven per cent) of victims of domestic homicides in England and Wales were female (ONS, 2020)[6]. The significance of sex and violence against women should, therefore, always be considered within a domestic homicide review.

2.10.4 Matters of pregnancy and domestic abuse were a significant feature of Stephanie's life. Stephanie had six of her seven children removed into local authority care and she had been pregnant and considering a termination shortly before she was killed. Each of Stephanie's pregnancies had been late presentations with sporadic antenatal care and the protected characteristic of pregnancy and maternity was therefore specifically considered within this review.

[5] 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

[6] The latest information from the Homicide Index relates to the three-year period ending March 2019. At the time of writing, data on the year April 2019 to March 2020 had not been released.

2.10.5 The perpetrator was 37 years of age at the time of the homicide and his own death. He was of Iraqi Kurdish ethnicity and had a long history of mental illness and problematic substance use. Mental health and problematic substance use were therefore considered in the review as vulnerabilities for both Stephanie and perpetrator.

2.10.6 Although the perpetrator had formerly identified as being a Sunni Muslim, he also disclosed to mental health services in 2016 that he no longer believed in anything and did not attend mosque. Nonetheless, matters of ethnicity were considered to be of significance and the review paid 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.

2.10.7 The Review applied an intersectional framework in order to understand the lived experiences of both victim and perpetrator. This means to think of each characteristic of an individual as inextricably linked with all of the other characteristics in order to fully understand an individual's journey and experience with local services and within their community.

2.11 Dissemination

2.11.1 The following individuals and organisations will receive copies of this review:

- Stephanie's family
- Agencies directly affected by this review
- Tesco PLC
- Oxford Safer Communities Partnership and its agencies
- Thames Valley Office of the Police and Crime Commissioner
- Oxfordshire Domestic Abuse Strategic Board

3. BACKGROUND INFORMATION

3.1 The homicide

3.1.1 On the evening that she was murdered, Stephanie took a taxi to the perpetrator's home, which was in a block of flats. She had stopped to pick up alcohol from the local shop on the way and, on arrival, asked the taxi driver to wait for 5 minutes in case she intended to return. A neighbour noted that although Stephanie entered the perpetrator's flat, she appeared reluctant to do so.

3.1.1 Later in the evening, emergency services were called to this block of flats following reports of a man falling from the upper floors and the perpetrator was pronounced dead at the scene. The inquest later found that he had smashed a window with a weights bar in order to access the 14th floor from which to jump. A post- mortem revealed that he had died from multiple injuries involved in this fall.

3.1.2 The police later found Stephanie inside the perpetrator's 4th floor flat having experienced fatal knife wounds. A post-mortem revealed that she had died from incised wounds of the neck and that there was also evidence of applied pressure (strangulation) to the neck.

3.1.3 The coroner arrived at the conclusion that Stephanie had been unlawfully killed. Whilst the coroner is not permitted to name the person responsible for the killing, it was noted that there was no evidence of another person being involved in the killing other than the perpetrator. The coroner also concluded that the perpetrator had committed suicide but the motivation for the killing and the suicide was not known.

3.2 Stephanie's background

3.2.1 Stephanie's early childhood was characterised by trauma and neglect. Her birth parents were heavy drug users and her mother, who left the family home when Stephanie was aged two, also had serious and enduring mental illness. Despite living in conditions that would undoubtedly cause alarm to professionals now, she was not taken into care until the age of seven, despite the level of deprivation, neglect and exposure to inappropriate adult behaviour being apparent. Social work practice at the time dictated that all efforts were to be made to keep father and daughter together. At the age of nearly nine, she was placed with foster parents who went on to adopt her and her birth mother died when Stephanie was aged 11. Stephanie's Adverse Childhood Experiences went onto have a significant impact upon her and her exposure to illicit substances at an early age, led her to problematically use alcohol and drugs throughout her adult life.

3.1.1 When she was aged 19, Stephanie had her first child and after her relationship with the child's father had ended, the child lived with the father and his family from the age of 1. Stephanie's parents tried to help her maintain contact with the

eldest child, but contact was lost between Stephanie and her eldest child until, at the age of 15, the child found her mother on her own initiative.

3.1.2 Stephanie's next three children were removed into local authority care at the ages of 4 years, 18 months and 4 months respectively. Thereafter, Stephanie went on to have three more children, each of whom were taken into local authority care at birth.

3.1.3 Stephanie had experienced domestic abuse in each of her three long-term relationships prior to her relationship with the perpetrator. Several reports had been made to the police concerning this domestic abuse and Stephanie had supported prosecutions against her abusers in the past. She was also known to the police for 6 convictions and 3 cautions in respect of theft, public disorder, anti-social behaviour, criminal damage and drugs in the years before the period in the scope of this review.

3.1.4 Stephanie attempted suicide at the age of 27, when experiencing domestic abuse, and thereafter had numerous further referrals to mental health services for assessment in the years that followed. Mental health services became aware of domestic abuse in her subsequent relationships as well as child protection concerns and Stephanie was diagnosed with an emotionally unstable personality disorder. She had been referred to a range of specialist services including those for mental health, complex needs, community and residential based drug and alcohol services and dedicated women's services. However, she mostly declined support or agencies were unable to engage with her for any period of time.

3.3 The perpetrator's background

3.3.1 The perpetrator was a 37-year-old Kurdish man who was born in Iraq and who had entered the UK illegally in 2003. Thereafter, he claimed asylum and became naturalised as a UK citizen in 2011. He told mental health services that he had three children from a previous relationship which had ended but told other agencies that he had never been in a relationship. He described himself as being the eldest of seven siblings and that his birth family remained in Northern Iraq.

3.3.2 The perpetrator had trained as a hair stylist in Iraq but did not continue with his career when he arrived in England. He acquired a history of offending with 20 offences recorded against his 27 alias names across Europe and England. He had been known to Thames Valley Police since 2013, almost exclusively as an offender connected to offences including theft, assault and drugs. The Police had been aware that he experienced problems with alcohol and had listed in his records a

warning marker for alcohol since 2014 and went on to list a warning marker for mental health once this was disclosed in 2016.

3.3.3 The perpetrator was first known to Oxfordshire mental health services in 2015. At this time, he was diagnosed with paranoid schizophrenia and psychosis and referred to the Early Intervention Service, but he did not attend any appointments that were offered to him.

4 CHRONOLOGY

Relationship begins whilst in temporary accommodation

4.1 At the start of 2016, Stephanie had been living in self-contained, temporary accommodation provided by the local authority, for two years. Her youngest child was in the care of the local authority and in the process of being adopted.

4.2 Stephanie wanted to have settled accommodation, particularly as she hoped that that would help her mental health, but she had outstanding debts including rent arrears and several agencies were trying to help her to manage these debts. Although she was often referred to agencies for support with her mental health, domestic abuse and substance misuse, she rarely engaged and often missed appointments. However, the temporary accommodation officer was seen to provide Stephanie with the most consistent support over several years and this continuity appeared to have been greatly valued by Stephanie.

4.3 During the time that Stephanie was in this temporary accommodation, the police were called five times by other residents complaining about disturbances including shouting, arguing, sounds of smashing and noisy parties within her bedsit. The police responded immediately each time: made contact with Stephanie and determined that her welfare was not at risk. On one occasion, she was under the influence of drugs or alcohol, and, on another, an un-identified male was present and reportedly arguing. In respect of the noisy parties, the police signposted the caller to the local authority's noise abatement service.

4.4 In June 2016, the perpetrator was arrested after pushing a woman who had tried to apprehend him whilst he was fleeing from a shop having committed a theft. This was the first of a number of minor offences for which he received non-custodial sentences and upon arrest, he was sometimes found in possession of small quantities of cannabis. He regularly disclosed alcohol abuse, but each time declined to speak with the Liaison and Diversion Services Referral Worker located in the custody suite about his substance misuse.

4.5 In August 2016, the perpetrator was arrested in respect of the theft of a motor vehicle. He was found to be acting bizarrely and displaying some disinhibited sexual gestures and whilst in custody underwent a Mental Health Act assessment. He reported that he had been hearing voices for the past six years which told him to steal but he denied thoughts of harming himself or others. He was detained in a private psychiatric hospital, under Section 2 then Section 3 of Mental Health Act 1983 as a result of psychosis which was possibly drug induced. The hospital was out of the area due to bed unavailability in Oxfordshire. Whilst unwell, it was

observed that the perpetrator could be aggressive, sexually disinhibited and suicidal. However, he responded well to treatment with anti-psychotic depot medication and to abstinence from illicit substances and was discharged home to live with a friend, with the identified need for long-term medication and ongoing support from the Early Intervention Service.

4.6 The Early Intervention Service continued to monitor the perpetrator's mood and medication, using an interpreter in the context of mental health assessments. He was supported by a Care Co-ordinator as well as a support worker to address his social and housing situation. The support worker sought to assist the perpetrator to access literacy support as he could barely read or write and would face difficulties with his bills. He was also referred to the local refugee service for more intense advocacy support, befriending and to prevent further social and cultural isolation, but he did not engage with these referrals. After a few months, he stopped taking his medication as he did not like its sedative effect and, as his presentation had improved, his Consultant Psychiatrist agreed for him to have a short period without taking it whilst maintaining monthly contact with his Care Co-ordinator.

4.7 On his discharge from hospital, the local authority's Housing Options Service placed him in a bedsit whilst they concluded their homeless enquiries. The perpetrator's Care Co-ordinator had notified the Housing Allocations Team about his risk assessment. The perpetrator had said that he became angry when he was unable to understand what was going on due to a lack of language fluency in English and no literacy skills. The risk assessment went on to state that when he was unwell, the perpetrator could be aggressive, sexually disinhibited and inappropriate with a history of neglect and expressed suicidal ideation. It was not known if his sexually disinhibited and inappropriate behaviour was an issue when he was mentally well.

4.8 The bedsit where he was placed was in the same block of temporary accommodation as Stephanie was living. Homeless staff were instructed not to visit him alone until a full care plan was received. It was during this period in temporary accommodation that Stephanie and perpetrator appeared to have first met.

4.9 In January 2017, Stephanie reported her former partner to the police for refusing to leave her property. The man, hereinafter referred to as Ex-partner 1, had left by the time the police arrived and Stephanie declined to complete the domestic abuse risk assessment. Nonetheless she was assessed as standard risk, this being the first reported incident involving this particular partner. No enquiries were made to trace and speak to Ex-partner 1 on this occasion.

Anti-social behaviour

4.10 In February 2017, Stephanie's neighbours made the first of a number of complaints about the noisy, drunken parties, indications of drug dealing and significant disturbances throughout the nights. After warnings had been issued by the Anti-Social Behaviour Team, Stephanie was issued with a Community Protection Notice which prohibited her from consuming or letting drugs be used or sold, having parties, fighting or disturbing other residents. The Community Protection Notice also required Stephanie to engage with the Complex Needs Service and keep appointments there or risk eviction.

4.11 In April 2017, Stephanie was arrested for assault of her neighbour and then for criminal damage of property in the police station. The neighbour declined to make a complaint against Stephanie who had been intoxicated at the time and Stephanie instead pled guilty to criminal damage. She was given a conditional discharge and ordered to pay compensation. It was noted that this was her first conviction since 2012. Whilst in custody, Stephanie declined to engage with the Liaison and Referral Worker regarding substance misuse issues.

Perpetrator discharged from mental health services

4.12 In May 2017, the consultant psychiatrist discharged the perpetrator from mental health services back to the care of his GP. The perpetrator had not taken any medication for five months and no longer wished to engage with the mental health team or take the support that was being offered. A home visit, some months before, indicated that he may have returned to cannabis use, but he did not show any signs of psychotic relapse. Nevertheless, mental health services did not notify housing services of his being discharged or the risk assessment that would accompany his discharge.

Serious assault by ex-partner

4.13 In June 2017, Stephanie suffered another serious assault by her former partner, Ex-Partner 1. The next morning, she attended the GP Practice with extensive bruising visible on arms, legs, shoulders, throat and neck areas as well as long, deep wound to her left arm. Despite the practice nurse trying to probe further into how these injuries had been sustained, Stephanie was adamant that they occurred as a result of a fall which occurred after having been partying all night.

Stephanie's presentation was erratic, and her mood ranged from anxious to panicky. The practice nurse bandaged her arm and advised her to go to the Emergency Department, calling the hospital to advise them to look out for her. The nurse also raised her safeguarding concerns with the GP who spoke with Social Services who advised the GP to refer to the police or Oxford Domestic Abuse Services (ODAS). The practice nurse recorded the injuries and was later called to provide an evidential statement for the police.

4.14 That day, Stephanie asked her temporary accommodation worker to visit her and recounted the assault saying that Ex-Partner 1 began to strangle her, kicked her in the head and pulled her hair out. When he threatened her with a Stanley knife, she had put her arm up to protect herself, and a large, gaping wound was visible on her arm. She told the temporary accommodation worker that she was reluctant to go to A&E as she had a phobia about needles and so the temporary accommodation worker took her to hospital and stayed with her whilst she was treated.

4.15 Stephanie told the doctor that she had been assaulted by her ex-partner. They recorded her injuries and checked that the police were aware and that she had somewhere safe to stay and booked her in to see the Plastic Surgery Clinic the next morning. However, on Stephanie's return to her bedsit, clinicians from the hospital rang to say that they wanted to attend to her injury straight away, but she agreed to keep the appointment on the following day. Thereafter, Stephanie did not attend the hospital but contacted the GP surgery for further dressings and more painkillers.

4.16 Stephanie did not report the assault to the police straight away but was encouraged to do so by her temporary accommodation officer who phoned 101 on her behalf and checked CCTV images for any evidence that could be shared with the police, but there was none. Stephanie made contact with the police, wanting to make a statement, but there were no police officers available to take a statement from her and despite attempts to contact her, they eventually spoke with her 2 days later. During this time, the temporary accommodation officer noted that victim was struggling with having to make a statement and offered to make a statement herself as well as taking photographs of Stephanie's injuries which were kept on their files in case evidence was needed in the future.

4.17 Although Stephanie had provided details of the scene and the offender and a description of his clothing, this did not prompt 'golden hour' enquiries to secure the evidence. The incident was graded as high-risk but resourcing issues prevented attempts to arrest the perpetrator for a further six hours who remained at large without safeguarding having been put in place for Stephanie.

Stephanie was assessed by the police as facing high risk and referred her to the Multi-Agency Risk Assessment Conference (MARAC).

4.18 Once the specialist Domestic Abuse Investigation Unit became involved, the case was investigated fully. However, in the meantime, Stephanie had started to disengage with criminal proceedings and the police made multiple attempts to contact her by phone, eventually requesting that a summons be issued in order to ensure her attendance at court. Partner 1 was convicted of wounding and actual bodily harm and given a custodial sentence and a restraining order.

4.19 In July 2017, Stephanie's circumstances were discussed at a well-attended MARAC and the Independent Domestic Violence Advisor (IDVA) was tasked with engaging with her, which she declined. No other actions were identified for other agencies in the absence of this engagement.

Resettlement

4.20 By the autumn of 2017, both Stephanie and the perpetrator had been moved into their respective furnished tenancies and been assisted with their resettlement by housing officers. For Stephanie, this signalled an end to her relationship with the temporary accommodation worker who had been a consistent source of support for her for nearly three years. She did not engage with the Tenancy Sustainment Team who were to take over her housing support and shortly after moving, her anti-social behaviour began but was curtailed by a warning letter. Housing Services were not aware that Stephanie and perpetrator had entered into a relationship, but nuisance reports began to emanate from the perpetrator's address.

4.21 In June 2018, Stephanie attended the Emergency Department of the local hospital with a fractured toe. Routine enquiry over domestic abuse was undertaken but she said that she had tripped on the stairs and felt safe at home. However, as she said that she had to leave because of children at home, the doctor referred to their Children Safeguarding Team to review who discovered that all of her children had been taken into care.

4.22 In September 2018, Stephanie registered with a new GP Practice, and it was established that she had a complex history and had been the victim of domestic violence. She told the GP that she was pregnant and that previous children had been taken into care. A face-to-face appointment was made for her for the next week by which time she had miscarried.

4.23 Within that time, Stephanie had contacted the Early Pregnancy Assessment Unit advising that she was approximately 10 weeks pregnant. A scan was booked with

her which she did not attend, and the Unit contacted her to re-book. She did not attend the second booking and no further contact was made by the hospital. The review was unable to establish the outcome of this pregnancy.

4.24 Over the months that followed, the GP referred her to mental health services stating that she was trying to make a new start and improve her life and that a Social Prescriber[7] would be supporting her in her goals. Stephanie was not offered a mental health assessment as it had previously been assessed that the best long-term outcome for her would be through the Complex Needs Service, which she could still access through self-referral. Both Stephanie and her GP were also notified about other options available to her including self-referrals to MIND for psycho-educational courses; self-referral to the Eve Project, for women who have experienced domestic abuse and a course of anti-depressants for the treatment of anxiety. The Social Prescriber at the GP Practice referred Stephanie to the Tenancy Sustainment Team for additional support as Stephanie had expressed concern that her ex-partner had been released on a tag.

4.25 In January 2019, a man phoned 999 and hung up. When the police returned the call, Stephanie answered saying that she was alone and could not account for the call that had been made from her phone. She appeared to have been crying but repeatedly said that she did not want police assistance. The log was closed as 'all in order' but no background checks had been undertaken and she was not asked to confirm her name and address.

Victim's head injury

4.26 In February 2019, Stephanie attended the hospital's Emergency Department with a fractured ankle and head injury, but she could not recall how the injuries had happened. She was assessed by the psychiatric team and no acute issues were found but she self-discharged before her therapies were concluded. Hospital staff provided Stephanie with take-out medication despite her self-discharge, alerted the GP and made appointments for her to return for suture removal and for a change of cast.

4.27 As both the hospital and GP surgery were unable to make contact with Stephanie, the nurse from the GP surgery asked the police to undertake a welfare visit. When the police visited, Stephanie opened the door saying that she had been asleep, and she was left in the care of the nurse. The police did not undertake any

[7] A social prescriber is a primary care link worker who takes a holistic approach to people's health and well-being. They connect individuals to community groups and statutory services for practical and emotional support.

background checks or record making enquiries regarding the cause of the head injury, although it was noticed that the front door appeared to have been forced at some point previously.

4.28 After missing a further four clinic appointments, Stephanie attended the hospital where her cast was removed but she had a panic attack before her sutures could be removed and did not attend any subsequent appointments and the GP was informed.

Assault by perpetrator

4.29 In June 2019, Stephanie reported to the police that she had been assaulted by the perpetrator at his flat, and that he had prevented her from leaving when she had wanted to. This was the first domestic abuse recorded by the police within this relationship. She had fled the perpetrator's address when a Tesco grocery delivery took place and sought refuge in the grocery delivery van. The perpetrator followed her and continued to assault her through the open window of the vehicle despite being witnessed and challenged by the van driver.

4.30 The perpetrator was arrested, and Stephanie went on to disclose three or four previously unreported assaults. In the domestic abuse risk assessment, she disclosed a concerning history involving the perpetrator's use of a stick against her; threats to kill; sexual abuse; obsessive jealousy; threats to kill himself when she recently tried to separate; her fear because he was unpredictable and that the abuse was escalating.

4.31 Unfortunately, two crime reports had inadvertently been created for the same incident and this led to the report with the full details of the incident being overlooked and the more detailed report was not sent to the Multi-Agency Safeguarding Hub for processing. In turn, this meant that the report was not sent to the specialist police Domestic Abuse Investigation Unit as it should have been for further risk management and safeguarding. An opportunity to explore the wider abuse, to reiterate the help available from other agencies and to ensure she knew how to keep herself safe was missed. Instead, the officers undertaking the domestic abuse risk assessment considered that Stephanie was facing a medium risk of serious harm as they were not party to all of the information that had been received and Stephanie, by this time, had become vaguer about the circumstances surrounding the incident.

4.32 The perpetrator was charged with battery and seen by the Criminal Justice Liaison and Diversion Service whilst in custody. The Service had access to his mental health records, but he presented as calm and showed no signs of relapse in his

mental health, there were no apparent requirements for mental health services at this time.

4.33 The perpetrator was released on conditional bail and a marker put on Stephanie's home address to enable an emergency response should any further reports occur. Although the police investigation of the incident progressed thoroughly, the initial incident report was not available and so there was very little recorded regarding the contact they had had with Stephanie. Moreover, Stephanie was not advised until two days later that the perpetrator had been bailed, by which time he had made contact with her in breach of the conditions of his bail, and she began to disengage from the police. She went on to contact the police a number of times stating that she had made false or exaggerated claims and wanted to change her statement. She also changed her mind about wanting a restraining order against the perpetrator.

Arranging a termination of pregnancy

4.34 In July 2019, Stephanie consulted her usual GP stating that she was 7 weeks pregnant. She said that she had been in an on-off relationship with the named perpetrator for three years and that the pregnancy was unplanned. As she was unsure of what to do, she wanted to have a scan before deciding for certain. The GP gave her details of the British Pregnancy Advisory Service (BPAS) and Stephanie called them to arrange a consultation.

4.35 After missing her first appointment, she attended the BPAS one month later with a male who was recorded as her partner, but whose name was not disclosed. She was initially seen alone as is normal practice and disclosed that it was an unplanned pregnancy and that she lived alone. She had also partially completed a self-assessment medical questionnaire whilst in the waiting room in which she minimised her drug and alcohol use and stated that she felt safe at home. She went on to complete the remainder of the self-questionnaire on her own with the nurse where she disclosed that her partner was not aware of the births of her last five children, or that they had been adopted, and therefore only wanted two of her children disclosed on these records. She was made aware that BPAS had a duty to inform children's services of the pregnancy.

4.36 An ultrasound revealed that she was 12 weeks pregnant, and, with her partner present, she declined to discuss abortion options, but called back 3 days later requesting to go ahead with the treatment. However, she either cancelled or did not attend the following 5 appointments. Once she was able to attend, she declined to complete the treatment as she felt that she could not tolerate the

procedure under local anaesthetic and wanted a general anaesthetic.[8] This procedure was not available at the local BPAS clinic but would have to be undertaken in their London clinic and an appointment was made for 12 days later which she did not attend, and which was rebooked.

Conviction for assault

4.37 In August 2019, the perpetrator pleaded guilty to assaulting Stephanie[9]. A pre-sentence report was completed by the National Probation Service, through an interpreter, identifying that the perpetrator had a "distorted perception of a healthy relationship and exhibited traits of controlling and entitled behaviour towards Stephanie ... [and his] … understanding of victim impact was very limited." The report went on to identify that Stephanie was pregnant with his child which increased the risk of his future offending; that he suffered from depression; had disclosed weekly alcohol and cannabis use and had been assessed as posing a medium risk of serious harm to intimate partners. The report author proposed to the Court that the perpetrator undertake a community order with a rehabilitation activity requirement of 20 days to include the 'Safeguarding' and 'Exploring Relationships' programmes. This domestic abuse programme was to be delivered on a one-to-one basis as he was not considered suitable for the 'Building Better Relationships' group work programme due to his language difficulties.

4.38 Although initial enquiries were made of the Police about domestic abuse, and email notifications sent to the MASH and Children's Services on the day of sentencing, it was noted that the relevant safeguarding referrals and protocols were to be completed by the Community Rehabilitation Company who were to take over his supervision post sentencing. It was not known by probation services at this point that Stephanie had had previous children removed into care.

4.39 The perpetrator was sentenced to a 24-month community order with a rehabilitation activity requirement in keeping with the proposal from probation. However, Stephanie phoned the Witness Care Unit, unhappy with the sentence that he had received.

4.40 Thereafter the reported to probation services in line with reporting requirements with an interpreter present during these interviews. He was determined to pose a medium risk of serious harm to Stephanie and a low risk to others. Safeguarding

[8] Stephanie had previously told her father that one of her previous terminations had been particularly unpleasant and this may have impacted upon her desire for a general anaesthetic.
[9] Assault by beating

checks were undertaken regarding the perpetrator but the probation officer had not read the pre-sentence report and did not realise that Stephanie was pregnant.

4.41 At the start of September 2019, Stephanie consulted a GP at her local practice with a cough and, after advising that she was not pregnant, a chest x-ray was planned. It appeared that the pregnancy was being concealed at this point.

4.42 Stephanie contacted London BPAS in early September, advising that she had no money to attend the clinic and had no-one to accompany her during the day. The procedure needed to be re-arranged a further 3 times and BPAS arranged travel on each occasion. However, when Stephanie became 18 weeks pregnant, the number of missed or cancelled appointments, prompted BPAS to contact her GP Practice. Her usual GP was not available, and they awaited a call back from the duty doctor. This call was made on the Thursday, four days before she was killed.

4.43 On the following day, BPAS made a referral to Children's Services advising that a further appointment was booked and requested that someone attends with her, but Children's Social Care advised that this was not a service that they could offer.

4.44 On the same day, Stephanie's mother contacted the MASH, via Adult Services, advising on the background and her daughter's missed appointments at the clinic. She requested that if her daughter wanted to continue with the pregnancy then there should be a plan in place to support her.

4.45 On the Monday, a pre-birth assessment request was sent to the John Radcliffe Hospital Social Work Team and was due to be allocated and arranged on the Wednesday. In the meantime, on the Tuesday, Stephanie spoke with BPAS about her intention to attend the clinic 3 days later, but she was killed later that evening.

5. OVERVIEW OF AGENCY INVOLVEMENT

5.0 This section considers the Individual Management Review and Information Reports completed by individual agencies and the outcomes of discussions with the review panel concerning improvements to services in the future.

Criminal Justice Agencies

5.1 Thames Valley Police

5.1.1 Thames Valley Police assessed their various responses to reports of anti-social behaviour; abandoned 999 calls made by Stephanie; incidents of domestic abuse; wider offences; arrests and in response to the perpetrator's mental health. In

many responses to reports concerning Stephanie, officers dealt with these effectively despite varying degrees of engagement with Stephanie.

5.1.2 In respect of the reports of domestic abuse from Stephanie's previous partner, Thames Valley Police assessed their response to the serious assault incident in June 2017. In this incident, Stephanie reported a stabbing from the previous day. She was reporting from the hospital where she was receiving treatment but the initial response from the police was slow and the delay in this case was not addressed according to the Force's escalation policy. It was assumed that Stephanie was safe in hospital even though the named offender was still at large. The police did not consider the ongoing risk of further harm once she had left the hospital and how best to manage it and the Force has taken this as a learning point.

5.1.3 Stephanie had made five calls to the police since 2016 which were either abandoned or made in error and each time she was spoken with, she confirmed that all was in order and no further action was undertaken. It was taken as a learning point that two of these calls, in which she either sounded distressed or a disturbance was evident, should have prompted background checks by Contact Management and a review by the duty supervisor to determine whether police attendance was necessary.

5.1.4 In respect of the anti-social behaviour, Thames Valley Police considered background checks had also not been undertaken by Contact Management and insufficient information was thereafter gathered by officers at the scene from the neighbours or those reporting concerns. There was little recorded information and officers were only dealing with what they found in front of them. Although officers ascertained Stephanie's welfare from her presentation, no risk assessments were documented. On another occasion, an un-identified male was present and had been reported as arguing in the bedsit but there was no indication that his identity had been sought. The more recent introduction of the Contact Management Platform within Thames Valley Police will enable background information to be automatically populated in the future and provide vital background information to attending officers.

5.1.5 Officers were sent to a report of a noise disturbance, and it was reflected that there was, at times, a lack of professional curiosity demonstrated by officers who only dealt with what they found in front of them when they arrived on scene. There appeared to be little recorded investigation as to what may have triggered the calls in the first place. At the time of writing, Thames Valley Police were in the process of delivering domestic abuse training across the Force. The College of Policing's 'Domestic Abuse Matters' cultural change programme aims to change

the attitudes, culture and behaviour of the police frontline response to domestic abuse and coercive control.

5.1.6 Whilst Stephanie had been subjected to repeated domestic abuse from previous partners, she had not reported any abuse from the perpetrator until the incident three months before her homicide. We have seen that her response to the domestic abuse risk assessment revealed some very concerning behaviours but, by the police's Contact Management unnecessarily creating a duplicate crime record, the process of tasking the MASH and facilitating further risk management with Stephanie did not take place. It was not evident to officers or supervisors that the tasking process had broken down. As a result, electronic prompts have been put in place within the relevant templates and their supervisors to ensure that these taskings are created in the future. As an additional safety net, each Local Police Area is also sent a daily record of cases that are untasked and require attention.

5.1.7 The domestic abuse risk assessment that was undertaken in this incident, revealed three or four previously unreported incidents of assault, each of which should have been considered and investigated. The review accepted that Stephanie gave very little detail of these incidents and claimed to be unable to provide more information which would have made them difficult to investigate. Nonetheless this becomes a learning point for the Force.

5.1.8 The review went on to consider the police's contact with Stephanie after this assault. Although the officer in charge claimed to have maintained regular contact with Stephanie, this was not recorded in line with the Code of Practice for Victims of Crime in England and Wales (MoJ, 2015)[10], hereinafter referred to as the Victims Code. Thereafter, Stephanie was not made aware that the perpetrator had been charged and released on conditional bail until two days later at which point, she disclosed that the perpetrator had already contacted her. This resulted in Stephanie appearing to lose confidence in the process and stating that she did not feel protected. Indeed, she should have been notified about his release and the conditions of bail within 24 hours (MoJ, 2015).

5.1.9 Thereafter, the recording of this incident was not subject to a supervisory review given that the offender had been arrested and charged with the crime. Such a review could have set actions around victim contact, the pursuance of the breach of conditional bail and addressed the failure to task this incident to the MASH. Although Thames Valley Police were able to secure a prosecution against the

[10] The Code of Practice for Victims of Crime in England and Wales has since been strengthened further (MoJ,2020)

perpetrator in this only reported incident of the perpetrator's domestic abuse of Stephanie, they recognised that there had been missed opportunities to build the confidence of Stephanie, strengthen her engagement with the police and take further action against the perpetrator for breach of his bail conditions.

5.1.10 Since 2019, Thames Valley Police has addressed shortcomings identified within a major programme of quality improvement, the Endeavour Programme led by the Assistant Chief Constable, which seeks to ensure that all crimes are investigated appropriately. A significant strand within this programme has been to improve the satisfaction of victims and to ensure police officers put the needs of victims at the heart of their approach. In this way, the quality and timeliness of contact with victims, the adherence to the Victims Code and victim satisfaction have each been subject to major improvement.

5.1.11 Despite this major programme of improvement, the Home Office Domestic Homicide Review Quality Assurance Group suggested that there would be value in adding recommendations for the police to ensure that the actions had addressed the shortcomings identified in this review.

Individual Recommendation: 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 justice 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

5.2 Probation Services

5.2.1 As the perpetrator was sentenced for assault only one month before he killed Stephanie, the involvement of probation services with the perpetrator was brief. During this time, the National Probation Service completed a pre-sentence report for court and Thames Valley Community Rehabilitation Company (CRC) took over his supervision for the month after he was sentenced.

5.2.2 Although the Responsible Officer[11] made the necessary checks with the police and children's safeguarding regarding the perpetrator, the pre-sentence report had not been accessed and it was therefore not known that Stephanie was pregnant with the perpetrator's child. The perpetrator minimised his involvement with Stephanie saying that that they were not in relationship but just slept together. The Responsible Officer had not known where to find the pre-sentence report in the system, as it had been stored in the wrong place. Had it been reviewed, it would have signalled an increased risk, the need for a home visit and a dialogue with children's services concerning the pregnancy. It was recognised that this issue of the passage of information between the two arms of probation services would be resolved with re-amalgamation of the service under the Probation Reform Programme (HMPPS, 2020)

5.2.3 The Responsible Officer was swift to identify a language barrier and demonstrated good practice in requesting an interpreter and revisiting the information provided at the induction meeting. Indeed, by doing so, the officer was able to identify a discrepancy in his reported alcohol use and mental health which he had later minimised.

5.2.4 Despite the index offence being domestic abuse related, the Spousal Assault Risk Assessment (SARA) had not been completed within the required 15 days of the initial appointment. The Responsible Officer was intending to complete the assessment once further information had been gathered from the perpetrator at the next visit. However, all the information to complete the SARA was available, including information from the pre-sentence report and from the Crown Prosecution Service and the Police. This information may not have affected the risk rating, which appeared accurate but would have provided an opportunity to explore risks and safeguarding in relation to the pregnancy and exposed the perpetrator's minimisation of the extent of his relationship with Stephanie. Thames Valley CRC have since put mechanisms in place to ensure that SARAs are completed in a timely way.

5.2.5 Thames Valley CRC have also identified that there were some shortcomings in the recording of the initial appointment case notes and adding equality information into case records and have made recommendations to address these points. The response of Thames Valley CRC has been subject to a Serious Further Offence Review (submitted to HMPPS on 07.01.2020) which also captures the recommendations and actions to address these shortcomings.

[11] The role of Responsible Officer in probation services is to carry out the statutory responsibility for delivery of community orders and Suspended Sentence Orders.

5.2.6 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.

Health and Social Care Agencies

5.3 Primary Care

5.3.1 Stephanie was generally seen by the same two GPs at South Oxford Health Centre who knew her well and often tried to enable her engagement with the Complex Needs Service and floating support[12] services and tried to engage her in harm reduction. She often attended the practice without an appointment, but the practice generally fitted her in nonetheless which was seen as a particularly flexible in response to someone with complex needs.

5.3.2 The GP Practice was not aware that Stephanie had been heard at MARAC in July 2017 or that she had head injuries in June 2019. Following a previous domestic homicide review in Oxfordshire, the local MARAC Review Group initiated a process in September 2017 whereby the representative from Oxford Health NHSFT would write to the GP of all victims discussed at MARAC meetings. In this way, GPs should be routinely informed about the role of MARAC in a person's life and the associated risks that high-risk domestic abuse represents. Oxford Clinical Commissioning Group has committed to auditing the process and examining what responses the letters generate.

5.3.3 Although the practice nurse raised a safeguarding concern with the GP when she had suspicions that injuries were due to an assault, safeguarding procedures encourage all professionals to act themselves if they have safeguarding concerns in case the message becomes diluted or inadvertently miscommunicated. The Clinical Commissioning Group has therefore recommended that all professionals in a GP practice should be reminded that safeguarding is everybody's business and that any concerns should be raised directly by the person with the concern.

5.3.4 Given Stephanie's known vulnerability and complex needs together with her extensive and alarming history of child protection interventions, the Practice were asked to consider whether they should have alerted Children's Services in July 2019 when Stephanie advised them that she was 7 weeks pregnant, irrespective

[12] Floating support means support in the community with issues such as domestic abuse, budgeting, life skills, drug or alcohol misuse. The support is not linked to accommodation and is therefore provided irrespective of the individual's housing situation.

of Stephanie's plans to see the BPAS. They considered that a pregnancy of 7 weeks was too early to make a referral, particularly as Stephanie was planning to approach the BPAS. This issue is taken up further in the thematic section which follows.

5.3.5 During the period explored within this review, the perpetrator attended initially Wood Farm and Bury Medical Centres and latterly at South Oxford Health Centre. He was mostly seen by the same GP at each of the medical practices and it appeared that the GPs tried hard to help him with referrals to mental health, housing, refugee, social and language support. However, for both Stephanie and perpetrator, GPs noted their difficulties in enabling their engagement with the support agencies or secondary care services that may have been needed.

5.4 Oxford Health NHS Foundation Trust

5.4.1 In the short interactions that Stephanie had with mental health services, clinicians were consistent in their clinical judgement that Stephanie had an Emotionally Unstable Personality Disorder.

5.4.2 Time had been taken to explore this diagnosis as Stephanie had described feeling a sense of it being a label. However, once she understood the meaning, she did not oppose the diagnosis and she appeared, at the outset, motivated to engage in the relevant treatment by self-referring to the Complex Needs Service as had been recommended to her. The Complex Needs Service operates within NICE Guidelines (2009) to meet the needs of those with Emotionally Unstable Personality Disorders through a psycho-dynamically informed therapeutic community treatment model.

5.4.3 Having self-referred to this Complex Needs Service, Stephanie thereafter did not attend the pre-assessment information session to which she was invited and did not respond to the follow-up letter and so was discharged from the service. It was noted that the effectiveness of this model of working has been shown to rely upon an individual being motivated and committed to engage and the demand for the service was high.

5.4.4 Stephanie had also been referred to the Acute Mental Health Team to enable signposting to other sources of support, particularly as domestic abuse had been identified as a cause of anxiety and trauma. As a result, Stephanie was signposted to Oxfordshire MIND and to the Eve Project which offered individual and group counselling for women who have experienced domestic abuse. However, the review recognised that Oxfordshire Domestic Abuse Service has a dedicated programme for women with multiple needs, the TAP Programme, and this may

have been a more bespoke referral in this case. Indeed, the Trust has recognised that it did not have a comprehensive menu of support services that were available but has since centralised its safeguarding team and has a MIND options worker based with them, both of which initiatives have strengthened their capacity for referring to relevant partner agencies. Nonetheless, the Trust has committed to further strengthening practitioner knowledge of the pathway to the commissioned domestic abuse services and specialist services for women with multiple needs in their area.

5.4.5 In respect of the Trust's engagement with the perpetrator, there was consistency in their understanding his earlier diagnosis, in 2016, as being a drug induced acute psychotic episode which had responded well to treatment. His care focussed on medication maintenance, monitoring and actions to address his housing situation. Indeed, practitioners considered at the time that he appeared to be motivated to engage with the mental health team in order to gain suitable housing and once this was achieved, it was noted that his engagement with them deteriorated.

5.4.6 Thereafter, the Trust reflected on their response to the perpetrator's request to refrain from medication for a few months when a further period of psychiatric stabilisation on medication may have been prudent. It was established that the compromise was reasonable in so far as the perpetrator was willing to engage in support and structured activity; to self-report about his wellbeing and to decrease in cannabis use.

5.4.7 The risk assessment undertaken by the Care Co-ordinator following the perpetrator's psychotic episode identified a series of risks in relation to when he was unwell. Although at that time, they were unaware of his relationship with Stephanie, no specific risks to others or children were identified. However, there were factors not known about when he was well, such as in regard to sexually disinhibited and inappropriate behaviour. The Trust had shared information with housing services when the perpetrator was discharged from hospital, but this was not refreshed with them when he was latterly discharged from mental health services, despite him continuing to live in multi-occupied temporary accommodation. This was explained by virtue of there being no ongoing relationship between mental health services and housing. However, the Trust has recognised that the temporary accommodation provider would have benefited from being advised of his discharge from mental health services, signs of relapse and advice on emergency referrals into services should that be required and have made an individual recommendation for themselves on this point.

5.4.8 Although the perpetrator's earlier psychosis was seen to have been drug induced, his pattern of cannabis use did not induce a relapse in his mental health and was not seen to be an issue of concern from a dual diagnosis perspective. Indeed, the

perpetrator consistently denied his drug use to mental health services. He also kept services at arm's length, and so it was neither possible to determine how problematic his substance misuse was, and whether the threshold for consideration under the dual diagnosis pathway had been met, nor have meaningful discussions to encourage him to engage with substance misuse services at that time. Nevertheless, he was provided with contact numbers for Turning Point, which was considered by the panel to be a proportionate response in the circumstances.

5.5 Oxford University Hospitals NHS Foundation Trust

5.5.1 Stephanie was known to the John Radcliffe Hospital throughout her maternity history and through attending the Emergency and Trauma Departments. The hospital had identified her vulnerability and needs concerning her experiences of long-term drug and alcohol misuse, periods of homelessness, mental health, self-neglect and child protection concerns. Whilst they were unaware of Stephanie's relationship with the perpetrator, they were aware of her experience of domestic abuse within a number of different relationships and had made a MARAC referral when her high risk was identified.

5.5.2 It was evident that each of the teams had worked hard to try to engage with Stephanie in each of the hospital setting. In particular, during her earlier maternity periods, she had been supported by an Assistant Practitioner because of her vulnerabilities and to help her to engage with ante-natal services. This Assistant Practitioner offered to be her birthing partner in the absence of her volunteering anyone else. Moreover, recognising that she would struggle to attend antenatal clinics, the midwife more frequently visited her at home. As a result of the child protection concerns and domestic abuse, there was significant safety planning undertaken by maternity staff. They made repeated attempts to refer her to additional agencies and to refer her to MASH and also, when her high risk was identified, to MARAC. Nonetheless, Stephanie mostly declined their support and hospital staff were not aware that many agencies were already involved with her.

5.5.3 It was noted that the Emergency Department undertook routine enquiry on domestic abuse when she presented with injuries and enlisted psychiatry when needed. Practitioners were attentive to the history of previous attendances; followed up concerns regarding children with their safeguarding team; escalated concerns to senior colleagues; undertook handover and referral to primary care. When Stephanie attended with a head injury in February 2019 and self-

discharged, the hospital clearly worked hard with the GP to try to contact Stephanie and enable further treatment.

5.5.4 However, when she contacted the Maternity Unit in September 2018 at 10 weeks pregnant with cramps, she had been adamant that she wasn't in a relationship. This resulted in practitioners not taking the opportunity to give advice on the impact of domestic abuse on an unborn child, and to only make the usual routine enquiry on domestic abuse. Whilst being able to demonstrate their adoption of an otherwise robust domestic abuse routine enquiry pathway, the Trust has recognised that they missed an opportunity to explore domestic abuse at this time and that routine discussion about risks from domestic abuse needs to be undertaken irrespective of someone's current relationship status. This has since been added into the Trust's policy and procedures. Moreover, the Early Pregnancy Unit has introduced the HARKS medical record prompts on domestic violence and abuse into its practice. The HARKS mnemonic (humiliation, afraid, rape, kick and safety), most commonly used within primary care[13], aims to remind health practitioners to make targeted enquiries about domestic abuse and offers a pop-up electronic prompt when symptoms or conditions associated with domestic abuse are being entered into records.

5.5.5 On several occasions, Stephanie did not attend follow-up appointments. This was particularly evident when she did not attend for plastic surgery to the scarring to her arm after she had defended herself from a knife attack from her ex-partner, and after her attendance at the Early Pregnancy Assessment Unit. It was noted that further follow-up was needed at this time and recognised that every department in the hospital needed to have a robust internal means of following up those that 'do not attend'. The panel discussed how methods internal to health agencies 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, too, has since been added into the Trust's draft policy and procedures.

5.5.6 Since this time, Oxford University Hospitals Trust has introduced the Lotus Maternity Team who provide casework support and continuity of care to vulnerable pregnant women. This dedicated service is seen as a good practice response to those with multiple needs who need additional time and attention provided to their engagement and to meeting their needs.

[13] HARKS medical records prompts for domestic abuse are an element of the Identification and Referral to Improve Safety (IRIS) domestic abuse programme used increasingly in primary care and sexual health settings. For more information see https://irisi.org/iris/about-the-iris-programme/

5.5.7 In addition to this, the Trust has recognised the particular value that having a co-located Independent Domestic Violence Advisor within the critical areas of the Emergency and Maternity Departments. As co-location is necessarily a multi-agency activity, a multi-agency recommendation has been made by the panel in this regard.

5.5.8 The Trust has also made recommendations for itself to ensure that supervision is recorded in patient's electronic patient records to reflect the complexity of support that has been needed and to aid multi-disciplinary consideration and response. The Trust recognised the particular pressure that staff are under when working with individuals with multiple and complex needs or from whom children would be taken into care at birth. They have therefore committed to providing psychological support and supervision for the purpose of both addressing staff stress and enabling alternative paths of action to be considered.

5.6 British Pregnancy Advisory Service (BPAS)

5.6.1 BPAS responded to Stephanie's wishes for a termination of her pregnancy and made significant efforts to enable her to attend the appointments which she frequently cancelled or missed.

5.6.2 Reflecting upon their safeguarding responsibilities, BPAS recognised that they had informed Stephanie that Children's Services would need to be informed if she intended the pregnancy to continue or if she went over the legal limit for a termination. They went on to make a referral to Children's Services and the GP following a number of failed appointments once Stephanie's reasonable explanations for missing these appointments had been exhausted. Although the BPAS was under the misapprehension that Children's Services would not accept a referral for a pre-birth assessment for pregnancies that were below 24 weeks[14], they were clear that they would nonetheless have made a referral as soon as it was clear that the pregnancy would continue, in view of Stephanie's history. However, on the two occasions that Stephanie cancelled an appointment, she had a good explanation and made positive attempts to rebook. In this way, BPAS were still confident that Stephanie intended to terminate the pregnancy until they were unable to contact her and then promptly made a referral to Children's Services at this time. Although this response was considered proportionate in the circumstances, BPAS were asked to reflect upon how staff may be prompted to

[14] Children's Services have made an individual recommendation for themselves to share information more widely about pre-birth assessments

consider earlier referral for women with multiple needs whilst balancing the need to keep the woman engaged.

5.6.3 Within BPAS policies, all vulnerable adults should have a safeguarding risk assessment completed and within their definitions, Stephanie would have been considered vulnerable by virtue of the previous removal of her children and her drug misuse. This was not completed for Stephanie because the forms were not readily available at that clinic at that time. An opportunity was therefore missed to further explore Stephanie's vulnerability and enable Stephanie to disclose the domestic abuse that she was experiencing. This risk assessment would require Stephanie to be asked specifically, "do you feel safe with the person you had sex with to make you pregnant?" whereas she had only completed a self-assessment questionnaire about her safety at home previously. The forms have since been made available and their use audited.

5.6.4 BPAS was aware that it was not favourable to send women out of area for a termination of their pregnancy. However, only certain clinics can perform surgical treatments, or late gestation abortions within legal time limits, under general anaesthetic due to the availability of surgical theatres. They therefore advised that they make every effort to treat women as early as possible in their pregnancy.

5.6.5 Once Stephanie had disclosed that she was struggling to fund travel to London, they offered her funding for herself and another person to accompany her, which she initially declined. Thereafter travel arrangements were made for her for every subsequent appointment. Due to the nature of the procedure, there was no clinical requirement for Stephanie to have someone accompany her, although funding was offered by BPAS for someone to accompany her if she wished.

5.6.6 As a result of this case, BPAS has committed to improve its responses by:

- Review Safeguarding Risk Assessment Forms to ensure chaperones are recorded in cases of domestic abuse.
- Implementation of a 'Did Not Attend' (DNA) policy to ensure that relevant agencies are informed in a timely manner when appointments are frequently missed or cancelled
- Reviewing their safeguarding policies and safeguarding training package to ensure that staff are aware of, and apply, their criteria for vulnerability.

5.7 Oxford City Council Housing Services

5.7.1 Housing Services initially provided Stephanie with temporary accommodation and thereafter a permanent home, whilst providing support through various teams and confronting her anti-social behaviour and rent arrears. They also provided the perpetrator with temporary accommodation and a permanent home although his need for support, despite his mental health, was seen as much less than that needed for Stephanie. In particular, the review considered how Stephanie and perpetrator met in temporary accommodation; what circumstances put these two vulnerable people together and the length of time that Stephanie stayed in temporary accommodation.

5.7.2 The perpetrator had been placed in the same block of self-contained accommodation units as Stephanie by the local authority's Allocations Team. The team were aware of Stephanie's history of abuse and had received the perpetrator's risk assessment from mental health services, but they were not aware of the perpetrator's violence towards others nor had much available choice in the accommodation being offered. The temporary accommodation units were self-contained with their own front doors and benefited from CCTV coverage in communal hallways as well as an additional level of support provided by fortnightly welfare checks by housing officers. The authority also noted that there has continued to be insufficient availability of accommodation to be able to arrange in single sex blocks and so vulnerable men and women, who may be violent or abused, could be housed adjacent to each other.

5.7.3 This absence of choice of accommodation may be partially relieved by the more recent adoption of the 'Housing First' programme and we shall see that this programme seeks to swiftly move multiply excluded vulnerable people into their own secure accommodation with dedicated support. In this way the programme could have the unanticipated benefit of alleviating some risks in temporary accommodation placement. The issue of the multi-agency approach to Housing First will be addressed in the thematic section which follows.

5.7.4 Stephanie had been in temporary accommodation for over three years and her move-on to permanent accommodation was initially delayed because she was not considered to be 'priority homeless'. Whilst the local authority had received evidence of Stephanie's diagnosis of Emotionally Unstable Personality Disorder and confirmation of her long history of psychological and emotional problems and drug and alcohol dependency, they had not considered that she would suffer greater injury or detriment from homelessness than the 'ordinary person' might,

which was the homelessness threshold applicable at the time[15]. Indeed, Stephanie's lack of engagement with the Mental Health Floating Support Team appears to have influenced the authority's decision that they had no statutory duty to rehouse her, but they gave her the opportunity to appeal against the decision. It was not until she became pregnant again that her eviction from temporary accommodation was cancelled and a homeless duty afforded to her. This homeless decision making was historic in this case and case law on homelessness has changed significantly in the intervening period. It was not therefore feasible for the review to assess the apparent counter-intuitiveness of a decision that an individual's inability to or unwillingness to engage with mental health services may have been seen as an indicator of lesser rather than potentially greater vulnerability and need. Neither was it within the review's scope to consider how Stephanie becoming pregnant again may have become functional for her as it provided an inadvertently positive influence upon her homeless status.

5.7.5 Latterly, Stephanie's re-housing was delayed because of her rent arrears and anti-social behaviour and the local authority was asked to consider whether this amount of time living in temporary accommodation may have exacerbated Stephanie's vulnerability. With reflection, they considered that the facilities of this block of temporary accommodation and support provided was the best available at the time for assessing and supporting the skills of tenancy sustainment that Stephanie would need.

5.7.6 Indeed, we have seen that the temporary accommodation officer provided Stephanie with much-valued, long term support before Stephanie was re-housed in 2017. However, after she had moved, the Tenancy Sustainment Team were unable to engage meaningfully with her. It was noted that the degree of background information that had been shared with the incoming teams for both Stephanie and perpetrator, was limited. Housing Services reflected that more in-depth handovers of information on vulnerable tenants leaving temporary accommodation was needed to ensure that the necessary level of support was flexibly maintained, or where appropriate, reduced in a structured way, and have made a recommendation for themselves to this effect. Moreover, a new database being introduced across Housing Services will ensure inter-departmental access to

[15] In October and November 2014, Oxford City Council applied what was commonly referred to as the 'Pereira test' to Stephanie's assessment homeless applications. The Court of Appeal, in Pereira v Camden Council, held that a person is vulnerable if their circumstances are such that they would suffer more when homeless than 'the ordinary homeless person' and would suffer an injury or other detriment that the ordinary homeless person would not. This test was overruled by the Supreme Court in May 2015.

current and background information to support future engagement and management of the transition between introductory and permanent tenancies.

5.7.7 It was evident that housing practitioners worked pro-actively with other agencies to harness the wider support that both individuals needed whilst in temporary accommodation and encouraged both individuals to engage with support.

6. THEMATIC ANALYSIS, LEARNING & RECOMMENDATIONS

6.0 Following on from the analysis of individual agencies responses, this section explores the thematic, multi-agency and system analysis that arises from the circumstances leading to Stephanie's homicide.

6.1 The impact of trauma and adversity

6.1.1 A growing body of research identifies the harmful effects that Adverse Childhood Experiences (ACEs) have on physical and mental health throughout the life course (Hughes et al, 2017). Stephanie had experienced an alarming range of early Adverse Childhood Experiences (ACEs) as well as experienced domestic abuse in each of her long term, intimate, adult relationships. Stephanie's parents recognised the significant impact that these early experiences had upon her throughout her life including consequences for her mental health, substance misuse, child removal and engagement with services and others. This combination of need would more recently be termed 'multiple disadvantage'.

6.1.2 Multiple disadvantage is a term used to refer to individuals who face a compounding set of problems. When used in relation to women, it usually refers to the compounding effects of domestic and other forms of abuse as trauma, and whose effects include a combination of mental ill-health, substance misuse, homelessness, poverty and the removal of children (National Commission on Domestic and Sexual Violence and Multiple Disadvantage, 2019). Indeed, the review was particularly alert to the complex grief and unresolved loss that will often accompany the repeated removal of children and which, for Stephanie, meant the loss of her seven children across the whole of her adult life. At the time of her homicide, Stephanie was further facing the risk of another pregnancy going to full term and for another child being removed from her care. We will see how recent investment in Oxfordshire seeks to address this growing concern about the

risk of subsequent removals of children from mothers who have had children removed into care, and the need to support this vulnerable population of women.

6.1.3 However, this focus of recent social policy on trauma was seen as a useful starting point to consider how a wide range of agencies and practitioners tried to engage with Stephanie and offer the support which they considered that she needed. Indeed, there was no doubt that many practitioners were working hard to try to engage with her: identifying her multiplicity of needs; trying to harness the range of services that she might need; demonstrating flexibility and some adaptability in their attempts to provide services. In order to shine a spotlight on the challenges these services faced and seek to understand the reasons why their attempts were largely unsuccessful, the review firstly explored how domestic abuse in Stephanie's life was indicated, manifested and understood.

6.2 Understanding and identifying domestic abuse

6.2.1 A key function of domestic homicide reviews is to contribute to a better understanding of domestic abuse (Section 7, Statutory Guidance).

6.2.2 Whilst Stephanie only reported the perpetrator to the police on one occasion, we have seen that she took the opportunity to disclose her fears about him which had been generated by the perpetrator's concerning and escalating domestic abuse towards her. She disclosed a range of his abusive behaviours included previously unreported assaults against her; being assaulted with a stick; his threats to kill her and himself; sexual abuse and obsessive jealousy. Later, during the pre-sentence assessment, the National Probation Service went on to identify the perpetrator's distorted perceptions of relationships and traits of controlling and entitled behaviour towards Stephanie.

6.2.3 It was noteworthy that Stephanie considered the perpetrator's behaviour to be escalating and unpredictable. Escalation of domestic abuse is often regarded as a means by which a domestic abuse perpetrator seeks to regain control and has been a frequent pre-cursor to domestic homicide (Monckton-Smith, 2018:19).

6.2.4 Moreover, this first report to the police was following Stephanie's attempts to separate from the perpetrator and she disclosed that he threatened to kill himself when she tried to separate. Separation is widely known to be key indicator and trigger of heightened risk, particularly when accompanied by a threat to kill oneself if Stephanie were to leave them (Stark, 2009). These tragic circumstances therefore add to the national body of evidence of domestic homicide risk

indicators contained within a decade of the Femicide Census (Femicide Census, 2020)

6.2.5 In her previous relationships, Stephanie experienced significant levels of domestic violence and abuse which, on many occasions, led or contributed to her children being removed from her care. Within the timeframe considered in this review, Stephanie was subjected to stabbing by her previous partner, providing a salient reminder that domestic abuse often does not end when a relationship ends. It is likely that these repeated experiences of domestic abuse will have contributed to a heightened degree of vulnerability in Stephanie.

6.2.6 We have seen above that health services play a critical role in identifying and responding to indicators of domestic abuse. Whilst improvements in Oxford University Hospitals' approach to domestic abuse was noted, so too was their desire to seek the resources with which to support a co-located Independent Domestic Violence Advisor (IDVA) in the Emergency and Maternity Departments of the hospital. This was seen to serve not only the individuals in need, but also support the ongoing professional development of staff in responding to domestic abuse.

6.2.7 To this end, the panel's attention was drawn to 'Pathfinder': a national project aimed at addressing the links between domestic abuse and health and improving the capacity of health professionals to respond to survivors effectively (Pathfinder, 2020). The Pathfinder was able to explore and articulate the particular advantages of health based Independent Domestic Violence Advisors (IDVA) located at critical points in health services, recognising the particular opportunities that Emergency and Maternity Departments bring (ibid). Survivors of domestic abuse are often seen in hospital in the immediate aftermath of a crisis and Health Based IDVAs have been able to provide immediate support to these survivors reducing risk and abuse earlier (ibid).

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

6.3 Multiple pregnancies as reproductive coercion

6.3.1 Stephanie was 19 years-of-age when her first child was born. Whilst this relatively young age for a first pregnancy is not untypical for young women who themselves

were taken into care during their childhoods (Roberts et al. 2019), there was then a gap of ten years before Stephanie became pregnant again. Thereafter she went on to have at least two terminations and six children over a nine-year period, with domestic violence and substance misuse being consistent factors in the removal of these children.

6.3.2 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 (Miller et al., 2010). Given the length of time that had elapsed, it was not feasible for the review to examine the extent to which earlier child protection proceedings considered the possibility of reproductive coercion. Health and social work practices have changed extensively in the intervening time. However, it should be noted for future practice that multiple pregnancies could have a range of causes. They could be indicators of risk taking and impulsivity, particularly in relation to someone with an Emotionally Unstable Personality Disorder. Equally, they could stem from the desire for another child where earlier children have been removed or be indicators of sexual assault and reproductive coercion. We shall see that the introduction of the Pause Programme in Oxfordshire will help to bring these considerations to the fore.

Learning Point: Reproductive Coercion

Practitioners must always consider the possibility of reproductive coercion where a woman has multiple pregnancies or late presentations to maternity services.

6.4 Removal of children and the Pause approach

6.4.1 Research has shown that women who experience recurrent removals of children from their care have experienced significant and multiple traumatic experiences in their own childhoods (Broadhurst et al, 2017). *Pause*[16], a national organisation specialising in intensive, trauma informed support to women who have experienced children removed from their care, have identified that 40 per cent of the women they work with have experience of care, 85 per cent have had mental health issues and 87 per cent have or are experiencing domestic abuse. At the same time, research suggests that following the compulsory removal of children, the plight of birth mothers all too easily falls outside service provision, leaving

[16] Further information about Pause can be found at https://www.pause.org.uk/

women to make their own sense of the lifestyle and relationship circumstances that have led to compulsory child protection intervention (Broadhurst and Mason, 2019).

6.4.2 A previous domestic homicide review in the area had identified the need to address these growing concerns about the repeated removal of children from vulnerable women and, as a result, Oxfordshire has recently commissioned *Pause* to provide this intensive, trauma informed model of support with the aim that the removal of a child should never have to happen to a woman more than once. A summary of Pause Oxfordshire can be found in Appendix A.

6.4.3 Evaluation of the programme, nationally, has shown that the critical success factor in this intervention, is that practitioners have the time, in terms of duration of intervention and capacity within workloads, the skills, knowledge and support to be tenacious in the tailored, responsive service that is offered (Boddy et al, 2020).

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 Oxfordshire women who have experienced domestic abuse

6.4.4 In terms of child protection, it was noted that it would be unusual for a GP practice to notify Children's Services when they became aware of a woman being 7 weeks pregnant, even with Stephanie's history. From the consultation it appeared that Stephanie was considering a termination and correctly signposted her to BPAS. However, with hindsight, the Practice reflected that her case should have been discussed at the Practice safeguarding meeting in order to receive support and supervision. Later in the pregnancy, we have seen that BPAS was under the misapprehension that Children's Services would not accept a referral for a pre-birth assessment for pregnancies that were below 24 weeks, although they were clear that a referral would have been made as soon as it was known that the pregnancy would continue.

6.4.5 What was evident was that Stephanie's considerable vulnerability and concerning history of child protection interventions warranted the involvement of Children's Services at the earliest feasible opportunity. A recommendation has therefore been made for Children's Services to share information more widely about pre-birth assessments.

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.

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.

6.5 Confidence in the Criminal Justice System

6.5.1 From a criminal justice perspective, the police reflected within their IMR that Stephanie had been very disappointed that the perpetrator had been given conditional bail after her disclosures to them. They reflected that this, together with the delays in notifying her of the perpetrator's release from custody, which has been addressed separately above, appeared to have led to her disengagement with them. It was considered that this incident may well have challenged her confidence in the criminal justice system to keep her safe. The use of conditional bail in this instance was not considered to be unusual in the circumstances, but clearly the timeframe in which this was explained to her was lacking and prevented opportunities for safety planning thereafter.

6.5.2 In respect of her previous partner's abuse, Thames Valley had proactively pursued a successful evidence-based prosecution on her behalf which was seen as good practice, although a summons was issued requiring her to appear against her will. It is not known whether the summons was issued or, if so, how this impacted upon her confidence in the criminal justice system is not known. However, panel members identified the benefit of having specialist domestic abuse support or Independent Domestic Violence Advisors assigned to victims and able to advocate on their behalf at such times.

6.6 Housing and temporary accommodation

6.6.1 The review noted that Oxford City Council is currently implementing the 'Housing First' model alongside partner agencies. Whilst the project is at an early stage, its objectives include reducing the period of time that multiply excluded individuals spend in temporary accommodation and providing them with secure accommodation with support from specialist agencies being made available flexibly to meet an individual's needs.

6.6.2 If undertaken in accordance with the Domestic Abuse Housing Alliance (DAHA) benchmarked method of working, this model has the potential to address some of the concerns recognised within this review about the lack of choice of single sex temporary accommodation; accommodating abused women alongside violent men in mixed-sex temporary accommodation blocks; the length of time spent in temporary accommodation and the challenges of providing sustained engagement and consistent support to multiply excluded homeless people, particularly those who have experienced domestic abuse. The City Council's more recent introduction of Domestic Abuse Housing Link workers will assist in the placement and support offered to domestic abuse victims in need of temporary accommodation

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.

6.6.3 In respect of the need for greater liaison between mental health and housing services where vulnerable people with mental health needs are placed in temporary accommodation, it was noted that in the intervening period, a mental health worker has been embedded temporarily in the housing team. It has been reported that the role has been particularly effective in accessing services where an individual's mental health was deteriorating. This is particularly relevant to this review as housing practitioners, despite being Mental Health First-Aid trained[17],

[17] Mental Health First Aid is an educational course which teaches people how to identify, understand and help a person who may be developing a mental health issue. In the same way as we learn physical first aid, Mental Health First Aid teaches how to recognize those crucial warning signs of mental ill health.

reported experiencing difficulties in accessing mental health services prior to this. At the time of writing, funding for the continuation of this role was being sought and a recommendation therefore follows in the event that funding applications are not successful.

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

6.7 Engaging women experiencing multiple disadvantage

6.7.1 There is a growing body of research which explores the needs of women with multiple needs experiencing domestic abuse (Alcohol Concern & AVA,2016; AVA and Agenda, 2017; Ava, 2019). Stephanie's long-term experiences of Adverse Childhood Experiences and domestic abuse left her vulnerable to further abuse from subsequent partners as well as experiencing problematic substance abuse, mental health issues and significantly, removal of multiple children into care. Research tells us that women having experienced abuse and the consequences of abuse in this way, will have particular needs which are rarely met by the way in which existing services are set up (Department of Health and Social Care & Agenda, 2018). Indeed, the National Commission for Domestic and Sexual Violence and Multiple Disadvantage recently recommended that

> *"services should work collaboratively to break down service silos and offer person centred, holistic support for women…Enquiry into current and historic domestic and … [historical abuse or neglect] … should be standard practice …Where abuse is identified, there must be appropriate trauma-informed support and pathways into care…"* (AVA & Agenda,2019, p.54)

6.7.2 The report from the national Women's Mental Health Taskforce described 'trauma-informed' services as those "which recognise the impact of trauma, often through violence and victimisation, avoid any likelihood of re-traumatisation for staff or service-users and which identify recovery from trauma as a primary goal" (Department of Health and Social Care & Agenda, 2018:37). Moreover, trauma-

informed practice acknowledges behaviours, which may be erratic or problematic, as legitimate responses to life events.

Learning Point: Trauma and gender informed practice
Individuals who have experienced trauma may behave in ways which appear risky, erratic or problematic in some way and 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.

6.7.3 The Taskforce further recognised that trauma-informed services are complementary to gender-informed services, which take account of and respond to the particular lives and experiences of women. Trauma-informed services:

> *"ensure that staff have the right competencies to work with women, that the environment makes women feel safe and welcome, and that appropriate structures are in place to be able to deliver this kind of service. These types of approaches also take account of the ways in which different parts of a woman's identity can overlap and result in different experiences of disadvantage*" (Department of Health and Social Care & Agenda, 2018, p.33)

6.7.4 We have seen that the review found many examples of positive efforts being made to engage with Stephanie over a number of years. Indeed, it was evident, through the consistent, long term, relationship that she was able to establish with the temporary accommodation officer that it was possible to build a relationship of trust with her, with time and in the right way and that she was disadvantaged when this professional relationship ended. At the same time, Stephanie complained on at least one occasion, that there were too many practitioners involved with her. These two points drive the value of having a long-term key worker to work with individuals experiencing multiple disadvantage.

6.7.5 It was therefore reassuring to see Oxfordshire's commitment to providing service models that incorporate: a trauma-informed key worker; harnessing and co-ordinating multi-agency wrap-around services; intensive casework support and safety planning. Indeed, in the intervening time since the death of Stephanie, Oxfordshire has developed a range of such services:

- the Pause Programme (detailed above)
- Housing First (detailed above)
- Oxfordshire Domestic Abuse Services' 'TAP' Programme
- Oxford University Hospitals' Lotus Maternity Services for women with multiple needs

6.7.6 Approaches to engagement with individuals experiencing multiple disadvantage often refer to the need to arrange services in different, more flexible and responsive ways such as with pro-active, assertive outreach rather than being reliant upon self-referral, individual motivation or traditional service models. It is clear from these more recent initiatives that the local area is responding to the drive for these new directions in public services. However, Stephanie may have qualified for any one of these programmes and consideration has to be given to how it will be determined which delivery model is best suited to individual domestic abuse victims with a wide range of needs who fall below the high-risk threshold of Multi-Agency Risk Assessment Conferences (MARAC). Moreover, practitioners working outside of these specific programmes also need to be trauma and gender informed and to be thinking more openly and creatively about how to engage and sustain the engagement of individuals who have experienced trauma as well as ensure that referrals to substance misuse services are enabled when that is a feature.

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
- promotes active referrals and engagement with substance misuse services

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

6.8 Language barriers

6.8.1 There appeared to be some difference of opinion amongst agencies regarding the perpetrator's command of English. However, most agencies recognised that his English could be poor, particularly at times of stress, and either used interpreters or Language Line to assist with assessments and medical reviews. It was significant that probation services found inconsistencies in the perpetrator's narrative when

they introduced an interpreter into their meetings with him. It was not known whether the perpetrator was illiterate in his own language as well as in 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.

6.9 Cultural attitudes

6.9.1 The perpetrator is thought to have left the Kurdish region of Northern Iraq when he was twenty years old. Throughout his formative years, his home country had been subject to war, dictatorship, international sanctions and religious conservatism. Within this environment, the Kurdish population, to which he belonged, were subject to systematic state violence, oppression and socio-economic marginalisation and experienced widespread illiteracy and poverty (Unifem, 2005; Alinia, 2013).

6.9.2 The personal impact of the trauma of having to flee his war-ravaged home country was not known to this review. It could reasonably be anticipated that these traumas may have impacted upon his mental health, substance misuse and mistrust of authorities, particularly as he sought asylum on the basis of fears of his government. His journey to the UK after leaving Iraq was not straightforward and is known to have involved criminal behaviour. It is possible that his vulnerable position during this precarious journey may have left him open to further exploitation and abuse.

6.9.3 Research has indicated that living through such times of persistent conflict could have the effect of normalising violence, and could impact upon an individual's sense of self, manhood and masculinity (Alinia, 2013). Moreover, the cumulative effects of his early life experiences may well be seen within the context of Adverse Childhood Experiences, as indeed Stephanie herself experienced.

6.9.4 Stigma surrounding mental illness is prevalent in most cultures. However, as the perpetrator's mental health deteriorated, the stigma around mental health that is particularly prevalent amongst the Kurdish community (Bolton et al, 2013) may have presented him with a barrier to engagement and receiving support from his community.

6.9.5 Likewise, women's inequality and violence against women, are a universal phenomenon and it is important not to make assumptions concerning cultural attitudes. At the same time, it is also important to recognise the intersecting oppressions within a culture that may potentially contribute to an individual's attitudes. Indeed, we have seen that the perpetrator's formative years were spent in a deeply patriarchal society. During his teenage years in the 1990s, national legislation in Iraq legalised many kinds of violence against women,[18]restricted women's access to public life and restricted women's freedom of movement (United Nations/World Bank, 2003:51). The decade that followed, resulted in alarming increases in violence against women and femicide in the name of honour across Iraq and Iraqi-Kurdistan (OCHA, 2005; United Nations/World Bank, 2003).

6.9.6 The extent to which prevailing patriarchal cultural attitudes toward women, relationships, inter-ethnic relationships, marriage, pregnancy, abortion and violence against women, impacted upon the perpetrator's later attitudes is not known. For example, it is not known whether the prospect of an abortion or birth of an illegitimate child may have raised issues of 'honour' for the perpetrator and led to so-called 'honour-based' violence within this context. In turn, the review considered the possibility that the perpetrator's attitudes to the pregnancy may have resulted in his being coercive around the termination. Again, this is not known and the only potential indicators that may give rise to considerations of coercion concerned Stephanie repeatedly postponing the termination, although BPAS were rigorous in exploring this possibility.

6.9.7 The review found no evidence that the perpetrator was embedded in the Kurdish diaspora and any consequent cultural influence thereafter during his adulthood. We have seen that he may have isolated himself from the Kurdish community as a result for fear of a perceived stigma attached to his mental ill-health.

6.9.8 Although we have seen that probation services identified the perpetrator's distorted perspectives and controlling attitudes towards women and relationships, in the main, agencies did not have the opportunity to explore the impact of his background upon him as they were unable to sustain meaningful engagement at that level. Mental health services were able to establish that he no longer followed his religion but sought to encourage his connection with the mosque for the support services that they provide. They also tried to link him into

[18] Law against domestic violence was re-introduced in 2011 by the Kurdish Regional Government and a National Strategy to Confront Violence Against Women was implemented in 2012, several years after the perpetrator had left the country

refugee services which would have been well placed to explore the impact of his background further. There was no indicator that he engaged with any of these services.

6.10 Good practice

6.10.1 During the course of the review, attention has been drawn to considerable elements of good practice which are worthy of restating here.

6.10.2 The temporary accommodation officer that developed a positive, trusting relationship with Stephanie over a period of two years was seen to have gone 'above and beyond' the expectations of her role. In doing so, she demonstrated the value of care, consistency, flexibility, positive regard and tenacity. Moreover, the worker had made it clear that she would always respond to Stephanie if she had contacted her even after moving on from her post.

6.10.3 The Tesco delivery driver should be commended for trying to protect Stephanie from the perpetrator by shielding her in his van until the police arrived. As the Domestic Abuse Bill makes its way through Parliament, much work is being undertaken nationally to expand the role of employers in responding to domestic abuse (Department for Business, 2020). Whilst this work focuses primarily upon employer's responsibilities to survivors within their workforce, by implication, it will extend the knowledge and responsiveness of business environments to domestic abuse. Moreover, the circumstances of this review highlight the role that we all drawn to play, in a wide variety of settings, in protecting each other from domestic abuse.

6.10.4 The Panel recognised that many Children's Services in England will not automatically undertake pre-birth assessments for pregnancies under 24 weeks. The commitment of Oxfordshire Children's Services to undertake pre-birth assessments as soon as the pregnancy has reached 12 weeks, was recognised to be good practice, enabling a longer period of time for the social worker to work with the mother in advance of the birth of a child. Children's Services has committed to raise awareness of this policy and practice amongst its partner agencies.

6.10.5 The introduction of new ways of working in the Pause Programme; Lotus Maternity Team and Housing First can each be seen as a prioritisation of investment and the determination of Oxfordshire to bring some of the most disadvantaged people in from the margins of society.

7. CONCLUSION

7.1 Stephanie had experienced domestic violence and abuse for much of her adult life. She also suffered those life experiences that are often seen as the consequences of abuse as well as having been removed into care as a child. These consequences included substance misuse, mental ill-health, homelessness and her own children being removed from her care.

7.2 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.

7.3 Significantly, Stephanie's vulnerability was manifested by the need to permanently remove six children from her care. Indeed, the review highlighted the need to be alert to reproductive coercion as a potential element of multiple pregnancies. The introduction of the Pause Programme was seen as particularly welcome in seeking to prevent such trauma for women and children in the future.

7.4 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.

7.5 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. It has also recognised the potential of Oxford's homeless pathway and Housing First initiative in mitigating some of those risks.

7.6 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. 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.

8. RECOMMENDATIONS

8.1 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

8.2 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 (TV-CRC)

- 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.

- Thames Valley Police 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

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Appendix A: Pause Oxfordshire

About Pause and Pause Oxfordshire

Pause Oxfordshire is a small team of five that was established in March 2021 and is a team based within Oxfordshire County Council. Pause Oxfordshire works with women who have experienced having children removed from their care. We offer an intensive, trauma informed model of support to women, so the removal of a child should never have to happen more than once. We work with women for up to 18 months when they are not pregnant and do not have children in their care and it is a voluntary programme and cannot be part of a court order or child protection plan. There is more information about Pause on the website www.pause.org.uk. Pause Oxfordshire is currently working with 23 women who have had 70 children.

Women who work with Pause

Research has shown that women who experience recurrent removals of children from their care have experienced significant and multiple traumatic experiences in their own childhoods. Around 40% of women who work with Pause have experience of care, 85% have had mental health issues and 87% have or are experiencing domestic abuse. Women who work with Pause also have experience of the criminal justice system, homelessness and substance misuse.

Outcomes and impact

The independent evaluation of Pause published in 2020 Link to Evaluation found that the Pause Programme is effective in making a positive difference in women's lives, improving their relationships with children, reducing rates of infant care entry in local areas and delivering cost savings for local areas. Key findings included:

- The life satisfaction and wellbeing of women on Pause improved – moving from a very low level (in the bottom 5% of the UK population) towards population norms.
- Pause has a positive effect on quality of contact and relationships with existing children.
- Women on Pause experience reductions in frequency and number of A&E visits and increased access to other support services.
- The number of infants entering care is reduced by an average of 14.4 per year per local authority area that has a Pause. This is equivalent to 215 children over three years in five local areas.
- For every £1 spent on Pause, £4.50 is saved over four years, and £7.61 over 18 years.

The trauma informed, relationship-based work that Pause Practices provide is effective in achieving positive outcomes for women and local areas.